EXHIBIT 4

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JOY EVANS, *et al.*, Plaintiffs, and UNITED STATES OF AMERICA, Plaintiff-Intervenor, v. ADRIAN M. FENTY, *et al.*, Defendants.	)	Civil Action No. 76-293 (ESH/JMF)

DECLARATION OF LAURA L. NUSS

I, Laura L. Nuss, declare and state as follows:

1. I am competent to testify to the matters set forth herein, and testify based on personal knowledge, information and belief.

I. Background Information

2. I hold a Bachelor of Science in Administration of Justice (1981) and a Master of Science in Community Systems Planning and Development (1987), both from the Pennsylvania State University.

3. My experience in the field of Intellectual and Developmental Disability ("IDD") includes learning from the perspective of a family member, private provider and state government official. Specifically, in addition to growing up with my Aunt who had a developmental disability, I served as her personal representative and health care decision maker for the last 20 years of her life.

4. The first 15 years of my professional career in this field were spent working for private organizations developing and operating small community-based residential (ICF/MR and HCBS waiver funded settings) and vocational services for individuals leaving the Pennhurst State School and Hospital and the Embreeville State School and Hospital, and for adults who sought or needed supports outside of the family home. I also served on family and consumer satisfaction survey teams through the Embreeville Consumer/Family Satisfaction Teams project.

5. I then moved to state government, serving three years as Branch Chief for the North Carolina Developmental Disabilities Administration, responsible for the management of the DD Home and Community-Based Services ("HCBS") waiver serving 6,000 individuals with a total operating budget of $300 million, department budget matters for a $650 million state agency serving 12,000 individuals, and systems change initiatives. In that capacity, I participated in the design and submission of the DD HCBS waiver renewal and rate setting initiatives.

6. In the state of Connecticut, I served one year as a Connecticut Department of Mental Retardation Regional Director with comprehensive responsibilities for all case management, family support, and private and public residential and vocational services serving 3,000 individuals with an operating budget of $85 million. I then served as the state-wide Director of Strategic Leadership for four years with responsibility for the state Medicaid HCBS waivers, Quality Assurance and Improvement, Staff Development, and Planning and Information Technology for the department with a total operating budget of $900 million serving 19,000 individuals. During that tenure, I re-wrote the "Comprehensive" MR/DD waiver for Connecticut to include self-determination, and wrote a second "Supports" waiver to introduce innovative in-home and self-directed services for individuals served by the Department, the tenth

such waiver approved in the country to be designated as an *Independence Plus* waiver. I co-wrote and served as the co-principal investigator for two CMS Systems Change Grants in the amount of $675,000 over a three-year period under the *Independence Plus* and the Quality Assurance/Quality Improvement under the federal systems change initiatives. Additionally, I played an instrumental role in the settlement of a class action "Waiting List" lawsuit by assisting with the design of a budget initiative totaling $12 million of state funds over a five-year period to serve an additional 750 persons off of the DD waiting list.

7. I have also served as a consultant on Medicaid waiver and quality assurance, and, in that capacity, co-wrote the District of Columbia ("District") DD Medicaid HCBS waiver renewal approved in November 2007. I have presented extensively at professional meetings nationally on quality assurance and improvement designs to meet the CMS Quality Framework requirements, Medicaid waivers, Individual Budgeting and Allocation methodologies, and Self-Determination subject matter.

8. I was appointed as the Deputy Director of the Department on Disability Services ("DDS"), responsible for the Developmental Disabilities Administration ("DDA"), formerly known as the Mental Retardation and Developmental Disabilities Administration ("MRDDA"), effective August 20, 2007.

II. Service Coordination/Individual Service Plans

9. DDS/DDA currently employs 71 service coordinators, who are tasked with, among other things, meeting at least annually with individual consumers, their families and/or significant others, and their providers, to gather information in order to develop each consumer's Individual Service Plan ("ISP").

10. The ISP can be revised or updated more frequently than annually to ensure that changes in an individual's condition and/or needs are taken into consideration in providing services and treatment.

11. On a quarterly basis for the past two years, between 86% and 98% of class members have met personally with their service coordinators. ISPs have been completed on a timely basis for class members on average 90% of the time for the past two years.

12. For the past six (6) years, DDS/DDA has maintained a ratio of one service coordinator to no more than 30 individuals (class and non-class members).

