United States v. State of Texas

Four-Year Report

Date of Report: June 23, 2014

Submitted By Monitoring Panel:
Michael Davis, Ph.D., BCBA-D
Alan Harchik, Ph.D., BCBA-D
Maria Laurence, MPA

Table of Contents

INTRODUCTION

In June 2009, the State of Texas (State) and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with intellectual disabilities and developmental disabilities (ID/DD) in state-operated Facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the Facilities' compliance with the Settlement. The parties selected as Monitors: Michael Davis, Ph.D., BCBA-D; Alan Harchik, Ph.D., BCBA-D; and Maria Laurence, MPA.

Within 60 days prior to the fourth anniversary of the effective date, Section III.Q of the Settlement Agreement requires the Monitors to: "provide to the Parties and the Court an assessment of the status of compliance with each substantive provision of this Agreement as to each Facility ('Four-Year' Report)." In June 2012, the Parties agreed to delay the Four-Year Report until January 2014, and in January 2013, the Parties again agreed to delay the Four-Year Report until June 2014.

The Monitors respectfully submit this report to the Parties and the Court in response to the requirement for a Four-Year Report. As the Settlement Agreement requires, the following report summarizes the status of the Facilities' compliance for each of the 20 substantive provisions of the Settlement Agreement (i.e., Sections II.C through II.V), including a description of where substantial compliance has been achieved, as well as where significant progress that should lead to substantial compliance has occurred. The Monitors also have identified existing obstacles to substantial compliance. In areas in which the Monitors believe action is needed across the system of SSLCs, systemic recommendations have been offered.

Background

The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) component of Rio Grande State Center (Facilities).

Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the Facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the Parties. In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor engaged an expert team (Monitoring Teams). These Monitoring Teams include consultants with expertise in psychiatry, medical care, nursing, psychology, habilitation, protection from harm, quality improvement, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping. The parties approved each expert Monitoring Team member.

Beginning in January 2010, the Monitors, with the assistance of their expert consultants, conducted baseline reviews. Beginning in July 2010, compliance reviews have been conducted every six months, with the exception of three months at the beginning of 2013, when the Parties agreed to a temporary stay in monitoring. These reviews involve onsite reviews, interviews with staff, observations of and interactions with individuals residing at the SSLCs, and extensive document review and analysis.

The reviews result in detailed reports that the Monitors submit to the Parties. Beginning in July 2010, the reports included compliance determinations for each of the 161 subsections of the

Settlement Agreement. The reports also have included recommendations that the Monitoring Teams believe can help the Facilities achieve compliance. However, the State and Facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

During this time, the Monitors have appreciated the professional relationships between the Parties and the Monitors and their teams, including the parties' efforts in assisting to define the requirements for substantial compliance for a number of Settlement Agreement provisions. The State and Facilities generally have worked hard to meet the requirements of the Settlement Agreement.

For the past four years, State Office and Facilities have taken many actions to improve the quality and provision of protections, services and supports, and to work towards achieving substantial compliance. During this time, all Facilities have achieved substantial compliance with a number of requirements of the Settlement Agreement. In addition, the Monitors have found that the Facilities have made progress with many of the provisions of the Settlement Agreement, even if substantial compliance was not achieved (i.e., the Settlement Agreement does not allow for a rating of partial compliance).

Section III.Q of the Settlement Agreement states: "…The parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year…" This expectation was not met, and all Facilities had many provisions not yet in compliance. Overall, Facilities met the requirements for substantial compliance with about a quarter to one-third of the provisions. To exit from monitoring, Section III.J of the Settlement Agreement requires a Facility to achieve substantial compliance with the substantive provision (i.e., the Sections identified by capital letter in Section II, such as Section C, Section D, etc.) and maintain substantial compliance for one year. For the period designated for this review (i.e., the seventh round of monitoring), no Facility exited from monitoring of any substantive provision, and only three Facilities had achieved substantial compliance with substantive sections. Specifically:

- **Section D - Protection from Harm – Abuse, Neglect, and Incident Management**: Although in the ID/DD field, unfortunately, there is no way to fully protect individuals from harm by completely eliminating abuse, neglect, and exploitation, and other serious incidents, two Facilities, Rio Grande State Center and Lubbock SSLC, achieved substantial compliance with all 22 provisions of Section D.
- **Section N – Pharmacy and Safe Medication Practices:** One Facility, Brenham SSLC, met substantial compliance with all of the eight provisions of Section N. The Monitors do want to note that since the eighth round of monitoring began, Brenham SSLC achieved substantial compliance for three rounds of reviews, and exited from this provision.

At this rate, it appears unlikely that the State will meet substantial compliance with the majority of provisions anytime soon. Action is required, be it at the initiation of the State or DOJ.

At the time of the submission of this report, the Parties recognized that changes to the way Facilities were monitored would be beneficial, and they were actively working to revise the monitoring process. The Monitors were encouraged by the Parties' intent to develop a system that would focus on the need for the State to be able to self-identify areas in need of improvement and over time, to decrease the reliance on external monitors, while at the same time effectuating change in existing areas of noncompliance. This included a proposal from the State to substantially improve its state-wide quality assurance program.

The parties also were taking into consideration the challenges of the three-team model the Settlement Agreement set up, and considering changes that would assist in ensuring consistency in the monitoring standards used across all 13 Facilities. The Monitors encourage the Parties to continue to work towards agreement on a system that increases the focus upon the quality of the services and supports offered to individuals, as well as the presence of processes that support their receipt of these quality services. It will be important for such a system to require the State Office staff to work closely with the Monitors, so that protocols and tools used by the Monitoring Teams can be reliably implemented by the State after Settlement Agreement monitoring has concluded. The Monitors look forward to working more with the Parties to define these changes and are hopeful that they will set the occasion for further progress, improved quality of services, and eventual substantial compliance with all aspects of the Settlement Agreement.

As noted above, the following report provides a status of the Facilities' compliance with each of the substantive sections of the Settlement Agreement (i.e., Sections II.C through II.V), as well as a summary of significant progress that should lead to compliance, and systemic recommendations. Details of the Facilities' compliance with the 161 subsections of the Settlement Agreement are included in Appendix B. Of note, the substantial compliance or noncompliance findings referenced in this report are based on the seventh round of compliance reviews. These onsite reviews occurred between September 2013 and March 2014.

In sum, the quality of service and support provision varied across Facilities and across Settlement Agreement provisions. In the following, the Monitors have provided overall comments. Thus, a positive (or negative) statement might refer to some, but not all of the Facilities. Further, for each substantive provision, the Monitors have provided recommendations for systemic actions, where appropriate.

Section C: Protection from Harm - Restraints

Section C requires each Facility to provide individuals with a safe and humane environment and ensure they are protected from harm. This Section provides requirements for, and limitations on, use of restraints. The eight subsections provide the conditions under which restraint may be used for immediate and serious risk of harm or for medical purposes; require termination of restraints as soon as the individual is no longer a danger to self or others; prohibit prone restraint or restraint used for punishment, convenience of staff, or in the absence of, or as an alternative to, treatment; set out requirements for monitoring of instances of restraint and checking for injury; provide for opportunities to exercise limbs, drink fluids, and use a toilet; require treatment team review when individuals are placed in non-medical restraints more than three times in a rolling 30-day period; and require review of each use of non-medical restraint.

Areas of Substantial Compliance and/or Progress

Within this Section, there have been several areas of progress, but there have also been requirements for which progress has been slow or inconsistent across the Facilities. Several Facilities have reduced use of crisis intervention restraint. Some have also reduced or use only limited amounts of medical restraint, including pretreatment sedation. Only two subsections of Section C (i.e., Section C.2 and Section C.3) have been met across most of the Facilities. This involves termination of restraint when the individual is no longer a danger to him/herself or others. Some requirements of broader provisions have also been met across all or most Facilities, such as the prohibition on prone restraint that is required in Section C.1.

In general, Facilities are doing a better job of reviewing restraints after they occur. Several review video monitoring when that is available. Some Facilities have documented significant reduction in restraint use for crisis intervention and prevention of self-injurious behavior. Facilities have put into place processes to record and track use of restraint.

Rates of use of restraint for crisis intervention declined significantly at several, but not all, Facilities.

Regarding the requirements for a thorough review of restraint use, several Facilities had improved their reviews of instances of restraint. Some Facilities reviewed videos of incidents when the restraint occurred in an area covered by the surveillance cameras. Some Facilities had Restraint Reduction Committees that met to review systemic trends, and to review when restraint was used more than three times in a rolling 30-day period.

Facilities were tracking restraint use, but only some were analyzing the information and taking action. For example, one Facility used data to develop corrective action plans when trends were identified. At another Facility, trend reports not only tracked restraints over time, but that tracking information was compared with other data in the Executive Safety Committee to inform decision-making. At one Facility, quality monitoring that the Behavioral Health Services Department and the Program Compliance Monitor conducted served to identify and direct corrections that helped bring this section closer to compliance with the Settlement Agreement.

Obstacles to Substantial Compliance

Several areas of concern remain. There has been very little action system-wide in establishing treatments or strategies to minimize or eliminate the need for restraint for routine medical or dental care. Although some Facilities have established procedures, treatments, and interventions that have significantly reduced use of crisis intervention restraints, others have not. Those Facilities that have not reduced restraint must attend to this assertively, by improving behavioral health services, addressing issues that might contribute to immediate and serious risk of harm, and establishing expectations that staff must seek means to avoid use of restraint whenever safe and appropriate.

Several of the Facilities need to improve the interdisciplinary review when an individual is restrained more than three times in a rolling 30-day period, implement more intensive and comprehensive assessments to identify the factors contributing to the need for restraint, develop and implement treatments and

interventions, and determine the effectiveness of those treatments and interventions. Documentation must also improve.

Although some Facilities made very little use of restraint and sedation for medical and dental purposes, others used a significant amount. No Facility had in place well-designed programs or other strategies for a significant number of individuals designed to reduce the need for restraint and sedation. Furthermore, the way in which the Facilities were identifying (or proposing to identify) individuals who required plans was problematic. More specifically, the criteria used to identify individuals (e.g., specific characteristics, such as spasticity or learning histories), as well as how medical or dental procedures were defined or classified, appeared to vary over time and across Facilities.

Most Facilities continued to have problems with accurate and complete documentation related to restraint episodes.

Although there was some improvement in reviews of restraint usage, no Facility had adequate planning for individuals who were restrained more than three times in a rolling 30-day period. Furthermore, for Facilities with a high number of behaviors resulting in restraint incidents, this appeared to be due to the lack of active engagement, limited programming based on personal preferences, and analysis of environmental factors that might maintain these problematic behaviors, and/or limited opportunity for individuals to choose how they spend their day/time.

Abdominal binders for individuals who receive enteral feeding may or may not be restraints, depending on the purpose. At some Facilities, there were at least some cases in which abdominal binders were likely being used as a physical mechanical restraint for self-injurious behavior (PMR-SIB), although the Facility did not classify them as such or follow policy requirements associated with PMR-SIB. At one Facility, a number of individuals at the Facility wore protective mechanical restraints (PMRs) for SIB or protective devices. This included helmets, binders, mittens, wristlets, seatbelts, and coveralls. Some of the restraints or devices did not seem to fall under the state's restraint policy or protective device policy.

