Report to the Joint Standing Committee on Health and Human Services
On Public Law 778
An Act to Implement the Recommendations of the Commission to Determine the Adequacy of Services to Persons with Mental Retardation

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Executive Summary

Public Law 778 required the Department of Mental health, Mental Retardation and Substance Abuse services to report to the Joint Standing Committee on Health and Human Services on six areas. These areas were as follows:

1. A. The status of the development of a Care Manager to oversee transition of students from school to adult services
   B. The number of 16 to 20 year olds awaiting services (to be done by the Department of Education in conjunction with DMHMRSAS)
2. The status of development of a Management Information System that provides understandable and usable information to parents, consumers and providers
3. A report on the numbers of individuals needing services and the cost of meeting those needs
4. A progress report on improvements in public information and education concerning programs for persons with mental retardation
5. A report on Departmental actions to encourage fair compensation
6. The development of a supplemental budget request to fund a cost-based cost of living salary increase for direct care staff

The attached report provides information to the Joint Committee on each of these issues. In summary, the major conclusions are as follows:

- Substantial increases in case management services, day services and residential services have taken place over the past three years.
- Employment services, a major priority area for new individuals into the service system, has increased by nearly 1/3 in the past three years.
- The types of residential services selected by individuals over the past three years has changed significantly.
- While significant work has been accomplished to provide case managers to more individuals as they transition from school to adult programs, more work and resources needs to be devoted to this area.
- Waiting list information can not easily be compared between DOE and DMHMRSAS.
- The Management Information System is well developed, useful for presenting information to a wide variety of audiences and is rapidly being made available to individuals, families and providers.
- Almost 3,700 individuals receive planning efforts that reveal their residential, day service, vocational or educational choices.
- Meeting the needs of individuals presently waiting for new or altered services would require an expenditure of some $6 million annually.
- A large variety of public education and training activities have been undertaken and more are planned.

- DMHMRSAS worked with a Task Force of providers to produce a fair compensation recommendation which should be based on the ICF/MR pay structure.
- The cost of implementing the altered wage scale would be approximately $2.8 million.

Introduction

The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) was very pleased to be an active participant in the Commission to Determine the Adequacy of Services to Persons with Mental Retardation. The Commission studied several issues that are central to the quality of services provided, i.e., personalized planning, adequate information gathering, development of full funded budgets, fair compensation for direct staff, quality public education and effective transitional planning.

In the last Legislative session, the Legislature provided funding to eliminate the waiting list for services for all individuals awaiting residential or day services in October 1997. Funding for fiscal years 1999 and 2000 is sufficient to meet that goal. Additionally, via Chapter 778, the Legislature recognized that additional individuals would be becoming eligible for services and requested that the Department provide a new estimate of those awaiting services as of January 1, 1999.

The actions on the part of the Legislature speak clearly to the commitment in Maine to develop strong and effective services for this very vulnerable population. DMHMRSAS is pleased to provide the Legislature with a brief assessment of accomplishments in the past three years, so that the Legislature will be certain of the commitment present within the Department.

Overall Pattern of Service Needs Met

There has been substantial pressure to increase the amount of service available in three basic service categories. In Case Management the number of individuals receiving active service has increased from 3,362 to 3,702 from December 1995 to December 1998. In Day Services the number of individuals served has increased from 3,108 to 3,332 and in residential services the number served has increased from 2,586 to 2,977. This pattern is portrayed in Chart 1 below.

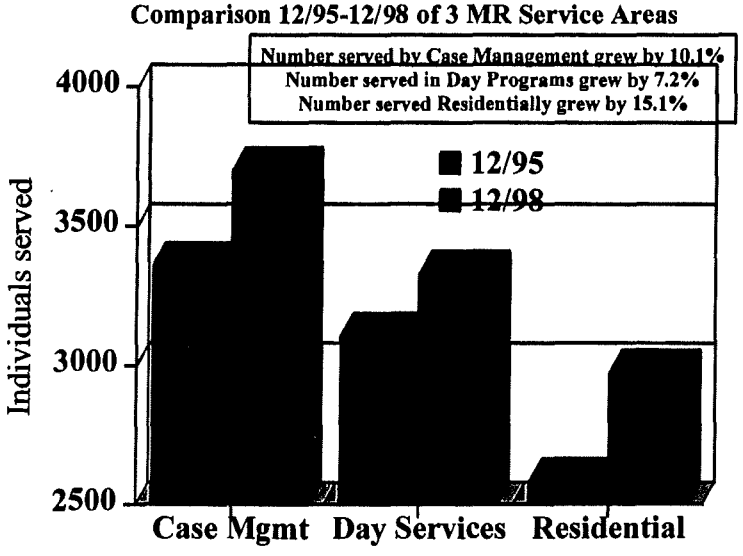
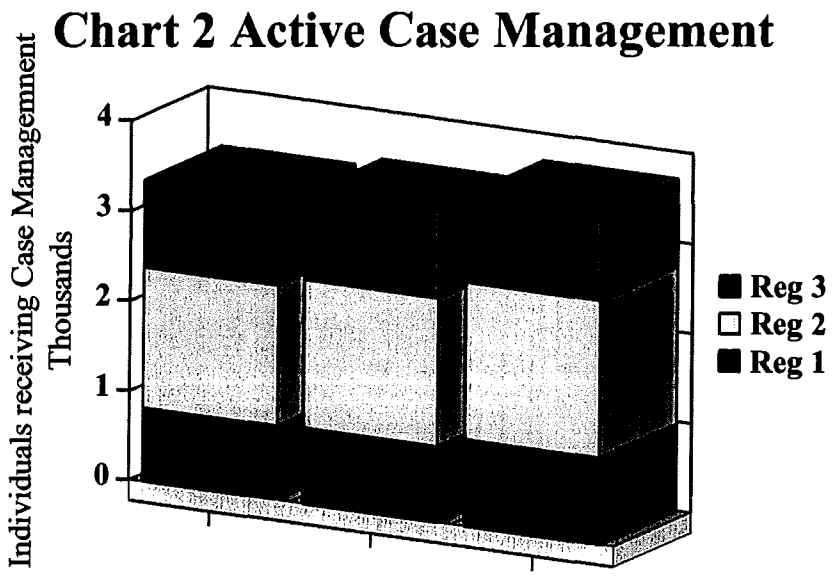


