Quality Trust
for Individuals with Disabilities

Fiscal Year 2016 Post Compliance Monitoring
Quarter Two Results

April 2016

INTRODUCTION

This report contains results of monitoring, and legal and lay advocacy activities completed by Quality Trust during the second quarter of Fiscal Year 2016. The report is organized into the following sections:

- Monitoring results (data from review of 37 class members from the sample of 177 class members), incidents and investigations
- Advocacy
- Involvement in DDS committees and stakeholder groups
- Presentations and other Activities

This is the second quarter results from our work related to the plan we submitted to the Court In May of 2015. In that plan Quality Trust outlined the activities in which we would engage for the year beginning October 1, 2015. In addition to our on-going work, we agreed to complete individual monitoring for 177 class members (a statistically significant number) through a simple random sample. During the first quarter we completed monitoring reviews for 64 class members, provided advocacy services for both class and non class members, and followed up on Serious Reportable Incidents and admissions to Long Term Acute Care (LTAC) settings for class and non-class members. As the second quarter of FY'16 began three of our monitors and one nurse were involved in the joint monitoring process for the final two goal areas in the Evans case. The joint monitoring work was completed by the middle of March and the QT team completed 37 monitoring reviews for class members during this past quarter.

The data indicates continued strong performance maintaining compliance with most all retired court orders as measured by the questions in the tool. There are a couple of areas where performance was not as strong. Scores were lower on the measure for updating and training on updates of the Health Care Management Plan (HCMP), and in the area of behavioral health related to ensuring that all requirements of the RCRC policy are implemented by the Committee. At the same time we observed improvements in the numbers around staff training at day programs. This could be related to the emphasis placed on day programming in the joint monitoring during this quarter. While we continue to see a significant number of unplanned hospitalizations, we are encouraged that the Quality Improvement Committee (QIC) is now engaged in a serious, systematic analysis of this issue. Overall data and our involvement in DDS Committees and workgroups indicate continued leadership by DDS in ensuring the hard fought gains made over the past several years continue. We highlight the following areas as those where continued enhancements are recommended.

- Ensure HCMP's references all the person's health care needs, and that when it is amended/updated staff are trained in the changes
- Continue to examine the root causes for unplanned hospital admissions-especially repeated hospitalizations (this issue is now being studied by the Quality Improvement Committee, (QIC)
- Clarify that timelines for completion of provider Plans of Corrections (POC's) are consistent between the date referenced in the SRI investigation and the dates listed in MCIS
- Ensure that the RCRC and HRAC adhere to all of requirements of their policies as they review rights restrictions for people receiving services and supports through DDS

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THE INFORMATION IN THIS SECTION INVOLVES EVANS CLASS MEMBERS ONLY

Monitoring

We began our review of 177 class members in October of 2015. During the first quarter of the fiscal year we completed 64 monitoring reviews. During the second quarter we completed and sent to DDS monitoring reviews for 37 class members, or (21%) of the entire project. With the 64 reviews completed in quarter one, we have now completed 101 reviews, or (57%) of reviews required for completion of a statistically significant sample. As we discussed in our first quarter report we completed fewer monitoring reviews because several of our staff members were participating in the joint monitoring process for the final goal areas in the *Evans* case. In addition and as we planned in quarter one, we used the second quarter to review provider compliance with recommendations contained in investigations of Serious Reportable Incidents (SRI's).

As we did in the first quarter report, we have attached the full body of results to this report. Here are some selected highlights:

Demographics:

- 25 people (68%) are supported through the HCBS waiver
- 12 people (32%) live in ICF's/IDD
- 13 people (35%) live in Supported Living arrangements; the least restrictive option available in the District
- 21 Men (57%) were reviewed
- 16 Women (43%) were reviewed
- 16 people (43%) were between the ages of 51-60
- 15 people (41%) were between 61-70
- These 31 people constituting (84%) of this quarter's sample is much older than the majority of people reviewed in quarter one, and is somewhat above the average age for the class as a whole
- It is not surprising then that 51% (19) people either use a wheelchair or walk with some other kind of support
- 12 different day programs are represented
- 20 people participated in Day Habilitation
- 4 people were retired
- 5 people participated in Day Treatment
- 1 person participated in Supported Employment