Systemic Recommendations

- Because the current State Office policy does not provide sufficient guidance, the State Office should provide clear guidelines regarding need for teams to consider desensitization or other strategies to minimize the use of pretreatment sedation or restraints.
- The State should offer Facilities training and/or mentoring on individualized approaches to reducing need for medical and dental restraints.
- Behavioral Health Services staff should provide leadership at the Facilities in development of desensitization and other strategies to reduce the need for medical and dental restraint because they should have expertise is shaping behavior, identification and use of reinforcers, etc.
- Facilities should take steps to ensure that all protective mechanical restraints are identified and addressed thoroughly as outlined in State policy.
- A process has been established for teams to review individuals that experience more than three episodes of restraint in a 30-day period. Facilities should put mechanisms in place to ensure that these reviews are completed consistently and timely.
- For those Facilities that have not developed effective programs and strategies to reduce the use of crisis interventions restraints, planning should be implemented to address the potential for reduction. The State should establish expectations for the reduction of the use of crisis intervention restraints. This might involve the use of consultants and/or additional training for staff in restraint reduction strategies.

SECTION D: Protection from Harm – Abuse, Neglect, and Incident Management

Overall, since the inception of the Settlement Agreement, the Facilities and the Department of Family and Protective Services (DFPS) made significant progress with the 22 subsections of Section D, which require DFPS and the Facilities to engage in a number of practices to protect individuals from abuse, neglect, and exploitation, as well as preventable incidents. In the early years of the Settlement Agreement, the State

Offices of DADS as well as DFPS worked closely with the Monitors to understand the areas needing improvement, and to put systems in place to make needed changes in these critical areas. Over time, these efforts resulted in fairly consistent implementation of a number of important standard practices across the 13 Facilities. Although in the ID/DD field, unfortunately, there is no way to fully protect individuals from harm by completely eliminating abuse, neglect, and exploitation, and other serious incidents, two Facilities, Rio Grande State Center and Lubbock SSLC, achieved substantial compliance with all 22 provisions of Section D.

Areas in which many Facilities had not achieved substantial compliance were some of the more difficult ones to accomplish, but some of the most important in terms of ensuring, to the extent possible, individuals are protected from harm. These include, for example, fully implementing corrective actions identified through the investigation process, conducting reviews designed to ensure all serious incidents are reported for investigation, and comprehensively analyzing and acting upon data related to investigations and incidents.

Areas of Substantial Compliance and/or Progress

All Facilities were in substantial compliance with Section D.1, which relates only to the development of policies. All Facilities' policies: 1) included a commitment that abuse/neglect of individuals would not be tolerated, and 2) required staff report abuse/neglect of individuals. This was an important foundation.

As required by Section D.5, the completion of background checks of all staff, as well as volunteers (i.e., those working more than five times a year with individuals) was an essential function with which all Facilities were now in substantial compliance. In 2010, State Office established procedures for conducting both initial and ongoing criminal and abuse registry checks and, since then, these were occurring consistently.

Another key component of a working incident management system is full reporting of incidents, including but not limited to allegations of abuse, neglect, and exploitation, as well as serious incidents. All staff and volunteers, as well as individuals, their families/friends, and guardians play a role in this system. To this end, Section D.2.a requires staff to immediately report serious incidents to the Facility Director, and allegations of abuse, neglect, and exploitation to DFPS as well as the Facility Director. At nine Facilities (69%), staff were consistently reporting incidents and allegations timely and to the appropriate entities. Section D.2.c requires competency-based training of staff. Based on the Monitoring Teams' reviews, 11 Facilities (85%) were consistently providing competency-based training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation to all staff as part of new employee orientation and on an annual basis, and staff interviewed were able to describe their responsibilities. As per Section D.2.d, all Facilities (100%) consistently required that all employees sign a statement confirming the obligation to report abuse, neglect, and exploitation, first at new employee orientation and, then, annually. Further, it is essential, when staff do make good-faith reports, that they are not retaliated against. This is addressed in Section D.2.h, with which all Facilities (100%) were in compliance.

In accordance with Section D.2.e, 11 of the 13 Facilities (85%) were providing educational materials regarding recognizing and reporting abuse and neglect to individuals and their guardians or others involved in their lives at annual Individual Support Plan (ISP) meetings. In addition, as required by Section D.2.f, all Facilities (100%) had posters hung in buildings throughout campus that used pictures/symbols to describe an individual's rights, and included information about how to exercise such rights, and how to report any violations.

Once allegations or serious incidents were reported, Facilities were required to take a number of steps to immediately protect individuals, investigate, and take action based on the findings of the investigations. With regard to taking immediate action, including removing alleged perpetrators from direct contact with individuals, providing needed treatment, and taking immediate programmatic action (e.g., providing training to staff, etc.), 12 Facilities (92%) were in substantial compliance with Section D.2.b. It also is essential that Facilities make referrals to law enforcement, as appropriate, to allow law enforcement the opportunity to conduct their investigations and that DFPS and the Facilities coordinate their investigations with law enforcement, so as to not interfere. Early in the life of the Settlement Agreement, the State developed a Memorandum of Understanding to provide guidance when investigative activity might overlap. All Facilities were in substantial compliance with Section D.2.g and D.3.c (100%), and 12 of 13 Facilities (92%) with

Section D.3.b, which require referring, as appropriate, allegations of abuse and neglect to law enforcement; coordination of investigations with law enforcement; and staff's cooperation with outside agencies' investigations, respectively.

Strong and competent investigations are necessary in order to confirm whether or not abuse or neglect have occurred and, if so, to identify actions needed, such as personnel action with staff, and/or programmatic action. To accomplish this, as required by Section D.3.a, at 12 Facilities (92%), Facility and DFPS investigators had completed training on completing investigations, including information specific to working with individuals with ID/DD. All 13 Facilities (100%) were implementing procedures to safeguard evidence collected during investigations, as well as to maintain investigation records in a manner allowing access to investigators needing them, as required by Sections D.3.d and D.3.j, respectively. Nine Facilities (69%) were in substantial compliance with Section D.3.h, which requires that investigations the Facilities complete on their own (i.e., those DFPS refers back to them, and those related to serious incidents) meet requirements related to quality, for example, adherence to standard processes used to conduct investigations and reconciliation of the evidence to support the findings. As discussed further below, DFPS and Facilities had made progress with other aspects of investigations, but more work was needed at a number of Facilities.

Obstacles to Substantial Compliance

As noted above, staff's timely reporting of incidents and allegations to the appropriate entities is an essential component of incident management. At four Facilities (31%), this still was not occurring consistently.

As noted above, DFPS and the Facilities had made good progress in conducting timely and thorough investigations of abuse and neglect, as well as serious incidents. However, areas in which continued efforts were needed included: 1) as required by Section D.3.e, investigations should be timely (i.e., started within 24 hours and finished in 10 days) and include relevant recommendations, for which seven (54%) Facilities were in substantial compliance; 2) as required by Section D.3.f, the quality of investigative reports should be consistent, including conducting necessary interviews, reviewing relevant evidence, and providing a clear basis for findings, for which seven Facilities (54%) had achieved substantial compliance; and 3) as required by Section D.3.g, consistent supervisory review to ensure investigations are thorough and complete and reports are accurate, complete, and coherent, and that deficiencies are corrected, for which six (46%) Facilities were in substantial compliance. It is important to note that, due to concerns related to the confidentiality of the DFPS supervisory process, the Monitoring Teams have not reviewed related documentation. As a result, the Monitoring Teams make no judgment regarding the adequacy of the DFPS supervisory process.

Eight Facilities (62%) were in substantial compliance with Section D.2.i, which requires audits to determine that significant injuries are reported for investigation. Although the State Office had developed a procedure to guide Facilities in this process, a missing piece was the use of existing data to identify individuals that had experienced significant patterns of injuries or those related to peer-to-peer aggression. In addition, some Facilities had not fully implemented the State Office process, but were in various stages of completing the process.

The areas in which most Facilities had not yet achieved substantial compliance were integral to protecting individuals from harm. For each of the following, only three Facilities (23%) were in substantial compliance:

1) Section D.3.i, which requires Facilities to implement corrections to prevent a reoccurrence promptly and thoroughly. Although Facilities generally had mechanisms to take personnel action when necessary (e.g., termination of employment or other disciplinary action), Facilities were at various stages with regard to tracking the implementation of recommendations and assessing outcomes of corrective actions taken from a programmatic perspective (e.g., staff training, new procedures, environmental changes, etc.). A common problem was that Facilities did not define expected outcomes and/or were not assessing whether or not the actions taken had the result of reducing the likelihood of similar incidents from occurring, and, thereby, reducing individuals' risk; and
2) Section D.4, which requires Facilities to track and trend incidents and investigation results, and implement corrective actions for problematic trends identified. Although Facilities generally had the ability to generate reports, including graphs to show trends of data, with which Facilities had shown

progress over time, most Facilities were not fully analyzing the data and trends, developing corrective action plans on an individual as well as systemic level, implementing the plans, and/or then assessing outcomes, and making modifications as necessary. The Facilities that were in substantial compliance with this subsection had developed and implemented working processes for reviewing complex data streams and identifying trends, and then using the data to drive decision-making. Some other Facilities were beginning to use these effective systems.

Systemic Recommendations

- The State Office should provide Facilities guidance on how to use incident management data to address systemic as well as individual issues, and ensure that it occurs.
- When a lack of reporting and/or late reporting is identified through investigations or other means, Facilities should take action to ensure staff members understand their responsibilities, including, as appropriate, disciplinary action.

SECTION E: Quality Assurance

Much work and progress occurred at all of the Facilities since the baseline monitoring reviews in early 2010. At that time, quality assurance programs were primarily responsible for hosting ICF regulatory visits and following up on any plans of correction that resulted from these surveys or investigations.

State Office has provided little to no guidance to the Facility QA Directors regarding how to develop, implement, and evaluate a quality assurance and quality improvement program. With suggestions and recommendations from the Monitoring Teams, QA Directors have created the infrastructure for a QA program, however, this is beyond the scope of the Monitoring Teams' responsibility and much more direction is needed from State Office.

On a positive note, in June 2013, State Office provided the Monitors and DOJ with an outline of a state-wide quality assurance system that contained a number of necessary elements, and based on discussions with State Office staff, they were beginning to lay some of the groundwork for implementation of such a system.

Areas of Substantial Compliance and/or Progress

Eight of the 13 Facilities achieved substantial compliance with Section E.3, regarding the dissemination of corrective action plans. Regarding the other provisions, most Facilities were showing progress with the design of a data tracking system (E.1), the analysis of data (E.2), and the management of a system of corrective actions (E.2-E.5). The Monitoring Teams found the QA programs at Lubbock SSLC and San Angelo SSLC to be the most developed of the 13 Facilities.

Over the past year or so, there was more inclusion of QA-related activities across disciplines and departments than ever before, suggesting more of a Facility-wide investment in quality, data, analysis, and action. QA plan narratives were improved and revised. They included definitions, processes, and other QA program details.

Work was done to create more comprehensive and valid lists of data and key indicators. For example, one Facility maintained a data inventory that was 71 pages long, contained 22 topic areas, was managed in a database that was easy to read and update, and comprehensively listed data collected by all departments and disciplines. An inventory of data being collected and a subset of key indicators existed for most of the 20 sections of the Settlement Agreement. The Facility had done a good job of reducing the full set of data in the inventory to those data that were most important to the QAQI Council. These key indicators became (or were becoming) part of the QA matrix and QA reporting processes.