Chart 1 MR Services

In each of the past four years, every region has been effected by the growth in active case management. DMHMRSAS has attempted to maintain a ratio of 35 to 1 for case managers for everyone needing that support and has, therefore, increased the number of case managers. The regional growth patterns from 12/95 through 12/96 and 12/98 are shown below in Chart 2.



Total Served

The numbers of people served, however, represent only a portion of the picture. What is also significant is the change in the pattern of services and the growth in priority service areas. Individuals receiving and awaiting services have identified employment as a high priority. The Department responded by submitting a Medicaid Waiver amendment on supported employment, making services available to any waiver eligible individual, not just to those who were previously institutionalized. The growth in employment options is seen in chart 3 below.

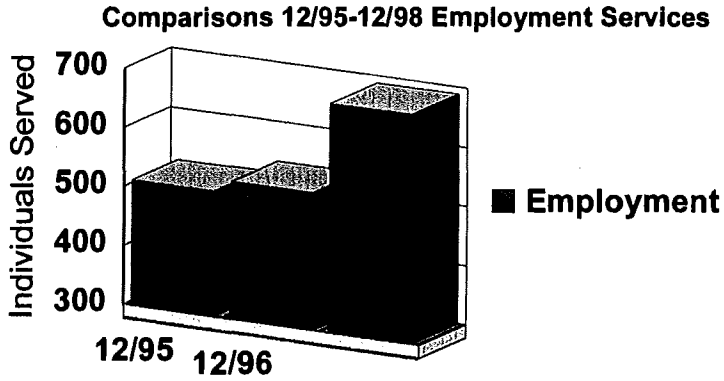


Chart 3 MR Employment Services

The number of individuals with a job, supported employment, or who had job development, a job coach or other employment increased by 32.4%.

Residential services have shown a significant change over the past three years. There are important changes in the pattern of choices made by individuals, with growth in the smaller less structured programs and a general movement away from ICF/MR programs. These patterns are shown below in charts 4 and 5.

Chart 4 Residential Option 12/95

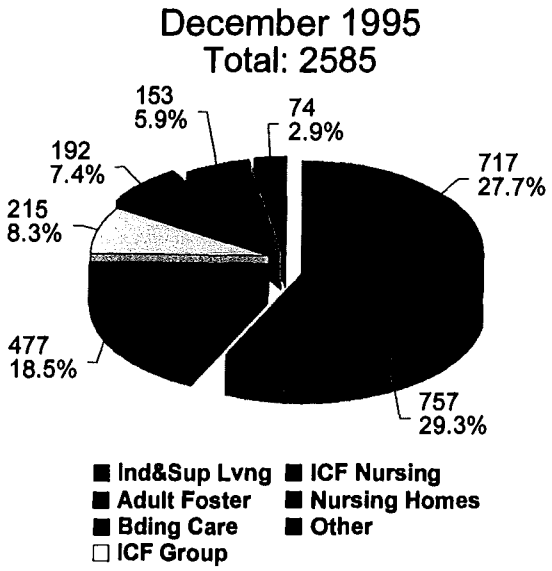
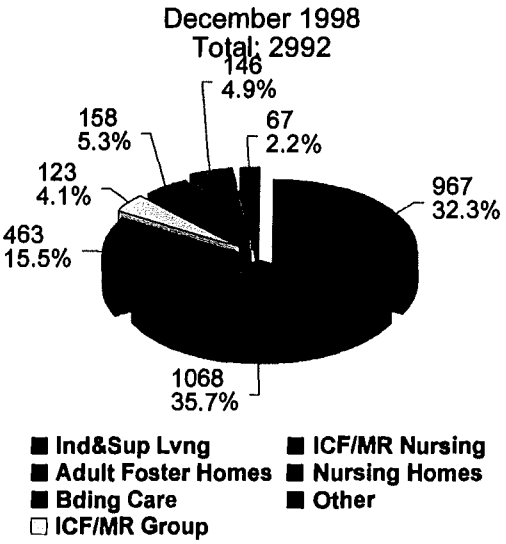
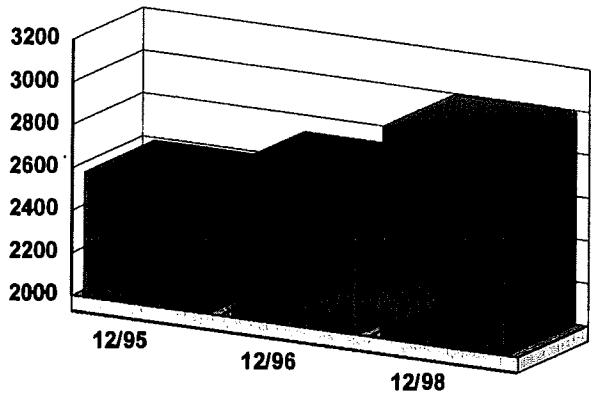


