Approved: February 15, 1995
Date

MINUTES OF THE HOUSE SELECT COMMITTEE ON DEVELOPMENTAL DISABILITIES.

The meeting was called to order by Chairman Jo Ann Pottorff at 3:30 p.m. on January 18, 1995, in Room 522-S of the Capitol.

All members were present except: Representative Jerry Henry, Excused
Representative, Susan Wagle, Excused

Committee staff present: Patricia Pierron, Legislative Research Department
Gordon Self, Revisor of Statutes
Marian F. Holeman, Committee Secretary

Conferees appearing before the committee: George Vega, SRS Commissioner, Division MH&RS
Rep. Ed McKechnie
Dr. Darvin Hirsch, SRS Director, MRS

Others attending: See attached list

Chairman Pottorff reminded members of the trip to KNI on January 19.

SRS Commissioner George Vega presented an update on SRS's handling of developmental disabilities in the recent past (Attachment 1). Mr. Vega explained that in "What Do We Need From the Legislature?", p.9 para.(c) simply means one budget managed by one part of SRS for the entire developmental disabilities system, and a funding stream that moves with the individual. SRS did not pursue that line because of possible problems with funds going from the community to the hospital. Perhaps there should be a "proviso" to deal with that issue.

SRS goals were discussed. Mr. Vega also outlined current measures employed to prevent abuse, keep customers safe and secure.

At the request of the Chairman, community service representatives and other interested persons attending the meeting introduced themselves to committee members and staff. (See attached list of "Others attending).

As a follow up to a summer 1994 interim committee, Representative McKechnie visited New Hampshire in the fall of 1994 (Attachment 2). Members discussed similarities/differences between the two approaches. The key seems to be to provide the least restrictive living situation possible. Dr. Darvin Hirsch also made the New Hampshire trip (Attachment 3). Among MRDD colleagues, New Hampshire is considered to be the state that is probably the most forward looking. The latest Developmental Disabilities dispatch has a good story of what they saw there. Dr. Hirsch would be happy to provide copies to interested persons.

Minutes of the January 10 meeting were distributed. Representatives Gilmore and McKechnie suggested the word "children" be deleted and "Kansans" substituted in paragraph 1, line 2. The minutes were approved as amended.

The committee will meet again Monday, January 23, in Room 521-S at 3:30 p.m.

Chairman Pottorff adjourned the meeting at 4:30 p.m.

HOUSE SELECT COMMITTEE ON DEVELOPMENTAL DISABILITIES COMMITTEE GUEST LIST

DATE: January 18, 1995

NAME	REPRESENTING
Doug Bowman	Coordinating Council Early Childhood Dev. Serv.
Gina McDonald	KACIL
Anita Aldrich	RCIL
Josie Torrez	Families Together, Inc
Bob Geers	The Arc of Kansas (Formally The Kansas Assn for Retarded Citizen)
martha Hodgesmith	KARF
Don Pendergast	Arrowhead West, Inc.
Patti [illegible]	Starkey, Inc.
Mark Elmore	Jo. Co. M.R. Center
Bill Brotton	Sg Co (Starkey Inc)
Darwin Hinrich	SRS/MH&RS
TK Shively	KS Legal Services Inc
Sue Chase	KNFA
Karen [illegible]	KAEB
Jane Rhys	KS. Dev. Dis Council
Sharon Spratt	Cottonwood Inc.
Jim Blume	DSNWK - Hays

Kansas Department of Social and Rehabilitation Services

Testimony Presented to
House Select Committee on Developmental Disabilities

January 18, 1995

Janet Schalansky, Acting Secretary
Department of Social and Rehabilitation Services
(913) 296-3274

SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

House SC - Developmental
Disabilities
1-18-95
Attachment 1

1-1

January 18, 1995

INTRODUCTION

Thank you for the opportunity to speak to this Select Committee on Developmental Disabilities regarding services to Kansas citizens with mental retardation and other developmental disabilities. I would like to provide a short perspective of the tremendous change that has occurred over the last five years.

The course and direction of MR/DD services has been thoroughly discussed and reviewed in recent years:

> **Gettings/Smith Report:** In early 1990, nationally recognized leaders, Robert Gettings and Gary Smith, staff with the National Association of State Directors of Developmental Disabilities Services, came to Kansas to review the state of the state and provide recommendations to the Senate Ways and Means Subcommittee and House Appropriations Subcommittee regarding future activities to expand Community MR/DD services. Three major recommendations were presented:
>
> 1. Cease development of and dependence on Intermediate Care Facilities for Mentally Retarded (ICFs/MR),
> 2. Develop community services through expansion of the Home and Community Based Services (HCBS-MR) waiver.
> 3. Increase the level of staffing to administer MR/DD Services in Kansas.

Their written report is available for review.

> **MH&RS Advisory Committee:** In 1990 MH&RS convened over 20 key stakeholders over an 18 month period to develop a Draft Plan which, in part, utilized the Gettings/Smith recommendations. The membership of the committee and draft service plan outline are attached. (Attachment 1)
>
> **Legislative Interim Committee of 1990:** The legislature convened an interim committee under the chairmanship of Representative Pottorff to further review the state of MR/DD services.
>
> **The Plan:** In 1991 an interim committee chaired by Representative Blumenthal reviewed the MR/DD Advisory Committee Draft Plan and, after finalizing it, adopted it as a general approach to further development of Community MR/DD services as part of the report of the Task Force on Social and Rehabilitation Services. A copy of the Subcommittee Report of the Legislative Task Force of 1991 (Attachment 2) is in your packet.

A copy of the final MR/DD Services plan is also in your packet. A quick overview of the essential needs and expectations of the plan can be found on pages 7-9.

REVIEW PAGES 7-9 WITH COMMITTEE

Follow-up Legislative Interim Committees: The legislature convened two subsequent interim committees to review progress on the plan, assess problems and determine if key policy decisions needed to be made relative to the development of Community MR/DD services.

Independent Review of Community Placements: In 1993 Lyn Rucker and David Powell independently reviewed the community placement process. Their review gave high marks to the values and concepts adopted in the placement process. In 1994 Legislative Post Audit also did a review of the community placement process with an eye for determining where there were bottlenecks. (These reports can be made available for anyone who wishes to do further research.)

These reviews and discussions have all resulted in reinforcing some basic principles which everyone involved with the MR/DD service system can support.

BASIC PRINCIPLES

Person Centered Services: All services for individuals who are MR/DD should relate to the needs, wants and desires of the individual and those who know and care about them.

Choices: To the extent practical and possible, individuals and those who know and care about them should be given a wide array of informed life choices and the services to support them in safety.

Children are Best Reared in Families: Affirmative, positive, responsive efforts should be made to increase family support and, if necessary surrogate family options, so that children can remain in families and not be placed in institutions.

Opportunities for Inclusion: Individuals should have the opportunity to be valued members of their home community. Services should be directed to expand these opportunities since, by proven experience, inclusionary services are most often chosen when appropriate services are available. Expansion of segregated services should be discouraged because, by proven experience, they are chosen far less often when there are alternatives which support inclusion.

Consumer Direction: Individuals and those who know and care about them who want to direct what services are provided, who provides them, and how they are provided should be given that opportunity.

Expansion of Community Services: All new financial and service resources should be directed toward the expansion of community services. Every reasonable effort should be made to:

* Eliminate the community services waiting list

* Place individuals desiring to leave state hospitals into community services

* Provide family supports for those who need them.

Local Direction: Services should be provided and administered at the local level by private not-for-profit entities whose Governing Boards are:

* Responsive to all individuals who are MR/DD (and those who know and care about them) in their service area

* Responsive to the basic beliefs adopted in the State plan

* Responsive to good stewardship of public funds.

Quality Services: The best services are those which are responsive to the needs, wants and desires of the individuals and those who know and care about them. State government's role is to ensure a responsive service system is effectively operating in each local area and to ensure basic health and safety standards are met. Such a system cannot be adequately or appropriately replaced by regulatory oversight or professional/peer review.

Value Direct Service Staff: The people who make it possible for these basic principles to be implemented on a daily individual level are direct service staff and service coordinators. These critical people should be valued by:

* Providing adequate salaries and benefits

* Providing recognition and appreciation

* Allowing reasonable autonomy and responsibility at the level closest to the individual served, and; by

* Avoiding unnecessary professional intrusion and oversight.

Stewardship of Public Funds: Sufficient funds should be provided to achieve implementation of these basic principles and not one dime more. Funding should:

* Support the basic principles

* Include Kansas' "fair share" of federal funds.

APPLICATION OF BASIC PRINCIPLES

MH&RS attempts to apply these basic principles in the following ways:

Placements - One Person at a Time: Individuals living in state hospitals and people who know and care about them are regularly and supportively asked if they would prefer to live in community settings close to home. It is the policy to never force an individual to be placed. If they agree, personally tailored services are designed and funded to support their needs.

Training and Reinforcement of the Basic Principles: Along with many other organizations MH&RS provides regular and frequent opportunities to train and reinforce the basic principles through:

* Support for Direct Service Staff Training

* Presentations, meetings and seminars

* Conferences

* Newsletters and Reports

* Research

Family Support Services: MH&RS started providing long term family support services through Family Subsidy, Family Support Grants and enabling children to be served with HCBS/MR funding in 1990-91. Most recently initial funding was approved for the Parent Assistance Network which will help reduce reliance on professional case management and could provide a much needed point of coordination for family support services. MH&RS will continue to emphasize these services.

Expanding and Refinancing the HCBS/MR Medicaid Waiver: The Home and Community Based Services Waiver for individuals who are MR/DD (HCBS/MR) allows the federal medicaid program to provide 60% of the cost of community services. Recently, Kansas received approval to greatly expand the number of people whose services are funded by the HCBS/MR waiver. MH&RS is working with service agencies and advocates to use already

1-5

existing funds to match federal medicaid funds through the HCBS/MR waiver in order to:

* Greatly reduce the waiting list

* Raise average rates provided to service agencies

* Bring in a higher percentage of federal funds for community services.

Consumer Driven Quality Enhancement: Twelve (12) staff have been hired by MR/DD Services to work cooperatively with individuals, their families and service agencies to ensure each local area operates an effective consumer driven continuously responsive quality enhancement process. These staff are also responsible to ensure basic health and safety standards are met. A proposal is also being developed which will recognize national accreditation in lieu of licensure provided the community agency agrees to fully implement a consumer driven quality enhancement process. MH&RS believes this resolves the accreditation issue. MH&RS believes such a compromise is better than requiring state funded national accreditation.

Administrative Program Direction: MH&RS is taking affirmative steps to apply the basic principles through its administrative actions such as:

* Establishing a single comprehensive service agreement

* Expecting compliance with the open meetings and open records requirements

* Establishing minimum expectations for Governing Boards in grants and contracts. This would address the concern for establishing standards for Governing Boards raised by this committee.

* Promulgating regulations only when all other alternatives have been exhausted

* Supporting and encouraging the use of the Person Centered Planning process

Closure of Large ICFs/MR: MH&RS is committed to using the tools the legislature has given it to close a large ICF/MR. Effective November 1, 1994, KDHE decertified and denied the license of a large 49 bed ICF/MR in Medicine Lodge and MH&RS entered into an agreement with the ICF/MR to permanently close. Arrowhead West, a Community MR Center in Dodge City, took the lead in placing people from this facility back to their home areas. All individuals were placed and the

1-6

facility was closed effective November 30. Arrowhead West and the community agencies who participated in this closure did an exceptional job.

Gatekeeping: MH&RS will convene key stakeholders to develop, implement and finance gatekeeping for state hospitals and private ICFs/MR.

State Hospitals as a Team: State Hospital Superintendents have agreed to manage together as a single system as person centered placements are made and the hospitals continue to downsize.

FRICTION

These activities have caused friction because:

* There appears to be increased potential for the state to exercise control over local service agencies

* Many agencies, families and consumers are changing as fast as they can, causing personal and agency stress

* Parts of the current service system are being displaced because new options cause them to be chosen less often. Such services are:

  - State Hospitals
  - Group Homes
  - Private ICFs/MR
  - Work Activity Centers

* Major crisis, real and imagined, have caused stakeholders to clash publicly in a way which undermines confidence. Examples of these include:

  - Closure of Terramara, Inc.
  - De-licensure of Wyandotte Developmental Disabilities Services
  - Southwest Developmental Services, Inc. Governing Board decisions
  - Proposed State Hospital Closure
  - Questions of Quality of Community Services
  - Basic principles not being implemented in all areas of the state.

CURRENT STATUS

Included in your packet is the Annual Report for MR/DD Services for the fiscal year ending June 30, 1994. This report provides:

1. Short descriptions of services funded or licensed by MR/DD Services
2. Short descriptions of funding sources
3. A definition of eligibility for funding through MR/DD Services
4. An overview of services statewide.

REVIEW ANNUAL REPORT WITH COMMITTEE

ATTACHMENT 1

FOR REFERENCE

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

Mike Hayden
Governor

Mental Health & Retardation Services
Fifth Floor North
(913) 296-3561

Dennis Taylor
Acting Secretary

November 7, 1990

To: Mental Health and Retardation Services Legislative Task Force

Re: MR/DD Advisory Committee

In August of 1989, I formed a committee to advise me on the establishment of policies, procedures, regulations and budgets pertaining to MR/DD services in Kansas. An outline of the committee's function and its participants is attached to this correspondence. Since its inception the committee has addressed several key issues including: designation of the primary service provider for individuals who are both mentally retarded and mentally ill, the development of a family service plan, the development of a plan to merge the primary SGF funding sources and an examination of certification requirements for direct care staff in ICFs/MR.

Most recently MH&RS has requested the committee's recommendations relative to a proposed service plan outline which would guide the future development of MR/DD services in Kansas. (The most current draft of the service plan outline is attached.) As you can see the members of the committee come from highly diverse prospectives. Obtaining general consensus for this outline has taken some time to achieve. However, we believe we have made significant progress in this regard and are already implementing many of the proposals in the plan.

I thought you may want to be aware of this committee and its work as you review issues pertaining to MH&RS in the coming months. If I can be of any other assistance in your work, do not hesitate to call me.

Sincerely,

Al Nemec
Commissioner

AN:RS:eb
Attachments

The Mental Retardation/Developmental Disabilities Advisory Committee

I. Function

The role of the Advisory Committee is to provide the Commissioner of Mental Health and Retardation Services with recommendations regarding policies, procedures, regulations and budgets pertaining to MR/DD services provided in Kansas. The goal of the committee is to help develop coordination and cooperation among all MR/DD service providers, clients and advocates so that the largest number of individuals are served effectively, efficiently and in the most integrated environment possible.

II. Membership Guidelines

The Advisory Committee will be selected by the Commissioner of MH&RS. The Commissioner of MH&RS will seek to provide representation from the following cross section of service agencies, advocacy groups and administering agencies:

- The Commissioner of Mental Health and Retardation Services
- Three individuals representing advocacy groups for individuals who are mentally retarded or developmentally disabled
- One individual representing Kansas Advocacy and Protective Services
- One individual representing Kansas Association of Rehabilitation Facilities
- Two individuals representing Community Mental Retardation Centers and/or Affiliates
- Two individuals representing Small Intermediate Care Facilities for the Mentally Retarded
- One individual representing Large Intermediate Care Facilities for the Mentally Retarded
- One individual representing Kansas Planning Council on Developmental Disabilities Services
- One individual representing the Department of Health and Environment, Adult and Child Care Bureau
- Three State Mental Retardation Hospital Superintendents
- One individual representing Mental Health
- One individual representing Special Education

The following divisions will provide one representative to the Advisory Committee on an Ad Hoc basis:

- Rehabilitation Services
- Youth Services
- Adult Services
- SRS Area Offices

III. Mental Retardation/Developmental Disabilities Advisory Committee Members - 11/7/90

Ethel May Miller - Association of Retarded Citizens
Dawn Merriman - Parent
Karen Testa - Parent
Gary Daniels - Parsons State Hospital
Tony Lybarger - Winfield State Hospital
Yo Bestgen - Kansas Association Rehabilitation Facilities
Lori Pendergast - Arrowhead West (CMRC)
Jim Blume - Developmental Services of NW Kansas (CMRC/ICF-MR)
Joan Strickler - Kansas Advoc. & Protective Services/DD Council
Carolyn Hill - Wichita SRS Area Office
Gary Bishop - Shawnee County Special Education Coop.
Richard Schmitz - Faith Village (ICF/MR)
Michael Strouse - Community Living Opportunities (ICF/MR)
Joseph Kroll - Health & Environment
John Howe - Hartford Training Center (ICF/MR)
Gary Cook - Occupational Center Central Kansas (CMRC)
Janet Schalansky - Topeka Area Office
Steve Schiffelbein - Rehabilitation Services
Jan Waide - Youth Services
Bob Day - Kansas Neurological Institute
Bob Clark - CLASS, Ltd. (CMRC)
Lee McLean - University Affiliated Programs

IV. Operational Guidelines

A. Due to the size of the Advisory Committee, it will not attempt to develop initial recommendations directly. The Advisory Committee, under the direction of the Commissioner, will form Ad Hoc Subcommittees consisting of its members or designees. These subcommittees will prepare formal draft recommendations on assigned issues. Completed formal draft recommendations will be reviewed by the full Advisory Committee. MH&RS will be represented on each Ad Hoc Subcommittee.

B. Agendas for meetings of the Advisory Committee will be established by the Commissioner of MH&RS primarily based on formal draft recommendations provided to the Advisory Committee by subcommittees. The agenda for each meeting and draft recommendations to be discussed will be distributed to Committee members ten days in advance of each meeting.

C. The Advisory Committee will discuss each draft recommendation and will formulate a final consensus recommendation for the Commissioner of MH&RS.

D. The Advisory Committee will meet at least quarterly. The Commissioner of MH&RS may request more frequent meetings based on requests of the Advisory Committee and/or Ad Hoc Subcommittees.

E. Expenses of participating on the Advisory Committee must be the responsibility of the individual member or sponsoring agency.

DRAFT 11/5/90

Mental Health and Retardation Services
Mental Retardation and Other Developmental Disabilities
Service Plan Outline

Statement of Social Value

All Kansans, including those with mental retardation and other developmental disabilities, have the right and should have the opportunity to participate and be integrated in the life of their community and to exercise options to choose where and with whom they live, where to work, to participate in preferred leisure activities, to be educated in schools of their choice in their neighborhoods and to build and maintain relationships with family and friends.

Mission Statement

A comprehensive array of support and direct services should be further developed and administered in Kansas which provides the greatest degree of integrated service options to individuals who are mentally retarded or otherwise developmentally disabled. This array of services should be enhanced and further developed in partnership with the individuals served, their parents and advocates, providers of service and state, federal and local governments.

Principles of Service Provision

The system of services to Kansans with mental retardation and developmental disabilities must be flexible and consumer driven, based on individual needs. Services should be offered at a time and place which does not segregate or stigmatize individuals and in a way which provides diverse service options based on the following minimum principles:

1. It is the responsibility of service providers to justify separate, nongeneric or more restrictive services - whether in special education, living arrangements, leisure opportunities or work.
2. All individuals have the right to due process.
3. All individuals and/or their guardians should have opportunities to make choices including, but not limited to, where to live, work and play. They should select and keep possessions, be treated with respect and live in surroundings that provide individuality and privacy.
4. All individuals should be dealt with in an equitable manner.
5. Each individual in a program should receive services tailored to address their unique personal strengths and needs rather than based on the availability of services.
6. Individuals should have the opportunity to have a safe, clean and healthy environment.

7. All services should continually meet at least minimum quality standards.

8. Services and the administration, management and oversight of services should be provided in the most cost effective manner possible.

9. All individuals and agencies should advocate for resources and services which are in keeping with these principles. This advocacy effort should be led by individuals who are mentally retarded or otherwise developmentally disabled, their family, friends and guardians and include service agencies, county, state and federal agencies, elected officials and the general public.

<u>Goals 1990-1995</u>

I. Enable children who are mentally retarded or developmentally disabled to live in families by:

  A. Providing a comprehensive system of family support services such as:
    1. In-home and out-of-home respite
    2. Supportive home care
    3. Service coordination
    4. Crisis intervention
    5. Counseling and parent education
  B. Providing alternative families for children whose families can not keep them in their natural home.
  C. Providing services to children in state hospitals or other congregate settings only in crisis or in an emergency on a short term basis.

II. Enable a greater number of individuals who are mentally retarded or developmentally disabled to be served in integrated settings.

  A. Develop a stable and predictable funding pattern for all MR/DD services which is more likely to insure adequate and appropriate resources through a shared funding base at the local, state and federal level.
  B. Increase the funding and/or capacity of community integrated programs to serve a greater number of individuals so there is no inordinately long wait for services.
  C. Increase the number of individuals served in integrated less restrictive work, residential and leisure settings.
  D. Develop procedures or systems for state operated facilities to provide technical support and consultation on request to assist community programs to serve those with more severe disabilities where there are shortages of local fiscal and professional resources and expertise.

E. Enable state operated facilities to serve no more than the national per capita average number of individuals in such facilities.
F. Enable large private ICFs/MR to serve no more than the national per capita average number of individuals in such facilities.
G. Eliminate any items in the nurse practices act which prevent quality health care services from being provided in nonmedical licensed facilities.
H. Establish recognized community MR/DD centers as the point of information and referral and for providing or arranging for provision of service coordination for all individuals who are mentally retarded or developmentally disabled who are seeking services in the center's service area unless they are otherwise eligible for and receiving other generic service coordination assistance.[1]
I. Define the role of the recognized community MR/DD center and its relationship to government agencies and its clients.