Monthly meetings between the QA Director, Settlement Agreement Coordinator, and department head were being held to review each section of the Settlement Agreement. One of the expectations was that data were to be presented. Some Facilities used this meeting as a forum to monitor and record each department's participation and completion of important quality assurance activities, such as updating key indicator lists, reviewing data, analyzing data, creating corrective action plans (CAPs), and monitoring CAP implementation.

Facilities were amassing considerable data in many areas. At some, trend analyses were used in an increasing number of areas, such as peer-to-peer aggression, infection control, and medication variance.

Facilities had various ways of summarizing, analyzing, and presenting data. A best practice was identified at Lubbock SSLC where the Executive Safety Committee reviewed data on incidents, injuries, and restraints, and was trending and analyzing the data over time. A variety of trending techniques were employed, such as co-graphing incidents, injuries, and restraints to examine any correlations. Also, data were analyzed by individual across multiple data sources to produce lists of those individuals with the most issues. This committee had the authority to direct immediate action, and they did. When the actions taken did not resolve an issue, the issue was referred to the Quality Assurance/Quality Improvement (QAQI) Council for additional review and intervention.

At many Facilities, QA reports prepared by the QA Department for the QAQI Council were extensive and provided much useful data for review, analysis, discussion, and decision-making. Additionally, section leads made a presentation at QAQI Council, usually at least quarterly. QAQI Council meetings observed by the Monitoring Teams included some good exchanges of information, and active and appropriate participation of attendees.

Much work was done to improve the CAP system. Most (but not yet all) CAPs appropriately addressed the specific problem for which they were created. There was improved tracking of CAPs that noted the status of each action step, designated the person with primary responsibility, and included comments about revisions. During the most recent reviews, most Facilities had more CAPs than in past reviews. Facility Directors were encouraging staff to consider CAP development when issues arose during QAQI meetings and in other forums.

The sophistication of CAPs had increased in some Facilities. For example, there was a CAP for peer-to-peer sexual incidents that included new approaches to teaching identified individuals about relationships, appropriate behavior in public, and security considerations. The CAP was cross-disciplinary and data driven.

Obstacles to Substantial Compliance

In many Facilities, the quality of the components of the QA program varied considerably from department to department. Further, in some Facilities, QA programs were not progressing due to other competing factors, such as ICF regulatory actions or staff turnover.

There were frequent references to root cause analyses, intense case analyses, continuous quality improvement, etc. This was great to see, however, the QA Departments and the section leaders need considerable training, guidance, and mentoring in order to implement root cause analyses that meet the generally accepted professional standard. QA Directors were eager to learn more.

Facilities needed to refine the list of key indicators to include both outcome and process indicators, and limit the number of key indicators addressed at any one time according to the priorities of the Facility. That being said, important sets of data were often not incorporated into the QA program, such as deaths, vandalism, confiscation of weapons, criminal activity, and follow-ups to ISPAs.

Definitions for key terms, methodologies for collecting the data, and steps to ensure validity and reliability of data needed to be put into place. Many key indicators were insufficient to measure improvement.

The data listing inventory, QA matrix, key indicators/matrix, QA report, and what was presented at QAQI Council were not aligned.

Data from most sections of the Settlement Agreement were summarized and graphed showing trends over time, but few analyzed data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals.

Most narrative analyses were descriptions of the data, of the problem, and of actions (regardless of whether they related to a cause). What was missing was an analysis of the causes of the problem.

Most CAPs were inadequate because the overall goal of the CAP was not clearly stated, the CAP was not worded in a measurable manner that related to the goal, and the action steps were not written in observable terms with criterion. Most failed to ultimately assess whether the problem had gotten any better.

An adequate written description did not exist that indicated how CAPs were generated. There was not yet an adequate system for tracking the status of CAPs. The majority of CAPs were not completed timely.

Systemic Recommendations

- State Office should provide regular and ongoing training for QA Directors about philosophies, approaches, and state of the art methodologies of quality assurance and quality improvement.
- State Office should provide QA Directors with directives regarding the minimum required components of a QA program that are the same for every Facility.
- A set of minimum data requirements for all Facilities should be determined.
- The content of the data listing inventories, QA matrix, QA report, and QAQI Council presentations need to line up with one another.
- State Office should provide Facilities with assistance to learn how to present and analyze data, and then use the analyses to develop strong corrective action plans.

SECTION F: Integrated Protections, Services, Treatments and Supports

The 17 subsections of Section F require interdisciplinary teams (IDTs) at Facilities to assess individuals and develop annual, measurable individualized plans that comprehensively address individuals' preferences, strengths, and needs in an integrated manner, monitor the plans' implementation on a monthly basis, and make changes as necessary. Section F also requires Facility staff to successfully complete competency-based training on the development and implementation of plans, and to have quality assurance processes in place to identify and correct any issues related to ISPs and their implementation. In the early years of the implementation of the Settlement Agreement, DADS State Office did a significant amount of work to develop a policy, including templates for the ISP, and provide training to staff across all 13 Facilities. Section F requires involvement of most of the departments at the Facilities, and although the Facilities have made progress, more work is needed to develop and implement comprehensive, quality ISPs. No Facility was in compliance with any of the subsections of Section F.

Areas of Substantial Compliance and/or Progress

In July 2010, DADS State Office issued a policy entitled: "Personal Support Plan Process," which incorporated most of the Settlement Agreement requirements, and which had been modified a couple of times since its initial issuance. In early 2011, the State engaged consultants to concentrate on developing training materials, and providing training to IDTs across the State (i.e., related to Section F.2.e). Since then, these two consultants were involved to varying degrees in providing training as well as technical assistance to teams at all Facilities. Over the last two years, the consultants worked more intensely with a few Facilities to identify and overcome barriers to good individualized planning. In addition, specific Facilities took the initiative to concentrate on the individual planning process. For example, some Facilities decided to concentrate on assessment submission and attendance at the annual IDT meetings, and some Facilities' QAQI Councils were reviewing related aggregate data, and taking action to make improvements. These efforts appeared to have resulted in improvements in these areas. Some Facilities had provided training to all IDT members on writing measurable goals and objectives. At one Facility, RN case managers received additional training on writing objectives for the Integrated Health Care Plans (IHCPs) from the RN Supervisor. One Facility operated a Programming Review Committee that offered a respectful peer review opportunity for the ISPs and monthly reviews of the plans. Some Facilities concentrated on ensuring the participation of individuals as well as direct support professionals in meetings, which contributed tremendous value to the interdisciplinary process. As a result of State Office and Facility-specific efforts, some improvements in integrated planning had occurred, particularly as observed on site during ISP meetings.

Section F.1.a requires that one team member facilitate the IDT to: "ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports." Some Facilities had shifted to using Facilitator Qualified Intellectual Disability Professionals (QIDPs) and Home QIDPs. The Facilitator QIDPs often had primary responsibility for the preparation for and facilitation of the ISP meetings, and/or drafting of the ISP documents, and the Home QIDPs participated in the ISP process and meetings, but also had other responsibilities related to the implementation of ISPs. The hope was that by better using various QIDPs' specific skill sets, it would result in improved ISP processes and documents, as well as provide better oversight of the implementation of ISPs.

In order for quality planning to occur, contributions from many departments were needed, and these needed to be well coordinated. One positive development that assisted in this process was the practice of holding ISP Preparation meetings 90 days prior to individuals' annual ISP meetings. Although different teams were more successful than others in making these meetings meaningful, the ISP Preparation meetings were designed to allow teams to review in some detail the previous year's ISP, determine which team members should attend the annual meetings (i.e., related to Section F.1.b), determine what assessments individuals needed to inform the current year's planning (i.e., Section F.1.c), identify some of the individuals' preferences as well as strengths and needs (i.e., Section F.2.a.1), and set forth tentative goals on which the various disciplines were expected to target their assessments (i.e., Section F.2.a.2).

An essential component of ISPs were the action plans that defined the supports, services, and protections teams would provide to the individuals over the next year, and the methods for measuring whether or not the plans were working (i.e., Sections F.2.a.1 through F.2.a.6, and F.2.b). This remained a very challenging area. However, on an extremely positive note, at one Facility, IDTs had worked to provide opportunities for individuals to attend day programming in the community. At other Facilities, IDTs incorporated action plans to assist individuals in expanding their vocational opportunities in community settings, but overall, this was limited, and was an area requiring significant expansion.

As is discussed in greater detail with regard to Section I, many individuals whom the Facilities supported had complex medical and/or behavioral needs, putting them at risk for a number of physical and behavioral health issues that required detailed action plans. Although still requiring improvement, most Facilities had made progress in integrating the risk identification process into the ISP process, and at some Facilities, teams were weaving the discussion about risk into the overall planning that occurred regarding the individual's preferences, daily schedule, and support needs.

With regard to Section F.2.g, most often ISP meetings were being held annually, and individuals newly-admitted to the Facilities were having ISP meetings within 30 days of their admission.

Obstacles to Substantial Compliance

As noted above, Section F.1.a relates to the facilitation of the ISP development and implementation process. QIDPs were designated to play the role of facilitator. However, a significant challenge to achieving substantial compliance was the turnover of QIDPs, which made it difficult to train staff to competency and then maintain a competent workforce. In addition, although various drafts were in use, a format for objectively assessing QIDPs' competence in facilitation had not yet been established.

Sections F.1.c and F.1.d relate to the preparation of and use of assessments in the planning process. Timeliness of assessments prepared for the annual ISP meetings and the quality of a number of these assessments continued to be problematic. On a positive note, most Facilities recognized the need to work with the disciplines to improve the quality of assessments, as well as the incorporation of assessment results into ISPs and skill acquisition programs.

Section F.1.e requires ISPs to be developed in accordance with the Americans with Disabilities Act and United States Supreme Court's decision in *Olmstead v. L.C.* Although Facilities had made some progress, this was an area that required improvement, as is discussed in more detail with regard to Section T.

With regard to Section F.2.a and its six subsections related to action plans within ISPs, although some limited improvement was seen, teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences or integrating these into one cohesive plan. ISPs also generally continued to lack measurable overall goals necessary to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, or maintaining his/her current status). Teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Teams also generally were not prioritizing individuals' needs. Methodologies for accomplishing goals were not consistently detailed. Although some progress was noted, ISP strategies often did not reflect encouragement of community participation in a meaningful manner. Recently, at most Facilities, action plans included more measurable action steps, which was positive, but this was an area in which work was still needed. Tightening up these actions steps was necessary to drive consistent implementation and data collection.

With regard to Section F.2.d that requires responsible IDT members for each program or support to assess the progress and efficacy of the related interventions, monthly reports still focused mainly on skill acquisition programs, and generally did not provide information about individuals' progress or lack thereof on issues related to behavior, psychiatry, healthcare, and/or habilitation therapy. Some Facilities were working towards expanding the monthly review process to include more of the interventions included in the ISPs, but this required significantly more work. However, even when reviews occurred, IDTs often did not revise supports when there was regression or lack of progress. In addition, based on incidents and injuries and changes in status, IDTs frequently should have taken assertive action to address the needs for services, supports, and protections, but did not.

With regard to Section F.2.f, implementation of the ISPs did not consistently begin in 30 days, and teams did not consistently make changes to ISPs as dictated by individuals' needs. A number of Facilities were working to develop and implement a system to train staff on the necessary components of the ISPs, and track this training. In addition to making ISPs available to staff, making sure they understood their responsibilities with regard to their implementation also was essential (i.e., Section F.2.c).