ISP:

- 100% of the people reviewed had a current ISP
- 34 (92%) of the people we met are deemed to need assistance with Decision making
- Of that total 32 (94%) had the recommended assistance
- 34 of 35 people (97%) use at least one piece of adaptive equipment
- 31 people (91%) had the equipment, it was in working order, and was being used correctly

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Personal Possessions

- 34 of 36 people (92%) were receiving their Personal Needs Allowance
- 36 of 37 people (97%) had an IFP based on their preferences
- 29 of 34 people (85%) had an IFP based on their interests

Staff Training (Combined residential & day program)

- In the residence we found evidence of required training for DSP's for 28 of the 37 people (76%), at the day program the number was 37 people, or (95%). This is a significant improvement in the day program percentage, as last quarter the number was (75%).
- In the home, staff for 34 of 37 people or (92%) could describe the person's preferences and needs, while at day program 35 of 37 people's staff or (95%) could describe the program/employment related goal. This is another substantial increase.
- At home, DSP's could describe their responsibilities for carrying out the person's HCMP for 24 of 37 people or (65%), while at day program staff for 27 of 30 people (90%) could describe their responsibilities. These increases in day program percentages might be explained by the emphasis on day programming during the last quarter.

Nursing (combined residential & day program)

- All 37 people (100%) had a current physical examination
- 32 of 37 people or (85%) had evidence of follow up on recommendations from their physicals
- 35 of 37 people (95%) had a current dental or a variance if appropriate
- 95% (36 of 37 people) had evidence of recommendations from medical specialists being implemented in a timely manner
- 25 of 37 people (68%) had a HCMP that referenced all of their health needs
- 66% (21 of 33 people's) HCMPs were updated according to DDS, H & W Standards within the required timeframe of identification of a new health concern
- We found evidence that staff for 26 of 37 (70%) people were trained when changes were made to the HCMP
- 89% of the nursing assessments met professional standards
- 84% of RN notes indicate they are coordinating healthcare services
- 78% of TME's were knowledgeable of intends effects and possible side effects of medications

Behavioral Healthcare (combined residential & day program)

- 15 people (41%) had a restricted control implemented for which a BSP is required
- All 15 people (100%) had evidence of consent or an approved opt out
- 11 of the 15 people (73%) had evidence that the BSP's we reviewed had been approved by DDS
- 100% BSP's were being reviewed quarterly by a Psychiatrist
- 100% of people supported by a BSP were being monitored for Tardive Dyskinesia
- In all but one case, (96%) the BSP was being implemented at both the home and the day program

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Day/Vocational Program

- 31 of the 37 people (84%) had a job or some other type of planned day activity
- All 31 people (100%) had a current ISP at their day or vocational program
- Staff at the program was collecting data toward the goals and outcomes for 30 of the 31 people or (97%)

Service Coordination

- 97% of Service Coordinators had a caseload of 30 people
- 92% of Service Coordinators had all required training
- 89% of Service Coordinators had documentation that they made all required visits
- 97% of Service Coordinators could identify the preferences of the people they support
- 97% of Service Coordinators were able to identify the person's health needs

Incidents & investigations

THE INFORMATION IN THIS SECTION OF THE REPORT INVOLVES CLASS AND NON CLASS MEMBERS

Incidents

Quality Trust received 299 Serious Reportable Incidents from DDS in the second quarter of FY 2016. Of that total 120 (40%) involved unplanned hospitalizations. This rate has been maintained for several years. The second largest category was serious physical injuries at 48. There were 46 allegations of neglect. There were 32 allegations of abuse reported. Together these four categories account for 246, or (82%) of the SRI's reported in the second quarter of the fiscal year. All of these results are consistent with numbers from quarter one, although the number of serious physical injuries rose.

Of the 299 incidents received, 75 (25%) involved class members. Of those 75 Serious Reportable Incidents, 35 (46%) involved unplanned trips to the hospital. This percentage is consistent with, but slightly lower than quarter one where (49%) of total SRI's involving class members were unplanned trips to the hospital. Ten providers had 10 or more Serious Reportable Incidents in the second quarter of FY 2016. Taken together these ten providers accounted for 133 (44%) of the 299 incidents reported during the time period January 1, 2016 to March 31, 2016. The following data involve the ten providers.