III. All services provided should meet minimally acceptable quality standards.

A. All facilities, services and programs will become accredited or ICF/MR certified.
B. Establish quality assurance staff in field offices.
C. Systems will be developed which involve advocates and consumers in monitoring and developing services.
D. Technical and legal assistance will be developed for parents, guardians and family to assist in insuring that services meet minimum quality standards.
D. Achieve wage equity for community MR/DD agency staff, especially direct service staff.

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[1] It is recognized that when service coordination is the responsibility of the primary community service provider there is an inherent conflict of interest. A better approach would be to establish independent case management services. However, it is believed that the cost of the development of independent case management would divert limited funds from planned expansion of community MR/DD services. Given the number of individuals in institutions and waiting for service such diversion of funds is unacceptable. Therefore, this compromise approach is necessary in order to avoid the possible diversion of limited funds for planned service expansion. In order for this compromise to work effectively individuals, parents, guardians, friends and advocates must be empowered to hold community MR/DD centers accountable for securing or providing services and to be responsive to individuals needs. As with all service systems the state will ultimately provide the final back-up if services are not provided by the community agencies.

E. Implement a comprehensive data collection and management system which supports and monitors quality assurance efforts.

IV. Services for individuals with special unmet needs should be developed.

A. Develop an array of services for individuals who are offenders and are mentally retarded or developmentally disabled but are not competent to stand trial.
B. Develop an array of services for individuals who are mentally retarded or developmentally disabled and mentally ill.

V. All services should be provided in the most cost effective manner possible while still meeting at least minimum quality standards.

A. Establish an administrative and legislative process by which the major portions of the MR/DD budget are reviewed as a whole.
B. Achieve the national average for per diem expenditure for MR/DD services.
C. Maintain and increase the use of local funding sources including county mill levy, private donations, HUD subsidies and grants.

<u>Objectives for FY 1991</u>

I. State General Funding of Community MR/DD Programs

A. Consolidate State Aid, Social Service Block Grant and Special Purpose Grants into one funding source.
B. Increase community MR/DD services so at least 150 unserved individuals can be placed from community waiting lists into integrated community services.
C. Establish the conditions and time lines under which community agencies would be required to be accredited.
D. Request funds which allows state support to keep pace with the increase in the cost of living.

II. The Existing HCBS Waiver

A. Transfer the MR/DD portion of the HCBS waiver to MH&RS.
B. Obtain HCFA approval for increased HCBS rates and increase rates for habilitation to $29/day and for residential to $37/day as appropriated for FY 91.
C. Request increased funds to raise the average rates for habilitation to $36/day and for residential to $44/day.
D. Encourage small bed ICF/MR providers to voluntarily decertify their facilities in favor of being funded using HCBS.

E. Allocate all available HCBS slots to SRS Area Offices to be used by existing community MR/DD programs. Some of these slots could fund, either directly or indirectly, the placement of individuals out of State MR/DD Hospitals.

III. New HCBS Waiver

A. Apply to HCFA for a the new HCBS waiver including services for children.
B. Request funds to support the new waiver.
C. Continue the implementation of the objectives for the existing waiver listed above.

IV. ICF/MR

A. Transfer the administration of the ICF/MR program to MH&RS.
B. Limit the number of additional ICF/MR beds.
C. Obtain recommendations from providers in the development and implement of a new reimbursement methodology which reimburses direct service costs based on the level of severity of disability of the individuals served in each facility.
D. Establish a functional ICF/MR eligibility criteria.
    1. Establish who, of currently served HCBS and ICF/MR clients, would become ineligible for services.
    2. Replace the ineligible HCBS clients with eligible clients on an agency by agency basis.
    3. Develop a plan on either phasing in the new eligibility criteria for ICF/MR or placing the ineligible clients.

V. Family Support

A. Develop a family support program plan.
B. Dedicate some existing funds to family support services.
    1. Request funds in the new HCBS application.
    2. Require some of the expansion in state general funds be used for family support services.
    3. Encourage community MR/DD providers to use available special purpose grant funds for family support programs.

VI. Personnel

A. Request 12 specialized Area Support/Quality Enhancement field staff.
B. Request staff for data processing and analysis.
C. Coordinate and cooperate with all relevant individuals and agencies to devise and implement a plan to support

the enhancement of staff training in community MR/DD agencies.

VII. Information Services

- A. Confirm that the Kansas Rehabilitation Information System (KRIS) is accurate and operational.
- B. Implement the use of the Developmental Disability Profile (DDP) for all clients.
- C. Complete the interface between KRIS and the DDP.
- D. Initiate the ICF/MR certification data system.

VIII. Targeted Case Management (Service Coordination)

- A. Design a plan for how Service Coordination can be provided by community MR/DD centers.
- B. Design a plan by which existing community MR/DD center funds already expended for Service Coordination can be used as the state portion of the match for medicaid funding of targeted case management.
- C. Prepare and implement a medicaid targeted case management plan provided by the community agencies.

IX. Reduce budgeted average daily census in the State MR/DD Hospitals by 50.

X. Merge the budget process for all MR/DD programs.

- A. Assign one SRS budget analyst for all MR/DD programs.
- B. Request one DOB analyst for MR/DD programs.
- C. Request one legislative analyst for MR/DD programs.
- D. Request one subcommittee from each house review the MR/DD budget.

XI. Prepare a plan which could allow for the separation of MH&RS from SRS. This could include a joint separation of several divisions so as to minimize the cost of such a separation by identifying any unnecessary duplication of effort in the funding and oversite of MR/DD services in state government.

XII. Maintain the MR/DD Advisory committee as a key element in providing advice and guidance in developing and implementing service and budget objectives.

- A. Add a UAP representative to the committee.
- B. Add more parents/advocates to the committee.

XIII. Plan and implement crisis intervention services.

- A. Start a pilot program which provides short term funding for crisis intervention.

1-18

B. Design an administratively feasible heavy care provision for ICFs/MR.
C. State MR/DD hospitals should develop a plan to provide short term intensive in-facility and outreach crisis intervention.

XIV. Services for MR/DD offenders and MR/DD and MI.

A. Research best practices in service delivery.
B. Design a service plan.
C. Standardize the method of dealing with difficulties in this area until an acceptable plan is implemented.

XV. Nurse Practices Act

A. Review the current nurse practices act to identify the impediments it could cause to expanding community service options to individuals who have health care needs.
B. Initiate a dialogue with the Board of Nurses regarding possible necessary revisions to the act.

<u>Objectives for FY 1992</u>

I. State General Funding of Community MR/DD Programs

A. Request funds to place 200 individuals from community waiting lists.
B. Initiate the first phase of the requirement for community agencies to be accredited.
C. Request an increase in the state's share of funding for community programs from 54% to 57%.
D. Request an increase in state funding to keep pace with inflation.

II. Family Support

A. Include requests for funds for direct provision of family support services in all funding requests.

III. State MR/DD Hospitals and large ICFs/MR

A. Reduce the combined census by 175 by placing individuals into small ICFs/MR and community agencies using HCBS funding.
B. Initiate more restrictive admissions procedures for children.
C. Require ICFs/MR to enter into interagency service agreements with community MR/DD centers.

IV. Plan and implement crisis intervention services.

A. Request short term emergency funding for crisis services state general funds and ICF/MR heavy care.
B. State MR/DD hospitals should implement a plan to provide short term intensive in-facility and outreach crisis intervention.

V. HCBS

A. Initiate the new HCBS waiver.
B. Establish tiered HCBS rates based on the DDP data.

VI. Propose necessary legislative changes to the nurse practices act.

RE: PROPOSAL NO. 19 – DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

INTRODUCTION

Proposal No. 19 directed the Task Force on Social and Rehabilitation Services to:

> Study and evaluate the administrative structure and functioning of the Department of Social and Rehabilitation Services, with an emphasis on improving the cost-effectiveness of the delivery of services; review the effectiveness of the administration of programs and functions with particular focus on reducing duplication in the delivery of services, improving cooperation among agencies and administrative units, and maximizing resources through better utilization of matching funds; review rules and regulations adopted by the federal government and the Secretary of Social and Rehabilitation Services to determine whether these regulations assist or hinder in the administration of programs and functions of the Department and identify and evaluate cause of programmatic cost increases.

The Task Force was first established by the Legislative Coordinating Council for the 1990 interim. The Task Force prepared a report and recommendations to the 1991 Legislature based upon the work of four subcommittees.

For the 1991 interim period, the Task Force divided into the following four subcommittees: mental health and retardation services; financing; prevention; and medical services and long-term care. Each Subcommittee was directed by the Task Force to study and review certain topics pertaining to the Department of Social and Rehabilitation Services. The Subcommittees met each month to receive information and develop recommendations in their subject area. In some cases subcommittees visited community facilities as a part of the information gathering process. The Subcommittee on Mental Health and Retardation Services participated in a "Uniting Our Vision" conference in September dealing with the concerns of people with developmental disabilities. Several Subcommittees, along with other legislators, took part in a November conference hosted by the University of Kansas School of Social Welfare concerning investing in social services. Subcommittees made reports to the full Task Force at a December meeting. The Finance Subcommittee met subsequently in early January to modify its recommendations in response to Congressional action.

For the 1991 interim, the Task Force consists of the following 17 legislative members and seven public members:

Rep. Gary Blumenthal, Chairperson
Sen. August Bogina, Vice-Chairperson

House Members	Senate Members
Rep. Ann Cozine	Sen. Paul Burke
Rep. Duane Goossen	Sen. Ross Doyen
Rep. Henry Helgerson	Sen. Frank Gaines
Rep. Sheila Hochhauser	Sen. Nancy Parrish
Rep. Jo Ann Pottorff	Sen. Doug Walker
Rep. Tim Shallenburger	Sen. Wint Winter, Jr.
Rep. Jack Sluiter	
Rep. Galen Weiland	
Rep. Steve Wiard	

Public Members

Dr. Robert Harder
Mr. Larry McCants
Dr. Nancy McCarthy Snyder
Ms. Sandra McMullen
Dr. Chris Petr
Dr. Joe Reitz
Ms. Mary Sue Severance

The remainder of this report details the activities and recommendations of each Subcommittee. Recommended legislation will be introduced early in the 1992 Session.

SUBCOMMITTEE REPORTS

Subcommittee on Mental Health and Retardation Services Mental Retardation and Developmental Disability

Summary

1. General Conclusions

The Subcommittee makes the following general recommendations concerning community support services for mentally retarded or otherwise developmentally disabled individuals:

- A comprehensive array of support and direct services should be developed in Kansas which provide the greatest possible degree of integrated service options to mentally retarded or otherwise developmentally disabled people. This array of services shall be enhanced in partnership with individuals served, their parents, advocates, service providers, and federal, state, and local governments.

- The system of services to Kansans with mental retardation and developmental disabilities must be flexible and based on individual needs. Services shall be offered at a time and place which does not segregate or stigmatize individuals, in a way which provides diverse service options based on the following principles:

    - It is the responsibility of service providers to justify separate, nongeneric, or more restrictive services -- whether in special education, living arrangements, leisure opportunities, or work.

    - All individuals have the right to due process.

    - All individuals and/or their guardians shall have opportunities to make informed choices including, but not limited to, where to live, work, and play. They shall select and keep possessions, be treated with respect and live in surroundings that provide individuality and privacy.

    - All individuals shall be dealt with in an equitable manner.

    - Each individual shall receive services tailored to address their unique personal strengths and needs rather than based on the availability of services.

    - Individuals shall have the opportunity to have a safe, clean, and healthy environment.

    - All services shall continually meet at least minimum quality standards.

    - Services and the administration, management, and oversight of services shall be provided in the most cost effective manner possible.

- All individuals and agencies shall advocate resources and services which are in keeping with these principles. This advocacy shall be guided by individuals who are mentally retarded or otherwise developmentally disabled, their families, friends, and guardians. Advocacy shall include service agencies, county, state and federal agencies, elected officials, and the general public.

The following new ideas should be embraced by the state and community service providers:

- Decisions should be based on future planning for individuals rather than "slots" in the system. Service coordinators should then be trained to implement such decisions.
- Nuclear and surrogate families should be paid to provide a home for children as an alternative to public and private institutions.
- Money should be allocated in such a way that services are wrapped around the individual based on a level of need; rather than funding facilities, programs, or services.
- The system should consider people before disabilities, facilities, systems, or bureaucracies, and should encourage the use of generic services rather than segregated, specialized services.

2. Legislation

The Subcommittee recommends that legislation be introduced to enlarge the statutory description of mental retardation to include mental retardation and developmental disabilities (MR/DD) such as autism, cerebral palsy, epilepsy, or other similar physical or mental impairment. The definition, set out in detail below, further defines mental retardation.

The Subcommittee also recommends passage of H.B. 2530, currently in the House Committee on Public Health and Welfare. This bill would allow the delegation of noninvasive nursing procedures in community settings that service persons with developmental disabilities.

3. Community Mental Retardation/Developmental Disability Programs

The Subcommittee adopts a five-year plan presented by Mental Health and Retardation Services (MHRS) (see Table I). According to the plan, the 1,400 clients currently on the waiting list for community services will receive full community service by 1995; the census of the state mental retardation hospitals will be reduced by 83 clients a year, to 497 by 1997; all children with MR/DD will be served by 1995; all large bed intermediate care facilities for mental retardation will be eliminated by the year 2000 by reducing their census by 67 persons per year; and a service coordination mechanism will be developed which should serve 10,500 persons by 1997.

The Subcommittee's report concludes that the infrastructure of the community system must be strengthened so that the needs of individuals are met. The Subcommittee makes six recommendations to develop a high quality service infrastructure. These recommendations are set out in the report.

The Subcommittee recommends that a comprehensive array of support and direct services be developed which provide the greatest possible degree of integrated service options to MR/DD people. This array of services shall be enhanced in partnership with individuals served, their parents, advocates, service providers, and federal, state, and local governments. Furthermore, services shall be offered at a time and place which does not segregate or stigmatize individuals, in a way which provides diverse service options based on nine principles which are enumerated in the report.

The Subcommittee recommends that decisions should be based on future planning for individuals rather than "slots" in the system. Service coordinators should then be trained to implement such decisions; nuclear and surrogate families should be paid to provide a home for children as an alternative to public and private institutions; money should be allocated in such a way that services are wrapped around the individual based on a level of need; the system should consider people before disabilities, facilities, systems, or bureaucracies, and should encourage the use of generic services rather than segregated, specialized services.

The Subcommittee recommends that recognized community mental retardation centers (CMRCs) provide all service coordination (targeted case management) for MR/DD adults. Additionally, the Subcommittee adopts a funding proposal presented by MHRS which utilizes a Medicaid matching process called "certified match."

4. Hospital Consolidation

The Subcommittee believes that decisions must be made for the ultimate benefit of the client and notes that the trend, nationwide, is to place as many individuals into community settings as possible.

The Subcommittee recommends that, as a result of implementation of the community services plan as articulated by the Subcommittee report, one state mental retardation hospital should be closed by FY 1995. It is not the intention of the Subcommittee, through this recommendation, to recommend the abandonment of state hospitals. The Subcommittee believes, however, that consolidation of existing hospitals is an appropriate issue for legislative review.

The Subcommittee recommends that a determination regarding which state mental retardation hospitals should be closed, or consolidated, be made by the Department of Social and Rehabilitation Services (SRS). The Subcommittee propounds several factors for SRS to consider when making this decision. These factors are enumerated in the report.

The Subcommittee also recommends that SRS be given the authority to contract with consultants to assist it in implementing the Subcommittee's recommendation.

The Subcommittee recommends that community programs give special consideration to hiring those hospital workers who are displaced by hospital consolidation or staff reductions, provided the workers are qualified for the particular community job.

5. Vocational Rehabilitation and Special Education

The Subcommittee recommends that a stable staff of transition counselors be utilized to provide direction and assistance; and to work actively with families, students, education, and community providers for long-range transition planning.

The Subcommittee recommends that special education be closely monitored and returned to at least a 90 percent funding level.

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6. Autism

The Subcommittee recommends the establishment and funding of a Kansas Resource Center on Autism.

7. Directions to Agencies

The Subcommittee requests a study be undertaken during the next legislative session, by SRS, to evaluate whether combining the funding of the state mental retardation hospitals and community programs is advisable.

The Subcommittee directs MHRS to establish standards for community development centers, core services, quality assurance, and quality enhancement. In addition, MHRS should establish minimum knowledge and performance competency levels for professional and paraprofessional personnel within the community.

The Subcommittee directs MHRS to work at establishing funding relationships with county governments.

The Subcommittee recommends that MHRS work with the Kansas Department of Transportation (KDOT) to review its rules and regulations to determine whether current methodology for operating costs is in keeping with the maximum cost in reimbursement allowances permitted by the federal government.

The Subcommittee also directs KDOT to ascertain whether Kansas' transportation policy is in compliance with the federal Americans With Disability Act, and to bring its conclusion to the attention of the House Appropriations and Senate Ways and Means SRS Subcommittees and the Transportation committees, during the 1992 Legislative Session.

Finally, the Subcommittee encourages the vocational rehabilitation system and the Department of Education (through special education) to work together to strengthen these programs.

Background

There are approximately 15,200 people with mental retardation and other developmental disabilities living in the State of Kansas. Of these, 65.9 percent have mental retardation, 20.9 percent have head injuries, 6.3 percent are epileptic, 5.1 percent have cerebral palsy, and 1.9 percent are autistic. About 7,300 (48 percent) of the mentally retarded/developmentally disabled population are children under the age of 21. Most mentally retarded or developmentally disabled people have additional disabilities. Approximately 30 percent have been diagnosed with psychiatric disorders.

In addition to the 986 persons in state hospitals, approximately 6,039 individuals are served in the community or in private, large-bed, intermediate care facilities (ICFs/MR). According to SRS, Division of MHRS, about 1,000 persons are served in private ICFs/MR, about 1,700 reside in a variety of community residential settings and just over 4,000 persons are served by 27 CMRCs. Over 1,500 persons served by CMRCs live at home with relatives; 300 live alone; 200 are in individual integrated living arrangements; 30 children live in foster care; and about 6,400 are children in special education programs in Kansas schools.

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Kansas has three state hospitals or institutions for the mentally retarded – Parsons State Hospital and Training Center, Winfield State Hospital and Training Center, and Kansas Neurological Institute (KNI), which serves approximately 986 clients. Kansas had four state hospitals for the mentally retarded until the closure of Norton State Hospital in 1988. In addition to mental retardation, many of the clients at these institutions have severe sensory and motor disabilities, behavior problems, chronic health conditions, and severe communication disorders. According to MHRS, there are more persons with severe or profound mental retardation in the community than there are in state institutions.

During the 1990 Legislative Session, a House Appropriations Subcommittee, while working with the budgets of the state mental retardation hospitals, recommended the closure of one of the hospitals. The corresponding Subcommittee of the Senate Ways and Means Committee did not agree. A compromise transpired when the 1990 Legislature mandated "that of the moneys appropriated for SRS for the current fiscal year, [FY 1991] expenditures shall be made for the development and implementation of a plan which shall be submitted by the secretary of SRS to the legislature on or before January 15, 1991, and which makes provisions to move a total of at least 50 clients from KNI, Parsons State Hospital or Winfield State Hospital into community placements and community facilities for persons who have mental retardation or other developmental disabilities. The plan shall include a detailed proposal covering:

1. the plan's impact on families of clients and staff at all three institutions;
2. the number of clients that the secretary of social and rehabilitation services anticipates will be placed into the community from each institution;
3. the status of available community facilities;
4. recommended funding alternatives for the placements;
5. identification and location of the one or more wards, cottages, units or equivalent client facilities to be closed at one or more designated institutions pursuant to the plan;
6. a breakdown of the number of clients, the level of mental retardation, physical handicaps and psychological impairment of the clients designated to be moved from the one or more closed wards, cottages, units or equivalent client facilities;
7. a specific plan for the reduction of staff at each designated institution and an evaluation of whether additional staff will be required at the other institution or institutions;
8. a review of the use of alternative Medicaid financing options, such as waiver availability for group homes and the personal care option as noted in the March, 1990 report presented to the above agency by the national association of state mental retardation directors; and
9. a recommended target date of June 1, 1991 to place as many additional institution clients from the waiting list as possible into the community throughout fiscal year 1991."

During the 1991 Session, the Legislature adopted a plan proposed by MHRS which called for downsizing the three state mental retardation institutions by a total of 113 clients. Under this plan, by the end of fiscal year 1992, the census of Winfield State Hospital and Training Center will be 332 (down 58 clients); the census of KNI will be 310 (down 45 clients); and the census of Parsons State Hospital, if possible, will be 260 (down ten clients).

In addition, the 1991 Legislature recommended, in H.B. 2640 that ". . . expenditures may be made by the above agency for fiscal year 1992 from the social services clearing fund for a master planner and associated staff and operating expenditures for the purpose of developing a plan to close two state institutions . . . one in fiscal year 1993 and one in fiscal year 1994; Provided, That recommendations made in such a plan selecting a specific mental health and a specific mental retardation institution shall include an analysis of the costs and savings associated with closure, including an analysis of the availability of community programs, an analysis of the community's economic ability to respond to the closure of the institution and future labor trends in each community . . . ." This section of the bill was vetoed by the Governor.