With regard to Section F.2.g, which requires quality improvement processes related to ISPs, the QIDP and QA Departments were generally monitoring ISP meetings, as well as ISP documents. Various tools were in use, and required refinement. In addition, efforts generally were in the initial stages of analyzing the data, and using it to drive the changes necessary to the ISP development and implementation functions.

<u>Systemic Recommendations</u>

- State Office should expand its efforts to provide IDTs with technical assistance to develop ISPs that comprehensively address individuals' preferences, strengths, and needs in an integrated manner. Areas of focus should include, but not be limited to developing individualized, observable, and measurable outcomes and implementation strategies; clearly defining the data teams will collect to determine whether or not the plans are effective; and including in ISPs supports that encourage greater exposure to a variety of activities, particularly in the community, and lead towards the acquisition of new skills based on known preferences and needs.
- State Office should work with Facilities on expanding the monthly review process to include all components of the ISPs. Teams should use data to drive decision-making regarding the need for ensuring implementation of existing plans and/or changing the plans.
- Although the Settlement Agreement does not specifically include requirements related to QIDP staffing, the regular turnover of QIDPs is a factor potentially hindering substantial compliance with Section F. The State Office should undertake a review of the reasons for turnover, and develop and implement actions, as appropriate, to improve retention.

SECTION G: Integrated Clinical Services

The two subsections of Section G cover one very broad area and one, more limited, requirement. Section G.1 requires each Facility to provided integrated clinical services to ensure that individuals receive the clinical

services they need. This requires Facilities to develop processes to share information among clinicians; for clinicians to participate in the ISP process, and for recommendations from various disciplines to be reconciled and included in ISPs as determined through the team process; and for treatments, interventions, individual ISP goals, and supports to involve the input and participation of multiple disciplines as appropriate and to be consistent with the information from assessments carried out by multiple disciplines. Section G.2 involves the requirement that Facility clinicians review recommendations from non-Facility clinicians and document whether to adopt recommendations or refer them to the interdisciplinary team (IDT) for integration with existing supports and services.

All Facilities had made at least some progress toward integrating clinical services. Much of this involved establishing or increasing membership of integrated committees and workgroups that addressed issues of healthcare. Examples of increased collaboration occurred around specific areas of clinical care, such as psychiatry clinics that involved several disciplines, involvement of psychiatry and speech clinicians with Behavioral Health Services staff in the development of plans to address problematic behaviors, and communication between neurologists and psychiatrists around medications prescribed for both seizures and psychiatric indications. However, at many Facilities, the focus of integration involved medical services, and there were not initiatives to increase integration across all clinical services. Furthermore, at some Facilities, the efforts at integrated planning were limited to the integrated work groups and did not include improvement in collaborative formulation of clinical service plans.

Three Facilities were found in substantial compliance with Section G2, which requires review by Facility clinicians of recommendations from non-facility clinicians.

Areas of Substantial Compliance and/or Progress

All 13 Facilities had clinical meetings each weekday. The participation at these meetings had evolved to include representation of most clinical disciplines. Several, but not all, Facilities had policies for this meeting that included listing the disciplines that were required participants at this meeting. These meetings provided information on hospitalizations, on-call provider reports, consultations scheduled and completed, reports of restraints, and other information that would be useful for all disciplines. One Facility's meeting included integrated discussion of individuals with emerging or complex health or behavioral issues and systemic issues that needed attention. In addition, there was great care taken to ensure that technical terminology, diagnoses, and specific interventions were explained so all clinicians present would understand them. Some Facilities' morning meetings provided for a review of the quality of content of post-hospital integrated support plan addenda (ISPAs) for individuals who experienced hospitalizations and ER visits, and ensured appropriate acute care and preventive steps were in place. Most Facilities kept minutes, and most of those included information on actions that were to be taken, individuals who either remained in the hospital or for whom post-hospitalization treatment plans were to be implemented, and other issues that needed follow-up.

Workgroups that involved several disciplines addressed important aspects of healthcare. All Facilities had an integrated Physical and Nutritional Management Team with the members required by the Settlement Agreement. This Team met regularly at each Facility. Several Facilities had committees that focused on skin integrity and wounds. These committees tracked and addressed incidences of skin integrity problems including decubiti. Medication variance committees at several Facilities included representation from several disciplines. Some Facilities had workgroups that addressed specific issues of care. For example, one Facility had a weight management meeting.

Quarterly psychiatric clinics at all Facilities typically included participation and collaboration among several disciplines, including psychiatry, psychology/behavioral services, nursing, and often the QIDP, direct support staff, and the individual and/or Legally Authorized Representative (LAR).

Collaboration between psychiatry and neurology had improved. At most Facilities, psychiatry staff regularly met with neurology consultants or attended neurology clinics. At some Facilities, the clinical pharmacist also attended neurology clinics.

The process of Facility review of consultations had improved at many Facilities. At most Facilities, consultations were reviewed at the integrated clinical meeting. At some, but not all, Facilities, discussion went beyond reports of consultations completed and included information from consultations that would be useful to a range of disciplines, and/or discussion of significant consults. At most, but not all, Facilities, review of consultation reports and recommendations by Facility primary care providers (PCPs) occurred regularly, although the reviews often did not provide complete information.

Obstacles to Substantial Compliance

Many Facilities had not established initiatives to increase integration of planning. No Facility had established a description of, or criteria for, integration and collaboration in assessment and case formulation.

Most focus on integration involved committees, work groups, and other meetings. Such meetings, while they might lead to improvements in integrated planning and systems, do not guarantee that services are developed and implemented in an integrated manner.

One area in which collaboration was required, the Integrated Risk Rating Form (IRRF) and accompanying Integrated Health Care Plans (IHCPs), showed variability. While the process to develop these sometimes involved integrated discussion, and observations of annual ISP meetings showed some such discussions were occurring, these did not consistently occur and/or result in integrated plans.

At meetings to plan ISPs, and other meetings to review and plan services and supports, IDT members were not consistently aware of important clinical information needed to make decisions, including information from clinical assessments. For example, at times, the IDT did not identify and reconcile discrepancies or inconsistencies among assessments for an individual.

Although there was evidence that Facility medical providers reviewed consultation reports from non-facility clinicians, integrated progress notes (IPNs) by medical providers were often not found or were completed more than five days following the consultation report. In many cases, IPNs contained little information to document the recommendations or plans to address the recommendations.

There was no statewide policy that set clear expectations of what integrated practices need to occur. Facilities did not all demonstrate an understanding of the characteristics of integrated clinical services that would include activity coordinated across disciplines to reach individual treatment goals and to provide services, supports, and treatments. Such characteristics include identifying and resolving inconsistencies across clinical assessments, services from multiple disciplines to address desired outcomes, and ensuring that interventions and treatments provided by one discipline do not conflict with recommendations by other disciplines.

Systemic Recommendations

- Because one does not yet exist, State Office should set policy and minimum expectations for integrated clinical services. These expectations should define expectations as to what integrated practices need to occur. They should further provide guidance for addressing recommendations by non-facility clinicians.
- The Facilities should work toward integration of all clinical services, not only medical services.
- Facilities should assess the status of integrated clinical services, including evidence of collaborative assessment and case formulation, and develop action plans to improve integration of services.

SECTION H: Minimum Common Elements of Clinical Care

Section H includes seven subsections that address several common elements of clinical care, including timeliness and comprehensiveness of assessments (both routine and in response to developments or changes in an individual's status), accuracy of diagnoses, implementation of treatments and interventions, the determination and use of clinical indicators of efficacy of treatments and interventions, modification of treatments and interventions in response to clinical indicators, and establishment and implementation of policies and procedures relevant to these requirements. The only subsection with which any Facility was found to be in substantial compliance was Section H.2, which relates to accurate diagnoses. Ten Facilities

were in substantial compliance with that Section. For other subsections, some Facilities were making progress in completing assessments, in treatments being timely and clinically appropriate, in determining clinical indicators of efficacy, and in developing and implementing policies.

Areas of Substantial Compliance and/or Progress

At several Facilities, effort had been directed to ensuring annual assessments were updated. This remained somewhat variable across disciplines, but there was significant improvement at those Facilities. Nevertheless, the progress was variable across disciplines and was not yet adequate to result in a finding of substantial compliance.

At most Facilities, both medical and psychiatric diagnoses were consistent with the appropriate diagnostic standards, and these diagnoses clinically fit relevant assessments and evaluations. At one Facility, both medical and psychiatric diagnoses met the standards, but medical diagnoses did not consistently fit assessments and evaluations; at two others, diagnoses did not consistently meet standards or fit assessments.

Clinical indicators to assess health status of individuals and whether or not standards of medical care had been met were developed at several Facilities for several healthcare conditions. These included osteoporosis, constipation, pneumonia and aspiration pneumonia, diabetes mellitus, and other chronic conditions. At one Facility, all clinical disciplines were required to identify metrics. At two Facilities, clinical indicators were integral aspects of internal medical quality assurance.

Some Facilities had developed processes to identify change of status that might require further assessment. For example, most Facilities included information on hospitalization and return from hospitalization in the integrated clinical meeting agenda.

Obstacles to Substantial Compliance

As noted above, timeliness of annual assessments had improved at some Facilities. At others, timely submission of assessments for the ISP meetings that were necessary to fully implement the ISP planning and integrated risk rating processes did not occur consistently across disciplines.

The quality and comprehensiveness of assessments varied across Facilities and across disciplines within Facilities. Although there had been significant improvement at some Facilities and for some disciplines, more improvement was needed. The State had established standardized assessment formats for several disciplines. In some cases, use of these formats had increased comprehensiveness of assessments, but this had occurred too recently to ensure this would consistently be the case.

Although response to acute medical conditions had improved at some Facilities, implementation of treatments and interventions for chronic conditions was not consistently timely as changes in status were identified.

At most Facilities, there was not a process to assess whether treatments and interventions were provided as prescribed, or whether clinical indicators showed that the treatments for individuals had the intended effect. Moreover, ISPs and IHCPs often did not define what these clinical indicators were or when, how, and who would measure and maintain data on them.

Although clinical indicators had been determined at several Facilities and were being tracked regularly for individuals at some, there was not consistent evidence that these were used to track individuals' progress and to determine when treatments needed to be revised or further assessments done. Facilities did not consistently have systems to clearly identify changes in status based on clinical indicators, and to show that IDTs responded appropriately to such changes. In addition, teams needed to include individualized clinical indicators in IHCPs, and implement mechanisms to track them to determine the efficacy of treatments, and to make changes to individuals' plans as needed. Tracking of clinical indicators and their use for determining needed changes in individuals' plans did occur for some conditions at some Facilities. For example, indicators for physical and nutritional management were tracked at some Facilities and used to identify need for more

intensive monitoring or for further diagnostic work, but that did not occur consistently across areas where it was needed.

At some Facilities, monthly monitoring by the QIDP and other responsible interdisciplinary team members was not consistent and did not regularly include analysis of progress. This monitoring should provide an opportunity to review clinical indicators and identify both change of status of lack of improvement, either of which should lead to action.

Systemic Recommendations

- Although other policies addressed some requirements of Section H, no comprehensive policy integrated all requirements Section H. State Office should set policy and minimum expectations for all of Section H.
- State Office should establish expectations and processes for use of clinical indicators for decisions on both treatments and interventions for individuals and for addressing clinical services systemically.
- Facilities that have developed clinical indicators and processes for tracking and using them should share this information so useful practices can be disseminated.
- Facilities should ensure all disciplines provide assessments timely as required by the various programmatic and clinical policies, so that they are available for review by the IDT and are used in making decisions.