13. In October 2008, DDS/DDA designed and implemented a new ISP format that is built on best practice and organized around the same eight (8) domains that are used throughout the District's planning and performance measurement systems: rights and dignity; safety and security; health and wellness; choice and decision-making; community inclusion; relationships; service planning and delivery; and satisfaction. The ISP itself is now an on-line document that is completed, reviewed, approved, and disseminated via the web application.

14. DDA service coordinators facilitate ISPs meetings and complete the document for all class members regardless of where he or she lives. DDA service coordinators assumed this responsibility for individuals residing in HCBS waiver settings on October 2, 2008 and for individuals residing in ICF/ID settings on August 1, 2009 as planned.

III. Home and Community-Based Services Waiver

15. DDA's implementation of the Medicaid Home and Community-Based Services ("HCBS") waiver has enabled the District to redesign its service system to provide expanded integrated-living alternatives and services to consumers.

16. Through the waiver program, the District is eligible for a federal reimbursement of 70%, which has the effect of maximizing more limited local dollars while simultaneously providing more services and supports to the consumers who need them.

17. The HCBS waiver is comprised of the following: Professional Services- including speech, hearing, or language services, occupational and physical therapy, skilled nursing, behavior supports, and less traditional therapy such as dance or drama therapy; Assistive Supports- including emergency response, vehicle modification, and environmental adaptation (such as the addition of ramps or grab bars) without which an individual might need to be institutionalized; Residential Supports- including residential habilitation (housing 4-6 individuals), supported living (housing 1-3 individuals), and in-home support or live-in caregivers that allow a person to live as independently as possible; and Day Supports- including day habilitation to allow individuals to develop skills to support, or further, community integration opportunities, as well as supported employment to enable an individual to live as autonomously as possible through an ability to earn income.

18. Each service under the HCBS waiver is available individually so that each individual has the maximum amount of choice consistent with his or her general support, medical, emotional, and/or physical needs.

19. In September 2008, the District of Columbia submitted an amendment to add skilled nursing and supported living with transportation services to the waiver menu. The amendment also sought to increase the payment rate for physical and occupation therapy and speech and nutrition services in order to improve recruitment efforts of new clinicians to the program. In April 2009, the Centers for Medicaid and Medicare Services ("CMS") approved the amendment, which will be implemented with the passage of final rulemaking in October 2009.

20. The District continues to pursue refinements to the HCBS waiver program as part of self-directed continuous quality improvement. During the summer of 2009, the District created an HCBS Waiver Advisory Committee to solicit broad stakeholder participation and input on proposed changes. To date, this advisory committee has held three meetings that have led to the preparation of changes to the waiver in the following areas: level of care; service planning and delivery; services; qualifications of providers; health and welfare; financial accountability; administrative oversight; and quality management plan. As DDA continues to enhance and refine its services, operations, policies and practices, those changes are subsequently incorporated into the HCBS waiver application for approval by CMS, and to continually update CMS of enhancements in the quality management strategy of the District to meet the six required assurances.

21. The District has demonstrated improvement in the provision of services under the ISPs. For example, for HCBS waiver participants, prior authorizations must be processed in a timely manner in order for services to be offered consistent with the ISPs. In fiscal year 2008, prior authorizations were issued late 70% of the time. In only a year, the District dramatically improved its performance such that in fiscal year 2009, prior authorizations were issued in advance 70% of the time.

IV. Recruitment and Retention of Qualified Providers

22. Since January 2009, DDA has successfully recruited five (5) waiver providers, increasing the total number of current waiver providers to 104. Sixty-four (64) percent of all residential services are currently delivered via the waiver program, and more than half of the *Evans* class is currently enrolled in the waiver.

23. As of September 1, 2009, there are forty-two (42) Day Habilitation providers, thirty-eight (38) Pre-vocational Services providers, thirty-eight (38) Supported Employment providers, ninety-one (91) Supported Living providers, ninety-four (94) Residential Habilitation providers, forty-five (45) Host Home providers, twenty (20) Live-in Caregiver providers and sixteen (16) Professional Services providers enrolled in the HCBS waiver.

24. In February 2009, DDA developed and implemented a more robust enrollment process, namely the Provider Readiness Review Protocol, to review new provider applicants vigorously through a process of paper application, interview and on-site observation and review to ensure that new applicants in fact were prepared to serve DDA consumers effectively upon enrollment in the program. Since the inception of the enhanced protocol, twenty-seven (27) providers passed this process successfully, two (2) failed, and six (6) have been delayed due to poor performance in the review process. This process significantly improves the process agreed upon in the "September 12, 2007 90 Day Order" as the District no longer needs to be concerned about a sufficient number of providers, but does seek to continually raise the bar on the capacity of these provider organizations to deliver high quality services and supports.