On July 8, 1991, the Governor sent a letter to Robert Harder, Acting Secretary of SRS requesting, for budget review purposes during the first part of November, a determination as to what the component parts of a study to close a state mental health or retardation hospital should include. The Governor opined that it was important to move with caution, and requested SRS to take into account "the question of an individual doing harm to themselves or others, the cost of care in the hospital or institution in contrast to care in the community, and the social and economic impact of a possible closing of a hospital or institution within the geographic area in which they are located." The Governor's letter asked for an integrated report on the subject and for a comprehensive assessment as to services available in the community. Her letter indicated that discussion of closing state hospitals was not budget driven, but "lie[d] in creating a system of care that serves our clients best."

The Task Force on Social and Rehabilitation Services was established as an ongoing study group by the Legislative Coordinating Council. The Task Force Subcommittee on Mental Health and Retardation Services studied the following topic:

1. Development of Community Services for the Mentally Ill and Mentally Retarded/Developmentally Disabled

Identification of what services and system changes must take place in the community to develop a full complement of services which would allow the closure of a state mental health and a state mental retardation hospital. Identification of gaps in the current community system and recommendations concerning the development of a community-based continuum of care to serve clients currently unserved in the community as well as current state hospital clients. Monitor mental health reform and the expansion of the HCBS-MR waiver and associated client movement. In addition, the Subcommittee would look at particular issues pertaining to persons with autism and would look at the needs of the family of an individual with a disability.

Subcommittee Activity

The Subcommittee first held hearings on August 12 and 13, 1991. Representatives of organizations and private individuals appeared on community and institutional mental retardation/developmental disability issues, with the primary focus on community services. Testimony included an update by the Special Committee on Community Services and Hospital Closings, an update of client movement from mental retardation hospitals to community programs, and a discussion of autism issues.

In addition to hearing testimony, the Subcommittee toured KNI and the Topeka Association of Retarded Citizens' sheltered workshop at the Topeka Industrial Park. In lieu of its September Subcommittee meeting, the Subcommittee participated in the "Uniting Our Vision" conference held on September 6 and 7, 1991. The conference dealt with the concerns of people with developmental disabilities. Conference sessions focused on early intervention, supported employment, family support, financing, community living, and transition planning.

Final Subcommittee meetings, held on October 16 and 30, 1991, focused on the results of the conference and the response of Mental Health and Retardation Services to issues raised during the conference. The Subcommittee also heard testimony from parents and family members of developmentally disabled persons who were concerned about the possible closure of state mental retardation hospitals, and who stressed the need for the state to maintain large state run hospitals or institutions.

Committee Activity

1. Closure and Consolidation of State Mental Retardation Facilities

The Subcommittee firmly believes that decisions must be made for the ultimate benefit of the client, and notes that the trend, nationwide, is to place as many individuals into community settings as possible. The Subcommittee begins its recommendations by defining the role of the state mental retardation hospitals. Since downsizing, closing, and consolidating the hospitals has been a recurrent theme throughout the last several legislative sessions, the Subcommittee's first recommendation is that, over the next five years, Kansas should downsize from three to two state mental retardation hospitals. The Subcommittee understands that consolidation of state hospitals will not return dollar for dollar savings.

This decision, on its face, seems to indicate that the Subcommittee does not support the use of large state-run institutions. This assumption is incorrect. The Subcommittee concludes that there is a significant and beneficial role for state mental retardation hospitals and institutions. The Subcommittee envisions a strong symbiotic relationship between community programs and hospitals in the state. With this recommendation, the Subcommittee intends to strike a balance between parental/guardian rights, family rights, and client rights. It is not the intention of this Subcommittee to recommend the abandonment of state hospitals. The Subcommittee believes, however, that consolidation of existing hospitals is an appropriate issue for legislative review.

As stated by the SRS Task Force in 1990, "all Kansans, including those with mental retardation and other developmental disabilities, have the right and should have the opportunity to participate and be integrated into the life of their community and to exercise options to choose where and with whom they live, where to work, to participate in preferred leisure activities, to be educated in schools of their choice in their neighborhoods . . . ." The Subcommittee reaffirms this language and concludes that choice should also include an institutional option. While the Subcommittee's goal is to streamline or consolidate institutions, an institutional setting should always be available for clients and their families; and as a safety net for those individuals who attempt to utilize community services but who are unable, for whatever reason, to live away from an institution.

The Subcommittee recommends that a determination regarding which state mental retardation hospital should be closed, or whether consolidation should be undertaken, be made by SRS. The Subcommittee further recommends that the decision be based on objective criteria rather than political or subjective standards. Any decision shall take into consideration, but not be limited to, the following factors:

1. the best interest of each client, including medical, housing, transportation, rehabilitation, and educational needs;
2. physical plant, *e.g.*, how much renovation will be necessary in the next few years to upgrade the facility;

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3. geographical considerations, *e.g.*, the location of families of consumers, the physical location of a hospital, the proximity of available alternative community services;
4. the per diem cost of each hospital;
5. the economic impact of closing a hospital on its host community; and
6. the availability of employment alternatives for hospital workers.

The Subcommittee recommends that SRS be given the authority to contract with consultants to assist it in implementing the Subcommittee's recommendation. The Subcommittee also recommends that, as a result of implementation of the community services plan as articulated by the Subcommittee report, one state mental retardation hospital should be closed by FY 1995.

The Subcommittee further recommends that community programs give special consideration to hiring those hospital workers who are displaced by hospital consolidation or staff reductions, provided the workers are qualified for the particularly community job.

2. Five-Year Plan

In conjunction with the recommendation to close and consolidate a state mental retardation facility, the Subcommittee also adopts a five-year plan presented by MHRS (see Table I). According to the plan, the 1,400 clients currently on the waiting list for community services will receive full community service by 1995; the census of the state mental retardation hospitals will be reduced by 83 clients a year, to 497 by 1997; all children with MR/DD will be served by 1995; all large bed intermediate care facilities for mental retardation will be eliminated by the year 2000 by reducing their census by 67 persons per year; and a service coordination mechanism will be developed which should serve 10,500 persons by 1997. The Subcommittee believes that it is imperative to provide quality assurance to the consumers of community services and their families. This plan, which would eliminate the waiting list, should ensure adequate service for persons who have mental retardation or developmental disabilities in Kansas by 1997. Table 2 and Table 3 provide additional information concerning clients served by community services, community waiting lists, types of developmental disabilities, and the intelligence level of persons served in community and hospital settings.

The Subcommittee concludes that the infrastructure of the community system must be strengthened so that the needs of individuals are met. To develop a solid, high quality service infrastructure, the Subcommittee directs SRS to work cooperatively with community providers to implement the following recommendations. The Subcommittee does not intend, by this request, for SRS to write burdensome rules and regulations which inhibit the ability of local MR/DD service providers to carry out their mission. The Subcommittee believes that it is incumbent upon the state to form a cooperative partnership with community providers to fund these programs.

1. rename CMRCs Community Developmental Centers and establish a slate of services which shall be available in each service area;
2. set minimum standards for knowledge and performance competence for paraprofessional and professional personnel who serve persons in the developmental service system;
3. establish a statewide, state level presence in area SRS offices to validate the mechanisms and monitor service provision, service quality, and service planning;

4. establish quality enhancement processes and procedures which go beyond minimally acceptable standards and which are led by consumers and parents;

5. establish a minimum wage or other salary enhancements for community provider staff; and

6. establish reimbursement levels that are tied to the level of individual need instead of funding services based on labels and categories. For example, design model contracts which provide funding for people, not programs.

The Subcommittee recommendations assume that funding will wrap around each individual rather than each program serving the individual. To safeguard this concept, several conferees suggested that funding for the mental retardation hospitals be combined with funding for community programs. Thus, when a client moves from the institution into the community, a certain percentage of the funding could follow. (Not all of the funding could follow because as each client leaves a hospital, the per diem costs of the hospital increase.) Combining the funding of the hospitals and the community programs would enable SRS to make necessary adjustments as clients were moved. Some concern was voiced by community providers that if hospitals were threatened with decertification, money would be pulled from the community budgets to correct the deficiency. This was resolved with a suggestion that money could only flow one way -- from the hospital into the community. This, however, poses an additional dilemma. Currently, each hospital has a separate budget, while community funding is part of the SRS budget. If the budgets were combined and the money flowed one way into the community, hospital superintendents would not know what the actual budget was; financial management would be difficult. Also, if a client needed or wanted to use the "safety net" and return to the institution, it would not be possible to reverse the funding flow. Although intrigued by the notion of combination funding for institutions and community programs, the Subcommittee does not take a position on this issue. The Subcommittee, however, requests that further studies be undertaken by SRS during the next legislative session.

3. The "Uniting Our Vision" Conference

On September 6 and 7, 1991, the Subcommittee participated in the "Uniting Our Vision Conference; a Kansas Conference on People with Developmental Disabilities." Conference sessions focused on early intervention, supported employment, family support, financing, community living, and transition planning. At the end of each session, conference participants were asked to complete a survey addressing recommendations for possible legislative actions, state agency changes, and changes in the current service system. Survey recommendations were summarized by the Kansas Association of Rehabilitation Facilities (KARF) and presented to MHRS. A joint meeting was then held with KARF representatives, MHRS, parents, and other interested parties to discuss the conference results. The outcome of this discussion, plus additional testimony from parents and providers, was presented at the October 16, 1991 Subcommittee meeting. The following Subcommittee recommendations evolved from the "Uniting Our Vision" Conference:

A. Philosophy of Community Support Services

1. The Subcommittee recommends that a comprehensive array of support and direct services should be developed in Kansas which provide the greatest possible degree of integrated service options to mentally retarded or otherwise developmentally disabled people. This array of services shall be enhanced in partnership with individuals served, their parents, advocates, service providers, and federal, state, and local governments.

2. The system of services to Kansans with mental retardation and developmental disabilities must be flexible and based on individual needs. Services shall be offered at a time and

place which does not segregate or stigmatize individuals, in a way which provides diverse service options based on the following principles:

a. It is the responsibility of service providers to justify separate, nongeneric, or more restrictive services -- whether in special education, living arrangements, leisure opportunities, or work.

b. All individuals have the right to due process.

c. All individuals and/or their guardians shall have opportunities to make informed choices including, but not limited to, where to live, work, and play. They shall select and keep possessions, be treated with respect and live in surroundings that provide individuality and privacy.

d. All individuals shall be dealt with in an equitable manner.

e. Each individual shall receive services tailored to address their unique personal strengths and needs rather than based on the availability of services.

f. Individuals shall have the opportunity to have a safe, clean, and healthy environment.

g. All services shall continually meet at least minimum quality standards.

h. Services and the administration, management, and oversight of services shall be provided in the most cost effective manner possible.

i. All individuals and agencies shall advocate resources and services which are in keeping with these principles. This advocacy shall be guided by individuals who are mentally retarded or otherwise developmentally disabled, their families, friends, and guardians. Advocacy shall include service agencies, county, state and federal agencies, elected officials, and the general public.

The Subcommittee further recommends that the following new ideas be embraced by the state and community service providers:

1. Decisions should be based on future planning for individuals rather than "slots" in the system. Service coordinators should then be trained to implement such decisions.

2. Nuclear and surrogate families should be paid to provide a home for children as an alternative to public and private institutions.

3. Money should be allocated in such a way that services are wrapped around the individual based on a level of need; rather than funding facilities, programs, or services.

4. The system should consider people before disabilities, facilities, systems, or bureaucracies, and should encourage the use of generic services rather than segregated, specialized services.

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B. Professional Standards

The Subcommittee believes that there are a large number of very competent providers of community services within the state; however, testimony indicates that there are no uniform standards of care for service providers. The Subcommittee directs MHRS to establish standards for Community Development Centers, core services, quality assurance, and quality enhancement. In addition, MHRS should establish minimum knowledge and performance competency levels for professional and paraprofessional personnel within the community.

C. Noninvasive Medical Procedures

The Subcommittee recommends passage of H.B. 2530, currently in the House Committee on Public Health and Welfare, which would allow the delegation of noninvasive nursing procedures in medical care facilities, adult care homes, or elsewhere to persons not licensed to practice nursing if supervised by a registered nurse or a licensed practical nurse. The Subcommittee believes that basic medical procedures, often performed at home by family members, should be available in all community settings serving persons with developmental disabilities.

D. Local Support

The Subcommittee reviewed information regarding the establishment of local support for community mental retardation and developmental disability facilities. The Subcommittee learned that in 1969 the Legislature authorized counties to establish mill levies to fund services to individuals who are mentally retarded or otherwise developmentally disabled.

In 1974, the Legislature authorized state aid funding as a match for local funding efforts. In early years, local funding exceeded state funding. In recent years, however, this has changed. Testimony indicated that from 1988 to 1991, county contributions increased 17 percent while state contributions (including social service block grants) increased 76 percent. Virtually all service expansion in community services in the last several years is a result of increased state and federal funds.

There are 27 recognized community mental retardation centers in Kansas. All but one CMRC provides services to individuals who are mentally retarded or otherwise developmentally disabled. These CMRCs are local agencies directly receiving county mill funds and state aid. The Subcommittee heard a proposal from MHRS which would establish a partnership with counties to provide services to individuals which are not Medicaid funded. When services are expanded to individuals which cannot be funded by Medicaid, the state would provide 60 percent of the cost and the local counties would provide 40 percent.

The Subcommittee makes no recommendation on this proposal but directs the Department of Mental Health and Retardation Services to work at establishing funding relationships with county governments.

E. Service Coordination

Service coordination, frequently called targeted case management, provides MR/DD individuals and their families with guidance, assistance, and advocacy in securing necessary services. Service coordinators guide people through the maze of federal, state, and provider bureaucracies to obtain services specifically designed for their needs. The Subcommittee learned that Kansas does not have a comprehensive service coordination system. CMRCs, state hospitals, and private ICFs/MR all provide some coordination services. However, services provided by these organizations are limited; not only by existing resources, but also by the services each agency usually performs.

The Subcommittee recommends that recognized CMRCs provide all service coordination for adults with MR/DD. Additionally, the Subcommittee adopts a funding proposal presented by MHRS which utilizes a Medicaid matching process called "certified match." Using this approach, community agencies would provide service coordination to everyone who requests it in their service area. The CMRC would bill SRS for the service and certify that it has already received the state Medicaid match in the form of SRS grants awarded to it within current appropriations. SRS would then pay only the federal matching portion of the cost of services. The Subcommittee notes that this approach would require specially trained SRS staff in regional areas to monitor the quality of services and case management provided by the CMRCs, at an estimated cost of $500,000 to $1,500,000. The Subcommittee believes, however, that this strategy is the most cost effective option available. Service coordination is a critical starting point for a successful statewide community program.

F. Transportation

The Subcommittee learned, during the "Uniting Our Vision" conference, that families have routinely complained of lack of transportation to and from available community services. The Subcommittee notes that K.S.A. 75-032 *et seq.*, refers to the Elderly and Handicapped Public Transportation Assistance Act. The Act established the Elderly and Handicapped Coordinated Public Transportation Assistance Fund and directs the Secretary of the Kansas Department of Transportation (KDOT) to develop a plan to implement the Act. The Act defines transportation as "the movement of individuals and meals in a four or more wheeled motorized vehicle designed to carry passengers. Transportation does not include emergency or school transportation." The Subcommittee recommends that MHRS work with KDOT to review its rules and regulations to determine whether current methodology for operating costs is in keeping with the maximum cost of reimbursement allowances permitted by the federal government. The Subcommittee also directs KDOT to ascertain whether Kansas' transportation policy is in compliance with the federal Americans With Disability Act, and to bring its conclusion to the attention of the House Appropriations and Senate Ways and Means SRS subcommittees and the Transportation committees during the 1992 Session.

G. Family Subsidy Pilot Project

The Subcommittee notes with approval that the 1991 Legislature implemented a family subsidy pilot project for respite care. In addition, MHRS has allowed more flexibility through special purpose grants, the HCBS waiver for respite care, van lifts, and home modifications. Testimony provided by MHRS indicates that the family subsidy program should be in operation by December 1, 1991. The Subcommittee applauds efforts made by MHRS to implement this program and recognizes that the program expands options and alternatives for families and community living.

H. Vocational Rehabilitation

The Subcommittee heard testimony from community providers regarding the need to strengthen the transitional vocational rehabilitation system. Testimony indicated that traditionally, adults with developmental disabilities have received training for employment through sheltered workshops. These workshops have served many purposes such as training people for community employment, providing a paid work environment, providing an environment where people with disabilities have the necessary support to enable them to work, and providing an alternative means of funding community programs. Recent trends, however, allow job placement directly into the competitive work environment or through the supported employment model which provides supports for the individual at the work site.

The Subcommittee encourages the vocation rehabilitation system and the Department of Education (through special education) to work together to strengthen vocational rehabilitation programs. In particular, the Subcommittee recommends that a stable staff of transition counselors be utilized to provide direction and assistance and to work actively with families, students, education, and community providers for long-range transition planning.

I. Special Education Programs

The Subcommittee expresses concern regarding the underfunding of Special Education programs. Testimony indicated that some public schools were cutting services rather than expenses. The Subcommittee recommends that special education funding be closely monitored and returned to at least a 90 percent funding level. Currently, special education is at a 73 percent funding level.

4. Autism

In addition to the mental retardation and developmental disability concerns discussed above, the Subcommittee also specifically focused on one particular developmental disability -- autism. Autism is a developmental disability which affects an individual's communication skills, social perceptions, and learning rate. It is a neurological disorder of the brain, frequently accompanied by disruptive, self-injurious, or aggressive behavior, stereotypic body movements, and a preoccupation with objects. There is no known cure. The 1987 Task Force Report on Autism estimated that there were 3,654 autistic individuals in Kansas at that time.

The Subcommittee learned that services are often not available to persons with autism and that individuals are frequently placed in settings inappropriate to their needs. Because professionals are untrained or unfamiliar with this disorder, parents and volunteers have shouldered the primary responsibility of providing programming suggestions, information, referrals, and even training of caretakers and providers.

The Subcommittee recommends the establishment of the Kansas Resource Center on Autism to provide a source for:

1. information on autism;
2. a central registry for autism for tracking purposes and statewide needs assessment;

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3. formation of specific training agreements and consultations with agencies to train agency staff to use the positive intervention strategy;

4. training, technical assistance, and consultation to teachers, advocates, and friends and family members of people with autism;

5. collect, update, and present information on autism to various professionals, families, community agencies, and the public;

6. provide parents and families with information and problem solving techniques;

7. provide accurate, timely information to state agencies and legislators, to facilitate networking, and to advocate for best practices; and

8. increase public awareness through new videotaped productions and literature.

The Resource Center would provide existing agencies and providers with the latest methods and practice in addressing this disorder. Approximate cost of the resource center would be $135,400. Estimated expenditures would include salaries and wages for three FTE (two professionals and one support person ($91,000)); rent ($6,000); travel ($19,200); communications ($4,700); staff training ($6,200); program equipment ($3,000); and a resource library ($4,100).

5. Uniting the Vision

In addition to the establishment of a Resource Center for Autism, the Subcommittee recommends legislation enlarging the statutory description of mental retardation to include mental retardation and developmental disabilities. As established by the "Uniting Our Vision" Conference, the Subcommittee believes that people with developmental disabilities and their families have unique needs, which are often inadequately addressed by community services. Services which should be available to all disabled individuals are often selectively doled out to those who fit only within a narrow statutory definition. The theme of the conference was unity, and it is the Subcommittee's unanimous recommendation that all persons with developmental disabilities be united through legislation which defines mental retardation <u>and</u> other developmental disabilities as follows:

Mental retardation means significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior. Other developmental disability means a condition such as autism, cerebral palsy, epilepsy, or other similar physical or mental impairment. In addition, mental retardation and otherwise developmentally disabled, also, means a severe, chronic disability which:

1. is attributable to a mental or physical impairment or a combination of mental and physical impairments, AND

2. is manifest before the age of 22, AND

3. is likely to continue indefinitely, AND

4. results in substantial limitations in any three or more of the following areas of life functioning:

    a. self-care,

   b. understanding and the use of language,
   c. learning and adapting,
   d. mobility,
   e. self-direction in setting goals and undertaking activities to accomplish these goals,
   f. living independently, and
   g. economic self-sufficiency, AND

5. reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated, AND

6. does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill or have disabilities solely as a result of infirmities of aging.