SECTION I: At-Risk Individuals

Section I includes three subsections, and requires IDTs to screen individuals to identify individuals whose health or well-being is at risk; conduct interdisciplinary assessments of individuals with at-risk conditions; develop and implement plans, including preventive interventions to minimize the conditions of risk; and respond to changes in an at-risk individual's condition, as measured by established at-risk criteria. Such plans are to be integrated into the individuals' ISPs, and include the clinical indicators to be monitored and the frequency of monitoring. Overall, some progress had been made, but none of the Facilities were in substantial compliance with any of the subsections of Section I. Although in the initial years of the Settlement Agreement's implementation, DADS State Office had provided significant guidance to the Facilities regarding the development of a system to address the needs of at-risk individuals, in the last year or so, State Office's role had diminished in this regard.

Areas of Substantial Compliance and/or Progress

In late 2010, DADS State Office issued an At-Risk Individuals Policy. As noted above, although State Office had initially provided intense training on the 2010 version of the policy, State Office was less involved recently. In an effort to comply with the requirements, in addition to using the guidelines State Office provided, some Facilities had spent considerable time developing and providing their own training programs.

Along the way, State Office had made some changes to the procedures, but the policy set the process for teams to use for screening individuals in order to identify areas in which they were at-risk, and then for developing and implementing plans to minimize the impact of the risks. Specifically, IDTs used an Integrated Risk Rating Form (IRRF) to assign risk ratings (i.e., low, medium, or high) for a variety of categories of risk, including physical health as well as behavioral/mental health. Facilities had begun to implement the policy, and at many Facilities, improvements were seen in IDTs' use of clinical data when assigning risk ratings. The analysis of complete data was an area that still required improvement, though.

Of note, one Facility had begun using Incident Management data regarding falls and restraint use when evaluating the accuracy of the risk ratings for falls and challenging behaviors. Several individuals with high restraint use or high numbers of falls, some which resulted in injuries, actually had lower risk ratings than appropriate. For these cases, special reviews of the risk levels were requested from the IDTs resulting in appropriate increases in the risk ratings.

In order for teams to accurately assign risk ratings and develop comprehensive plans to mitigate risk to the extent possible, team members with the necessary expertise needed to attend meetings, and assessments needed to be accurate and thorough. An area of improvement at some Facilities was better attendance of

necessary team members at annual ISP meetings, where at-risk discussions occurred, but this remained a concern at other Facilities. At some Facilities, observations of ISP meetings showed some improvements in IDTs' integrated discussions regarding risk levels and supports needed to address risks identified, but this did not consistently result in written plans that included the necessary components. As discussed below, an area still requiring improvement was completion of thorough and accurate assessments, although for some disciplines, improvements in the quality of assessments were noted. These improvements are discussed elsewhere in this document (e.g., Section K for Psychology, Section J for Psychiatry, Section P for Occupational and Physical Therapy, etc.).

As the DADS Policy required, IDTs were developing Integrated Health Care Plans (IHCPs) for individuals identified as being at medium or high risk in the variety of clinical categories. However, as discussed below, the quality of the IHCPs required considerable improvement, as well as implementation of the plans and documentation to confirm implementation had occurred.

Obstacles to Substantial Compliance

As noted above, although some improvements were seen, many Facilities still struggled with the identification and participation of the necessary team members at ISP meetings. Another basic process that was not consistently in place was the timely submission of assessments for the ISP meetings that were necessary to fully implement the IRRF process. The quality of these assessments varied, as is discussed in other sections of this report. As also noted above, improvements were seen in the assignment of risk ratings, but this varied between Facilities, and even between different IDTs at the same Facility. A remaining problem was the integration of information across risk categories. Without accurate risk ratings, including full identification of risks, plans to address such risks were sometimes never developed.

The quality of IHCPs remained problematic at most Facilities. Some of the many concerns included: integration between all appropriate disciplines was still a work in progress; integration of Physical and Nutritional Management Team (PNMT) recommendations into IHCPs, as well as medical, psychiatric, and psychological supports did not occur consistently; similarly, nursing protocols were sometimes included, but often were not individualized and/or included in a proactive manner, but only were to be implemented in reaction to acute events; the IHCPs often did not include action plans with the necessary clinical intensity to address designated risk levels; adequate preventative measures often were not included; and clear and measurable objectives to allow measurement of the efficacy of treatment often were missing.

Timely and full implementation of IHCPs often were difficult to measure because teams were not completing comprehensive, integrated monthly reviews and they were not documenting the completion dates for the various steps in the plans. In addition, some problems continued to exist with the measurability of action steps within IHCPs, thus, it could not be determined whether or not such action steps had been completed. Generally, supports were not being monitored and revised as needed to address individuals' risks.

Teams should be, but often were not, carefully identifying and monitoring indicators that would trigger the need for a new assessment or revision in supports and services with enough frequency that risk areas were identified before a critical incident occurs. Most often, the only changes in status for which teams met to discuss making changes to the IHCPs were acute events, such as hospitalizations, Infirmary Admissions, or Emergency Room visits. In other words, an individual had to become acutely ill for his or her IHCP to be reviewed and revised. The goal of the at-risk system should be to identify these changes in status much earlier in the process, and prevent more acute illness, to the extent possible.

Many staff were responsible for the implementation of IHCPs, including direct support professionals. Some Facilities had begun to use Direct Support Professional Instruction Sheets, which were designed to highlight the portions of IHCPs for which they were directly responsible. However, overall, training of direct support professionals on their roles in the plans was an area needing improvement.

In summary, although some progress had been made, it had slowed considerably from the State's initial efforts in this area, and much work remained to achieve the goal of a fully functioning at-risk system across

all 13 Facilities. Given the importance of these requirements of the Settlement Agreement, it was concerning at this juncture of the Settlement Agreement that the State had not made more progress in this area.

Systemic Recommendations

- The State Office should work with the Facilities that have developed training for IDTs on the at-risk system to identify the best resources and share them with other Facilities.
- Facilities should focus on the development and implementation of quality supports to address risks, and this should be a focus of the training mentioned in the recommendation above.
- The State Office and Facility Administrations should provide IDTs with further training and mentoring on mechanisms to recognize increased risk, including use of relevant clinical indicators, in order to identify the need for a new assessment or revision in supports and services with the goal of intervening before a critical event occurs.

SECTION J: Psychiatric Care and Services

Facility Psychiatric Departments and others responsible for implementation of Section J had achieved many substantial compliance ratings. The Monitoring Teams found every Facility in substantial compliance with at least one of the provisions of Section J. Lubbock SSLC met substantial compliance with 13 of the 15 provisions, El Paso SSLC met 10, and six other Facilities met nine.

Areas of Substantial Compliance and/or Progress

Every Facility met substantial compliance with provision J.1, which requires that qualified professionals provide psychiatric services. The SSLCs accomplished this with psychiatric staff, contracted psychiatrists, and locum tenens psychiatrists. Most were board certified or board eligible.

Ten of the 13 Facilities met substantial compliance with Section J.2, which requires evaluation and diagnosis in a clinically justifiable manner, before the prescribing and administering of psychotropic medications.

Comprehensive psychiatric evaluations (CPEs) were provided to all individuals for whom they were required in some of the Facilities. The treating psychiatrists adhered to the Settlement Agreement's Appendix B when completing CPEs by including the review of appropriate behavioral data, developing a meaningful bio-psycho-social-spiritual assessment, and relying on Diagnostic and Statistical Manual–Revision IV (DSM-IV) criteria. Most included a five-axis diagnosis and a detailed discussion of justification of diagnostics. There were improvements in the consistency of correct diagnoses across the reports of different disciplines.

Psychiatrists displayed competency in defining the rationale for the prescription of medication, for the biological reasons that an individual could be experiencing difficulties, and for how a specific medication could address his or her difficulties. Some Facilities, but not all, maintained thorough documentation of the symptoms needed to establish the individual's psychiatric diagnosis, as well as the differentiation of those behaviors derived from the psychiatric diagnosis, as opposed to those present on a behavioral basis. There were improvements in the quality of collaborative case formulation between psychiatry and behavioral health services, including differentiation of function.

Facilities tracked the occurrence of the Quarterly Psychiatric Reviews (QPR), and most occurred as scheduled. Psychiatrists also often did follow-up or completed urgent consults in between the Quarterly Reviews. The documentation that accompanied the QPRs was detailed, included discussion of risk-versus-benefit considerations, and verified that the consents were up-to-date. Medications were not overtly used for staff convenience or as punishment, although documentation of chemical restraint was not consistently thorough.

During each compliance review, the Monitoring Teams observed numerous psychiatry clinics during which QPRs were conducted. The presentation of materials was comprehensive and the psychiatrist typically asked questions to explore the material presented. Progress was made in collecting and presenting psychiatric symptom data. Typically, there was participation in the discussion and collaboration between the disciplines (e.g., psychiatry, behavioral health, nursing, QIDP, direct care staff, and the individual).

Many, but not all, Facilities assessed polypharmacy at both the system and individual level by ensuring appropriate diagnosis, data on targeted symptoms and behaviors, and appropriateness of polypharmacy. Some Psychiatry Departments made a distinction between those individuals whose medications were being actively tapered, and those for whom the continued use of the medication was thought to be essential for their continued stability. For these latter cases, there was progress in assembling the necessary documentation to justify the efficacy of the psychotropic medications.

Most Facilities had a good system in place to monitor side effects of psychotropic medications. This often included clinical correlation on the Monitoring of Side Effects Scale (MOSES)/Dyskinesia Identification System: Condensed User Scale (DISCUS) forms, comparison of results from previous rating scales in the "Psychiatry Clinic" note, inclusion of MOSES/DISCUS review in the QPR documentation, and the review of these rating scales during psychiatry clinic.

In some Facilities, a member of the Psychiatry Department attended the majority of the ISPs for individuals prescribed psychotropic medication. In these Facilities, the Psychiatry Department submitted the relevant psychiatry assessments and updates to the IDT at least 10 days before the individual's annual ISP. In some Facilities, there were noted improvements in the psychiatric participation in the development of the Positive Behavior Support Plan (PBSP).

Many Psychiatry Departments were now responsible for documentation regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication. They were also responsible for contact with, or attempts to contact, the individual's LAR with regard to informed consent. These psychiatrists were now obtaining informed consent for annual medication renewals.

Onsite neuro-psychiatric clinics were occurring in most Facilities. There was now good communication between the neurologist and psychiatrists around medications prescribed for both epilepsy and psychiatric indications. Psychiatrists routinely attended neurology clinics.

Obstacles to Substantial Compliance

In some Facilities, extensive turnover in the Psychiatry Department competed with their ability to make progress towards substantial compliance, including attending ISP and other relevant meetings for individuals on their caseloads. Psychiatrists were experiencing difficulty with the level of documentation required. They might consider using electronic documentation completed during psychiatry clinic in an effort to reduce redundancy.

Although progress in completing CPEs is noted above, some Facilities had not yet completed these evaluations for all individuals. Further, some diagnoses were not fully justified according to DSM-IV criteria, because the CPEs did not provide sufficient information on the behavioral symptoms that supported the provided diagnoses. At a number of Facilities, QPRs omitted many elements, such as the expected timeline for the therapeutic effects of the medication, the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, and how this monitoring will occur. At some Facilities, Reiss Screening or psychiatric referral due to change of status was not occurring.