25. The District through DDA and the Department of Health Care Finance ("DHCF") removed three (3) providers from the waiver program in the past 12 months due to performance deficits, providing further evidence that the District's ability and commitment to remove poorly-performing providers from the DDA service-delivery system.

V. Intermediate Care Facilities for the Intellectually Disabled

26. An intermediate care facility for the intellectually disabled ("ICF/ID") in the District serves no more than eight (8) individuals and provides active treatment to those individuals who require more intermediate levels of care. To meet the needs of the extremely

medically-complex and fragile persons who currently reside in hospital settings, DDA issued a Request for Proposal ("RFP") for a small ICF/ID setting to effectively serve these individuals in the community. The RFP was awarded to Volunteers of America ("VOA"), a national provider that practices person-centered service delivery and specializes in serving medically complex individuals in the District. VOA believes inclusive, personalized services can also be delivered under the ICF/ID model.

27. Many of the individuals served by ICFs/ID are non-ambulatory and have seizure disorders, behavioral support needs, mental illness, visual or hearing impairments, chronic, significant health conditions or a combination of these.

28. While the District makes every effort to serve as many consumers as possible via the waiver, this alternate housing option must also continue to be made accessible, as these settings at times can be as or more appropriate to serve the more complicated and complex needs of a subset of consumers.

29. Through the efforts of DDA, DHCF and the Money Follows the Person program, discussed in ¶ 30, a strategic plan is being fully implemented to reduce all ICF/ID homes to six (6) persons or less to improve the ability of these homes to provide more personalized services and supports, close older and non-accessible ICF/ID homes and reduce the overall number of persons receiving services via the ICF/ID program, consistent with the District's goal of treatment in the least restrictive environment. In fiscal year 2009, the number of eight-person homes decreased to six (6) persons or less from 15 to 12 with a plan on file for DC Healthcare to reduce all of its homes to six (6) or less via the MFP program; nine (9) homes closed or were reduced in size and converted to the HCBS waiver program; and in total the number of

individuals receiving services through the ICF/ID program decreased by 13% from the start to close of fiscal year 2009, and for class members decreased by 11%.

VI. Money Follows the Person Grant

30. In July 2008, CMS awarded the District a three-year, multi-million dollar grant through the Money Follows the Person Rebalancing Demonstration Program ("MFP").

31. This initiative has enabled the District to reduce its reliance on ICFs/ID for people with a wide range of developmental and physical disabilities, as well as older adults and persons with chronic mental illness.

32. The MFP enables the District to receive a 15 percent higher, i.e., from 70% to 85%, Medicaid matching rate for each person whom it assists to a community setting for the first 365 days enrolled in a HCBS waiver and the grant is expected to result in an additional $4 million to $6 million in federal Medicaid funding to the District over the lifetime of the grant. The District uses the higher federal Medicaid match that it receives from the grant to help people who wish to leave intermediate care facilities or nursing homes to move into homes or apartments of their choice, and to provide the Medicaid waiver services that these consumers need to live in the community. This program thus allows individuals to avoid being institutionalized and to exercise far greater choice and control over the essentials of their lives, such as where and with whom to live; what to do during the week and weekend; and what supports to receive and from whom. In addition, individuals in this program are participating in pilots to demonstrate the effectiveness of peer counseling, transition coordination and enhanced primary care coordination.

33. From August 2008 through September 2009, DDS transitioned 43 individuals with developmental disabilities from ICFs/ID to smaller settings including apartments in which

they live alone or with one or two other persons; there are an additional 29 individuals who are in some phase of exploring the MFP process. As of March 2009, DDS had offered MFP housing services to another fifteen (15) individuals and their families who declined those services. Some of these individuals declined MFP services due to deteriorating health; others were satisfied with their current placements; and still others refused because their families were not supportive of the proposed changes. This program illustrates the District's commitment to deinstitutionalization and individual choice. It allows an individual with IDD to choose his or her environment within a range of professionally acceptable alternatives, rather than imposing a state-selected placement.