Rep. Gary Blumenthal, Subcommittee Chairperson
Rep. Henry Helgerson, Subcommittee Vice-Chairperson
Rep. Ann Cozine
Rep. Tim Shallenburger
Sen. Wint Winter, Jr.
Ms. Sandra McMullen

TABLE I

Estimated Costs of Providing Full Services for Persons
Who have Mental Retardation or Developmental Disabilities
In Kansas by 1997
As recommended by the 1991 MH&RS Legislative Subcommittee

Revised 01/03/92

Att. No. 19

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SERVICE TYPE	FY 93			FY 94			FY 95			FY 96			FY 97		
	Persons Served	SGF Cost (millions	FED Cost (millions	Persons Served	SGF Cost (millions	FED Cost (millions	Persons Served	SGF Cost (millions	FED Cost (millions	Persons Served	SGF Cost (millions	FED Cost (millions	Persons Served	SGF Cost (millions	FED Cost (millions
Service Coordination	5064	$0.00	$3.04	6162	$0.50	$3.85	7118	$0.75	$4.62	8070	$1.00	$5.45	9000	$1.50	$6.32
Supported Employment/Supported Living Services															
* VR Matching Grants	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80
* MH&RS Continuation Grants	75	$1.00		150	$2.07		225	$3.23		300	$4.48		375	$5.84	
* State General Funds	218	$2.45		436	$5.09		654	$7.94		872	$11.00		1090	$14.34	
Medical Services															
* HCBS/MR Recipients	1218	$1.75	$2.63	1615	$2.33	$3.49	1900	$2.74	$4.10	2166	$3.12	$4.68	2470	$3.56	$5.34
* SGF Recipients	3816	$3.82		4176	$4.18		4544	$4.54		4837	$4.84		5130	$5.13	
Day and Residential Habilitation Services															
* Existing SGF Services(Incl.SS	3478	$30.98		3478	$30.98		3478	$30.98		3478	$30.98		3478	$30.98	
* COLA for Existing Services		$1.24			$2.53			$3.87			$5.27			$6.82	
* Existing HCBS/MR Recipients	786	$7.58	$11.37	786	$8.35	$12.52	786	$9.12	$13.68	786	$9.48	$14.22	786	$9.86	$14.79
* New HCBS/MR Recipients	108	$1.04	$1.56	358	$3.80	$5.70	466	$5.41	$8.11	570	$6.88	$10.31	712	$8.93	$13.40
* Reduce Institutions using HCB															
State Institutions	190	$3.46	$5.19	273	$5.17	$7.76	356	$7.02	$10.53	439	$9.00	$13.50	510	$10.90	$16.35
Private Institutions	134	$1.63	$2.44	213	$2.69	$4.04	292	$3.84	$5.76	371	$5.07	$7.60	402	$5.73	$8.59
Family Support Services															
* Family Subsidy	400	$1.20		800	$2.40		1200	$3.60		1600	$4.80		2000	$6.00	
* Other Family Support Services	144	$0.43		288	$0.86		432	$1.29		576	$1.73		719	$2.16	
Agency Support Services															
* SRS Field Staff		$0.25	$0.25		$0.26	$0.26		$0.27	$0.27		$0.28	$0.28		$0.29	$0.29
* Local Consumer Councils		$0.41			$0.42			$0.44			$0.46			$0.47	
* CMRC Staff Training		$0.79			$1.15			$1.43			$1.71			$1.98	
* Bi-Annual Needs Assesment		$0.22			$0.24			$0.26			$0.28			$0.29	
* Rate Setting Study		$0.20													
Institutional Services															
* Three State Institutions	829	$27.36	$41.04	746	$26.80	$40.20	663	$26.16	$39.24	580	$25.41	$38.12	497	$21.34	$29.48
* Large Private ICFs/MR	516	$7.32	$10.98	437	$6.70	$10.04	358	$5.93	$8.89	279	$4.99	$7.48	200	$3.86	$5.79
* Small Private ICFs/MR	346	$7.37	$11.05	346	$7.95	$11.93	346	$8.59	$12.89	346	$9.27	$13.91	346	$10.02	$15.07
Total (Unduplicated)	7155	$100.90	$91.36	8098	$114.87	$101.59	8899	$127.80	$109.87	9696	$140.44	$117.36	10471	$150.41	$117.23
FY 92 SGF $82.85 mm Inflated		$86.16	$68.90		$89.61	$71.66		$93.21	$74.53		$96.93	$77.51		$101.08	$8.08
Additional State General Funds		$14.73	$22.46		$25.26	$29.93		$34.59	$35.34		$43.51	$39.85		$49.34	$109.15

NOTES:
1. This sheet estimates costs for a full service system for persons who are developmentally disabled.
2. This sheet does not reflect SRS appropriation requests due to limited state resources.
3. This sheet does not reflect SGF costs for service coordination because existing SGF will be used as certified Medicaid match.
4. Most funds on this spread sheet, including the $82.55mm appropriated for fy 92, were inflated 4% per year.
5. This sheet does not include any additional support from local counties.
6. In FY 97 Kansas will consolidate from three state mental retardation hospitals to two.

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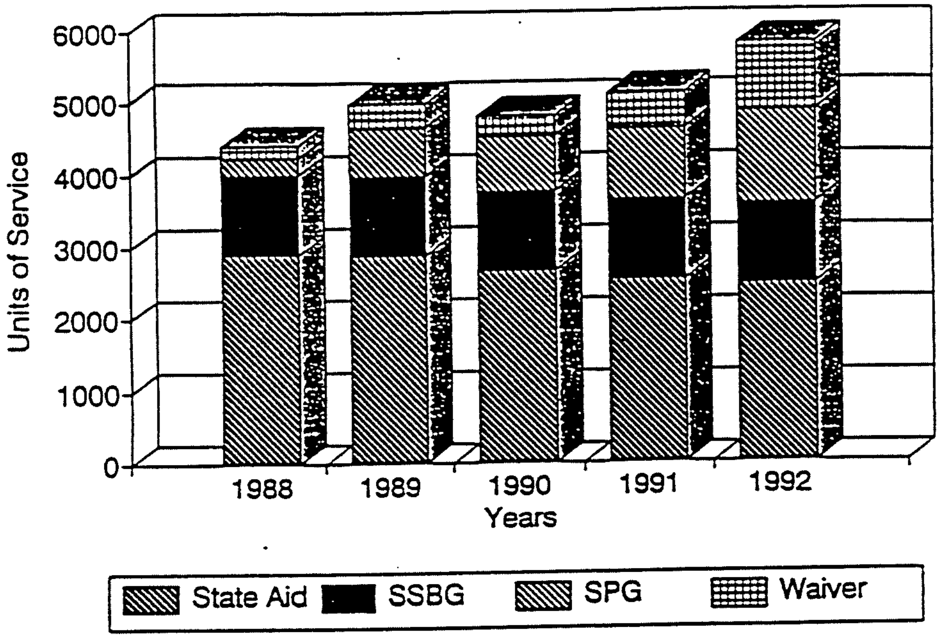
Table 2

Persons Served by Community Units of Service

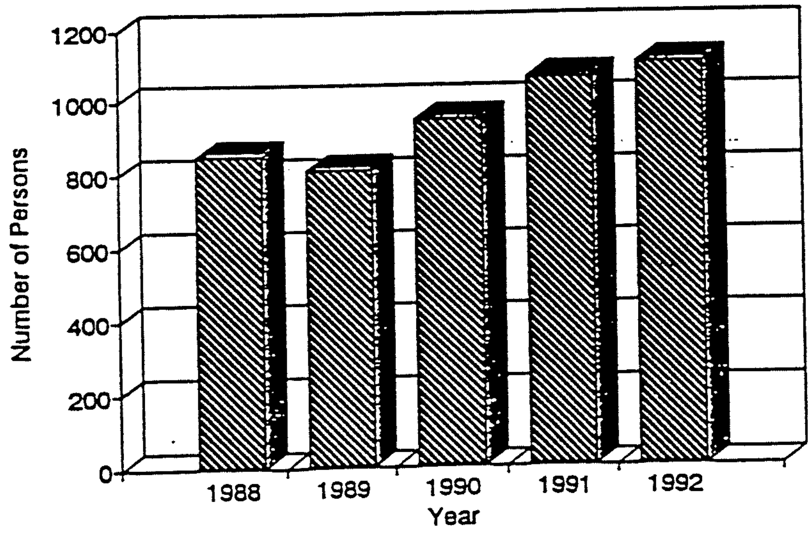
in Kansas 1988-1992



- There has been a real increase in the number of persons served, as the mix of funding changed (State Aid, Title XX Social Service Block Grant, Special Purpose Grants, and Home & Community Based Services Waiver), and as community services capacity building became a priority

People Waiting for Service at CMRCs

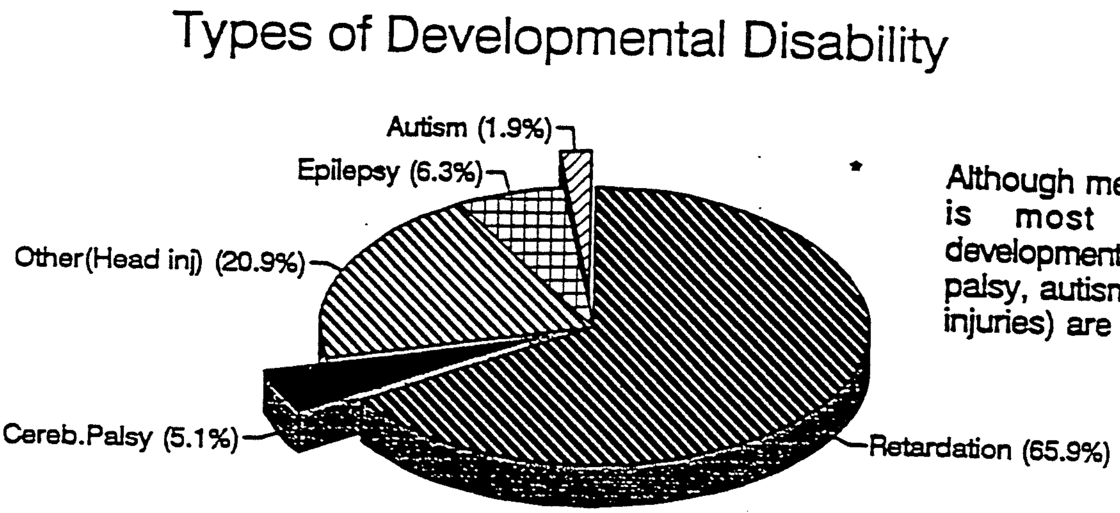
in Kansas 1988-1992



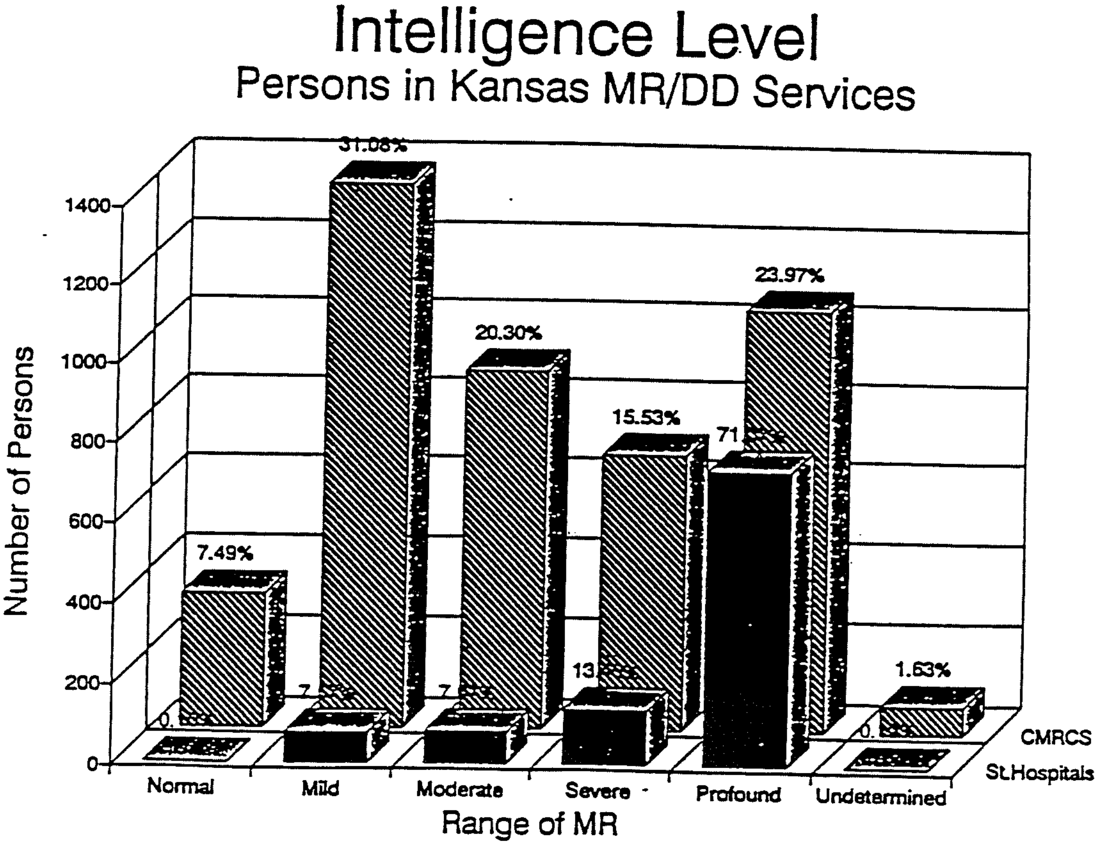
- Over 1,100 persons (children & adults) are waiting for community based services

Prepared by Mental Health and Retardation Services.

Table 3


Types of Developmental Disability

* Although mental retardation is most prevalent, other developmental disabilities (cerebral palsy, autism, epilepsy, and head injuries) are included


Intelligence Level
Persons in Kansas MR/DD Services

Prepared by Mental Health and Retardation Services.

* There are more persons with severe or profound mental retardation in the community than there are in state institutions

SUPPORTING KANSANS WITH DEVELOPMENTAL DISABILITIES

STATE OF KANSAS
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
DONNA WHITEMAN, SECRETARY

MENTAL HEALTH & RETARDATION SERVICES COMMISSION
GEORGE D. VEGA, COMMISSIONER

Original
October, 1991

Update
February, 1994

SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

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As William Allen White wrote in The Nation (April 19. 1922), Kansans are:

"a people neighbor minded in the Golden Rule. a people neighbor bound by ties of duty, by a sense of obligation. by a belief in the social compact....."

These values placed Kansas at the forefront of social progress. I believe the ideas presented here are very much in keeping with this tradition.

This report is about people who need society's help. some temporarily, and some for a lifetime... People who are and want to be our neighbors.

My vision for Kansas is to have a system of services that, once again, ranks among the leaders of our nation. The key ideas presented in this report would make a difference for all Kansans with developmental disabilities. I hope you will give them your thoughtful consideration and support.

Sincerely,

George D. Vega
Commissioner
Mental Health & Retardation Services

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PREFACE

Mental Health and Retardation Services (MH&RS) Division of MR/DD Services originally produced **Supporting Kansans with Developmental Disabilities** in October, 1991. It was updated in January, 1992 and endorsed by the Legislative Task Force on SRS as proposed by the Subcommittee on Mental Health and Retardation Services.[1] The mission and principles of service provision were approved and ideas such as person centered planning, supporting children in families, reallocation of resources, and a people first value system were formally recommended to the Legislature by the Task Force. The funding plan on page 11 was expanded, at the recommendation of the Task Force, from an original three year plan to a five year plan and included the closure of one state mental retardation hospital by FY 1997.

The September, 1993 revision of the strategic plan was updated to include a revised funding plan to reflect the current status of MR/DD services funding, but it was not changed substantially from the original publication. This most recent revision includes corrections on pages 8 and 11 to reflect FY 1997 projections.

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[1] Task Force on Social and Rehabilitation Services. (January, 1992). **Report on Kansas Legislative Interim Studies to the 1992 Legislature**. Filed with the Legislative Coordinating Council. Pp. 3-20

WHAT IS OCCURRING IN MR/DD SERVICES

KEY INFLUENCES

Resources

It is a continual struggle, particularly in difficult economic times, to adequately fund social service programs. This struggle is currently being waged simultaneously with moving from a program model of service to a model of support. Relationships in the system of services for people with developmental disabilities are driven economically; money spent on services creates local jobs, has economic impact on communities, and creates pressures on legislators and policy makers to preserve formalized structures.

Direct care workers have historically been low paid and lacked adequate training. These problems have often resulted in high turnover rates which created inconsistency in service delivery. The implementation of tiered rates for the home and community based waiver (HCBS/MR) services, which included salaries comparable to state institution beginning staff salaries, and the inclusion of money in HCBS/MR rates and grants to provider agencies for staff training coordinators have begun to address these issues related to turnover.

There are shortages of many licensed professionals in health care and other services, especially in rural areas. Access to medical and therapeutic services has been limited by state medicaid coverage limitations and the lack of availability of medical professionals with knowledge concerning developmental disabilities.

With the national trend of extending eligibility for services beyond persons with mental retardation to those with other developmental disabilities, more people are competing for scarce funding resources. Policy makers must develop creative mechanisms to use existing funds more efficiently, or develop eligibility criteria which prioritize who will have access to available dollars.

Advocacy

Advocacy by consumers, families, and providers of service is the linchpin of a responsive, adequately funded system of services which asks "What do you want and need?" - a system which supports *persons* rather than *programs*. In reality, advocacy for individual services may bring key actors into conflict (e.g., when one family is adamant their child receive institutional services while others advocate for more community services) at the expense of improving the overall system of services. When there is cooperation, however, the advocacy of consumers, families, and providers can result in movement toward common goals.

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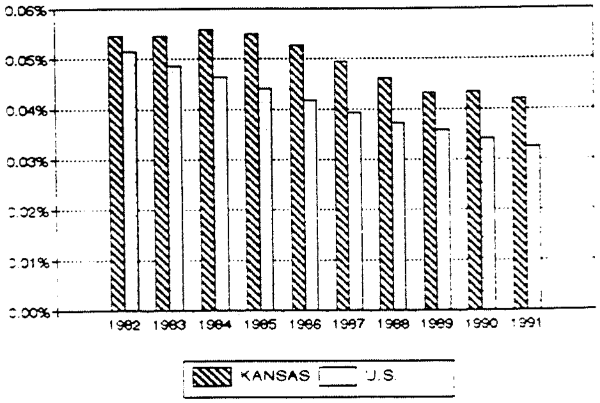
Expansion

Community services for people with developmental disabilities have expanded steadily in Kansas since FY 1982, and very rapidly since FY 1991 with the approval of the home and community based services (HCBS) waiver. Additionally, school age children and their families are now being served by agencies which traditionally served only adults. Overall, expenditures for community services have increased by 388% since FY 1982, from $23,149,808 to $89,915,651. Forty percent more people were served in the community in FY 1993 than in FY 1988. This rapid expansion has taxed the system and the people working in it, even though many people are still waiting to receive services.

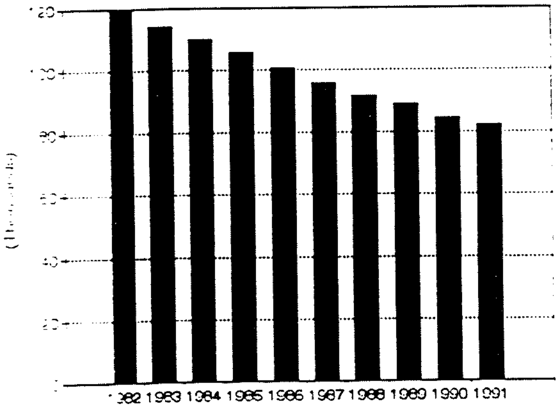
Trends

Nationally, services for people with developmental disabilities have shifted from a congregate model - largely institutional - to integrated small community settings. More recently, there has been a move away from the system of specially built facilities and programs to individualized services and supports which maximize the use of existing housing stock and available jobs in the community. While Kansas has closed one state institution (Norton State Hospital), nationally, institutional census reduction has outpaced us.

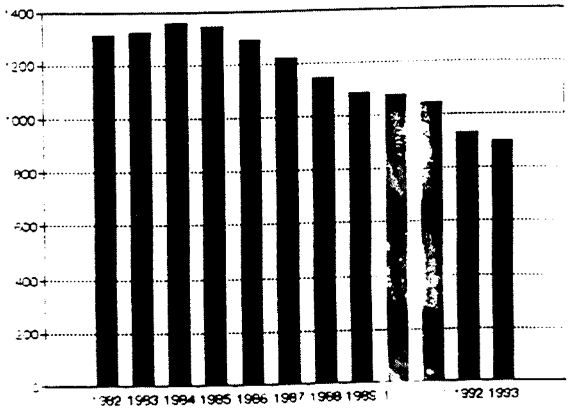
POPULATION PERCENTAGE OF
MR INSTITUTIONS IN KANSAS VS THE U.S.



INSTITUTIONAL RESIDENTS IN THE U.S.



KANSAS INSTITUTIONAL RESIDENTS



Concurrent with the change in how services are being delivered, quality of service issues are drawing more attention, particularly how services address individual needs and preferences. Consumer control and exercising the opportunity to make real choices have become increasingly important as providers of service understand that inclusion *in* the community will result in acceptance *by* the community, negating the need for specialized, segregated services.

……

WHAT PEOPLE WANT

CHOICE	in daily decisions about job, friends, recreation, and residence.
CITIZENSHIP	as a part of the community. Having interdependence and partnership. Exercising decisions affecting oneself.
ECONOMIC OPPORTUNITY	to work, to contribute, to have options for success.
FREEDOM	of movement. Freedom from stigma.
INDIVIDUALITY	by having a name and a personal history in the community and the opportunity to choose with whom to live with dignity and status.
A VOICE REGARDING	money, transportation, services, medications, and resources.
PERMANENCY	of a stable life in the community without fear of return to an institution. To be with family and friends.
PRIVACY	of records, files, and histories.
RECOGNITION	of abilities, capacities, and gifts.
RELATIONSHIPS	with family, friends, and partners.
SECURITY	and protection from harm in environments where risk is controlled. To have safety and to receive competent services.

WHAT TO DO

There is, of course, a large gap between the vision of what persons with MR/DD want and need and the current type and adequacy of services available in Kansas. Over the past two decades the Kansas Department of Social and Rehabilitation Services (SRS) Commission of Mental Health and Retardation Services (MH&RS) has produced several planning documents. These include five year plans (1986 - 1991), annual budgets, as well as action documents: Home and Community Based Services (HCBS) Waiver, etc., which have established goals, objectives, and outcomes. The most recent document resulting from the agency's planning effort is the 1990 service plan outline developed by the MR/DD Advisory Council covering the 1991-1995 period. Common threads among these documents include values and mission statements, and principles of service provision.