- Provider A: Total Incidents= 18
  - 12 of 18 were UEIH's (66%)
  - Of the 12, (5) five were for one person (CM). We visited this person, completed a focused healthcare review and made several recommendations for improved performance
- Provider B: Total Incidents= 16
  - 11 different people accounted for the 16 incidents
  - 5 of the 16 were UEIH's (31%)
  - 5 (31%) involved allegations of abuse
  - 3 (19%) involved serious physical injury
- Provider C: Total Incidents = 14
  - 7 of 14 were UEIH's (50%)

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    - 6 (43%)serious physical injuries were reported, four (66%) of which were experienced by one person
- Provider D: Total Incidents= 14
    - 13 different people accounted for the 14 incidents
    - 7 (50%) of the incidents were UEIH's
    - There were three each serious physical injuries and allegations of neglect
    - There were two deaths
- Provider E: Total Incidents= 12
    - 12 people accounted for the 12 incidents
- 4 of the 12 (33%) involved allegations of neglect
- 4 of the 12 (33%) involved UEIH's
- 2 involved exploitation
- Provider F: Total Incidents= 12
    - 11 people accounted for the 12 incidents
    - 4 of the 12 incidents (33%) involved allegations of neglect
    - 4 (33%) involved UEIH's
    - 2 involved missing persons
- Provider G: Total Incidents= 12
    - 11 people were involved in these incidents
    - 5 (42%)involved UEIH's
    - There were three (3) deaths (25%)
    - Two (2) incidents (17%) involved unapproved use of restraints
- Provider H: Total Incidents= 11
    - 10 people accounted for the 11 incidents
    - 4 (36%) involved serious physical injuries
    - 3 (27%) involved allegations of abuse
- Provider I: Total Incidents= 11
    - 10 people account for the 11 incidents
    - 6 of the 11 incidents (55%) involves UEIH's
    - 4 of the 11 incidents (36%) involved allegations of serious physical injuries

The information above is provided to give a sense of the types and frequency of incidents which were most commonly reported during the second quarter as evidenced by the 10 providers with the most reported incidents. They also mirror the overall numbers cited above. There are many variables which contribute to the number of incidents reported by any given provider, so drawing conclusions one way or another about these incidents is difficult. Among the providers on the list are providers who support a large number of people and providers who support people with significant challenges. Once again, unplanned trips to the hospital were the highest reported category of incident, with serious physical injuries and neglect also significantly reported. As we track these incidents by provider, we are most concerned when we see multiple incidents experienced by one person-especially in a short period of time. That is why we completed a more focused review of the nursing services and supports provided to the person from provider A, who had five UEIH's. The response to our visits from the provider's nurse was timely and all of the concerns we noted were addressed.

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Investigations

As noted in our first quarter report we began to follow up on recommendations from investigations this quarter. We reviewed recommendations from 44 investigations in order to determine if the provider staff could demonstrate that they had mastered the skills for which they received retraining.

Below are key findings from the review of 44 investigations during the second quarter. Of the 44 investigations 24, or (54.5%) involved Unplanned Emergency Inpatient Hospitalizations, 10 involved Neglect (23%), 3 involved allegations of Abuse (percentage), 3 involved Serious Physical Injury (7%), 2 were for Serious Medication Errors and 1 involved Exploitation.

- 21 (48%) involved class members
- 23 (52%) were for non-class members
- 32 (73%) occurred in the person's home
- 4 (9%) were at day program
- 3 (6%) were in the community
- 5 (11%) were listed another
- The due dates for provider Plans Of Correction (POC) for 34 investigations (77%) were later than the dates found in the Provider Recommendation tab of MCIS
- 30 of the 44 (68%) included at least one recommendation related to staff training
- Retraining on HCMP's and BSP's were the overwhelming issue
- We located documentation of retraining for 28 of the 30 (93%)
- 26 of the 30 (87%) were able to demonstrate the skill involved during our observations

Advocacy

The chart below indicates the volume and type of requests for advocacy we continue to receive. The reasons for requesting support are varied as are the sources of the formal request; although families provide the highest number of referrals. The length of our involvement varies. Our goal is to limit our advocacy support to a timeframe of 90 days. In many cases we find that no more than 30 days is required to bring about desired outcomes.