Chart 5 Residential Options 12/98



As noted above, the growth in residential services and supports is also impressive, from fewer than 2,600 served in December of 1995 to almost 3,000 served just three years later. (See Chart 6 below)

Chart 6 Number Served Residentially

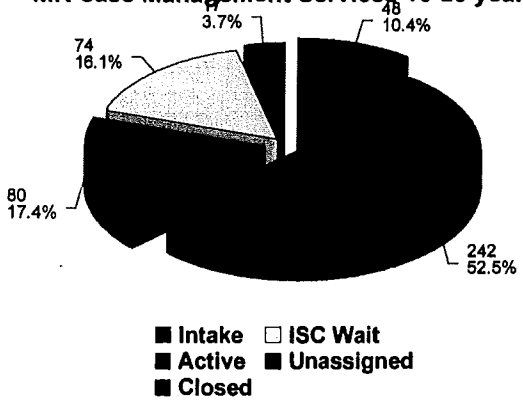


Overall, there has been substantial change in the pattern of services delivered, significant growth in the number of individuals served and greater commitment to identifying and meeting the specific needs of individuals. The Department continues to work to meet the needs of the many individuals and families who seek supports.

Section 1-A Care Manager

This section of the Legislation requires that the Department, in conjunction with school administrative units, designate a single case manager who will serve as the single contact person in assuring interagency coordination and effective transition from school to adult services. Mental Retardation services has taken a number of steps to improve the transition process. As case management services in general have grown to meet the demands of adults being served, there has also been an increase in case management services to children still in school. Chart 7 below shows the number served at present.

Chart 7
MR Case Management Services 16-20 year olds



Regional Offices have approached the transition planning task in a variety of ways. Generally, each office assigns a case manager based the geographic area served by the case worker. In

some instances this means all case workers might serve individuals in transition while in other offices the transition work is divided between two or three case workers. One of the regional offices has established a pilot program to work in conjunction with the area Council on Transition. Other Councils on Transition have also been active in connecting individuals with DMHMRSAS.

In the large scale program development work that has been taking place to reduce the waiting list for services, a great deal of work has been done to identify the needs of and develop programs for individuals transitioning from school to adult programs. This has frequently involved very detailed planning, exploration of various types of programs and significant involvement of parents and individuals in their own personalized planning process.

Despite all of these efforts, however, many real problems exist. While contact between local school districts and regional offices has improved substantially, there are still occasions when districts wait until the last moment to make the department aware of individuals who will be transitioning. Despite exchanges of information between the Department of Education (DOE) and DMHMRSAS on numbers of individuals coded as a part of special education services, it is not possible at this time to actually exchange names of individuals due to confidentiality issues. As a result it is still possible for individuals to graduate from school without any contact with DMHMRSAS.

Second, DMHMRSAS has attempted to maintain a ratio of 35 to 1 within the case management system. That is a specific requirement of the Community Consent Decree and also good practice. As a result, as the numbers of individuals seeking services increases, the ability of case workers to serve all school graduates is limited.

Third, despite significant improvements in information sharing between DMHMRSAS, DHS, DOE and the Department of Corrections resulting from recent legislation and agreements from the French law Suit, the ability of DMHMRSAS to identify individuals two years prior to graduation is still limited.

Fourth, while the work of the Councils on Transition has been and continues to be effective, the overall resources committed to their efforts do not allow them to function as case managers for every individual.

Addressing these important issues will require continued coordination of efforts between various departments, improved on line data sharing capacities, expanded roles for existing case workers and Councils on Transition and more than likely additional resources and personnel.