VALUES

Kansans with mental retardation or developmental disabilities should have the opportunity to be included and integrated in the life of their community. They should be able to exercise options to choose where and with whom they live, where to work, to participate in preferred leisure activities, to be educated in schools in their neighborhoods and to build and maintain relationships with family and friends.

MISSION

A comprehensive array of support and direct services should be developed in Kansas which provides the greatest degree of integrated service options to the person who is mentally retarded or otherwise developmentally disabled. This array of services should be enhanced in partnership with individuals served, their parents, advocates, providers of service, federal, state and local governments.

PRINCIPLES OF SERVICE PROVISION

The system of services to Kansans with mental retardation and developmental disabilities must be flexible and based on individual needs. Services should be offered at a time and place which does not segregate or stigmatize individuals, in a way which provides diverse service options based on the following minimum principles:

1. It is the responsibility of service providers to justify separate, nongeneric or more restrictive services - whether in special education, living arrangements, leisure opportunities or work.

2. All individuals have the right to due process.

3. All individuals and/or their guardians should have opportunities to make choices including, but not limited to, where to live, work and play. They should select and keep possessions, be treated with respect and live in surroundings that provide individuality and privacy.

4. All individuals should be dealt with in an equitable manner.

5. Each individual should receive services tailored to address their unique personal strengths and needs rather than based on the availability of services.

6. Individuals should have the opportunity to have a safe, clean and healthy environment.

7. All services should continually meet at least minimum quality standards.

8. Services and the administration, management and oversight of services should be provided in the most cost effective manner possible.

9. All individuals and agencies should advocate for resources and services which are in keeping with these principles. This advocacy effort should be guided by individuals who are mentally retarded or otherwise developmentally disabled, their family, friends and guardians and include service agencies, county, state and federal agencies, elected officials and the general public.

WHAT IS NEEDED

- Embrace new ideas

  a) Base decisions on futures planning for individuals rather than slots in the system. Then, train service coordinators to implement such strategies.
  b) Pay nuclear and surrogate families to make a home for children as an alternative to public and private institutions.
  c) Rework the way money is allocated by providing funds to support individuals based on level of need, rather than funding facilities, programs, or services.
  d) Embrace a people first value system which considers people before disabilities, facilities, systems, or bureaucracies, and which encourages use of generic services rather than segregated specialized services.

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* Reconfigure services for adults and children to reflect their values

a) For children, develop natural supports and family supports
b) For adults, reinforce the preference for individual supports rather than facility based services (e.g., home/apartment or supported living rather than segregated group home; supported employment rather than programs based on the "readiness" model)
c) Build no more group homes
d) Look to other uses for segregated work activity and day activity centers

* Establish service capacity to provide full community integrated services

a) Eliminate the community waiting list by 1997
b) Reduce state MR hospital census to 497 by 1997
c) Serve all children including the 183 currently in state MR hospitals by 1997
d) Eliminate all large ICFs/MR by the year 2000 by reducing their census by 78 persons per year
e) Develop a service coordination mechanism independent of service provision to serve 9,000 persons by 1997

* Develop a solid, high quality service infrastructure

a) Rename CMRCs to Community Developmental Centers and establish a full service mandate to be available in each service area
b) Establish a list of core services which must be available in each service area
c) Set minimally acceptable standards for knowledge and performance competencies of paraprofessional and professional personnel who serve persons in the developmental service system
d) Establish a state-wide, state level presence in area SRS offices to validate the mechanisms and monitor service provision, service quality, and service planning
e) Establish quality enhancement processes and procedures which go beyond minimally acceptable standards and which are led by consumers and parents
f) Establish a minimum wage for community provider staff
g) Establish reimbursement levels that are tied to the level of individual need rather than funding services based on labels and categories (for example, design model contracts which provide funding for people, not programs

WHAT DO WE NEED FROM OUR COMMUNITY AGENCIES?

- Commitment to
  a) supporting individuals rather than facilities
  b) developing, coordinating and providing family supports for children and adults
  c) bringing all persons back home from public and private institutions
  d) quality enhancement
  e) training through inclusionary rather than medical or educational models
  f) tolerance for vacancies in and conversion of existing facilities
  g) leadership and participation in cooperative service development and implementation
  h) focus on increased financial support at the local level
  i) serve all types of persons with developmental disabilities (e.g., cerebral palsy, autism, etc.) and all age groups

WHAT DO WE NEED FROM OUR STATE AGENCIES?

- Support for
  a) local planning and coordination
  b) self advocacy
  c) monitoring and validating local efforts rather than directing and sanctioning
  d) provider staff training
  e) raising wages of staff in community programs
  f) merging legislative appropriations for institutional and community services
  g) flexibility and accountability in the use of funds

WHAT DO WE NEED FROM THE LEGISLATURE?

- Fiscal and Policy Resources
  a) Establish a minimum local funding base
  b) Authorize MH&RS to establish standards for Community Development Centers, core services, quality assurance, and quality enhancement
  c) Establish an appropriations process that merges state hospital and community provider funding
  d) Modify current law governing CMRCs and MH&RS to broaden the mission to cover persons with developmental disabilities.
  e) Authorize MH&RS to establish minimum knowledge and performance competencies for professional and paraprofesional personnel in community developmental services and fund a mechanism to achieve these
  f) Modify current statutes to reflect a mission which includes persons with developmental disabilities
  g) Pass legislation which mandates development of training and delegation of non-invasive medical procedures to be available in all community settings serving persons with developmental disabilities

WHAT WILL IT COST?

The development of a full service system responsive to the needs of all persons with mental retardation and other developmental disabilities and their families cannot be accomplished merely by reconfiguring or refinancing the current service system. Today there is a critical shortage of two vital components of a responsive system: service coordination and quality assurance and enhancement. Only the infusion of new fiscal resources will add these in full measure to the system.

The estimated cost and interaction of fiscal resources has been projected through 1997. At that time, the system could be at full service. Then, as recommended by the Legislative Subcommittee on MH&RS/MRDD, service reconfiguration (including the closure of one state hospital with concurrent redirection of funds to community services) and refinancing of services within the system could be the mechanisms to meet the new technologies as they fully evolve. The ongoing costs would increase by cost of living and by graduates from special education programs.

There is a waiting list for services. Only the infusion of new fiscal resources will eliminate this list. **This plan will totally eliminate the waiting list for community services.** It will also establish a comprehensive service coordination mechanism which will provide greater system efficiency and effectiveness on behalf of persons who are mentally retarded or developmentally disabled and their families.

* Please note that the costs illustrated are estimated and approximate, denoting the resources needed for a full service system for persons who are developmentally disabled. **They do not represent SRS/MH&RS budget requests.**

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ESTIMATED COSTS OF PROVIDING FULL SERVICES FOR PERSONS WHO ARE MENTALLY RETARDED OR OTHERWISE DEVELOPMENTALLY DISABLED AS RECOMMENDED BY THE 1991 MH&RS LEGISLATIVE SUBCOMMITTEE

FEBRUARY 14, 1994

										ORIGINAL ESTIMATES					
	Actual - FY 93			Estimated - FY 94			B-Level Request FY 95			FY 1996			FY 1997		
Type of Service	# Serve	SFG (Mills)	All Funds (Mills	# Serve	SFG (Mills)	All Funds (Mills	# Serve	SFG (Mills)	All Funds (Mills	# Serve	SFG (Mills)	All Funds (Mills	# Serve	SFG (Mills)	All Funds (Mills
Service Coordination	1,952	$0.00	$0.87	3,000	$0.00	$2.50	4,800	$0.00	$4.00	8,070	$1.00	$5.45	9,000	$1.50	$6.32
Supported Employment/Living															
- VR Matching Funds	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80
- MH&RS Continuation	75	$1.00	$1.00	175	$2.02	$2.02	250	$3.02	$3.02	300	$4.48	$4.48	375	$5.84	$5.84
- State General Funds	0	$0.00	$0.00	0	$0.00	$0.00	0	$0.00	$0.00	872	$11.00	$11.00	1,090	$14.34	$14.34
Therapeutic Consultation (1)															
- HCBS/MR Recipients	0	$0.00	$0.00	0	$0.00	$0.00	0	$0.00	$0.00	2,166	$3.12	$7.80	247	$3.56	$8.90
- SGF Recipients	0	$0.00	$0.00	0	$0.00	$0.00	0	$0.00	$0.00	4,837	$4.48	$4.48	5,130	$5.13	$5.13
Day & Residential Services															
- Grants & Local Funds (1)	3,466	$21.99	$30.98	3,266	$16.92	$25.91	3,266	$16.92	$25.91	3,478	$30.98	$30.98	3,478	$30.98	$30.98
- Grant COLAs		$0.00	$0.00		$0.00	$0.00		$0.00	$0.00		$5.27	$5.27		$6.82	$6.82
- Base HCBS/MR	786	$5.71	$13.98	786	$7.30	$17.88	786	$7.30	$17.88	786	$9.48	$23.70	786	$9.86	$24.65
- New HCBS/MR from Community	108	$0.53	$1.30	543	$4.17	$10.21	761	$5.28	$12.94	570	$6.88	$17.19	712	$8.93	$22.33
- HCBS/MR from State Institutions	142	$1.36	$3.34	274	$3.13	$7.68	274	$4.27	10	439	$9.00	$22.50	510	$10.90	$16.15
Family Support Services															
- Family Subsidy	250	$0.79	$0.79	416	$1.00	$1.00	416	$1.00	$1.00	1,600	$4.80	$4.80	2,000	$6.00	$6.00
- Family Support	618	$0.61	$0.61	618	$1.48	$1.48	618	$1.48	$1.48	576	$1.73	$1.73	719	$2.16	$2.16
Agency Support Services															
- SRS Field Staff		$0.14	$0.27		$0.18	$0.36		$0.21	$0.42		$0.28	$0.56		$0.29	$0.58
- Consumer Councils		$0.00	$0.00		$0.00	$0.00		$0.00	$0.00		$0.44	$0.44		$0.47	$0.47
- CMRC Staff Training (1)		$0.00	$0.00		$0.00	$0.00		$0.00	$0.00		$1.71	$1.71		$1.98	$1.98
- Bi-annual assessment		$0.00	$0.00		$0.00	$0.00		$0.00	$0.00		$0.28	$0.28		$0.29	$0.29
- Rate Study		$0.20	$0.20		$0.00	$0.00		$0.00	$0.00		$0.00	$0.00		$0.00	$0.00
- Institutional Placement Start-Up		$0.32	$0.32		$0.32	$0.32		$0.32	$0.32		$0.00	$0.00		$0.00	$0.00
Institutional Services															
- State Institutions	876	$31.33	$71.59	743	$27.90	$70.86	(2) 743	$33.88	$70.53	580	$25.41	$63.53	497	$21.34	$50.82
- Private Institutions	976	$14.92	$35.91	961	$15.14	$37.10	961	$14.41	$35.31	625	$14.26	$35.65	546	$13.88	$34.74
Total (Unduplicated)		$79.30	$162.96		$79.96	$179.12		$88.49	$185.09		$135.00	$243.35		$144.67	$240.30

(1) In FY 1994 approximately 200 individuals were taken off of grants and placed on HCBS/MR funding. This allowed payment rates to be increased. These increases were intended to cover the cost of therapeutic consultation and staff training originally identified separately in the funding plan. Therefore these costs are no longer shown separately but are included in payment rates for grants and HCBS/MR on this revision. This change allowed $1.5 million to be returned to the state general fund and the remaining savings were used to provide the state match to serve the 200 individuals moved from the grants and raise rates to cover the cost of therapeutic consultation and staff training.

(2) The FY 1995 budget request does not reflect placement of individuals from State MR institutions to community services. When placements do occur the funds necessary to pay for community services will be transfered from state MR institutions to HCBS/MR. The state MR institution budget request however reflects a full year's savings for people placed for part of a year in FY 1994.

MENTAL HEALTH & RETARDATION SERVICES
DIVISION OF MR/DD
1994 ANNUAL REPORT

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

July 1, 1994

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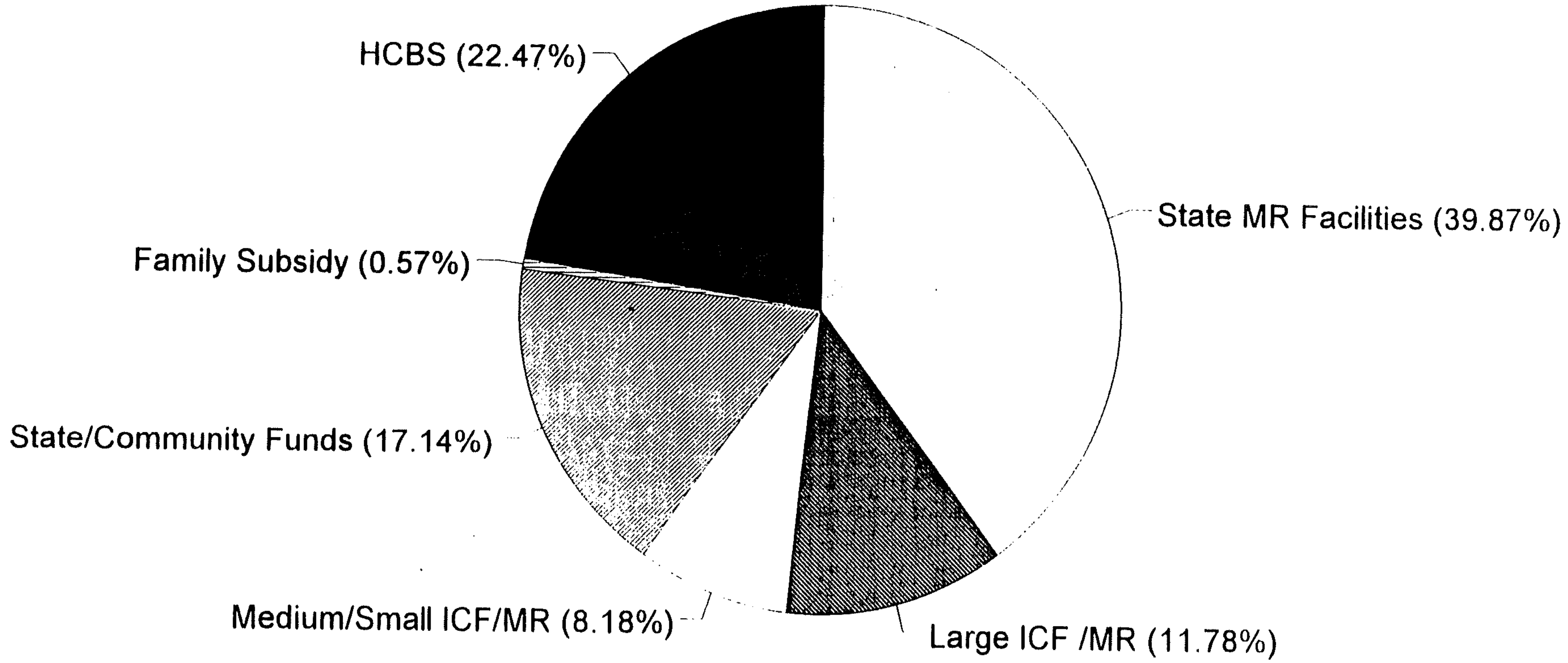
For Copies of this Report write or contact:

Mental Health & Retardation Services
915 SW Harrison - 5th Floor
Topeka, KS 66612
(913) 296-3476

1-54

DISTRIBUTION OF MR/DD SERVICE BUDGET

1-55



This graph replaces the one on page 7.

1-55

MENTAL HEALTH & RETARDATION SERVICES
MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

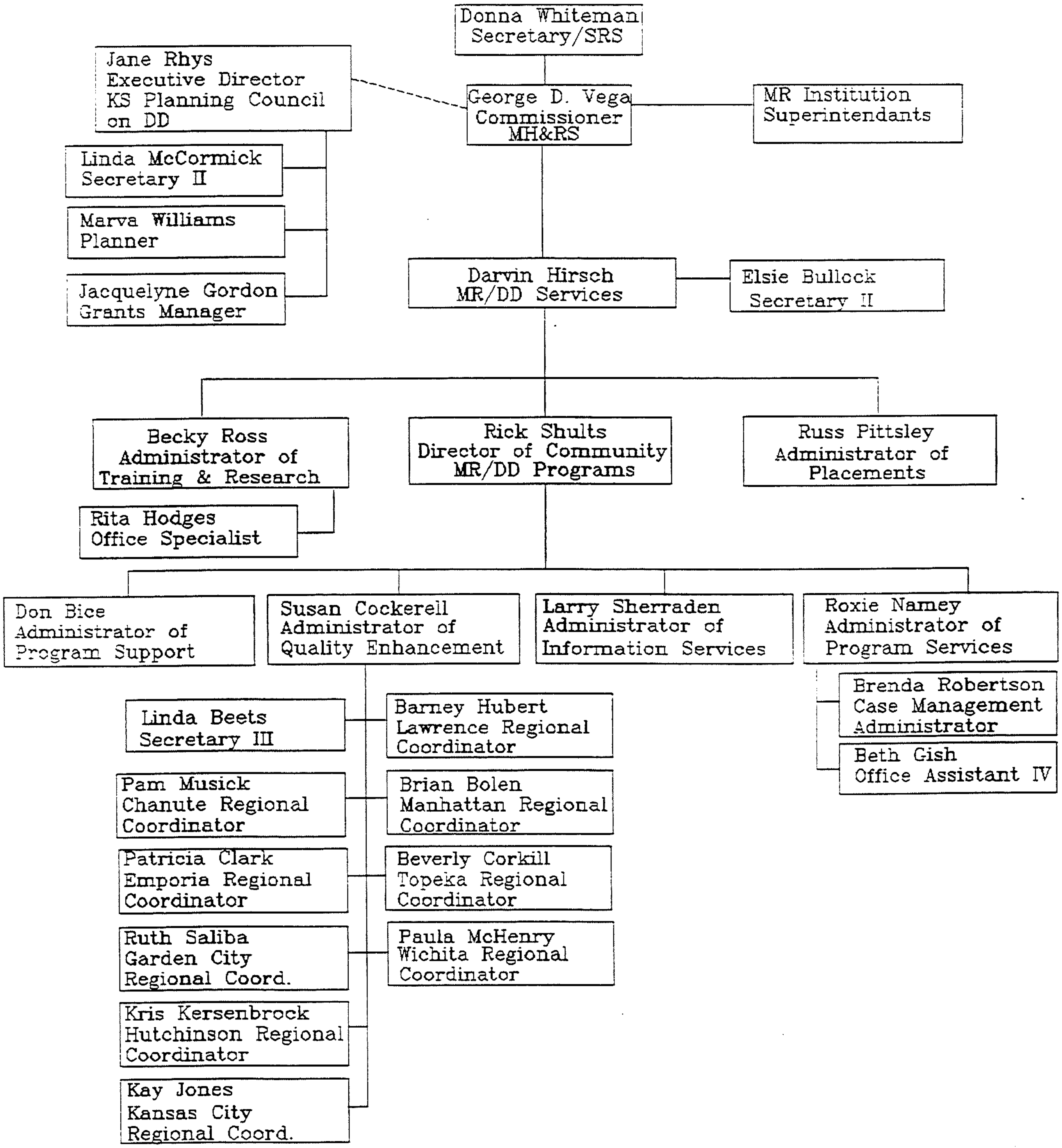
VALUES

Kansans with mental retardation or developmental disabilities should have the opportunity to be included and integrated in the life of their community. They should be able to exercise options to choose where and with whom they live, where to work, to participate in preferred leisure activities, to be educated in schools in their neighborhoods and to build and maintain relationships with family and friends.

MISSION

A comprehensive array of support and direct services should be developed in Kansas which provides the greatest degree of integrated service options to the person who is mentally retarded or otherwise developmentally disabled. This array of services should be enhanced in partnership with individuals served, their parents, advocates, providers of service, federal, state and local governments.

SOCIAL AND REHABILITATION SERVICES
MENTAL HEALTH AND RETARDATION SERVICES
MENTAL RETARDATION/ DEVELOPMENTAL DISABILITIES SERVICES



SERVICE DESCRIPTIONS

Mental Retardation/Developmental Disabilities (MR/DD) Services within the Mental Health and Retardation Services Commission administers funds for, or licenses, the following services:

Residential Services

These are a range of services designed to provide assistance, support, or training to persons in group homes or apartments. The majority of such settings are owned or leased by community mental retardation centers (CMRCs) or their affiliates, but some are owned or leased by consumers themselves,

Supported Employment

This is competitive work in an integrated setting with ongoing support in a site where the majority of co-workers are not disabled, or in small work groups which have regular contact with individuals who are not disabled.

Case Management

This provides support to eligible persons by developing, linking, coordinating and monitoring services, supports and resources.

ICF/MR

Intermediate care facilities for persons with mental retardation or related conditions must serve at least four people per facility, and provide continuous active treatment in residential and day programs in compliance with federal regulations.

Day Training

Adult life skills, work activity, and work adjustment are all designed to assist individuals to acquire skills in valued activities, including work, while providing meaningful activity during the day.

Support Services

These include respite care, supportive home care or personal assistance, home modifications and family subsidy. All of these services are designed to assist persons with developmental disabilities to remain in their own, or their family's, home.

Supported Family Living

This is a surrogate family service provided to children through age 22 to avoid placement in a non-family congregate setting such as an institution when they cannot, for whatever reason, remain with their natural families.

State Institutions

Kansas operates three ICFs/MR: Kansas Neurological Institute, Parsons State Hospital and Training Center, and Winfield State Hospital and Training Center.