VII. Health and Welfare

34. With the on-the-ground implementation of the Health Care Agreement ("HCA") initiated in May 2008, DDS has devoted considerable resources and funding exceeding $2.5 million and has successfully improved the quality and quantity of health care offered to consumers.

35. The HCA established a Health Care Quality Initiative ("Initiative") in partnership with George Washington and Georgetown Universities. The Initiative has been able to recruit new providers such as Seton House (affiliated with Providence Hospital), which now provides for the comprehensive psychiatric service needs of more than 100 individuals, and two additional primary care physicians ("PCPs"). A third PCP is now being supported as he begins a homebound visiting practice in District of Columbia Wards 7 and 8.

36. The HCA has also enabled the District to deliver enhanced primary care coordination for individuals considered to be high-risk who are in the waiver, and as a clinically-based research project, has provided outcome findings and recommendations for further

enhancements to the District's IDD and overall health care delivery-system as anticipated by the Initiative. Such coordination has occurred for 158 individuals, all class members, since the inception of the program, and was designed to be a proactive strategy for DDS/DDA to track the transition of individuals from the Medical Director ICF/IDD model into the waiver program, identify possible barriers to clinical care, and address any patient safety threats that could emerge as a result of this transition. Select findings of the first year of the project included as follows: access to medical services impedes ability to meet timeline requirements established by the IDD service system; access to PCP services during evening and weekend hours contributes to high use of emergency services; PCPs received the pilot project positively to improve communication and support for care coordination; care coordination between the PCP and specialist remains a communication challenge in the fee for service medical model; service coordination understanding of clinical conditions was adequate in most circumstances; and, clinical issues that emerge as significant areas include mobility, fall risks and sub-optimal use of physical therapy. These findings now drive quality improvement initiatives in health care by targeting service coordination training, exploring new health care delivery models with DHCF, and focused interventions targeted toward mobility, fall prevention, and expansion of physical therapy services.

37. George Washington University has also hosted webinars for physicians serving individuals with intellectual and developmental disabilities by leading physicians in the field on the following topics during the Initiative to date: Seizure Disorders; Renal Disease; Asthma; Bone Health; and, Wound Care. These webinars are archived and available for viewing for the subsequent 12 months and marketed through the Area Health Education Consortium for the District of Columbia ("AHEC").

38. The District of Columbia's Health Resource Partnership ("DC HRP") seeks to expand the community health care capacity for individuals with IDD by (1) providing health and mental health services that are accessible; and (2) implementing strategies to promote quality health outcomes. Since January 2009, DC HRP has added eight (8) full-time clinicians, who provide services in homes and day/vocational settings with a focus on quality, technical assistance, and training. In the last roughly six (6) months alone, the DC HRP interdisciplinary team has completed 1,058 targeted technical assistance requests in a range of areas including occupational and physical therapy, speech, psychology, medicine, health education, and nursing. In addition, the DC HRP medical director has assumed an increasingly active role in facilitating communication exchange between and among PCPs, the hospitals, medical specialists and interdisciplinary team members. This information has been useful in reducing hospital stays, ensuring timely care provision, assisting teams to develop priorities for people with complicated health conditions and competing needs for treatments. This has also helped to educate hospital staff about the needs of people with disabilities and to better understand the community-based system of services and supports.

39. To increase the number of experienced practitioners, DC HRP provides community-wide training in a variety of areas to teach those who serve individuals with IDD how to provide better care. Training includes, for example, "Using Visual Strategies to Prevent and Reduce Behavior Problems," "End of Life Planning," and "Substitute Decision-Making in Healthcare." And in a significant development for the long-term sustainability of the service-delivery system, for the third consecutive year, Georgetown University family medicine residents must devote a portion of their residency to the health care of adults with IDD, to assist in recruiting providers to this practice area. The additional training to medical students and

especially residents, specifically addresses the capacity-building and pipeline needs to DC IDD residents. The capacity for PCP panels is currently small and therefore access to care has been increasingly difficult. Without a mechanism to expand the PCP base, reliance on an older workforce of doctors creates unique and multiple service delivery challenges. Without the education efforts through the DC HRP, the current expansion in the provider network would not have become a reality. In order for DC HRP to accomplish the tasks of capacity building, increase in quality care and best practices, a strong training component was required, not only through physician consultation, coordination and technical support, but, educational training for soon-to-be practicing physicians in the local area. The connections and training of area resident family practitioners have allowed for physicians to include our individuals with IDD into their panel. DC HRP successfully recruited several graduates from the Georgetown Family Practice residency programs who also see our patients at community health centers ("CHC").