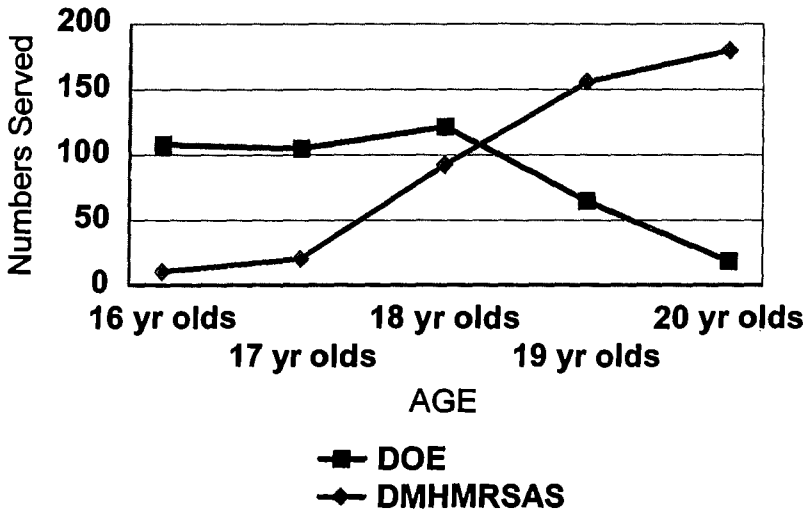
Section 1-B Annual Report

Given the data that is currently available from the Department of Education (DOE) and from DMHMRSAS, it is difficult to determine the exact extent of unmet need for the variety of services that are available. The confusion in data results from a number of problems: different data formats between departments; the inability to compare directly the names of specific

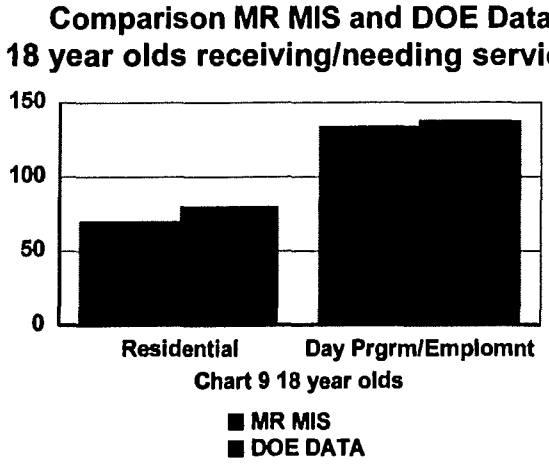
individuals needing or receiving services; the fact that individual school districts and private schools submit data to DOE, while DMHMRSAS data is directly received from its 3 regions; DOE data suggests that school districts are increasingly applying the label Multihandicapped to some children who may have mental retardation or autism, thus making direct number comparisons still more difficult.

What does seem to emerge, however, is a pattern. It would appear that DMHMRSAS is picking up most young adults labeled mentally retarded or autistic by the time the child is 18 years old. Chart 8 below compares some DOE and DMHMRSAS data for individuals known to the two systems.

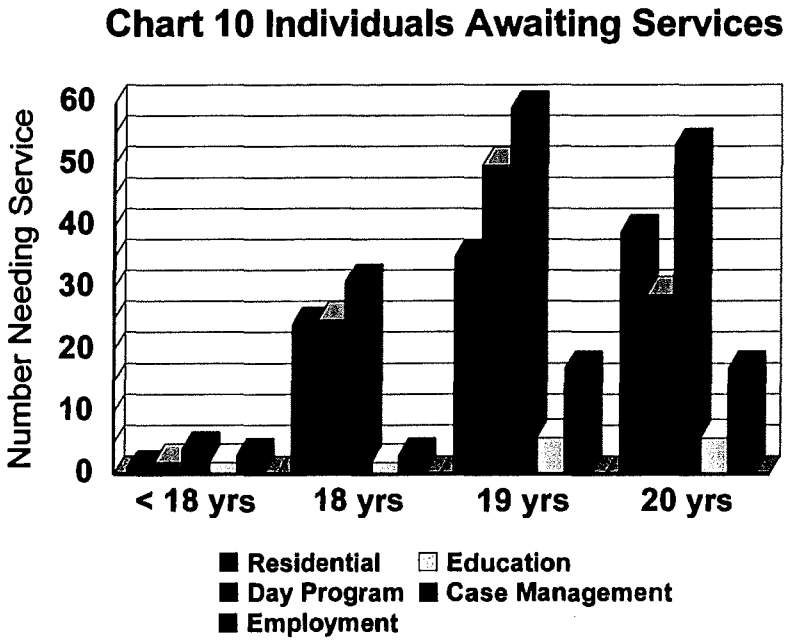
Chart 8
Education and DMHMRSAS
Individuals served by Age



In regard to specific service areas, DOE and DMHMRSAS data seem closely in line for 18 year olds receiving or needing residential or day/employment supports. Chart 9 below demonstrates those comparisons.