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FUNDING SOURCES

Community services for persons with developmental disabilities can be paid for in a variety of ways. Funding administered by DD Services is federal and state money. Community mental retardation centers (CMRCs) also receive county mill levy money and donations as well as funds from other commissions of SRS, state departments, and school districts.

Medicaid

In Kansas, medicaid funds ICF/MR, home and community-based services (HCBS), and targeted case management. This 60-40 federal-state combination is a categorical, means-tested funding source. Individuals must fit into specific categories (e.g., aged, disabled) and must have income and resources below specified thresholds.

Social Service Block Grant

SSBG is money provided to states by the federal government, on a formula basis, and combined with state dollars to fund a variety of social services. CMRCs receive SSBG money as a part of their consolidated grants to fund services for a specific number of people.

County Mill Levy

Counties collect a mill levy which CMRCs use as discretionary money to provide services to individuals, pay for operating expenses, or staff salaries.

State Aid

This funding source is state funds authorized by statute, and allocated to CMRCs on a population formula basis. It is not tied to specific consumers, however, it is used in combination with other money to serve approximately 2,300 people.

Special Purpose Grants

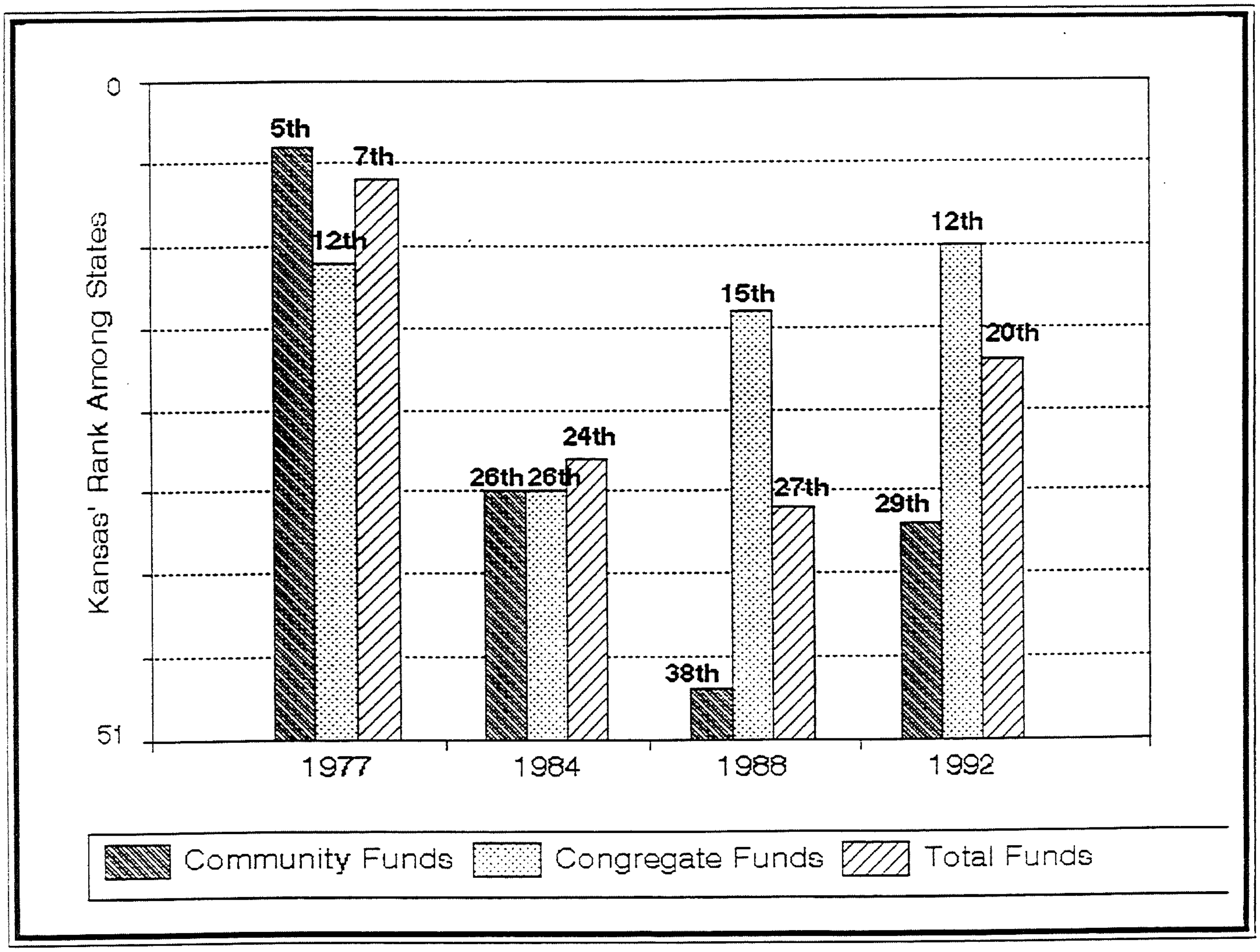
These grants are state funds awarded to CMRCs and their affiliates to provide specific units of service to persons with developmental disabilities.

Family Subsidy

Funds for a cash subsidy are to help ease the burden of raising children with developmental disabilities. This money is not designated for a specific purpose, but is directed to families for assistance with extraordinary financial expenses incurred in caring for a child with developmental disabilities.

FISCAL EFFORT

Kansas ranks 29th in spending for community developmental disabilities services as a percentage of personal income.[1] In 1977 the state ranked fifth among all states in the fiscal effort for community services, but dropped to 38th in 1988.[2] Approval of a separate home and community-based services (HCBS) waiver for people with developmental disabilities, a new family subsidy program, and Vocational Rehabilitation/Mental Health and Retardation Services supported living/employment grants have all contributed to the state's upward movement. The graph below compares Kansas's fiscal effort for community services with that for congregate (facilities with 16 or more beds) services since 1977.



The graphs on the following page provide a breakdown of FY 1994 developmental disabilities expenditures by category, and clearly demonstrate substantial increases in HCBS funding since FY 1991.

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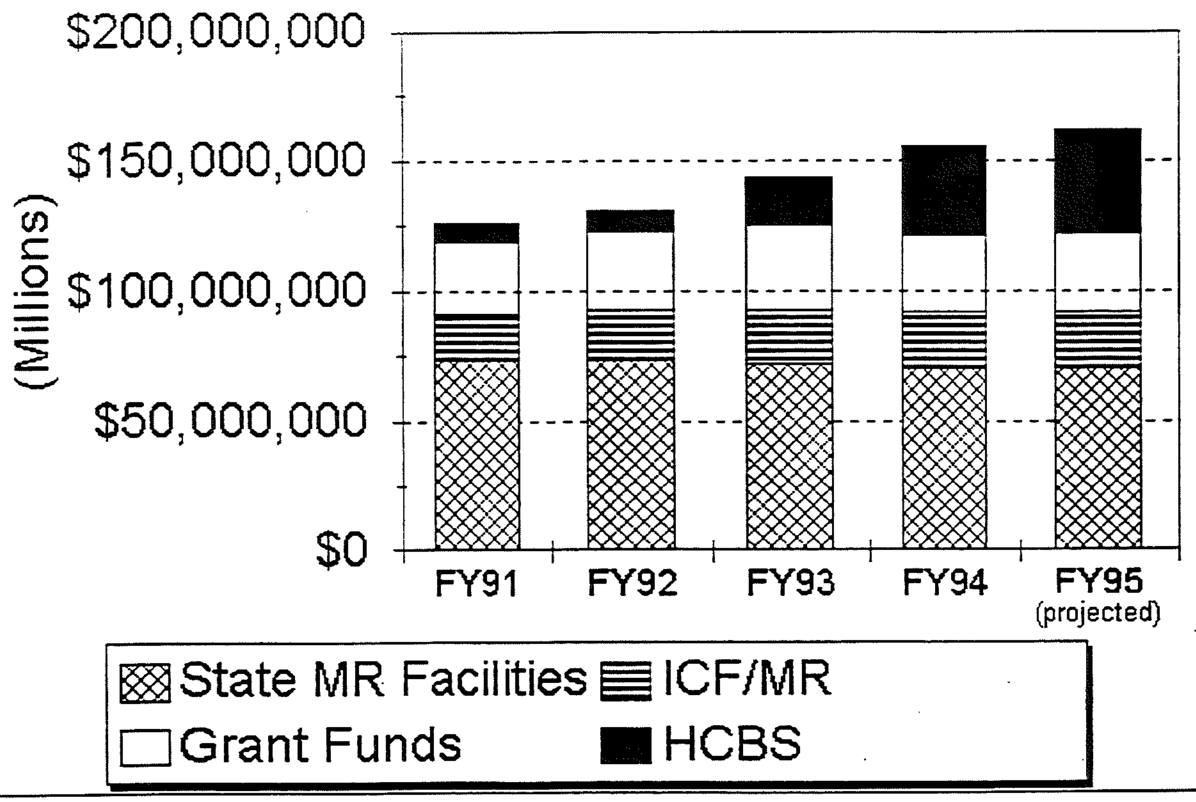
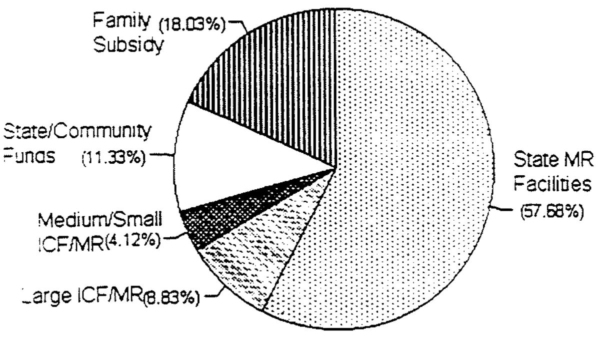
[1] Institute on Disability and Human Development (UAP), University of Illinois at Chicago, 1994.

[2] Braddock, D. Hemp, R., Fujiura, G., Bachelder, L., and Mitchell, D. (1990). **The State of the States in Developmental Disabilities.** Baltimore: Paul H. Brookes.

KANSAS DD EXPENDITURES

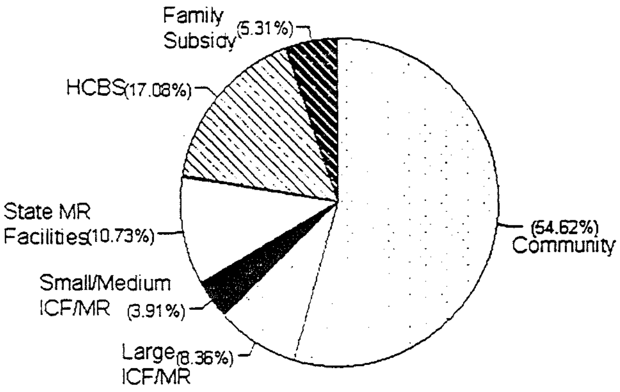


DISTRIBUTION OF DD SERVICE BUDGET



Data as of December, 1993

DD POPULATION SERVICE SETTINGS



Data as of December, 1993

WHO IS ELIGIBLE?

In order to assure that limited resources are used as efficiently as possible MR/DD Services has developed specific eligibility criteria. These criteria are not intended to define mental retardation or other developmental disabilities, but to define the group of persons with MR/DD who can be served with funds we administer.

To be eligible for services funded by MH&RS persons must meet the following criteria:

Mental retardation means significantly sub-average intellectual functioning as evidenced by an IQ score of 70 or below on a standardized measure of intelligence. Other developmental disability means a condition such as autism, cerebral palsy, epilepsy, or other similar physical or mental impairment. In addition, **mental retardation and otherwise developmentally disabled** is evidenced by a severe, chronic disability which:

1. is attributable to a mental or physical impairment or a combination of mental and physical impairments, **AND**
2. is manifest before the age of 22, **AND**
3. is likely to continue indefinitely, **AND**
4. results in substantial functional limitations in any three or more of the following areas of life functioning:
   a. self-care,
   b. understanding and the use of language,
   c. learning and adapting,
   d. mobility,
   e. self-direction in setting goals and undertaking activities to accomplish those goals,
   f. living independently,
   g. economic self-sufficiency, **AND**
5. reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated, **AND**
6. does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill or have disabilities solely as a result of infirmities of aging.

When an assessment of "substantial functional limitations" is needed the **Eligibility Determination Instrument** is available from MR/DD Services.

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FY 1994 ACCOMPLISHMENTS

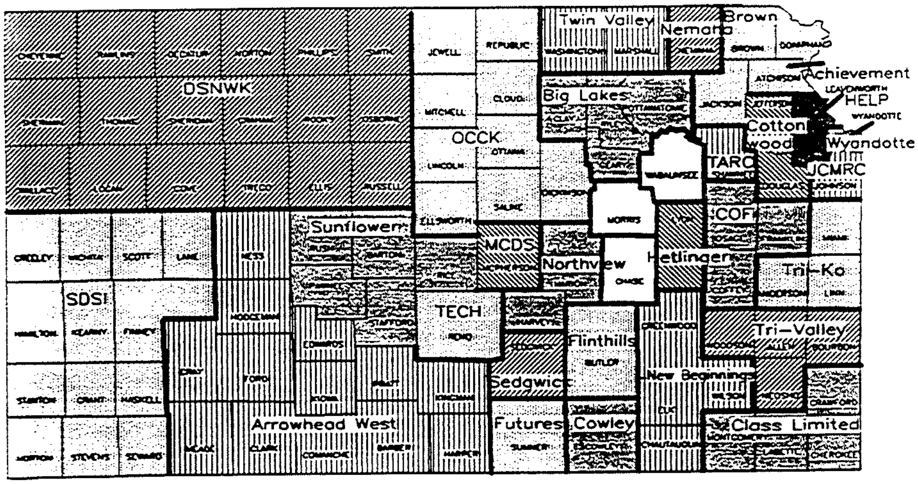
- 340 persons are being provided supported employment and 178 are being provided supported living through consolidated grants.
- Overall census at the three state mental retardation institutions has been reduced by 70, and 61 people have been placed into the community since July, 1993, using HCBS/MR funds.
- Three additional Regional Mental Retardation Coordinators have been hired.
- 541 families will be receiving $200 per month cash subsidy by January, 1995.
- $1,476,025 for support services is being provided by community mental retardation agencies through consolidated grants.
- HCBS/MR funding is paying for supports and services for 235 additional people who were unserved in the community.
- An additional staff person was hired to assist case managers.
- The first annual Kansas Conference on Developmental Disabilities was attended by 416 people.
- The number of Kansas counties unserved by community mental retardation centers was reduced by two.

FY 1995 CHALLENGES

- Place 63 additional people from state mental retardation institutions to meet census reduction goals.
- Increase the number of community mental retardation agencies willing to serve persons with severe and multiple disabilities.
- Increase services to children with developmental disabilities and their families.
- Continue efforts to convert congregate residential settings and sheltered workshops to supported living and supported employment.
- Implement closure of at least one large, private ICF/MR.
- Provide education for consumers and families about their rights, guardianship, benefits, and services/supports so they can make informed, responsible choices.
- Begin work to develop a unified statewide waiting list for all developmental disabilities services.
- Determine whether sufficient medical, dental, and therapeutic services are available statewide across all service settings.
- Help change the bias toward institutionalizing Kansans in need.

WHERE ARE SERVICES RECEIVED?

Community Mental Retardation Centers (CMRCs)

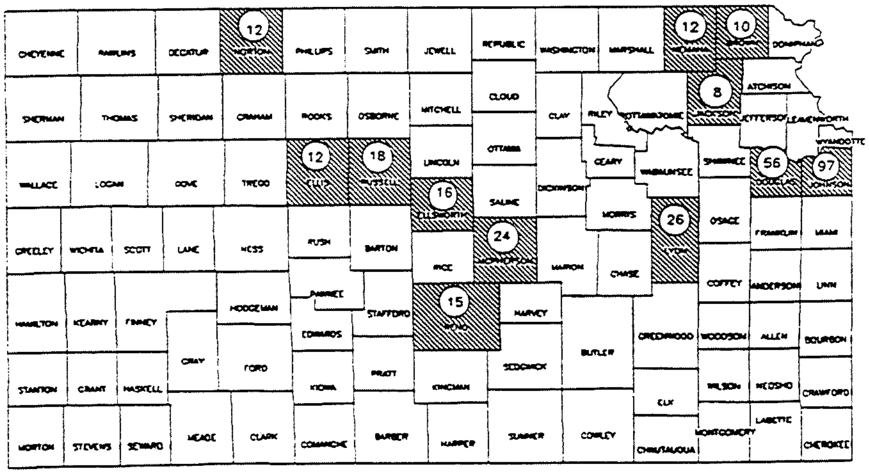


Date of Map: July1, 1994

There are 28 recognized non-profit CMRCs which receive county mill levy money in addition to other local, state, and federal funds. These agencies serve persons in designated geographic areas. Some CMRCs also work with affiliate agencies to ensure a comprehensive array of services is available. Currently, these agencies serve approximately 5,600 people in a variety of residential, day, or support services.

Small ICFs/MR

Approximately 300 people are served in 34 small ICFs/MR (16 beds or less). Many of these facilities are operated by CMRCs.



Total Beds = 306

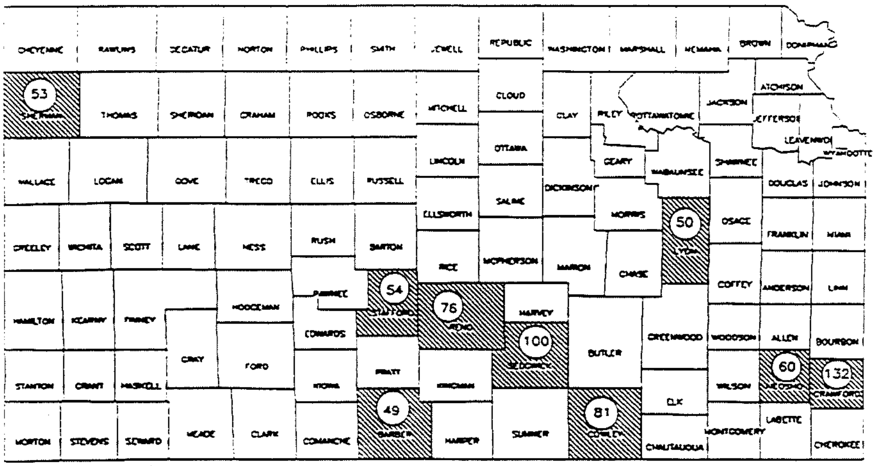
○ = Number in circle equals beds in county

Date of map: June 16,1994

1-64

Large ICFs/MR

Ten large ICFs/MR (greater than 16 beds) serve roughly 650 people. These facilities are operated by for profit providers, several of which also operate nursing facilities. It is the intent of MR/DD Services to close all these facilities by the year 2000.



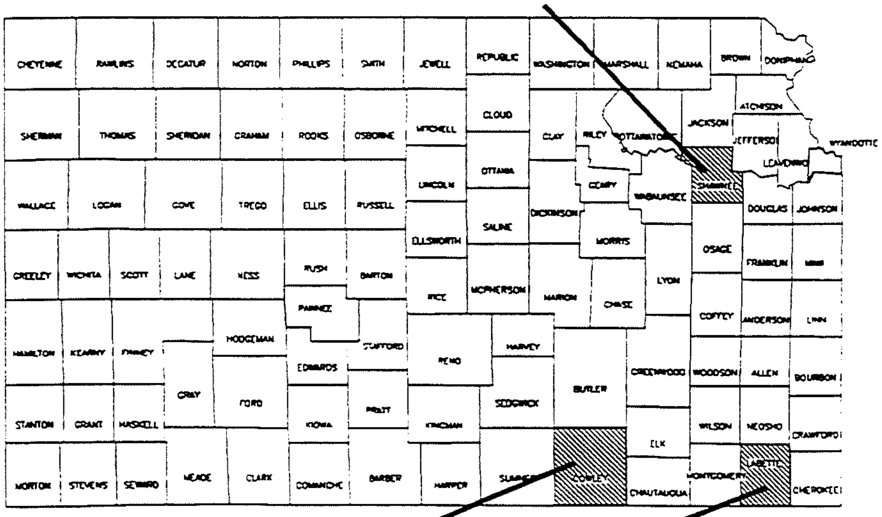
Total Beds = 655

◯ = Number in circle equals beds in county.

Date of map: June 16,1994

State Institutions

Kansas Neurological Institute



Date of Map: July 29, 1994

Winfield State Hospital

Parsons State Hospital

Kansas operates three MR facilities, whose FY 1994 year end censuses were:

Kansas Neurological Institute	285
Parsons State Hospital & Training Center	225
Winfield State Hospital & Training Center	296

1-65

DEVELOPMENTAL DISABILITIES PROFILE (DDP) AND TIERED REIMBURSEMENT RATES

The DDP is a four-page instrument designed to record salient characteristics of individuals with developmental disabilities. It was developed by New York's Office of Mental Retardation and Developmental Disabilities (OMRDD) over a two year period.[3] The information collected via the DDP includes a broad range of adaptive functioning skills as well as behavioral challenges and health factors. The instrument yields a score on each of three indexes: adaptive functioning, maladaptive behavior, and health needs. The higher the score, the greater (more severe) the need.

Because the indexes are not equivalent numerically, Kansas computes a converted score by dividing each index score by the highest score obtained in Kansas in the first year of use for the corresponding index. The three resulting figures are added together and the sum is multiplied by 100.