40. I concur with the recent summary report from Dr. Kim Bullock, DC HRP Medical Director, regarding the effectiveness of the Health Passport. Dr. Bullock stated that "the **Health Passport** has become a crucial information exchange document for the emergency department and the hospitals. Since the health passport has been implemented, providers have noted its value in providing a concise, clear presentation of the client's medical-related history, current and past. This information has been crucial in the emergency environment, as well as enabling, (1) medication reconciliation for hospitalization, (2) identifying point of contact for agency staff, physician, consultants, case worker, which has facilitated in-hospital correspondence by phone and in writing, (3) improved timing for discharge planning meetings, as well as emergency meetings concerning clinical care, (4) Provided timely information for

emergency and acute in-hospital clinical decision-making that impacts on interventions, and (5) serves as a life document that has the potential to memorialize the client's health information over time.

Over the last year the health passport has been a portable document accompanying clients to all area hospitals. Providence Hospital has received the largest number of IDD clients, and the positive impact of the Health Passport has been noted by staff and upper-level administration. In the last three months there have been forty (40) patients with complex medical problems either seen in the ED or admitted. In these cases, the health passport has been instrumental in influencing patient's outcomes. The use of a Health Passport has proven to be invaluable in reducing errors, decreasing delays in getting pertinent health information about a complex client to the right person at the right time."

41. DC HRP prepared a report for DDA on Preventative Health Screenings and results from a pilot study of the same for individuals served by DDA in residential settings. In 2005, DDA introduced the use of Health Form 1, a document to record preventive health screenings that includes the recommendations of the Preventive Services Task Force ("USPSTF"). This documentation is required in the health records of all individuals receiving residential services funded via the HCBS waiver or ICFs/ID. The USPSTF is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

42. Several entities tracking health care quality cited receipt of preventive health screening and adult immunizations. This includes Health People 2010, the Commonwealth Fund National Scorecard on U.S. Health System Performance, the Agency for Healthcare Research

and Quality, the Institute of Medicine of the National Academies (Committee on the State of the USA Health Indicators, Board on Population Health and Public Health Practice) and the federal Department of Health and Human Services (Community Health Status Indicators). Specifically, measures such as detection of hypertension, colorectal cancer screening and breast cancer screening are important measures of health in the District of Columbia due to the high incidence of hypertension, cardiovascular disease and breast and colon cancer among residents of the District of Columbia. They are far more important indicators than the rating of completion of health management care plans. While health management care plans are important documents for health planning and health care delivery, their usefulness in measuring the extent to which the District of Columbia has advanced in the delivery of essential health care to people receiving services from DDA is severely limited.

43. DC HRP conducted a study of preventive health screenings, namely colorectal cancer, mammography and Pap smears, and clinical breast exams, for individuals served in three (3) agencies. A total of one hundred and forty seven (147) individuals were reviewed, approximately 11% of all individuals served by DDA in residential services. Selected findings demonstrate that these sample screening rates meet and in most instances exceed the national and target rates. This is particularly significant given the barriers to preparation and completion of these invasive procedures. The full report contains recommendations for continued improvements in the District's health care system for persons with intellectual and developmental disabilities that will be reviewed by the DDA Quality Improvement Committee for inclusion in the agency's initiatives.

VIII. Payments to Providers

44. The District has made every effort to pay providers in a timely manner. Ninety-eight percent (98%) of all claims are adjudicated in 30 days.

45. DHCF has moved to a weekly payment cycle, meaning payments are sent out once a week instead of every other week.

46. DDA and DHCF continue weekly conference calls to resolve emerging billing concerns. DHCF provides on-site provider technical assistance, and DDA and DHCF compare billing reports against prior authorizations under the HCBS waiver program to proactively identify potential billing problems prior to significant delays emerging.

47. To further improve financing of services, the District has submitted to CMS a State Plan Amendment that provides an alternative method of determining ICF/ID provider reimbursement. DHCF, the District Medicaid State Agency, worked collaboratively with both DDS/DDA and the providers to develop the new methodology. This alternative moves away from a cost-based reimbursement methodology where providers were locked into rates based on cost caps set at the median cost in 1993 inflated forward. Because the way in which care is provided has changed so much in the interim—for example, minimum wage increases, changes in rent, increases in utility costs, staffing ratio changes—these median cost caps do not reflect the actual cost of care today. The new methodology allows providers to set a price for their services and they are rewarded for reducing cost so long as they continue to provide quality services.

