



**Maryland Department of Health and Mental Hygiene
Developmental Disabilities Administration
Office of Health Care Quality**

**Task Force on the Quality of Services for
Individuals with Developmental Disabilities
Final Recommendations**

May 2015

Introduction

Bernie Simons, Deputy Secretary of Disabilities, and Tricia Tomsco Nay, Executive Director of the Office of Health Care Quality, convened and co-chaired a task force on the quality oversight of services for individuals with developmental disabilities. The Department of Human Resources and the Governor's Office for Children were integrally involved in the task force. The task force membership was recruited from a wide community of stakeholders to welcome opinion from a variety of informed contributors in the field:

- Patricia Arriaza, Governor's Office for Children
- Brian Cox, Developmental Disabilities Council
- Kathleen Durkin, The Arc Baltimore
- Janet Furman, Developmental Disabilities Administration
- Darlene Ham, Office of Licensing and Monitoring
- Margie Heald, Office of Health Care Quality
- Margaret Holmes, Legal Aid Bureau, Inc.
- Laura Howell, Maryland Association of Community Services
- Sharon Krevor-Weisbaum, Brown Goldstein Levy
- Christine Marchand, The Arc Maryland
- Jason Noel, Mortality and Quality Review Committee
- Allison Orlina, Office of Health Care Quality
- Susan Panek, Medicaid
- Nancy Pineles, Maryland Disability Law Center
- Valerie Roddy, Developmental Disabilities Administration
- Christopher Smith, Kennedy Krieger Institute
- Shelley Tinney, Maryland Association of Resources for Families and Youth

Purpose of the Task Force

The task force was created to bring stakeholder perspective and priorities into the recommendations for improving government oversight of services for individuals with developmental disabilities. Medically fragile foster children who reside in group homes are among the most vulnerable of those in need of developmental disabilities services. Much of the discussion and focus of the task force was directed at this particular client population. Recommendations for improving oversight of this especially vulnerable population are likely to present improvements to government oversight of the quality of developmental disabilities services as a whole.

Task Force Meetings

The Developmental Disabilities Administration (DDA) and the Office of Health Care Quality (OHCQ) co-hosted three meetings. Invitations to sit on the task force were sent to providers, advocacy and advisory groups, and other governmental agencies. These public meetings were open to guests. The Office of Health Care Quality created a web page for materials related to the task force, including membership, agenda, minutes, legislative reports, testimony, and other materials from the Department of Health and Mental Hygiene (DHMH) and the Department of Human Resources (DHR).

At the conclusion of the three meetings, the opinions and advocacy from the meeting discussions were re-presented to the task force as potential recommendations. Further discussion of potential recommendations resulted in a list of proposed recommendations for rating and comment in a survey. The validity and feasibility of the proposed recommendations were then evaluated so that top recommendations could emerge with input from all members.

Meeting on November 19, 2014

The first meeting focused on departmental processes. Both DHR and OHCQ presented their core functions of licensing, contracting, and inspection and how they conduct oversight of providers.

Task force member feedback was largely about how joint oversight is conducted; how the various agencies share information; and the scope of governmental oversight. Members inquired about the number of providers and the size of the foster child population.

Meeting on December 3, 2014

The second meeting focused on the benefits of limiting task force discussion, recommendations, and problem mapping to medically fragile foster children, many of whom are placed in residential provider settings (i.e. group homes). Recommendations already presented to the legislature by DHMH were reintroduced to the task force. Member recommendations centered on the potential for expanding medically fragile foster placements to family homes; tightening oversight among government agencies through more cohesive and inclusive case management; and consolidating government agency responsibility for licensure, placement, and monitoring.

Meeting on January 7, 2015

The third and final meeting was held on January 7, 2015. The meeting opened with the chairs presenting a list of potential recommendations. These had been drawn from the meeting discussions to date and member suggestions to the task force. The potential recommendations were discussed and edited during the meeting with opportunity for additions. A survey for rating the recommendations was distributed to each member.

Scoring Methodology and Selection of Final Recommendations

For each recommendation task force members rated its validity and feasibility on a scale of 1 to 9, with 9 being the most valid or feasible. Validity indicates how well the recommendation addresses the mandate, and feasibility represents the recommendation's potential for being implemented. Each member was also allowed to select any three recommendations as their personal choices for inclusion among the final recommendations.

The surveys were anonymous and absent members had an opportunity to send in their ratings after the final meeting. All members submitted ratings, top selections, and comments within a week of the final meeting. Averages for validity and feasibility were calculated and the number of selections as a top-three recommendation were tallied. From those averages and tallies, the recommendations were ranked according to overall score.

Three proposed recommendations had the highest scores and addressed the overall goal of the task force: to enhance oversight of the quality of services provided to medically fragile foster children with developmental disabilities. The results of the surveys were made available to all members of the task force and the public on the web page created for the task force and hosted on the OHCQ site.

Final Recommendations

At a legislative hearing on January 28, 2015, DHMH and DHR presented the final recommendations of the task force:

1. For the medically fragile foster children in group homes who are enrolled in the Rare and Expensive Case Management (REM) Program, DHMH will require that the REM case manager coordinate each child's care and communicate with all involved.
2. DHR and DHMH will work together to develop and implement transition plans for medically fragile foster children to ensure a smooth transition to appropriate services at age 21.
3. By April 2015, DDA will implement a financial incident reporting system for DDA providers, similar to the process implemented by DHR for children's providers.

Moving Forward

In October 2014, the Department of Health and Mental Hygiene made five recommendations in its open report to the legislature titled *Review of Services for Medically Fragile Foster Care Youth*. The task force was specifically called for in that report as the next step in making recommendations for improved oversight of group homes for medically fragile foster children. The departments involved in monitoring these providers wanted stakeholders to have a formal opportunity make recommendations from their unique and informed perspectives.

The recommendations of the task force dovetail with those already recommended by DHMH. They will become part of the planned improvements to shared oversight of this type of provider and this population. The Department of Human Resources remains a committed partner in implementing the full set of recommendations from both the task force and the report to the legislature. Partner agencies from both departments have already begun to implement improvements in data collection and information sharing. Both departments look forward to working together to implement the recommendations from the task force as well.

Between the legislative report and the task force recommendations, all agencies involved in the oversight of services to medically fragile foster children have actions they can take toward those goals. Responsibility has been distributed across involved agencies with opportunity for improved oversight from each. Agencies from both departments are already involved in cooperative projects to keep each other informed of monitoring activities over these providers. The recommendations from this task force: financial monitoring, more coordinated case management, and preparation for adulthood – will both contribute to and benefit from that enhanced interdepartmental collaboration.