The DDP has been used as an eligibility instrument for ICF/MR and HCBS since July 1, 1990. To be eligible for these services, an individual must have a converted score of 50 or above. The DDP converted score is the foundation of the ICF/MR reimbursement system. Facilities are grouped according to their facility converted scores. These scores are obtained by taking the average score of all the residents in the facility for each index and performing the computations above. Certain HCBS reimbursement rates are also tied to tiers which relate to ranges of DDP index scores so providers are reimbursed at rates corresponding to the relative severity of disability.

Tiered HCBS rates are not intended to provide exactly the amount of funding needed for each and every person served. Instead, it is believed that the funds provided through tiered rates will, on the average, provide an amount sufficient to appropriately serve everyone no matter how severely disabled. As this becomes reality, HCBS funded services will indeed be able to meet the needs of everyone in community integrated services. It is important to realize average reimbursement does not mean individuals must be served in group settings. It is still possible to provide individualized community based services using tiered rates.

At the present time, there is no reliable, valid instrument which can predict the cost of services for an individual. What few studies have been performed on this subject indicate what is most likely to determine the cost of services is the provider of those services.

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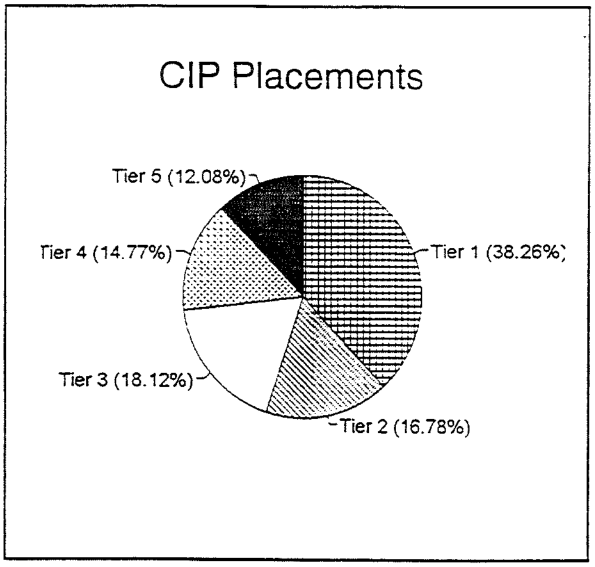
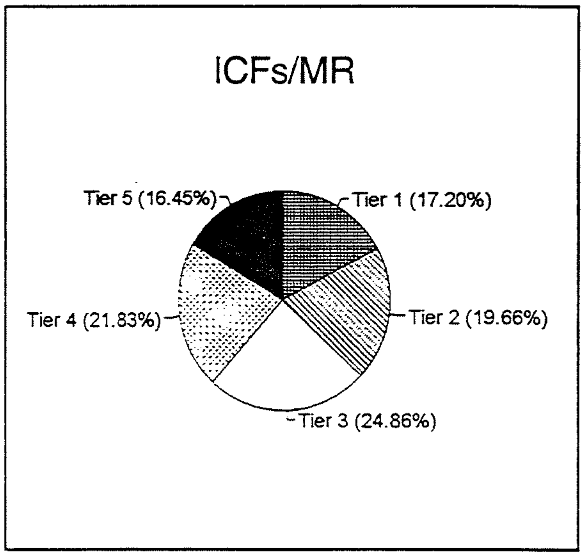
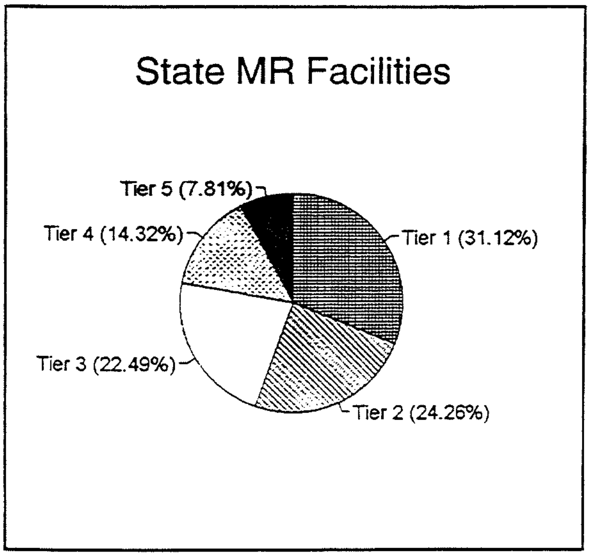
[3] For a discussion of that development, see **The Developmental Disabilities Profile Final Report: The Design, Development & Resting of the Core Instrument** (OMRDD, 1990).

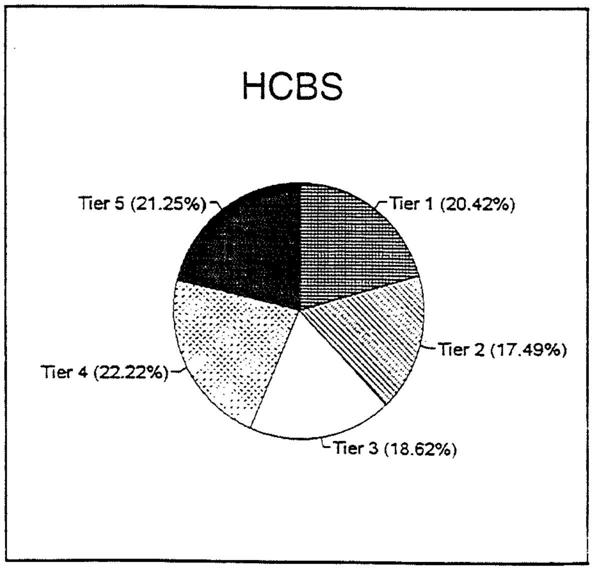
Distribution of DDP Tiers by Service

As of December, 1993





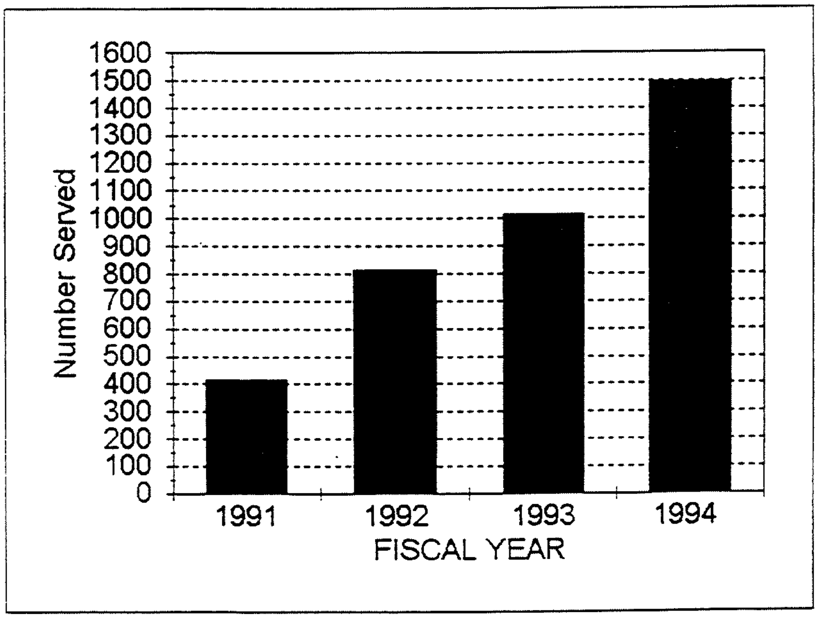




HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER

The HCBS waiver is a Medicaid program which funds services and supports for people with developmental disabilities in their communities as an alternative to institutional care. Kansas received approval from the federal government to operate such a waiver specifically for people with developmental disabilities in 1991. Since that time the number of people served by the waiver has grown from 416 to over 1500. The HCBS waiver has been instrumental in providing services to children with disabilities and their families, as well as in supporting people who move from state mental retardation institutions to their home communities.

In August, 1993 the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services reviewed the HCBS waiver. The overall review was very positive, but two findings were identified related to overdue re-evaluations and case management services provided by agencies which also provide other waiver services.



An independent assessment of the HCBS waiver was completed by Rucker, Powell, and Associates, Ltd. in May, 1994. Such an assessment is a prerequisite for renewal of the waiver which was approved initially for three years. The assessment concluded "(t)he Kansas HCBS Waiver Program has, overall, been a liberating and exciting success. ...There is general consensus that services are meeting individual needs and the individual's life, today, is clearly better than three years ago. ...The goal of 'ordinary life' is beginning to be realized for more and more Kansans with all levels of disabilities."[4]

A request to renew the waiver for five years was recently submitted to HCFA. If approved, and sufficient funding is made available by the Kansas Legislature, a potential of 6,495 people could be supported by FY 1999.

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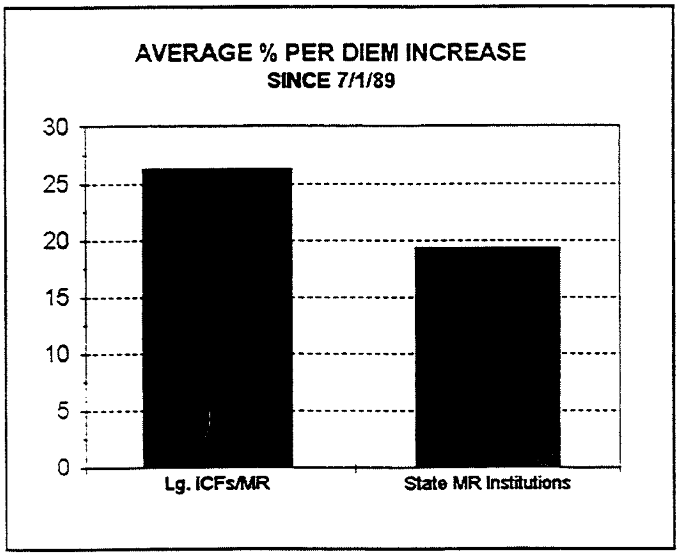
[4] Rucker, Powell & Associates, Ltd. (1994). **About Like Anyone: Review of the Home and Community-Based Services MR/DD Waiver.** Herington, KS: Author.

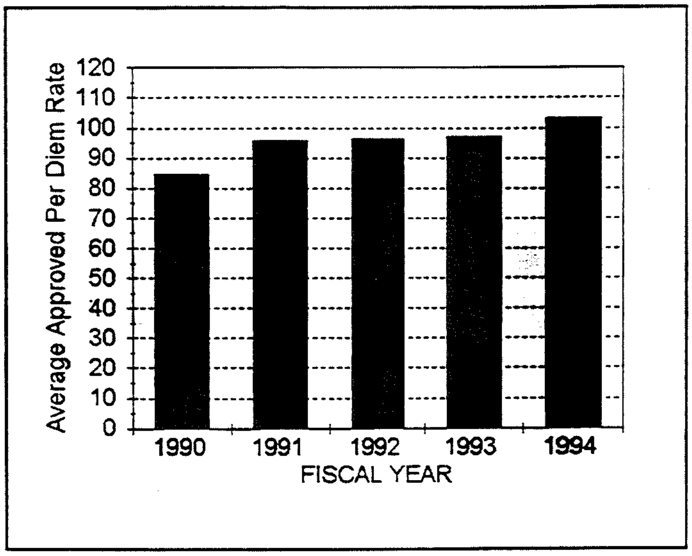
1-68

INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH MENTAL RETARDATION (ICFs/MR)

As Kansas joins other states in reducing the population in its public ICFs/MR (Kansas Neurological Institute, Parsons State Hospital & Training Center, and Winfield State Hospital & Training Center), a concerted effort is also being made to eliminate large (16+ beds) privately operated ICFs/MR in order to provide Kansans with developmental disabilities opportunities to live and work in their home communities. The map on page 11 of this report illustrates where these facilities are located.

The graph below shows the increase in per diem rates for these ten facilities since Fiscal Year 1991.





Preliminary discussions have been held regarding closure arrangements with four facilities. The 1993 Legislature appropriated funds to enable Developmental Disabilities Services to assist providers to close their facilities.

Since January, 1993, three small ICFs/MR totalling 27 beds have closed. Their former residents are served with HCBS/MR funds. Since the initiation of the HCBS/MR waiver July 1, 1991, 39 small ICFs/MR beds have closed.

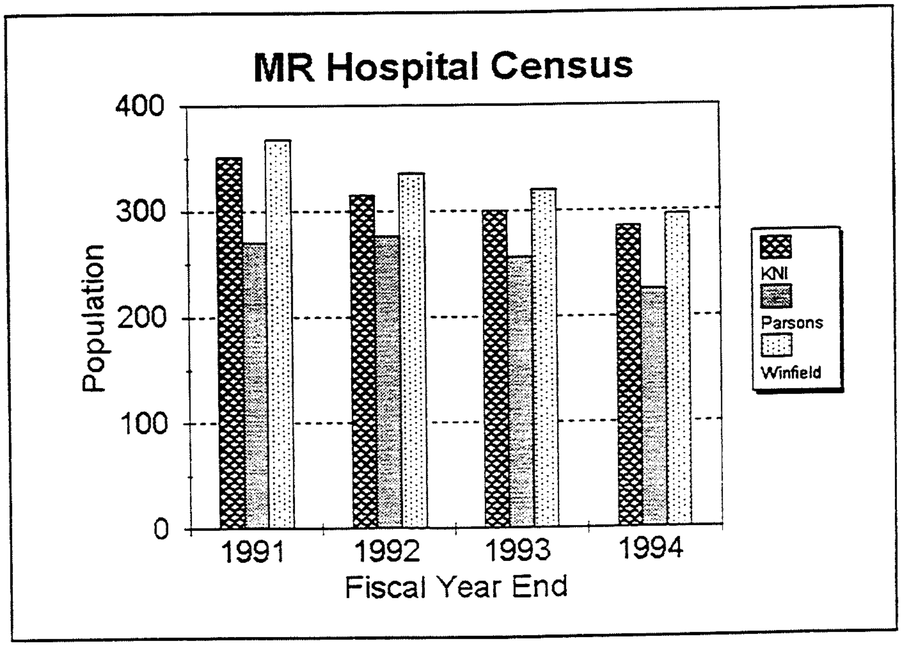
COMMUNITY INTEGRATION PROJECT

Since February, 1991 the census at our three state mental retardation institutions has been reduced by 154 persons. This reduction has been accomplished by:

1. Preventing admissions to state institutions. Only 5 persons have been admitted since July 1, 1992.

2. Moving persons into their home communities via a person centered planning process which allows supports and services to be developed specific to each person. Community agencies may negotiate individual reimbursement rates for persons moving into inclusionary settings. Services for persons moving into congregate settings are reimbursed at the established tiered rates.

Though the person-centered planning process is time consuming, the positive aspects of the process are worth the time investment. Returns to state institutions have been minimal, and empowering persons to make decisions about their own lives has enabled smooth transitions into community settings.



The major problem the Community Integration Project has experienced has been the speed at which placements have been made. Goals were developed for each year and will be approximately sixty (60) placements behind schedule. The goal for FY 95 is to "catch up" with the census goals and to place an additional thirty children. Though all stakeholders would like to increase the pace, all seem unwilling to sacrifice the quality of the placements to increase the speed.[5]

The institution census goal for June 30, 1994 is 743. Reaching this number has now been adopted as the goal for June 30, 1995. If we are successful in achieving the census goal and placing 30 children the institution census will be 713 on June 30, 1995. The census goal for FY 1996 has been set at 650.

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[5] Legislative Division of Post Audit (April, 1995). **Reviewing the Transfer of Mentally Retarded Patients from State Institutions to Community Living Facilities.** Topeka, KS: Author.

CHILDREN IN INSTITUTIONS

In the five year plan **Supporting Kansans with Developmental Disabilities**, the Division of Mental Retardation Services set a goal of serving all institutionalized children in the community by 1995. As of December 1, 1993, 138 children under age 21 resided in the three state mental retardation institutions. Fourteen percent of those children are currently in the custody of SRS.

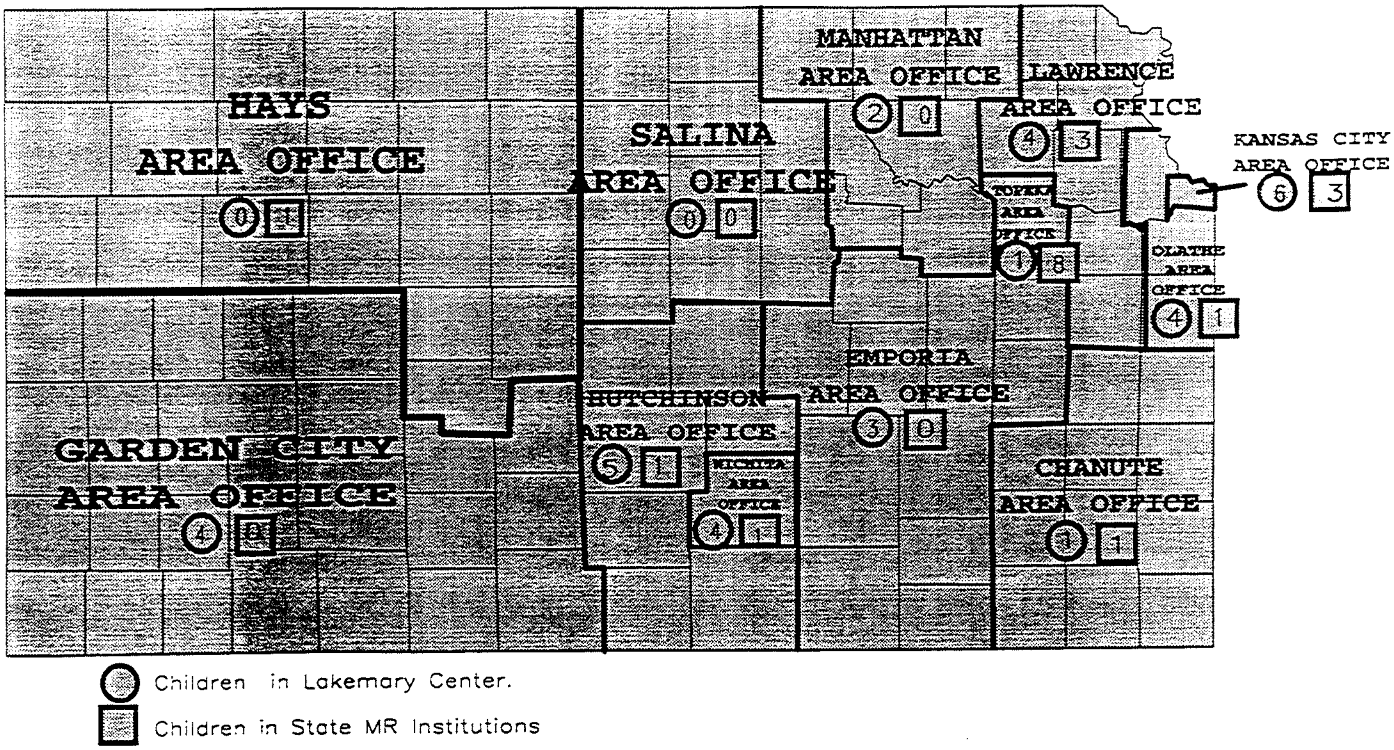
CHILDREN IN SRS CUSTODY IN STATE MENTAL RETARDATION HOSPITALS BY AREA OFFICE*
APRIL 14, 1994

AREA OFFICE	INSTITUTIONS			TOTAL BY A.O.
	KNI	PSH	WSH	
CHANUTE		1		1
EMPORIA				0
GARDEN CITY				0
HAYS		1		1
HUTCHINSON		1		1
KANSAS CITY		2	1	3
LAWRENCE	2	1		3
MANHATTAN				0
OLATHE		1		1
SALINA				0
TOPEKA	3	4	1	8
WICHITA			1	1
TOTAL BY INSTITUTION	5	11	3	19

*Information reported by the hospitals

In spite of the success of the Community Integration Project, returning children from institutions to their families or surrogate families has not occurred with any great frequency. The superintendents of the three institutions have, however, successfully prevented admissions of children to their facilities, and many of the children who currently reside there will be eligible for adult services in the next two years.

In addition to children in public institutions, as of January, 1994, 34 children in the custody of SRS were residing at Lakemary Center, a private institution. The map on the next page shows the areas from which these children, and those in custody living in public institutions came.



Kansas continues to lag behind most states in moving toward a goal of serving no children in institutions. Information from the Center on Residential Services and Community Living[6] indicates that nationally, as of June 30, 1991, children accounted for 8.7% of all state institution residents. At that time, Kansas was one of eight states where children made up more than 15% of the developmental disabilities institutional population. Nine states' institutional populations included less than 3% children. The tables below indicate the states with high, and low, incidences of institutionalizing children.

STATES WHERE CHILDREN EXCEED 15% OF INSTITUTIONAL POPULATION	
Arkansas	Nevada
Kansas	New Mexico
Louisiana	Oklahoma
Mississippi	South Carolina

STATES WHERE CHILDREN ACCOUNT FOR LESS THAN 3% OF INSTITUTIONAL POPULATION		
Alaska	Minnesota	Rhode Island*
Arizona	New Hampshire*	Vermont*
Massachusetts	Pennsylvania	West Virginia
*since closed all state DD institutions		

Although these figures are based on 1991 data, the total percentage of children with developmental disabilities in Kansas state mental retardation institutions remains essentially the same. The percentage will begin decreasing, however, since no children have been admitted in the past year. In addition, the Division of MR/DD Services plans to return 20-30 children to their families, or to surrogate families in the next year. An agreement with SRS Youth and Adult Services will result in the children in SRS custody finding homes in the community.