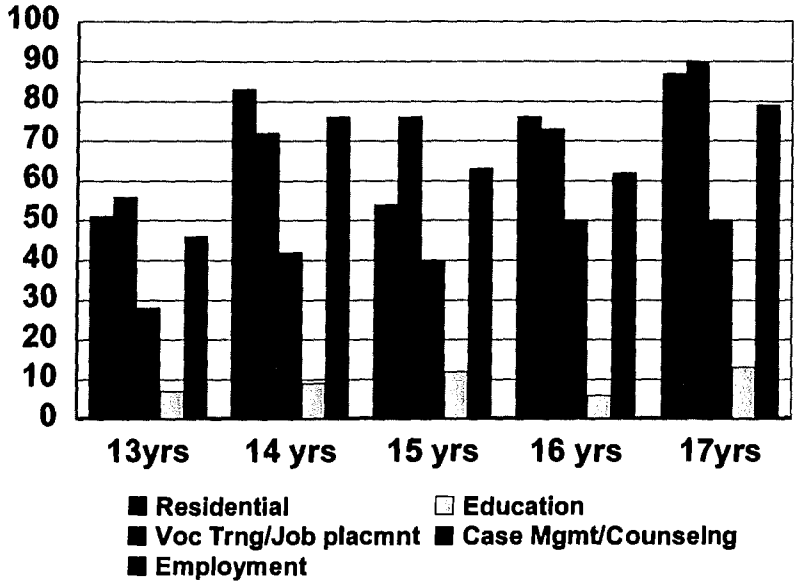
However, despite the similarity of numbers, individual families report that the transition from school to adult services is difficult and that there is frequently a delay in acquiring services. The MR Management Information System (MIS) appears to accurately reflect the needs of those 18 years of age and older and seems to substantiate the experience reported by families. It does not reflect well the needs of those below the age of 18. Chart 10 below presents the MR MIS data for the services needed by individuals.



DOE data seems to reflect more accurately needs below the age of 18. However, it is not clear whether the definitions of services needed is the same as the definition used in the adult service area, nor whether local school districts are classifying only some of the individuals as mentally retarded or autistic and instead are classifying some children with those disabilities as

multihandicapped. Chart 11 below presents the DOE data for services needed for individuals coded mentally retarded or autistic and between the ages of 13 and 18.

Chart 11DOE Data by Age for Services Needed



To overcome the problems noted above, DOE and DMHMRSAS will work to coordinate their efforts to gather information in similar ways, utilizing similar definitions, categorizing students in identical ways and allowing for the exchange of specific names as a check on data quality.

Section 2 Management Information System.

The first goal of this section of the Legislation was to ensure that information gathered in the MIS system would be accessible and understandable to consumers, their families, service providers and policy makers.

The work to continue to improve the management information system has moved in several major areas:

- DMHMRSAS has distributed hardware regional and central office staff and has upgraded network systems in order to improve the gathering and reliability of information.
- Staff training in hardware and software use has been substantial.
- The system itself has been converted to a "user friendly" Approach system.
- Discussions have been held and are continuing with Plaintiffs in the Community Consent Decree concerning additional improvements to the system.

- The Department has embarked on a very ambitious two year development task which will create an integrated management information system across the entire department and one that will allow sharing of information with other state departments.

The Mental Retardation MIS system, a carefully designed computer application with a comprehensive structure and a mature database, was introduced during the Fall and Winter of 1994-1995. The MR MIS tracks approximately 600 fields of information for each of over 5,000 consumer records. Data was first entered into the system from paper record keeping systems from November 1994 through February 1995. Data quality has improved steadily.

The MR MIS is the key tool for securing and managing resources for people with mental retardation or autism. The Departments uses the MR MIS to record and aggregate unmet consumer needs, develop budget requests, provide information to Executive and Legislative Branches, share information with consumers, families and providers, share information with other departments and track our progress in achieving resource development goals. The MR MIS identifies residential, programmatic, educational, and vocational unmet needs, indicates when these needs were identified and thus permits prioritizing of needs.

The system that existed at the time of the Study Committee, while essentially accurate, was not easily used by case workers in the system. As a result many case workers could not readily share information with consumers, families or providers. With the completion of a very aggressive distribution of computer equipment and basic training in the use of the machines, the stage was set for a revision of the software utilized. Over 100 individuals have now been trained to utilize a new platform and have direct access to the database through their Local and Wide Area Networks in the Regional Offices and the Department's Central Office. As a result, case workers and others can now more easily interpret and share information.

The MR MIS has been demonstrated to the MARS and ANCOR provider organizations and providers of consumer services have been reviewing the accuracy of the MR MIS information for the individuals they serve. Departmental policies and practices are being modified to require that MR Caseworkers ensure that MR MIS information is made accessible to consumers, their families and service providers. MR MIS information regarding a consumer's unmet needs will be included whenever planning information is conveyed to consumers, their families and service providers. Regional staff have been notified of the importance of including the MR MIS printout regarding services needed and received with any other Person-Centered Planning documents, including those distributed to consumers, their families and providers. Uniform adherence to such practices is just one component of compliance with this legislative requirement of access to such information.

Future Needs and Development

1) Three new regional training positions have been created. Steps must be taken to train consumers and families more completely in the use and interpretation of the MIS

information. This task will be assigned to the Regional training staff in February as soon as all positions are filled.