IX. Centers for Medicaid and Medicare Services ("CMS") Monitoring of DDS

48. CMS is the federal agency that administers the Medicare and Medicaid programs and already provides extensive oversight for services provided by DDS/DDA.

49. The District submits to CMS an annual report (known as the 372 report) that details fiscal and quality performance measures. In addition, CMS will be initiating expanded

372 quality-reporting in the next fiscal year that mirrors the expanded quality management requirements now found in the HCBS waiver program. CMS also conducts unannounced random audits on various areas of its six (6) assurances, including level of care, service plan, qualified providers, health and welfare, administrative oversight, and financial accountability. Most recently, in August 2009, DHCF and DDS/DDA were evaluated on Provider Enrollment protocols.

50. From February 2007 to March 2009, CMS engaged in even more intensive monitoring to ensure the then MAA and DDS/DDA's compliance with the federal HCBS waiver requirements. This included monthly written and telephonic monitoring of a corrective action plan in three of the six assurances: Plan of Care; Health and Welfare; and. Administrative Oversight. In March 2009, however, CMS determined that the District had "made major changes in the performance, structure, oversight mechanism, and systems sufficient enough to engage in continuous Quality Improvement ("QI")." To qualify for such a finding, a state must demonstrate a robust system of "discovery, remediation and improvement" in all six assurances. Based on DDS/DDA's "demonstrated effectiveness of the many newly implemented systems to meet the CMS quality requirements," CMS discontinued its intensified monitoring.

X. The District's Establishment of An Aggressive Internal Quality-Assurance System

51. DDA's Quality Management Division ("QMD") monitors all aspects of the service-delivery system to ensure compliance with federal and local law, national best practices, and applicable court orders. The QMD focuses on strengthening DDA's ability to discover areas of concern, remediate both discrete and systemic issues, and implement strategies for continuous improvement.

52. The QMD is divided into four (4) functional units: Health and Wellness, Quality Enhancement and Quality Improvement ("QE/QI"), Incident Management and Enforcement ("IMEU"), and Mortality Review. The Health and Wellness Unit supports the health of individuals by providing oversight and support to individuals residing in natural homes, nursing homes, hospitals, and small and mid-sized provider agencies. The oversight includes provision of technical assistance, community outreach, and monitoring of health management care plans, behavior support plans, meal protocols, and other treatment regimes necessary to realize optimal health status and outcomes. In the past quarterly reporting period alone, two (2) individuals were successfully transitioned from nursing homes to community-based residential settings as a result of this focused assistance. The DDA Health and Wellness Unit and the DC HRP as a contractor to DDA work hand-in-hand in these areas across the DDA service delivery system.

53. The Quality Enhancement and Quality Improvement Unit currently uses the Provider Certification Review ("PCR") process as the mechanism that measures provider performance, determines whether the provider/vendor does or does not meet the minimum thresholds for performance, and acknowledges each provider as able to deliver services and supports to people served by DDA. The PCR replaced the Basic Assurance Standards Authorization ("BASA") review and is a far superior tool to evaluate quality. The new PCR process (1) allows for the identification of positive practices and areas for improvement in providers' services and supports; (2) allows for the ability to aggregate, analyze, and compare data from various sources including information from the Department of Health Health Regulation and Licensing Administration ("HRLA"), the IMEU, Service Coordination, Provider Resource Management, Mortality and Fatality Review Committees, and DDS's Contracts Department; and (3) provides evidence that providers are operating in accordance with HCBS

waiver regulations, D.C. Rules and Regulations, and DDS/DDA approved policies. Further, under BASA, only a small sub-set of living settings, including ICFs/ID, group homes, and supported living residential service providers, were reviewed. Moreover, only 10% or less of total recipients of the agency were evaluated. In contrast, the PCR is applied to a broader range of providers including in-home supports, host home services, day habilitation, pre-vocational services and supported employment, and expands the sampling methodology to be statistically significant for *each service* delivered by the provider agency. The implementation of the PCR process is yet another example of the agency's ability to improve the quality assurance capacity of the District. DDS/DDA completed the Request For Proposal ("RFP") process to award the contract to a nationally recognized vendor to assume responsibility for certifying all HCBS waiver providers using the PCR and is pending Council approval. The Quality contract also includes an independent audit of the DDA Service Coordination service delivery, providing the DDA Director and DHCF with an independent performance evaluation of this critical function. A third component of this contract includes a 10% sample of all ISPs to assess implementation of all services per the ISP on an annual basis. Both elements are critical performance measures for CMS as described in the DDA Quality Management Strategy, and to provision of services to the *Evans* class. DDA included these elements for an additional high quality, arm's length source of performance measurement of DDA service delivery, and did so independent of any direction or requirement from an external party.