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[6] Lakin, K.C., Blake, E.M., Prouty, R.W., Mangan, T. & Bruininks, R.H. (1993). **Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1991**. Minneapolis: University of Minnesota Center on Residential Services and Community Living, Institute on Community Integration/UAP.

GROUP HOMES

Since 1991, with the implementation of the HCBS/MR waiver, community mental retardation agencies have been downsizing and closing group homes and increasing thier efforts in the provision of supported living services. Waiver funding and grants combining Vocational Rehabilitation and MH&RS funds have helped to expedite this movement.

The table below lists agencies which have downsized or closed homes, along with the number of beds eliminated.

REDUCTION IN CONGREGATE HOMES*

AGENCY	# HOMES DOWNSIZED	# HOMES CLOSED	TOTAL BEDS ELIMINATED
Arrowhead West		3	24
Brown County Dev. Ctr.	1		2
COF	6		20
Cottonwood	5		12
Faith Village	1		2
HELP, Inc.	1		3
KETCH	1	1	15
Lakemary	1		1
Northview		1	5
Residential Alternatives	5	1	11
Starkey	1		1
STEPS	5		12
Tri-Ko	1		4
Tri-Valley	2		2
WDDS		3	20
TOTALS	30	9	134

*Reflects cumulative data since 1991.

In addition to the closures and reductions listed above, the following agencies assisted people, displaced by the closure of twelve group homes (72 total beds) in Butler, Greenwood, and Elk counties, in locating alternative arrangements: CLASS, Cowley County Developmental Services, Doniphan County Workshop, Flint Hills Services, and New Beginnings Enterprises. With these 72 beds, in all, 206 group home beds and 21 group homes have been eliminated in Kansas since 1991.

SERVICE PLAN PROGRESS

Supporting Kansans with Developmental Disabilities presented a five year plan which would eliminate the waiting list, close one state MR facility, and provide case management to children as well as adults. FY 1993 was the first year of this five year period. The columns below compare the plan with actual expenditures for FY 1994.

	Actual Expenditures			Original Full Year Estimates		
	FY 1994			FY 1994		
Type of Service	# Served	SGF	All Funds	# Served	SGF	All Funds
SERVICE COORDINATION	2700	0.00	1.77	6162	0.50	3.85
SUPPORTED EMPLOYMENT/LIVING						
VR Matching Funds	75	0.40	1.80	75	0.40	1.80
MH&RS Continuation	175	2.02	2.02	150	2.07	2.07
State General Funds	0	0.00	0.00	436	5.09	5.09
THERAPEUTIC CONSULTATION(1)	0	0.00	0.00	5791	6.51	10.00
DAY & RESIDENTIAL SERVICES						
Grants & Local Funds(2)	3198	16.83	25.82	3478	21.99	30.98
Grant COLAs		0.00	0.00		2.53	2.53
1993 Base HCBS/MR	786	6.38	15.62	786	8.35	20.87
New HCBS/MR from the community	618	5.02	12.29	358	3.80	9.50
HCBS/MR from the State Institutions	14.80	2.98	7.29	273	5.17	12.93
FAMILY SUPPORT SERVICES						
Family Subsidy	416	1.00	1.00	800	2.40	2.40
Family Support(3)	617	1.48	1.48	288	0.86	0.86
AGENCY SUPPORT SERVICES						
SRS Field Staff		0.16	0.31		0.26	0.52
Consumer Councils		0.00	0.00		0.42	0.42
CMRC Staff Training		0.00	0.00		1.15	1.15
Bi-annual assessment		0	0		0.24	0.24
Rate Study		0	0		0.00	0.00
Institutional Placement Start-Up		0.32	0.32		0	0
INSTITUTIONAL SERVICES						
State Institutions	806	27.81	71.80	746	26.80	67.00
Private Institutions	961	14.59	35.74	783	14.65	36.62
TOTAL	7800	78.99	177.26	8173	103.19	208.83

1. Increases in Grants and HCBS/MR rates provide for the cost of these services. A separate cost allocation is no longer needed.
2. The number served on this line include those whose services are funded with discretionary funds such as mill levy and state aid.
3. The numbers of persons served is an estimate and not based on direct counts of persons served.

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NCSL TASK FORCE ON
DEVELOPMENTAL DISABILITIES

Comments to the Select Committee on Developmental Disabilities
Rep. Ed McKechnie
Jan. 18, 1995

Thank you Chairperson Pottoroff and members of the committee,

Want to give a very brief overview on my observations of the Developmental Disability programs in New Hampshire. There is no perfect comparison state to Kansas because of population, tax base, service history and executive and legislative commitment.

New Hampshire did close a hospital and that is what much of the conversation in Kansas has surrounded the past few years so from that perspective it was helpful.

Just a couple of key points -

The goal in New Hampshire was not to close a hospital, at least initially it wasn't. The goal was to provide quality services to citizens with disabilities in the least restrictive environment. The overall process took almost 15 years to complete and it wasn't until about two-thirds of the way through the process that closure became a discussion point. By that time it became clear the hospital just simply wasn't going to be needed any longer.

The path for the least restrictive environment was complete agreement by leadership staff in the state MH&DD bureaucracy to provide the best care available. This was carried out from the Governor all the way down through the hospital administrator and staff.

This wholeness, the New Hampshire staff now believes in looking back at the process, was the key to the success. Similarly, the lack of that

House SC - Developmental
Disabilities - 1-18-95
Attachment 2

wholeness could be the key to our failure in Kansas to provide least restrictive services.

In New Hampshire there is no local money - no property taxes, no fundraising.

After the movement of patients out of the hospital was underway, there was then an organized and methodical plan to relocate state employees. Over the 15 year process only 75 were terminated without similar employment in the community.

Services are provided through area agencies and vendors. Vendors work on year-long contracts to ensure stability.

Differences in physical size of state, distances between communities, no ICFMR's, population

DEVELOPMENTAL DISABILITIES DISPATCH

Volume III No. 1 January, 1995

NEW HAMPSHIRE

A group of eight Kansans visited New Hampshire recently to examine firsthand how that state provides community services to individuals who are mentally retarded or otherwise developmentally disabled. The group from Kansas included four legislators, Senators Morris, Petty and Brady and Representative McKechnie; one consumer, Kathy Lobb; one parent who also works at a state mental retardation hospital, Sara Moberg, and an executive director of a community mental retardation center in Kansas, Dan Kline. They were accompanied by two staff from Mental Health and Retardation Services.

New Hampshire was selected to visit because it has many things in common with Kansas and because its community services for individuals with mental retardation or other developmental disabilities were purported to be further advanced than Kansas's. In New Hampshire, nearly all individuals who are MR/DD are served in community integrated settings through local not-for-profit Area Agencies similar to Kansas's community mental retardation centers. These services were developed as a result of a 1979 lawsuit which, when settled in 1983, required New Hampshire to reduce the size of its state mental retardation hospital. The clear and outstanding success of community services ultimately resulted in the complete closure of the state hospital. According to state officials this was accomplished in concert with the state's long tradition of fiscal conservatism and populist government.

On November 15th the Kansas group met with the staff from Area Agency VI serving south central New Hampshire in Nashua and Merrimack. The Area Agency staff explained how they determine whether individuals are eligible for services based on a statutory definition of MR/DD similar to that used by Mental Health and Retardation Services in Kansas. After being determined eligible most individuals are provided community services consistent with person centered plans which emphasize family support, natural support and community integration. The Area Agency may provide the services directly or it may contract out with vendors who are similar in some respects to affiliates in Kansas. Area Agency VI provides no services, except service coordination, but instead vendorizes all direct services.

House SC on Developmental Disabilities - 1-18-95
Attachment 3

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The Kansas group was told New Hampshire does have a waiting list for services. Individuals are served from the waiting list based on their relative need for immediate services not on a first come, first serve basis. The Area Agency noted these decisions are relatively easy to make and the system works very well.

The Area Agency also explained how placements were made from Laconia State Hospital one person at a time based on individual person centered plans. Placements from Laconia started in 1983 and the facility was closed in 1991. New Hampshire has no other state mental retardation hospital for individuals who are MR/DD.

Also on the 15th, the Kansas group met with Don Shumway, Commissioner and Rich Crocker, MR/DD Director from the New Hampshire Division of Mental Health and Developmental Services. Crocker explained that New Hampshire strongly emphasizes values based training for all participants in MR/DD services. This training was credited with the success of placing individuals out of state mental retardation hospitals and preventing Area Agencies from placing individuals from the community into the hospitals. Closure of the hospital was described as the logical conclusion of this training effort.

Shumway stressed the need to access as much medicaid funding as possible in order to achieve the values based goals Crocker described. New Hampshire funds approximately 90% of all of its commun[illegible]DD services with medicaid funds. He emphasized the progress in New Hampsh[illegible]d not have been accomplished with state funds alone. Much of what New Hampshire is doing with medicaid is similar to Kansas's project to expand use of the Home and Community Based Services waiver for individuals who are MR/DD.

On November 16th the Kansas group met with staff from Manadnock Developmental Services, the Area Agency which services southwestern New Hampshire. The Area Agency explained the responsibilities of a Personal Agent. A Personal Agent is a service coordinator who works only on behalf of the individual with MR/DD to achieve self determination and quality of life. A Personal Agent takes his/her direction from the individual being served and not their employer or service provider. They make supports available for the individual to address their needs, wants and desires without consideration to what services are available. The Area Agency stressed they have been able to accomplish implementing this approach, for the most part, more cheaply than other more traditional approaches. However, the group was told this should never be the driving force behind such decisions.

The general consensus of the Kansas group appeared to be that Kansas has many of the same positive characteristics New Hampshire has in its MR/DD service system. One of the clear messages of the visit was that Kansas is heading in the correct direction and must remain on course in order to continue improving the lives of people with MR/DD. Kansas needs to focus on, and emphasize, valuing people with disabilities as neighbors and friends. The tough decisions and how to make them will follow logically from this commitment.

SPECIAL COMMITTEE ON WAYS & MEANS

During the 1995 interim the Kansas Legislature appointed a Special Committee on Ways and Means to review the status of the state's MR/DD services. The Committee was chaired by Representative Rochelle Chronister, chairman of the House Appropriations Committee, and included influential legislators from the Senate Committee on Ways and Means and the House Appropriations Committee. The Committee met three times during the interim, and heard input from service agencies, advocacy organizations, and MR/DD Services in an effort to determine the need for mental retardation reform.

The final two day meeting of the Committee took place on November 21 and 22 resulting in the following deliberations and actions.

The Committee discussed the advisability of using old HB 2523 as the basis for placing mental retardation reform in statute and decided against that course of action at this time.

The Committee voted to request a Governor's Task Force be established by Governor-elect Graves to report to the 1996 legislature on the following:

* A review of where Kansas is and where it came from in MR/DD Services

* A quick review of what is happening elsewhere although it appears the Committee feels Kansas is doing what other leading states are doing

* Recommendations on the following key policy issues

- Consumer directed services
- The role of CMRCs particularly: governance, their apparent monopoly on service dollars, the refusal of some to adopt "zero reject policy", the waiting lists for community services, and the history of CMRCs and possibility for establishing competition through services independent of the CMRC
- Family support services
- Parent Assistance Network statewide
- Transition from Special Education
- Part H and Part B funds and how can they best be administered
- Establishing and arbitration or ombudsman process to mediate disputes between providers and SRS on individual rates
- Role of the Kansas Planning Council on Developmental Disabilities
- Role of Vocational Rehabilitation and use of 110 funds
- How to eliminate large for profit ICFs/MR
- How to assure continuous oversight of community services through the quality assurance process
- MR/DD Reform Legislation
- Recommending a process to be established to determine which hospital(s) should be closed (not name the hospital). An example given was the Closure Commission established at the federal level to nominate which military bases should be closed.

The Committee recommended the Task Force consist primarily of consumers and services agencies. Secretary Whiteman indicated MR/DD Services would provide the staffing and

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support for the Task Force. The Committee also will recommend no legislators serve on the task force. Pursuing a model similar to the Mental Health Reform Task Force was discussed, but concerns were raised about the number of providers and provider representatives initially involved in that group.

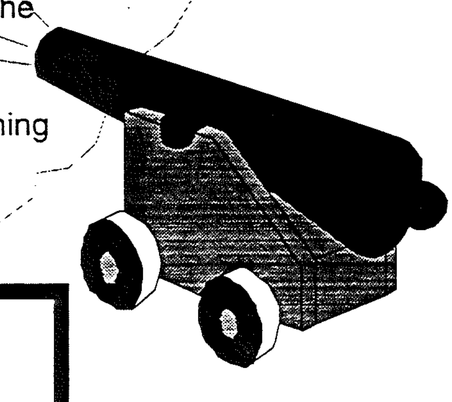
Among other areas of discussion, the conclusion appeared to be Kansas will continue to downsize mental retardation state hospitals and in the next three or four years closing of one or more may become inevitable. The Legislature's goal will be to try to deal with the economic effect on employees and the community(s).

MR/DD Services looks forward to working with all the stake-holders should Governor-elect Graves implement the recommendations of the Special Committee on Ways and Means. Kansas has made exceptional progress over the past few years with the support of consumers, parents, community agencies and the Legislature. Continued collaboration can only increase the benefit to Kansas citizens with mental retardation and other developmental disabilities.

CONTEST WINNER

Tonia Kiister, who lives in Chanute and is provided services by Tri-Valley Developmental Services, Inc., submitted the winning artwork for the 1995 Kansas Conference on Developmental Disabilities. We received seventeen entries. Ms. Kiister's picture was chosen as best representing the theme of the conference, Crossing the Bridge: Natural Supports for Community Inclusion. Her picture will be used on all conference literature, and recently adorned the call for presentations we sent out.

The 1995 conference will be held June 7-9, 1995, at the Wichita Marriott. Watch for more information. Ms. Kiister will attend the conference with a companion, all expenses paid, as her prize for submitting the winning artwork. All other entries will also be displayed at the conference.



Please address your comments and questions about this newsletter to:

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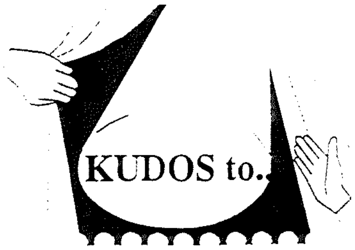
915 SW Harrison - 5th Floor
Topeka, KS 66612



Kim Buser, Carole Buser, Athalen McNay, Kim Haynes, Tony Bogardus, and Barry Harris of Goodwill Industries for being the first group in Sedgwick County to adopt the new licensing process. They were very enthusiastic and positive with the end result being a lot of good information that will assist the agency in developing future supports and services.

Randy Bottorff, Wichita SRS Office, for all his assistance in transferring the DDP re-evaluation process over to the agencies in Sedgwick County.

The following agencies and individuals for assisting in developing alternative homes for people residing at Friendship Manor in Medicine Lodge, which recently closed:

Karen Larson - Arrowhead West, Medicine Lodge, Lori Pendergast - Arrowhead West, Don Pendergast - Arrowhead West, Case Managers - Arrowhead West, Michael Van Hook - Friendship Manor, John Van Hook - Friendship Manor, Staff Members - Friendship Manor, Anne Jackson - Parkview Learning Center, Gary Ingenthron - KDHE, Julie Lemons, Salina SRS, HELP, Inc. - Leavenworth, WDDS - Kansas City, STEPS - Wichita, Starkey, Inc. - Wichita, Arrowhead West - All locations, CLASS, Inc. - Columbus, OCCK - Salina, KETCH - Wichita, Northview - Newton, TECH - Hutchinson, SDSI - Garden City, CLO - Lawrence, Sunflower - Great Bend, MCDS - McPherson, New Horizons - Valley Center, Big Lakes - Manhattan, Friendship Manor - Haven

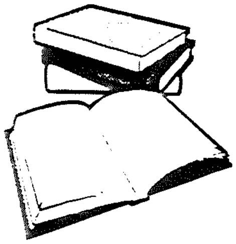
45 persons were moved in a total of 28 days. (Next month's **Dispatch** will carry a full report of the closure of Friendship Manor at Medicine Lodge.)

Numerous persons served by the following agencies and their family members for participating in a new consumer Licensing Review Assessment:

Brown County Developmental Services, H.E.L.P. Inc., Residential Alternatives, Community Living Opportunities (Lawrence), Doniphan County Sheltered Workshop, and Twin Valley Developmental Services.

This assessment involves persons served by the agency and their family members reviewing the agency's success in meeting basic licensing requirements, and giving input to the agency regarding their observations.

Developmental Services of NW Kansas, Inc. for closing a six-bed home in Atwood in response to consumer requests for individualized supported living.



RESOURCES

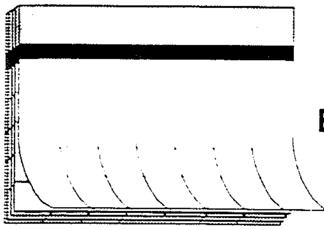
Making Contact: A strategy to Train Health Care Professionals to Communicate with Adults with Mental Retardation is a video/instructional manual available in a medical/nursing program version and a dental program version. It is designed to assist health care workers to interact with adults who are mentally retarded, and addresses issues of delivering health care instructions and eliciting information. To order either, or both, versions ($79 each) call Suncoast Media, Inc. at 1-800-899-1008.

HAVE YOU HEARD?

Acquire the art of detachment, the virtue of method, and the quality of thoroughness, but above all the grace of humility.
Sir William Osler

Never underestimate the power of simple courtesy. Your courtesy may not be returned or remembered, but discourtesy will.
Princess Jackson Smith

Our deeds determine us, as much as we determine our deeds.
George Eliot



CALENDAR

Essential Lifestyle Planning with Michael Smull, Wichita. **January 18-20, 1995.**
Contact: Tanya Dorf, KARF
(913) 235-5103

The following training is presented via a contract with Mainstream, Inc. More detailed information will be available nearer the dates of the workshops. **Please do not call Mainstream to register until 6 weeks prior to the training.** For more information, contact:

Mainstream, Inc.
P.O. Box 47054
Topeka, KS 66647
(913) 266-6422.

DDP/ELIGIBILITY TRAININGS

Maximum attendance is 30 persons each training.

Tuesday, April 11, 1995
Instructor: Pat Daugherty
Location: KETCH, Wichita, Kansas

AN INTRODUCTION TO DEVELOPMENTAL DISABILITIES: TRAINING THE TRAINERS

Maximum attendance is 30 people.

Two trainers per agency will be accepted until January 27, 1995. Additional agency employees can be called in after January 2, 1995, based on availability.

Instructor: Jim Rast, Vroon Enterprises
Location: Harvey Hotel, Wichita, Kansas

Dates:
Tuesday & Wednesday, February 7 & 8, 1995
Tuesday & Wednesday, Feb. 21 & 22, 1995
Tuesday & Wednesday, March 7 & 8, 1995
Tuesday & Wednesday, March 28 & 29, 1995
Tuesday & Wednesday, April 11 & 12, 1995

Individuals are responsible for bringing their agency copy of the manuals. For [illegible]st

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manuals, it is the responsibility of the agency to purchase replacements from KUAP.

SYSTEMS CHANGE WORKSHOPS

Maximum attendance is 50 persons per workshop.

Friday, January 20, 1995 at the Holiday Inn - Lenexa. Instructor: Tina Campanella, Accreditation Council on Service for People with Developmental Disabilities. Topic: Quality enhancement in services to people with developmental disabilities.

Wednesday, March 15, 1995 at the Holiday Inn - Wichita Airport. Instructor: John O'Brien, Responsive System Associates. Topic: Social support for people with developmental disabilities.

Friday, May 5, 1995 in Topeka, Kansas. Instructor: Michael Callahan, Marc Gold & Associates. Topic: Supported employment.

PERSON CENTERED PLANNING WORKSHOPS

Maximum attendance is 50 persons per workshop.

Friday, February 10, 1995 at the Ramada Hotel & Suites in Overland Park, Kansas. Instructor: Michael Smull, University of Maryland at Baltimore.

Thursday, March 16, 1995 at the Holiday Inn - Wichita Airport. Instructor: John O'Brien, Responsive System Associates.

Third Workshop - To Be Announced.

Let Your Rights Come Alive in '95, Topeka, **January 28, 1995.**

Contact: Families Together, Inc.
501 Jackson, Suite 400
Topeka, KS 66603
1-800-264-6343 (parents only)
(913) 233-4777 V/TDD
(913) 233-4787 FAX

National Conference on Aging and Disabilities, Minot, North Dakota, **June 22-24, 1995**.

Contact: Dr. Demetrios Vassiliou
Minot State University, Box 131
500 University Avenue West
Minot, ND 58707

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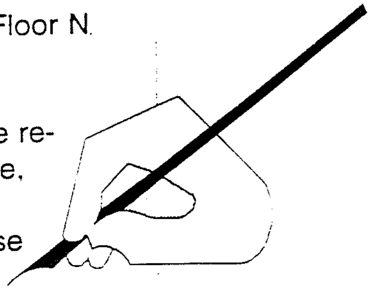

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Topeka, KS 66612
TDD#: (913) 296-3471

ATTENTION ATTENTION ATTENTION

If you have items to include in the **CALENDAR, KUDOS,** or **HAVE YOU HEARD?** sections of the **DEVELOPMENTAL DISABILITIES DISPATCH,** please submit them to Becky Ross by the 15th of the month to be included in the following month's edition.

THANK YOU THANK YOU THANK YOU

If you would like to be placed on the mailing list for this newsletter, fill out and return this section to:

Rita Hodges
MH&RS
915 SW Harrison - 5th Floor
Topeka, KS 66612

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Address____________________________

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City_______________________________

State____________ Zip____________

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