2) Departmental policies and practices will be modified during the next several months to include persons making the transition from school-based services to adult services in our MR MIS. MR Services caseworkers will receive referrals from Children's Services staff when consumers served by Children's Services reach the age of 16. Information regarding the consumer, including current or projected unmet needs, will be entered into the MR MIS at that time

Section 3 Report on Planning and Budgeting

This section of the Legislation requires that DMHMRSAS report on the implementation of adopting Person Centered Planning (PCP) for all individuals requiring mental retardation services. Additionally, DMHMRSAS is required to submit a budget based upon the individual needs expressed through the person centered planning process.

The Person Centered Planning Process is required for all members of the Community Consent Decree Class and is, therefore, received by some 95% of the more than 1,000 class members. The remaining class members have either chosen another planning format or declined any planning format. Under both the ICF/MR structure and the Medicaid Waiver program, anyone, class member or non class member, must have an annual plan. As a result, 95% of the nearly 2,700 non class members receive annual planning. Thus, of the almost 3,700 individuals requiring mental retardation services more than 3,550 individuals receive an annual plan.

The form of plan developed varies from plans specifically called "Person Centered Plans" to ones that are referred to as "Service Plans," "Inter Disciplinary Team Plans or "Individual Program Plans," "Nursing Plan of Care," "Plan of Care" for Individuals living in Private Non Medical Institutions (PNMI) facilities or "Individual Rehabilitation Plans." Additionally, for individuals who are still in school settings "Individual Education Plans" or "Transition Plans" are developed. Because all of these planning forms require listing of needs in conformance with the MR MIS system, the four major needs areas, residential, programmatic, educational, and vocational needs, are reported both within the planning documents and within the MIS. As a result DMHMRSAS is able to submit a budget that reflects an accurate listing of needs and does so in the annual budgeting cycle.

Table 1 below portrays the various forms of plans presently received.

Table 2 below presents the budget as submitted based upon the unmet needs reflected in the planning process.

Section 4 Improve public information and education

Reg.		PCP	Service Plan	Rehab Plan	IEP	Trans. Plan	Refused	IDT/IPP	PNMI Plan	Nursing Plan	No Plan	No Indication
1	972	608	109	18	53	16	65	9	1	1	80	12
2A	791	271	279	21	40	19	11	76	45	3	220	6
2L	544	326	132	1	16	0	0	32	3	1	6	27
2T	417	143	157	0	14	1	0	86	5	2	6	3
3B	629	327	257	0	8	1	2	19	0	1	7	7
3P	341	249	72	1	5	1	0	4	4	0	5	0
Totals	3,694	1,924	1,006	41	136	38	78	226	58	8	124	55

Reg 1 Office is Portland	Reg 2T Office is Thomaston
Reg 2A Office is Augusta	Reg 3B Office is Bangor
Reg 2L Office is Lewsiston	Region 3P Office is Presque Isle

Table 1

Department of Mental Health, Mental Retardation, &
Substance Abuse Services
Mental Retardation Services
Part II Summary for MR Unmet Needs

	Region I			Region II			Region III			Total		
	Grant*	Seed**	# of Consumers	Grant*	Seed**	# of Consumers	Grant*	Seed**	# of Consumers	Grant*	Seed**	# of Consumers
2000												
Residential		1,036,095	45	28,350	1,060,678	64	77,700	1,400,015	82	106,050	3,496,788	191
Day Services		222,000	37	153,994	134,841	61	85,000	659,867	120	238,994	1,016,708	218
Professional	30,000			143,157	113,887	154	105,000	80,772	88	278,157	194,659	242
Respite	100,000			124,800	20,500	39	73,500		29	298,300	20,500	68
Total 2000	130,000	1,258,095	82	450,301	1,329,906	318	341,200	2,140,654	319	**921,501**	**4,728,655**	**719**
2001												
Residential		1,037,323	45	28,350	1,061,935	64	77,700	1,401,675	82	106,050	3,500,933	191
Day Services		222,263	37	153,994	135,001	61	85,000	660,649	120	238,994	1,017,913	218
Professional	30,000			143,157	114,022	154	105,000	80,868	88	278,157	194,890	242
Respite	100,000			124,800	20,524	39	73,500		29	298,300	20,524	68
Total 2001	130,000	1,259,586	82	450,301	1,331,482	318	341,200	2,143,192	319	**921,501**	**4,734,260**	**719**

*Grant Funds are direct state dollar payments via contract with a provider of services.