54. DDS/DDA recently undertook an initiative to ensure that Quality Improvement Specialists in the Technical Assistance ("TA") Unit increase the number of unannounced visits and contacts that occur on a monthly basis. The QMD began tracking the number of contacts in August 2008, and since that time, there has been a more than 200% increase in the number of

monthly contacts (including initial visits, re-visits, unannounced visits, and telephone contact) made by TA staff. This has allowed the TA Unit to more effectively discover and remediate issues in a timely manner. Further, QE/QI assumes the responsibility of data integration for all information that reflects provider performance and its impact on people served through the DDA service-delivery system.

55. The IMEU is critical as it provides the mechanism to track and remediate problems, or incidents. There have been several developments implemented by the District that have contributed to the improvement of the investigatory process. These include requiring all investigators to pass LRA Level I certification to improve investigatory skills; assigning investigators to specific providers enabling each investigator to better recognize trends in the quality of services; providing trainings; and conducting quality assurance review of investigations submitted by providers. In fiscal year 2009, IMEU provided training to more than 20 provider agencies, conducted more than 100 quality assurance reviews, and made approximately 40 technical assistance contacts with providers. In addition, a recent update to the Consumer Information System ("MCIS") allows DDA to track the outcome of an investigation and capture the responsible provider, allowing IMEU to accurately track and trend data for specific providers. Although the role of the District, and all state DD agencies, is to seek to prevent the occurrence of abuse, neglect, theft or a serious injury, these incidents do occur, hence the CMS requirements for a robust system of safeguards for prevention, discovery and remediation. In fiscal year 2009, it is important to note that only 7% of the entire class experienced a substantiated incident of this type.

56. The District also has a mortality-review process (consisting of the Fatality Review Committee "FRC" and the Mortality Review Committee "MRC"), which allows DDS/DDA to

identify and, as necessary, address potential quality-of-care issues. In fiscal year 2009, the FRC maintained a 90% compliance rate of reviewing all cases within 90 days. Further, as of this filing, DDA's MRC has concluded reviews of all completed death investigations pending in fiscal year 2009.

57. Finally, the HRLA licenses and inspects group homes for persons with developmental disabilities and certifies ICFs/ID. HRLA conducts annual on-site and ad hoc monitoring surveys to ensure that these facilities maintain compliance with District and federal health, safety, sanitation, and habilitative requirements. Regulated facilities include Certified (Federal) Intermediate Care Facilities and Group Homes for Persons with Mental Retardation.

XI. Additional Healthcare Agreement Initiatives

58. The Crisis Intervention beds RFP was awarded in the spring of 2009, and two (2) beds opened at National Children's Center ("NCC") in August 2009.

59. The Values Based Training Initiative underwent several "best and final offers" with an award being offered at this writing for implementation in fiscal year 2010.

60. DDS/DDA developed a comprehensive pre-employment competency-based training curriculum, associated tests and new Training Policy to enhance the competency of direct support professionals in day/vocational and residential support services throughout the DDA service delivery system. The new requirements are effective October 12, 2010. The policy, PowerPoint curriculum and competency tests can be accessed on line at www.dds.dc.gov.

61. The District obtained permission from CMS and the State of Connecticut to adopt the Connecticut Level of Need Assessment and Risk Screening tool, which is a web-based database system producing clear person-centered planning assessment results detailing strengths, preferences and support needs in the areas of health and medical supports, behavioral supports,

mental health, mobility, personal care, daily living, comprehension, communication, social life, safety, and caregiver supports. This tool also generates a "risk screening" to assist the individual and the team to systematically ensure that each potential risk has been fully explained, evaluated and addressed by the person and the team, and is clearly documented in the record. The software and user's guide are being modified for the District's use at this time. Training and the roll-out of the tool is scheduled for the first quarter of this fiscal year.