Currently we support several people who have received advocacy for more than 90 days. This is largely due to residential moves and the intake process for DDA and RSA. We often find that bringing the key players together to identify and overcome barriers is our most time efficient method. That was evident in the process for achieving 3 met outcomes where communication between providers, the person and families was a concern.

There was one legal referral concerning guardianship, specifically if the person needed one to make medical decisions. Unfortunately, that person died from cancer soon after referral.

Two people were closed with no outcomes met; one was an allegation of neglect and abuse that was taken over by APS. One additional person was attempting to have RSA fund a day program not funded through DDS. After his appeal was denied, we provided with resources for two other programs that are similar in nature.

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People in active advocacy: 16

People referred to legal: 1

People's outcomes met: 11

People Supported Through Advocacy

January Ongoing	January Closed	February Ongoing	February Closed	March Ongoing	March Closed
13	7	11	2	14	3

Outcomes Met

Medical/ Nursing Concerns	Medical/ Therapy Appointments /Referrals	Residential Move	APS Introduced	Family/ Provider Communication	Legal Referral	Day/ Employment RSA	Court Appt. Advocate
3	**1**	**0**	**0**	**3**	**1**	**2**	**1**

Referral Sources

January	February	March	Totals
DDS:	DDS:	DDS:	DDS:
LTAC F/U:	LTAC F/U:	LTAC F/U:	LTAC F/U:
SRI F/U:	SRI F/U:	SRI F/U: 1	SRI F/U: 1
Outside Agency:	Outside Agency: 1	Outside Agency:	Outside Agency: 1
Family: 3	Family:	Family: 2	Family: 5
Provider:	Provider: 1	Provider: 1	Provider: 2
Guardian:	Guardian:	Guardian:	Guardian: 0
APS:	APS:	APS:	APS: 0
QT Legal:	QT Legal:	QT Legal: 1	QT Legal: 1
Georgetown: 2	Georgetown:	Georgetown:	Georgetown: 2

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Number of New Advocacy Referrals by Month

January	February	March
5	2	5

RCRC Review:

Quality Trust's legal team reviews and analyzes the data from the meeting minutes of the Restrictive Control Review Committee ("RCRC"). These minutes are provided to us by DDS on a monthly basis. Based on that review, during the second quarter of FY 2016:

- RCRC reviewed 158 Behavioral Support Plans (BSPs) for 152 people.
  - This represents a 14% increase in the number of BSPs RCRC reviewed compared to last quarter (158 versus 139).
  - The majority was non-emergency reviews of new BSPs (135; 85%) and updated BSPs (12; 8%). 11 reviews (7%) were on an emergency basis.

- 135 (85%) of the BSPs were approved, 5 (3%) were approved for 2 years, 3 (2%) were approved for 60 days; 2 (1%) were approved "once the [RCRC recommended] revisions have been made to the BSP, and 1 (less than 1%) was approved for 90 days.
  - 47 BSPs (30%) were approved even though the RCRC minutes including substantive comments requiring the revision of the BSP, requesting additional information or justification for the restriction, and/or raising issues that called into question whether the BSP met the 8 criteria listed in DDS' RCRC Procedure (Procedure No. 2013-DDA-PR014).
  - 1 BSP was approved without the RCRC listing its answers to the 8 criteria listed in DDS' Procedure.

- 10 (6%) of the BSPs were deferred.
  - 9 BSPs were deferred even though the RCRC answered "No" to one of the 8 criteria listed in DDS' Procedure.

- 2 (1%) of the BSPs were rejected.