**Seed Funds are the state share of Medicaid.

	Pers Serv	All Other
Position Request	01	02
2000	417,361	60,000
2001	812,043	114,000

Total Grant and Seed (Includes Position Request)

FY2000	6,127,517	2000
FY2001	6,581,804	2001

The above reflects annual cost. The final Part II submission represents a phase in of the above. Those amounts are as follows:

	Grant	Seed	Total
FY00	822,924	1,773,246	2,596,170
FY01	1,732,356	4,142,479	5,874,835

Next Biennial budge would include the following:

FY02-Part I	1,732,356	4,142,479	5,874,835
FY02-Part II	115,188	591,781	706,969
Total FY02	1,847,544	4,734,260	6,581,804

Table 2

10b

This Legislation required DMHMRSAS to produce a plan to improve public information and education concerning persons with mental retardation. Many important pieces of such a plan are already in place or are actively under development. These are:

- Consumers and families are informed at intake of the services provided by the Department access to services, and rights of appeal, including grievance information. This information is also available on a continuing basis through the personal planning process and in response to consumer/family questions.
- Booklets describing the appeal process have been sent to all Community Consent Decree Class Members, families and correspondents. These booklets and copies of consumer rights are also given to all applicants for services at intake.
- The Office of Guardianship sponsored a day-long workshop on guardianship issues in May 1997 which was attended by approximately 170 people, including 50 or more family members. A similar event will be scheduled in 1999.
- The Guardianship Program Manager routinely responds to questions about guardianship, as do caseworkers and advocates. A comprehensive summary of guardianship information, "Q&A Guardianship", is available on the Department's Internet web site, www.state.me.us/dmhmrsa. This web site also has links to national organizations which provide information to families and professionals.
- Families with questions about financial and estate planning are referred to local attorneys. The Department will sponsor one or more workshops on financial and estate planning in 1999-2000.
- The regional Quality Improvement Groups are charged with developing public education, and the Department will continue to work closely with the regional groups in these efforts.
- The consumer self-advocacy group, Speaking Up for Us of Maine, is involved in preparing a consumer's guide to rights. This guide will be produced in print, audio, and video versions. Speaking Up for Us and Department staff will be conducting consumer workshops on rights and the grievance and appeal process.
- The Department has produced a variety of materials related to the personal planing process, including a brochure, the booklet "Planning With People," a planning facilitator's guide, "Companions on the Journey", and an illustrated consumer guide and workbook. These have been widely disseminated to consumers, families and service providers.
- The Department has produced a videotape version of "Planning With People" describing the personal planning process, and has copies available in each regional office for loan to consumers, families, or interested others.
- Regional offices also have copies of "It's My Life!", a video which features consumers, families and service providers reflecting on the person-centered approach in Minnesota. A similar video is under production in Maine.
- Family members and guardians receive notices of training events related to personal planning in each region.
- The Department has created positions for three Mental Retardation Regional Training Coordinators who will provide training and public information within their regions as

well as on statewide initiatives. Two persons have been hired to start in these positions in January, and the third person will be starting early in February. The Training Coordinators will work closely with the regional crisis teams to increase their outreach education to local and county mental health services, law enforcement, emergency services, hospitals, etc. The Training Coordinators will also work with regional service providers, consumer groups, families and Quality Improvement Councils.

- The DMHMRSAS quarterly publication, **Perspectives,** contains articles focused on services to individuals with mental retardation and their families.
- Video tapes have been developed on specialty support areas, psychiatry, psychological services, education, occupational therapy, physical therapy and speech and language therapy, and will be available shortly in each regional office.
- Crisis team staff have worked actively with local police departments and local emergency rooms to make police and emergency personnel more aware of the sometimes special needs of this population.
- The Department has presented one Interactive Television presentation on mental health needs of individuals with mental retardation and is preparing for a January presentation on deaf services within the mental retardation system. These presentations will also be available on video tape in each regional office.
- An area that is a priority for this next year will be the development of a cooperative relationship with the Regional Councils on Transition and Children's Services to make young adults and their families more aware of the adult services system so they will be better able to make decisions for post-educational services. Each region has in the past offered a variety of means, provider forum sessions, brochures, individual meetings, etc. to assist families. In the future, however, these efforts must involve the Councils on transition and local school districts.

Section 5 Encouraging fair compensation

DMHMRSAS agreed with the Study Committee on Mental Retardation Services that wage equity was an important issue. The Legislation asked DMHMRSAS to take all necessary steps to encourage fair compensation. The Department was able to implement an increase in Direct Staff salaries within existing resources and agreed to convene a Task Force to examine other necessary steps. Members of the task force included Sawin Millett, Don Trites and Jane Gallivan from DMHMRSAS and Charlene Kinnelly of Uplift Inc., Arthur Lerman of Port Resources, Kevin Baack of Goodwill Industries of Maine, Jim Pierce of Independence Association, Ron Langworthy of Community Living Association, Fred Rovillard of Ken-a-Set Association, and Susan Cady and Betty Libby of Community Partners.

The Task Force met for the first time in June and looked at the issue of fair compensation for Direct Support Staff from four perspectives:

- What does it take to attract qualified staff?
- What does it take to retain qualified staff?
- What constitutes a livable wage?

- What would be a fair wage in respect to wage parity among Direct support Staff doing essentially the same work in different service areas administered by DMHMRSAS?