62. As part of the behavioral health initiatives, the DC HRP clinical psychologist works in collaboration with the DDA clinical psychologist on individual, agency and systemic issues. He has introduced the use of a *Best Practice Guide.* This is a method for working with the individual and their direct support staff to identify strategies that promote well-being, identify when stressors are beginning and how to respond, and identify what to do in the event of a crisis. These simple tools are complementary to the formal behavior support plan, but are easier for the direct support professional ("DSP") to understand. In addition, because the DSP is integral to the development of this tool, they are more likely to remember and follow the outlined strategies. *Best Practice Guides* was developed for all of the individuals transitioning from St. Elizabeth's to the community, and it has played an important role in transferring the knowledge from the St. Elizabeth's staff to the new residential setting.

63. The clinical psychologist and speech therapist have collaborated on training and technical assistance aimed at increasing the use of visual teaching strategies, which is an essential component of a comprehensive approach for people with autism. The team has also worked with community therapists to increase their skills in identifying autism spectrum disorders, particularly in older adults who may have been misdiagnosed.

64. Health and clinical services training offerings are being developed and held, open to the DDA service delivery system. In the period between July and September 2009 alone, DC HRP developed and hosted 19 different training sessions on best practice topics in health, clinical and behavioral health topics.

XII. Inter-Agency Collaboration

65. I have chaired the Mayor's Inter-Agency Task Force on Coordination and Management of the Supports and Services Delivery System for Persons with Intellectual and Developmental Disabilities, as established by Mayor's Order 2009-119 dated June 25, 2009, having held three (3) meetings to date, to further strengthen the collaboration among agencies. Composed of high-level leadership from DDS/DDA, DHCF, HRLA, and the City Administrator's Office, the Task Force has established a mission statement, and framework within which to focus problem-solving and initiatives to advance the effectiveness of and innovation in services to persons with intellectual and developmental disabilities. **Goal/Mission Statement:** Because of interagency coordination and collaboration, people with intellectual and developmental disabilities ("ID/DD") in the District of Columbia will have the supports and services to live full and meaningful lives. **Core Task Force Work Elements:** Enhance supports and services options; Expand accessible and affordable housing; Grow meaningful work opportunities; Improve coordination of school to work transitions; Develop age appropriate supports and living options for elders with ID/DD; Expand accessible transportation options; Build an interagency workforce development initiative; Establish an interagency plan for health and wellness; Develop an interagency plan for family supports; Create an interagency early intervention plan (birth to three). This framework addresses a lifespan and inclusive approach to services and supports. Initial topics of collaborative problem-solving leading to improvements

include work on the Nursing Assistive Personnel Training Regulations, and the MTM 1915(b)4 waiver application to design improved transportation services for persons with IDD/DD in the Medicaid program.

66. The DHCF Medicaid Infrastructure Grant is being used to fund the DDA's participation in the State Employment Leadership Network ("SELN") as evidence of the DHCF's support of an employment first agenda to advance the quality of day and vocational services in the District. DDS/DDA joined the SELN, a cross-state cooperative venture of state developmental disability agencies that are committed to improving employment outcomes for adolescents and adults with intellectual and developmental disabilities. The District is one of only 16 participating states.

67. DHCF, HRLA and DDA are collaborating on a training initiative for ICF/ID providers aimed at improving the quality of services and supports delivered through that residential service option.

68. DHCF, DDS and the District of Columbia Housing Authority have entered into a Memorandum of Understanding to improve coordination between the agencies and subsequent access to housing authority vouchers, and to track affordable housing units across the District to facilitate movement to the least restrictive living alternatives.

XIII. Conclusion

69. The structure and management staff of the DDA has remained in place now for more than one and a half years. I have been in this position for just over two years, two of DDA's three Division Directors for eighteen (18) months, the third has been with the organization for eight (8) months now, and all of the remaining managers have been in place for more than one year. Although to those outside of the District that may seem short-lived, for this

history, it is evidence of a team committed to the residents of the District and the *Evans* class members. It is this team that seeks to continue to fulfill the obligations of the state DD agency to the residents of the District of Columbia without the necessity of further judicial intervention and oversight.

I declare under penalty of perjury that the foregoing statements are true and correct to the best of my information, knowledge and belief. Executed on October 7, 2009.

Laura L. Nuss, Deputy Director
Developmental Disabilities Administration
D.C. Department on Disability Services