- The BSPs reviewed included:
  - 157 (99%) requests for the use of psychotropic medication
  - 54 (34%) requests for the use of behavioral one-to-one aides[1]
  - 10 (6%) requests for the use of behavioral two-to-ones aides
  - 10 (6%) request for the use of other environmental modifications
  - 8 (5%) requests for the use of medical sedation
  - 7 (4%) requests for the use of individualized housing
  - 6 (4%) requests for the use of protective/safety helmets
  - 6 (4%) requests for the use of sharps restrictions
  - 6 (4%) requests for the use of physical restraint

[1] Note that 7 BSP reviews included reference to medical one-to-one "aides." Per DDS Procedure No. 2013-DDA-PR08), such requests are generally reviewed by the DDA Health and Wellness Unit, rather than RCRC.

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- 4 (3%) requests for the use of environmental sweeps
- 3 (2%) requests for the use of protective mittens
- 2 (1%) requests for the use of a smoking protocol
- 2 (1%) requests for an incentive plan
- 2 (1%) request for the use of a geri-sleeve or wrist guard
- 1 (less than %) request for the use of visitation restrictions

- RCRCs reviewed 10 requests for exemption from the requirement of having a BSP. 5 (50%) were approved without an explanation or justification being include within the minutes.

Based on our review, we have the following recommendations, many of which we also raised in our last quarterly report:

(1) Ensure, pursuant to Section 3(D)(4)(a) of its Procedure, that RCRC only approves a BSP when it is sure that the plan, as written, satisfies all 8 criteria in Section 3(D)(3).

(2) Direct RCRC, pursuant to Sections 2(D)(4)(b) and (c) of its Procedure, to defer or reject -- rather than approve -- BSPs when it is requiring revisions to the plan, requesting additional information or justification for a restriction, or has doubts as to whether the plan meets the 8 criteria.

(3) Direct RCRC, pursuant to Section 2(D) (4) (c) of its Procedure, to reject -- rather than defer -- a BSP when it finds that the plan does not meet one or more of the 8 criteria, making it clear that there is no "harm" to the person in doing so, since both designations mean that the BSP cannot be implemented as written.

(4) Direct RCRC to use, when appropriate, "Yes with Recommendations for Improvement," when one or more of the 8 criteria in the Procedure is/are met, but the team has non-mandatory suggestions to strengthen the BSP. As DDS' Guidance for RCRC Review of BSPs recognizes, designations of "Yes with Recommendations for Improvement" under RCRC Procedure Section 3(D)(3) are "intended to be suggestions to improve or strengthen the plan." Plans that are approved with recommendations for improvement "are acceptable as written and do not *require* further revision" (emphasis added).

(5) Direct RCRC to document their review of requests for exemption from a BSP and provide justifications for any approvals, based on Section 6(D) of the DDS BSP Policy (Policy No. 2013-DDA-POL008), within its minutes.

HRAC Review:

Quality Trust's legal team reviews and analyzes the data from the DDS meeting minutes of the Human Rights Advisory Committee ("HRAC"). For the last quarter, DDS provided us HRAC meeting minutes for January and February 2016. We were informed on April 29, 2016, that DDS could not provide us with the HRAC minutes for March 2016, because those minutes had not yet been approved by HRAC.

Based on the January and February HRAC minutes provided:

- HRAC reviewed 1 human rights issue (i.e., closed circuit video monitoring of common areas of residential sites) that affected 10 people being served by a particular provider.

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- HRAC reviewed 26 other matters for 25 people.
  - 12 (46%) of these reviews were about Long Term Acute Care ("LTAC") placements; 9 (35%) were about out-of-state placements, 2 (8%) were about institutional placements, 1 (4%) was about a DDA case closure, 1 (4%) was about concerns in reference to a person's bank account, and 1 (4%) was about the use of hand mittens and a liquid absorbent glove.