One of the challenges that confronted the Psychiatry Departments was the integration of the psychiatric clinical material into the ISP, IRRF, and IHCP. More work was needed to ensure that teams had discussions and documented the necessary deliberations related to the use of psychotropic medications and alternatives.

There was little development or implementation of programs to minimize the need for pretreatment sedation. Only a few desensitization plans or other strategies to reduce the use of pretreatment sedation were in place. There remained a need to reduce reliance upon the use of multiple medications for pretreatment sedation.

In some Facilities, there were problems in the timely completion of side effect monitoring assessments.

In some Facilities, there remained inadequate informed consent practices. In order to obtain substantial compliance, the prescribing practitioner needed to disclose to the individual or LAR all information necessary for informed consent, documenting appropriately. Many Psychology Departments continued to be responsible for the consent process for psychotropic medication instead of the prescribing practitioner. At the time of the writing of this report, the State was making changes to its rules related to consent for psychotropic medication. It will be important for the Facilities to receive clear guidance once these are finalized.

Systemic Recommendations

- To comply with Section J.5, State Office should develop a statewide plan for the ongoing recruitment and retention of psychiatrists.
- The State and Facilities should consider the use of nurse practitioners with expertise in psychiatry to supplement the psychiatry staff teams.
- Facilities should address the challenges of having appropriate amounts of psychiatry participation in the many and varied IDT and ISP processes.
- Facilities should consider ways to simplify psychiatry documentation and/or management of documentation.
- State Office should work with Facilities to review pretreatment sedation and ways to increase implementation of supports to minimize use of pretreatment sedation (strategies that include, but are not limited to, formal desensitization procedures), including a focus on individuals with the need for pretreatment sedation for medical appointments, as well as dental appointments.
- Once the new rules on consent are finalized, State Office should provide clear guidance to the Psychiatry Departments regarding their role in the informed consent process for psychotropic medications.
- Facilities should ensure the use of chemical restraint meets generally accepted professional standards.

SECTION K: Psychological Care and Services

Areas of Substantial Compliance and/or Progress

Every Psychology Department was now called the Behavioral Health Services Department, and all Psychologists were now called Behavioral Health Specialists (except those few who were licensed as psychologists).

There was excellent leadership in the Behavioral Health Services Department at the Facilities. The Directors were licensed or certified as behavior analysts. As a result, 12 of the 13 Facilities met substantial compliance with Section K.2. Many of the staff who wrote and managed PBSPs were board certified behavior analysts (BCBAs) or were pursuing certification via coursework and supervised experience. One Facility had a sufficient number to meet substantial compliance with Sections K.1 and K.13.

Facilities had established more flexible data collection systems that allowed for more timely, reliable, and valid data collection, but as discussed below, this was not consistent across all Facilities. Progress continued to be evident in the area of data display. There was initiation of the assessment of interobserver agreement (IOA) for every PBSP in many Facilities. Individual notebooks contained target and replacement data sheets and were more accessible to direct support professionals (DSPs). One Facility had advanced to the point of meeting substantial compliance for Section K.4.

There were improvements in the number of individuals with PBSPs with current functional assessments and, overall, the quality of the functional assessments had improved. For instance, there was greater emphasis on direct observation of identified problem behavior, some identified preferences were tested to evaluate their effectiveness as reinforcers, and some assessed denser schedules of reinforcement for appropriate behavior. Progress occurred in the completion of psychological assessments at some Facilities, including standardized tests of intelligence and tests of adaptive behavior. As a result, three Facilities met substantial compliance with Section K.5, one with Section K.6, and four with Section K.7.

The quality of behavior interventions improved substantially. In some Facilities, PBSPs included all required elements, and reflected sophisticated examples of behavior intervention methods. At one Facility, substantial compliance was met for the corresponding Section K.9. All PBSPs reviewed included staff instructions that met readability expectations, resulting in substantial compliance for Section K.11 for 12 Facilities. However, no Facilities had ensured that every staff person who worked with the individual received training in the PBSP (Section K.12).

Data-based treatment decision-making was often evident in PBSP reviews. Efforts to collect and monitor behavior treatment data had improved, including the addition of monthly review of all behavior data by BCBAs. In many Facilities, there were monthly progress notes for all individuals with PBSPs and corresponding progress notes indicated that some activity to address the lack of progress had occurred. A more consistent use of simplified graphs of target behaviors helped with these reviews.

Most Facilities had an active internal and external peer review system resulting in eight of the Facilities meeting substantial compliance with Section K.3. Peer review offered an excellent opportunity for increased training and development of skills. Another purpose was to review individuals who were displaying limited progress on their PBSPs or who presented as especially challenging cases.

Procedures to assess and improve the integrity of implementation of PBSPs occurred at every Facility. In some Facilities, the Monitoring Teams found that PBSPs were implemented as written. Frequent observation and training of staff was required of the Behavioral Health Services staff. Competency-based training was reported in most Facilities. In some Facilities, behavior coaches provided support and training to the direct support professionals while they were directly working with individuals. These coaches were available during the two daytime shifts, seven days a week. Other promising practices included regular scheduling of professional staff in the homes and day programs, setting clear expectations for timely completion of all paperwork, and conducting staff training that included role-play and on-the-job performance checks and feedback. Only one Facility, however, had met substantial compliance with the corresponding Section K.10.

Improvements in the comprehensiveness of psychological services other than PBSPs were evident in most Facilities, and three Facilities met substantial compliance with Section K.8. Two Facilities had an extensive system of various types of group and individual counseling therapies.

Obstacles to Substantial Compliance

Although assessments of intellectual and adaptive behavior were completed more timely, many individuals did not yet have updated assessments. Many Facilities continued to need to improve the quality of the functional assessments, especially regarding hypothesized antecedents to target behaviors and hypothesized consequences of target behaviors.

Some Facilities continued to allow staff to record data only at the end of the shift, increasing the probability of data collection errors and potentially limiting the ability to develop sound treatment decisions. Some Facilities did not consistently conduct assessments for data reliability or treatment integrity. Current data were not consistently graphed and available at interdisciplinary meetings and psychiatry clinics. Behavioral progress notes and verbal reports from Behavioral Health Services staff frequently described poor quality data, missing data collection forms, and poor cooperation by staff.

Peer review was not regularly implemented in all Facilities. Follow-up recommendations were not consistently addressed.

Many PBSPs did not contain replacement behaviors that were functional, or an explanation why functional replacement behaviors were not possible or practical. Concerns with regard to the quality of operational definitions for replacement behaviors and adequate behavioral objectives for target and replacement behaviors remained. A focus for the future should be on improved preventative strategies, including but not limited to more comprehensive habilitation programming, and the use of differential reinforcement strategies that utilize reinforcers specific to the individual.

PBSPs were not consistently implemented within 14 days of receiving consent. Not every staff assigned to work with an individual, including float/relief staff, was trained in the implementation of the PBSP. Training documentation did not always identify if the training was competency-based or if it included supervisors.

Some counseling plans lacked a basis in evidence-based practices. Improvements were needed in the adequacy of monthly PBSP notes in many Facilities.

Systemic Recommendations

- There should be a focus upon better choices of replacement and alternative behaviors and the quality of the way they are taught, maintained, and generalized.
- Increased opportunities for improving adaptive skills, communication, and participation in engaging activities should be a foundation of Facility efforts to address behavioral health (see Section S).
- Assessments should be completed as required.
- Standards for the training and ongoing management of staff performance on all components of the PBSP should be established.
- Standards for interventions other than PBSPs (e.g., counseling) should be established.

SECTION L: Medical Care

This section of the Settlement Agreement focuses upon the provision of medical care. One Facility achieved substantial compliance with one provision. Individuals received basic medical services at most Facilities. Section L.1 encompasses all preventive, acute, and emergency medical care. So, even if many medical services were being provided at the generally accepted professional standard of care, the full range of services were required for a Facility to be in substantial compliance. To compare, elsewhere in the Settlement Agreement, full ranges of services are monitored across a number of subsections (e.g., Sections J, K, M, N, and O).

Most progress was seen in those Facilities where the medical leadership and medical staff were stable. High turnover and the use of locum tenens competed with the ability of many Facilities to provide consistent and quality medical care. In most cases, caseloads were of an appropriate size per PCP, though in some Facilities, Medical Directors were carrying caseloads that made it difficult for them to complete their many management and system analysis responsibilities.

Every Facility held a daily medical-clinical meeting during which the previous day's events and upcoming appointments were reviewed and discussed. These meetings were typically well attended by several disciplines. Critical clinical discussions occurred at many meetings, however, at some Facilities the content was often no more than the mere reading of statuses and appointments.

A number of medical-related performance and management problems at the Lufkin SSLC resulted in the Monitoring Team conducting an additional onsite visit in May 2014, between scheduled six-month visits. The Facility had put procedures in place to address the problems found during the January 2014 onsite review.

Areas of Substantial Compliance and/or Progress

Overall, at most Facilities, the primary care physicians did a good job providing basic medical care and preventive care. Components of quality medical care were reflected in improved documentation in the active records concerning chronic care and concerning acute changes in health status.

Routine screenings, preventive services, and core immunizations were generally provided. Compliance with most cancer screenings was very good and, overall, was increasing. Preventive care was one of the strengths of the Medical Department at most (but not all) Facilities, especially regarding the completion of mammograms, pap smears, DEXA scans, and colonoscopies. Some Facilities assigned a nurse to manage immunizations.

For some Facilities, there was documentation that annual and quarterly assessments were completed along with routine annual labs and screenings. Annual and quarterly medical assessments were mostly current. In some cases, there was progress in obtaining quality family histories.

The Monitoring Teams noted improvements in many Facilities regarding management of specific medical conditions, such as diabetes mellitus, low bone density, and pneumonia. Addressing pneumonia, a very important area for the population at the SSLCs, was done adequately at some, but surprisingly not at all Facilities. For example, much work was done at one Facility, including forming a specialized task group. On the other hand, at two Facilities, little had been done, even though the incidences were relatively high.

At some, but not all, Facilities, there was improvement in participation of medical staff in the interdisciplinary team process, including ISP planning meetings. In most Facilities, there were anecdotal accounts that the PCPs were very accessible to the IDTs and staff and, overall, worked well with other disciplines, but rarely attended IDT-related meetings.

Most Facilities completed external and internal reviews of medical services, as required. At these Facilities, corrective actions were implemented and follow-up was done in most areas.

Efforts to develop a medical quality improvement program continued at a few of the Facilities. Work on the development of the clinical indicators continued at many Facilities and included quality indicator monitoring tools and audits. One Facility, Richmond SSLC, obtained substantial compliance for Section L.3. That Facility's program included an internal medical review, an audit that addressed clinical performance across a broad range of conditions, a comprehensive data-based system that identified clinical indicators of care, and aggregate data for systemic review of the efficacy of health care and integrated clinical services. There were indications of follow-up on action plans to determine efficacy.

Some Facilities had updated their policies and procedures and had provided training to medical staff.

Obstacles to Substantial Compliance

Some Facilities needed to improve their ability to manage chronic care issues, such as seizure disorders, osteoporosis, cerebral palsy, and fractures. Individuals with numerous chronic medical conditions were often treated with standing orders without physician notification. All medical conditions that are active, and/or require regular monitoring by the medical provider must be listed on the active problem list.