Research assignments were divided up among members of the Task force. Data and information was collected from a wide range of sources, including the State Economist, the Maine Development Foundation, the State Planning Office, research conducted by the University of Vermont, DMHMRSAS, various Councils on Government, Bureau of Labor Statistics, U.S. Department of Labor, and conversations with individuals working in the private sector. The results of the research are as follows:

- Current Direct Support Staff wages are not sufficient to attract and hold qualified staff in sufficient numbers to meet the needs of existing programs. The demand for new staff for the new programs to meet the needs of individuals on DMHMRSAS's waiting list, for whom funding is now available, makes the situation even more problematic. Community service providers compete for workers with fast food restaurants, telemarketing companies, retail sales establishments and a variety of similar low paying, entry level job providers,. In some parts of the State, competing entry level job providers even offer higher starting pay than providers of services to individuals with mental retardation. It is estimated that a one to two dollar per hour increase in staring pay would allow providers to compete successfully for available workers.

- Retaining capable staff poses many of the problems described. In addition, it is not uncommon for staff who are trained and experienced working with people with mental retardation to leave their positions to work in Mental Health or Children's Services where pay is sometimes higher. An increase in pay of one to two dollars per hour might appreciably diminish this reason for turnover.

- The Maine Development Foundation and the State Legislature's Commission on Livable Wage defined "livable wage" as between $8.00 and $11.50 per hour, based on family size. While the State of Maine identifies the amount of pay required for a livable wage, the 8 year State policy of freezing grants and has severely limited the ability of private providers to pay a livable wage to Direct Support Staff.

- Wage parity is a real issue. Starting salaries in other human service occupations, nursing homes, programs operated by other state departments and hospitals are often higher than those provided in the mental retardation field. Because of the first time development of Mental Health and Children's programs, wages paid to staff in these programs for comparable work is often higher than wages set several years ago for those providing services to individuals with mental retardation. Even within MR Services, there are significant differences between wages paid to individuals working in waiver homes and those working in ICFs/MR.

- The wage disparity between Waiver homes and ICF/MR facilities results from a wage parity bill passed for ICF/MR facilities which took effect in April of 1989 and

established a pay structure for ICF/MR staff that was tied to comparable wages at the Pineland Institution. This parity structure has resulted in annual increases at all levels within the ICF/MR facilities; however, it has not been extended to workers in waiver programs.

- The Task Force considered the history of this development important and presents the following summary of that history:

  In the early 1980s, ICFs/MR were the primary alternatives to institutionalization at Pineland Center. The reimbursement rules which were in effect at that time resulted in direct support staff wages that were barely above minimum wage. Recruitment and retention were major problems. The resulting instability of staffing in the ICF/MR facilities led to unstable services and many individuals were forced to return to Pineland Center because the community ICF/MR facilities could not meet their needs.

  In 1987, the Legislature created the Advisory Committee on Staff Retention and directed it to study the problem and report its findings and recommendations back to the Legislature. The Committee found that retention was a significant issue and turnover was very high. It found that employees were very young, had only high school graduation often being the highest educational level achieved and that the average tenure in entry level jobs was less than three years. Exit interviews conducted with employees found that inadequate pay and lack of career advancement were the two primary reasons for leaving jobs. The Committee developed a career ladder within the ICF/MR program and recommended the implementation of a competitive wage scale. Movement up the career ladder required training or formal education, coupled with experience working with individuals with developmental disabilities.

  The Legislature authorized the implementation of the career ladder, effective April 1, 1989. Title 22, Section 3186 was amended to require the Department of Human Services to amend reimbursement rules to permit the implementation of the career ladder in ICF/MR facilities. As a direct result of this legislation, staffing in ICF/MR facilities was stabilized and the quality of services improved. That pattern continues today.

  Because the career ladder was not extended to other service areas within the mental retardation community, the pattern of high turnover rates and difficulty in securing well trained staff exists in waiver facilities today. As more and more individuals decide that they want a less structured environment than those found in ICF/MR facilities, and as people on the waiting list become eligible for services, the need for a well trained and stable work force grows.

Recommendations

- The Task Force recommends that the existing ICF/MR pay structure be extended to Direct Support Staff in non ICF/MR programs. This long term solution to the salary

issue must include both career advancement opportunities and annual cost of living increases. These issues are addressed in the current ICF/MR pay structure because contracting is done on a cost reimbursement basis. The ICF/MR pay structure has resulted in attracting and retaining quality staff and would, of course, create parity within the various forms of MR Services.

- Contract and service agreement language with providers of mental retardation services must be amended to ensure that rate adjustments are used to increase direct staff salaries and to implement an appropriate career ladder.

- Sufficient funds must be made available so that DMHMRSAS can implement rate setting that permits implementation of the career ladder and salary levels for non ICF/MR staff.

- Work on job descriptions and training requirements must be completed and the department and the provider community will work together to implement necessary training.

Section 6 Supplemental budget request

In order to estimate the cost of implementing this recommendation, the Task Force conducted a survey of all MR Service Providers in the State of Maine. The survey results indicated that the initial cost of implementation would be approximately 2.8 million dollars in state funds. DMHMRSAS requested Part Two funding in that amount.