Rather than repeat the recommendations that we made in our last quarterly report, we will focus on additional ones we identified:

(1) Out-of-State Placements – DDS procedure requires the HRAC to review, at least annually, all placements of people who live outside a 25 mile radius of the District of Columbia "to ensure that the person is in the least restrictive and most appropriate settings to meet his or her needs" (DDS Procedure No. 2013-DDA-H&W–PR012, Section 3(A)(2)(b)). In January, HRAC expressed concern that DDS and out-of-state providers are not consistently providing it with enough information to reliably make such determinations. The HRAC asked for the development of a separate DDS form that would require out-of-state providers to supply more "relevant information about the person's life." It may be because of this concern that HRAC made no decision on any of the out-of-state placements reviewed in January and February – even in the case of a person who, according to its minutes, "clearly stated to their service coordinator that they no longer wish to reside out of state." HRAC decisions on the appropriateness of out-of-state placements are important human rights protections for the people involved. DDS should provide clarification to HRAC on its role in reviewing, approving, and/or disapproving out-of-state placements and ensure that HRAC receives the information it needs to fulfill those responsibilities.

(2) LTAC Placements for IV Antibiotic Treatment – In January, the HRAC asked DDS for "a final answer as to how to determine if IV [antibiotic] treatment can be provided in the residential setting," rather than an LTAC – yet it still approved two LTAC placements for people who were placed there with that very reason included as a justification. In February, the HRAC approved 3 LTAC placements because of the need for IV antibiotic treatment, without indicating in the minutes whether it had received the answer it wanted from DDS. Such an answer is immediately relevant to the HRAC being able to approve an LTAC placement as "the least restrictive and most appropriate placement to meet the needs for the person" (DDS Procedure No. 2013-DDA-H&W-PR012, Section 3(A)(3)(f)(i), since it presumably could not if the person were able to receive IV antibiotic treatment in the more integrated setting of their own home, rather than a facility. DDS should direct HRAC to defer – and not approve – placements when the committee needs additional information (*id.* at Section 3(a)(3)(f)(ii)) and to record in its minutes thorough justification for the placements it approves.

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Participation on Committees and Stakeholder groups:

Quality Trust agreed to resume participation in a number of activities with DDS/DDA as part of the proposed monitoring plan for FY 2016.

The Deputy Director of Programs now attends meetings of the QIC Committee. Since resuming participation with the Quality Improvement Committee we have expressed concern about the number of people who experience unplanned trips to the hospital and our admitted. When trips not requiring admission are added the number increases dramatically. The Chair of the Committee has responded with urgency and strong leadership on this issue. A small look at readmissions was made by DDA Health & Wellness staff in March of 2016, and researchers from the Georgetown Health Initiative are formulating a larger more detailed look at this issue. The goal is to put the issue of "rapid Readmission" into context, seek to find any trends and hopefully make recommendations for improvements in services and supports where necessary.

Also during the second quarter, we participated in DDS committees, including the Mortality Review Committee to review death investigations and the HRAC Settings Advisory to review the Host Home regulations and the HCBS Transition Plan. We also participated in DDS-sponsored public forums to provide further input on the HCBS Transition Plan, as well as the DDS budget and the District's Workforce Innovation and Opportunity Act Unified State Plan. We remained a member of the D.C. Olmstead Working Group and the Center for Court Excellence's D.C. Adult Guardianship and Alternatives Project.

Quality Trust continues to participate with DDS/DDA as a core team member of the Supporting Families Community of Practice.

During the past quarter, we submitted testimony to the Committee on Human Services regarding DDS performance in the past year in March 2016 and testified at the budget hearing April 2016.

Presentations and other Activities:

Quality Trust also conducted a number of presentations and trainings on topics impacting people with developmental disabilities. Specifically, this quarter, we:

- Presented at the 7th Annual Secondary Transition Forum sponsored by the D.C. Department on Disability Services, D.C. Developmental Disability Council, and the D.C. Office of the State Superintendent of Education, among others.
- Presented a training on "What Happens When My Child Turns 18?: Decision-Making Supports for Adults with Disabilities" for parents of students attending The Ivymount School.
- Presented a primer on adult guardianship and alternatives in D.C to the Public Defender Services for the District of Columbia.
- Presented to the Social Security Administration Board on Supported Decision-Making and the representative payee system.

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- Presented to the National Council on Disability on Supported Decision-Making as an alternative to guardianship and means of increasing self-determination.

- We also provided comments to DDS on how to incorporate Supported Decision-Making into its Health and Wellness Standards and submitted written testimony for DDS' performance and oversight hearing before the D.C. Council's Committee on Health and Human Services.