In some Facilities, acute care documentation frequently involved only one note, and documentation of the resolution of acute conditions was infrequent. Some providers utilized a four-line format for SOAP notes that contained very few words and little information about the acute conditions.

In at least a few Facilities, individuals were not being assessed as required following hospitalization and emergency department evaluations. In some cases, medical staff conducted phone consults with nursing in lieu of actual evaluations following return from the hospital. For the post-hospital ISPA to be of value, the pre-hospital review and the hospital reviews needed to be completed prior to the IDT meeting for the ISPA.

Improvements were still needed at some Facilities regarding preventive care. There were some problems with follow-up of abnormal studies, with the monitoring of individuals who received psychotropics and anti-epileptic drugs, and for individuals with recurrent pneumonia.

In general, many Facilities were not actively attempting to identify underlying causes of clinical issues, but were merely treating overt manifestations. For instance, one Facility was not ensuring that underlying causes of low bone mineral density were assessed, assessing efficacy of supports and services for recurrent pneumonia, or routinely clinically assessing individuals following seizure activity.

Pneumonia care continued to present challenges. For the individuals who had recurrent pneumonia, of any type, there was little evidence that appropriate diagnostics and interventions were implemented to minimize recurrence. The Monitoring Teams found incidents of pneumonia not included in the pneumonia data and other inconsistencies in the categorization of pneumonias.

In at least one Facility, Do Not Resuscitate (DNR) order status required further research to determine whether there was justification or not for the DNR order.

Physician participation in ISP and IDT-related meetings remained relatively low. Medical providers must ensure that the IDT is well informed about all medical conditions, the etiology of medical conditions, how the condition impacts the individual's life, all potential treatments, and associated risks and benefits of treatment.

The external medical provider quality assurance audit process did not assess the medical providers' clinical performance in a number of important areas. Some Facilities did not complete the external and internal audits in accordance with State Office guidelines and/or there were conflicting reports related to the status of corrective action plans.

The mortality review process must be significantly revised to ensure that medical providers conduct a comprehensive case review of all deaths, and that meaningful recommendations are provided for each death, derived by a root cause analysis. It is essential that the mortality review process provide a comprehensive understanding of the cause of death, to determine if alternate medical treatments or enhanced support services could improve the overall care of individuals at the Facilities.

At most Facilities, there was little or no progress in the development of a medical quality program. In some Facilities, there did not appear to be a sense of urgency to do so and the status of many projects remained no different than they were at the time of previous reviews. A medical quality assurance program should track and trend positive outcomes and adverse outcomes for its medical practices. Some of the databases had conflicting data at many Facilities. Some preventive care databases appeared out-of-date and did not accurately reflect the clinical care at the Facilities. Facility QA Departments provided little guidance to Medical Departments in the development and management of a medical quality program.

There was an outstanding need to develop local policies based on State Office-issued clinical guidelines, and to guide the delivery of health care services. Basic responsibilities of the medical staff were not defined in medical policy and most Facilities had no system to ensure that policies and procedures were updated.

<u>Systemic Recommendations</u>

- State Office should establish the minimum required components of SSLC medical quality programs, including data on provision and outcomes of health care.
- The DADS external medical performance review should be enhanced to address additional significant and common medical conditions that occur in people with intellectual and developmental disabilities, and ensure that the clinical issues being reviewed assess the clinical performance related to the actual treatment of the medical conditions being audited.
- State Office should provide Facilities assistance with data management, including consolidation of multiple databases collecting the same or similar information, as well as mechanisms to confirm that the data are accurate and complete.
- State Office should establish SSLC standards for the management of pneumonias.
- Although the Settlement Agreement does not specifically include requirements related to medical staffing, the needs for consistent medical leadership and staff are factors potentially hindering substantial compliance with Section L at some Facilities. The State Office should develop and implement actions, as appropriate, to improve recruitment and retention.

SECTION M: Nursing Care

The six subsections of Section M include requirements related to development and implementation of nursing protocols, quarterly and annual nursing assessments, nursing care plans, and nursing assessment of and services for at-risk individuals, as well as medication administration, and nurses' roles in assessing and identifying individuals' health care problems and notifying physicians. None of the Facilities were in substantial compliance with all of Section M, and the vast majority of Facilities had achieved substantial compliance with none of the subsections. As is discussed in further detail below, only four Facilities (31%) were in substantial compliance with any of the subsections. Although some progress had been made,

significant work remained to ensure that individuals had the nursing supports and services they required. Given that most of the Facilities supported numerous individuals with complex medical and behavioral needs, the ongoing lack of acceptable nursing services at this juncture of the Settlement Agreement was of serious concern.

Areas of Substantial Compliance and/or Progress

As Section M.1 summarizes, Facilities are required to ensure that nurses "document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status." Some Facilities had shown progress in some of the basic requirements included in this overarching requirement of the Settlement Agreement. For example, improvement was noted at some Facilities with regard to nursing staff's knowledge of the use of emergency equipment, and in the conduct of emergency drills, and emergency equipment was accessible, functional, and available in the designated areas.

Some Facilities had stable nursing staff, but, as noted below, this remained a challenge at other Facilities.

Infection control efforts at some Facilities were resulting in improved reporting of infections. One Facility showed progress in monitoring, identifying, and analyzing the occurrence of infections, and in implementing appropriate infection control measures. Other Facilities had identified outbreaks of infections and developed interdisciplinary plans to prevent the spread of infections, including coordination with local health departments. Some Facilities had worked to improve the reliability of the infection control data by comparing the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics. Others were using real-time audits as a mechanism to improve acute care plans for infections. However, improvements in infection control were still needed, and improvements noted here were not consistent across Facilities.

Hospital Liaison nurses made visits to individuals that were hospitalized, and at many Facilities, this had resulted in improved communication processes between the Facility, external health care facilities, and IDTs.

Section M.2 requires at least quarterly nursing assessments. Two Facilities (15%) had achieved substantial compliance with this provision. Section M.3 relates to nursing care plans, and although as noted below, no Facilities were in substantial compliance, some Facilities were noted to have strong acute care plans, and at others, improvements were seen in some care plans related to infections.

Section M.4 requires the development and implementation of nursing protocols. Four Facilities (31%) were in substantial compliance with this provision. It was positive that State Office had issued a set of nursing protocols that addressed some of the most common health conditions individuals experienced. Across Facilities, training had occurred on the nursing protocols, and they were readily available to nurses on rings that nurses carried with them. As discussed in further detail below, although some Facilities were found to have implemented the protocols, significantly more work was needed to ensure Facilities used the protocols in all applicable aspects of the provision of nursing supports.

Section M.6 requires Facilities to implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care, and to provide the necessary supervision and training to minimize medication errors. Four Facilities (31%) were in substantial compliance with this subsection. At these few Facilities, there was a robust system for identifying, reporting, tracking, and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances. At other Facilities, some improvements were seen. For example, some Facilities had implemented procedures to track excesses and shortages of medications in an attempt to reconcile these numbers and identify the issues related to medications that were being returned to the Pharmacy without explanation, and to link such errors to potentially negative clinical outcomes (e.g., seizures, constipation).

Obstacles to Substantial Compliance

As noted above, Section M.1 included broad requirements related to the provision of nursing care. None of the Facilities were in substantial compliance with this provision. Some Facilities continued to struggle with

maintaining adequate numbers of nurses, including Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs), and were relying on overtime and/or the use of agency nurses to maintain minimum staffing levels. In addition, a number of Facilities had experienced turnover in key nursing leadership positions. In addition, to maximize nursing resources, many Facilities needed to review the structure of the Nursing Departments and the assignments of nurses based on acuity (e.g., using individuals' risk ratings). These staffing issues negatively impacted Facilities' ability to comply with the Settlement Agreement because turnover and use of external agencies to staff nursing positions resulted in the need for frequent retraining of staff, and often procedures that were not memorialized in policy were lost when staff left their positions.

Of significant concern, reviews of hospitalized individuals, as well as individuals with acute infections at a number of Facilities frequently showed that nurses were not proactively conducting assessments of individuals with known diagnoses, did not consistently follow-up when assessments showed signs and symptoms of illness, and often did not notify physicians timely of changes in health status.

With regard to Section M.2, although State Office had provided the Facilities with templates for annual and quarterly nursing assessments, one of the challenges that many Facilities still faced was the lack of comprehensive analysis of the data and information collected as part of the assessment process. At many Facilities, because nursing protocols were not implemented regularly, assessments of individuals' status were missing, and so data were not available for analysis. Another concern was the lack of clinical indicators in IHCPs, including the collection of baseline and ongoing data to allow objective comparison of individuals' health status from year to year, and quarter to quarter.

Section M.3 requires nurses to develop and implement annual plans outlining the needed nursing interventions for individuals' health conditions, and to update them as necessary. No Facility was in substantial compliance with this subsection. IHCPs and acute care plans often lacked individualization, were not sufficiently measurable, lacked specificity as to what was to be monitored and documented, and did not fully integrate nursing protocols. In addition, there frequently was a lack of documentation to show nursing care plans were carried out and followed through to resolution.

With regard to Section M.4, most Facilities had not fully implemented nursing protocols, which provided the steps nurses should take to address specific health conditions (e.g., constipation, aspiration, falls). For example, nursing protocols were not consistently individualized and included in nursing assessments and IHCPs, nor were they consistently reflected in the Integrated Progress Notes to show that nurses had used the protocols to proactively assess individuals with known health conditions and/or in response to signs and symptoms of illness. A fairly consistent problem was the lack of proactive use of the protocols, and only reactive use of them. In other words, nursing staff often only included them in IHCPs as steps that would be taken when an individual experienced a health concern, as opposed to on an ongoing basis to catch a potential health issue before it became acute. At this juncture of the Settlement Agreement, it was concerning that the use of basic nursing protocols, which set forth the generally accepted standards of nursing care, were not prevalent in nursing practice throughout all nursing activities at all of the Facilities.

Section M.5 requires Facilities to develop and implement a system of assessing and documenting clinical indicators of risk for each individual, and for IDTs to discuss plans and progress at integrated reviews. No Facility was in substantial compliance with this subsection. As discussed in further detail with regard to Section I, some progress had been made in defining the system to determine individuals' risks, but much work was needed to improve the development and implementation of IHCPs to address such risks, including the use of clinical indicators to objectively measure whether individuals were doing better, regressing, or remaining stable. This was necessary to guide teams' decision-making about the need to modify the IHCPs.

With regard to Section M.6 related to medication administration, at some Facilities, there continued to be serious omissions in following accepted standard of practices when administering medications. At one Facility, there was an absence of a fundamental medication safety system to ensure checks and balances in the completion of physician orders, a reliable system for medication reconciliation/verification of physician's orders, transcription of the orders, and administration of medications. Underreporting of medication variances was problematic at some Facilities, as was sufficient analysis of existing medication variance data

and action plans to address problematic trends. Medication administration is an extremely basic nursing process, and these ongoing problems were of significant concern.

Systemic Recommendations

- Although the Settlement Agreement does not specifically include requirements related to nursing staffing, the regular turnover of nursing staff and vacancies at some Facilities were factors potentially hindering substantial compliance with Section M. The State Office should develop and implement actions, as appropriate, to improve retention and fill vacancies.
- State Office had begun and is encouraged to continue to develop strategies to address the structure of the Nursing Departments and the responsibilities that had been assigned to the different nursing positions.
- State Office should identify and use a competent source to provide competency-based training and mentoring on the completion of nursing assessments and nursing care plans, including acute care plans and IHCPs, as well as the integration of nursing protocols throughout nursing practice at the Facilities.
- State Office should set forth expectations with regard to the content and responsibility for the development of the various components of IHCPs.

SECTION N: Pharmacy Services and Safe Medication Practices

Pharmacy practices at many Facilities improved over the past few years to the point where one Facility met substantial compliance with all eight of the provisions of this section (Brenham SSLC) and four other Facilities met substantial compliance with six or seven of the provisions. Most progress occurred when there was stable staffing in the Facility's Pharmacy Department's leadership and clinical staff. The absence of this was the primary reason that two Facilities met substantial compliance in only one or in no provisions. Note that at one Facility, the nearby State Hospital dispensed medications.

Areas of Substantial Compliance and/or Progress

Section N.1 and N.4 require frequent and meaningful contact between pharmacists and prescribers, especially when the pharmacy identified potential contraindications or the need to determine lab values. There was much improvement; eight of the Facilities met substantial compliance with Section N.1 and 10 with Section N.4. The Intelligent Alerts system contributed to this progress.

For Facilities in compliance with Section N.1, all new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose, and necessary clinical diagnostics. There was an increase in documentation of interactions between prescribers and pharmacists, including recording order clarifications, Intelligent Alerts, and retrospective recommendations made during clinics.

Section N.2 requires completion of quarterly drug regimen reviews (QDRRs). Seven Facilities met substantial compliance. At these Facilities, QDRRs were completed in a timely manner and were, for the most part, done well. The majority of QDRRs were coherent, addressed relevant clinical issues, and provided recommendations. There was improvement with the level of review of diagnostics and assessment of metabolic syndrome and anticholinergics. In almost every case, the appropriate medical provider reviewed, signed, and concurred with the pharmacist's recommendations.

Section N.3 requires the pharmacy and Facility to monitor a variety of emergency uses of medications, chemical restraint, and a variety of conditions. Six Facilities met substantial compliance with this provision. These Facilities ensured that metabolic syndrome, polypharmacy, anticholinergic, and benzodiazepine usage were addressed when completing QDRRs and ensured that regularly scheduled systems review of benzodiazepine, anticholinergic, and polypharmacy usage occurred through relevant committee structure. Further, chemical restraint forms were completed in a timely manner, and included quality information.

Assessing and monitoring side effects of medication are targeted in Section N.5. Six Facilities met substantial compliance by properly administering, reviewing, and applying the findings from periodic MOSES and DISCUS evaluations.

In Section N.6, the system of reporting and following up on adverse drug reactions (ADR) is monitored. Six of the Facilities met substantial compliance with this provision. ADRs were reported and the ADR process was much improved. A number of Facilities had enhanced their training for all relevant staff on the ADR identification and reporting process, revised their ADR reporting forms to include a section for pharmacist's comments, ensured that pharmacists and medical providers documented on the ADR, and ensured that there was clinical follow-up by the medical provider for all reported ADRs.

Drug utilization evaluations (DUEs) were monitored in relation to Section N.7. Nine of the Facilities met substantial compliance. Pharmacies at these Facilities did a good job in the completion and follow-up of DUEs. Documentation indicated that corrective actions were implemented when appropriate and were followed up to completion. The DUEs provided clinically relevant information, and provided medical providers and pharmacists with information to enhance clinical practice.

Section N.8 relates to monitoring of the Facility's medication variance program. Only three Facilities met substantial compliance, indicating that much work was still needed. In those three Facilities, staff maintained a medication variance process that promptly addressed all reported medication variances; and tracked and trended prescribing, documenting, dispensing, administering, and storage of medication variances. Nursing, pharmacy, and medical leadership participated in the medication variance process. The process ensured that all relevant departments, including the Nursing, Pharmacy, and Medical Departments were closely monitoring for medication variances, and for potential medication variances.

Obstacles to Substantial Compliance

In some Facilities, Intelligent Alerts were implemented, but the prescribers frequently opted to not follow the monitoring guidelines, that is, they were rejecting a significant number of prospective recommendations. There were problems with pharmacy/prescriber communication when severe drug interactions were involved. Further, Intelligent Alerts did not appear for some frequently used medications, which called into question the functionality of the system.

There was significant delay in completing QDRRs within the quarterly time frame in some Facilities. In one Facility, only 40% of the QDRRs were up-to-date. Further, the psychiatrist did not indicate review of the QDRRs, and did not indicate either agreement or disagreement with the pharmacist's recommendation.

Some Facilities did not have an adequate system to review psychotropic polypharmacy, and there was no consensus on how that would be achieved. There were no clinically meaningful individual reviews for stat psychotropic medication usage in at least one Facility.

In those Facilities that did not meet substantial compliance with Section N.5, there were delays in the psychiatry review of MOSES and DISCUS documents, and there was no evidence that the primary medical providers reviewed this information, even when the findings were abnormal.

There were not sufficient procedures for identifying and implementing generally accepted professional standards regarding ADRs and DUEs at some Facilities, including the under reporting of ADRs and the absence of meaningful DUEs.

The biggest challenge for the Facilities was developing, implementing, modifying, and continually improving a medication variance program. A frequently identified problem was excess medication returned to the pharmacy for which there was no explanation as to the excess (e.g., failure to administer, too much medication delivered, hospitalization). Further, problems in data systems often obscured the magnitude of the variances. Data should indicate the drug(s) involved and the number of days the variance occurred.

Systemic Recommendations

- State Office should clarify criteria for reporting ADRs.
- State Office should set standards for medication variance programs and provide sufficient support and oversight to Facilities to ensure proper implementation, modification, and review.

SECTION O: Minimum Common Elements of Physical and Nutritional Management

Section O provides requirements for the development and implementation of physical and nutritional management (PNM) services. The eight subsections provide requirements for the Physical and Nutritional Management Plan (PNMP) and mealtime and positioning plans; the establishment, membership, and role of a physical and nutritional management team (PNMT); identification of each individual who cannot feed himself or herself, requires positioning assistance associated with swallowing activities, has difficulty swallowing, or is at risk of choking or aspiration; training for staff who will implement these plans; monitoring to ensure plans are implemented competently; monitoring of progress of individuals and revision of interventions as appropriate; and, for individuals fed by a tube, evaluation to ensure that continued use is medically necessary, or that the Facility implements a plan to return the individual to oral feeding.

Although substantial progress was made in meeting several requirements of this Section, the actual implementation of mealtime and positioning plans continued to include numerous instances in which PNMPs and dining plans were not implemented accurately, which put individuals at risk. Only one Facility approached an acceptable level of accurate implementation. In some cases, monitoring by trained monitors including clinicians was clearly inaccurate, indicating a higher level of accurate implementation than the Monitoring Teams observed. Regardless of the quality of assessments and plans, accurate implementation of safe practices is critically important.

One Facility was rated in substantial compliance with three subsections of Section O, two were rated in substantial compliance with two subsections, and five were rated in substantial compliance with one subsection.

Areas of Substantial Compliance and/or Progress

Twelve Facilities had Physical and Nutritional Management Teams (PNMTs) that were comprised of at least the required disciplines and met regularly. At one Facility, two core disciplines did not regularly attend and participate in the PNMT. Core PNMT members were engaging in relevant training.

At 12 Facilities, physical and nutritional management plans (PNMPs) had improved significantly. These were consistently comprehensive and of good quality at most Facilities.

Several Facilities had implemented mealtime coordinator processes or mealtime management systems. Some included table captains. There was still a need for greater training of these staff and for improvements in logistics. A best practice was noted at several Facilities that had continued to revise the Mealtime Coordination system to achieve the outcome of ensuring staff did not engage in unsafe mealtime practices, identifying and correcting problems when they did occur, and striving to encourage a mealtime environment that supported independence for individuals. This system had resulted in significant improvement in implementation of dining plans.

Although variable across Facilities, there was improvement in implementation of plans for positioning individuals.

At most Facilities, PNMPs were available to staff where they were needed. PNMPs usually (though not always at all Facilities) included photographs that were large and clear enough to show detail for staff references.

All Facilities required newly hired staff to complete competency-based training on essential aspects of physical and nutritional management before beginning to work with individuals. This training included mealtime practices and positioning. Some Facilities had additional requirements following completion of orientation, including shadowing other staff, on-the-job training at the assigned worksite, and competency checklists. Current staff received refresher training annually. Several Facilities had specific procedures to ensure new staff received individual-specific training for all individuals who had specialized PNMPs. Three

Facilities had sustainable systems to ensure that pulled staff received individual-specific training before working with individuals, and one Facility developed individual-specific performance check-off training.

At one Facility, a protocol and tool for monitoring effectiveness was being implemented on a trial basis.

Two Facilities developed protocols or processes to assess and determine whether an individual was a candidate to return to oral eating and to develop a program or pathway to progress toward this goal.

Obstacles to Substantial Compliance

While the SSLCs had evidence of a comprehensive PNMT as it related to core membership, this did not always translate to a comprehensive assessment of issues related to physical and nutritional health. Often, when there was a change of status, the assessment process consisted of only reviewing the current supports; there was no evidence that the assessment process included root cause analysis or detailed investigation as to what caused the change in status. That information is essential to planning treatments, interventions, and supports that might be effective in improving the individual's health status.

As noted above, implementation of mealtime practices that included accurate implementation of PNMPs and dining plans approached an acceptable level at one Facility. At most Facilities, staff were observed not implementing PNMPs accurately and not displaying safe practices to minimize the risk of PNM decline or the exacerbation of existing health conditions. There were errors in diet texture and preparation of thickened liquids, and staff were not implementing foundational PNMP and dining plan strategies.

At several Facilities, PNMP monitoring was not occurring at the established frequency for individuals with high and/or medium PNM risks (and, at some Facilities, the criteria for increased levels of monitoring were not clear), and/or monitoring did not identify unsafe or inaccurate implementation of PNM practices and prescribed PNMP strategies. At some Facilities, there was significant discrepancy between the Facility's monitoring data and the Monitoring Team's observations. In at least one case, this occurred when both the Facility staff and the Monitoring Team were observing the same individuals at the same time.

At some Facilities, although staff received competency-based foundational training, there was not a process in place to ensure staff were provided with individual-specific training prior to working with individuals who were at moderate or high risk, and no process was in place to ensure PNM supports for those individuals were provided only by staff who had received the necessary training.

PNMPs were not consistently comprehensively reviewed by the IDT during the annual ISP planning meeting (or at other times). At several Facilities, there was a lack of integration of the PNMT recommendations into the ISP and Integrated Health Care Plan (IHCP). In many cases, recommendations and actions identified in PNMT assessments were not adequately documented in ISPs, IHCPs, and Integrated Risk Rating Forms.

Measurable outcomes related to baseline clinical indicators were not routinely available and tracked. Implementation of individuals' IHCPs did not consistently generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Aspiration trigger data sheets did not consistently have individual-specific triggers, and aspiration pneumonia trigger data sheets were not completed as required each day or, if completed, were not always monitored by nurses, as required.

Although positioning had improved at several Facilities, instances of poor positioning or of lack of implementation of positioning strategies in the PNMP continued to occur.

As noted above, two Facilities had developed protocols or processes related to return to oral eating. Other Facilities did not have appropriate evaluations to determine the medical necessity of enteral feeding or did not consistently do the evaluations.

At some Facilities, there were not clear criteria for referring individuals to the PNMT for assessment, or individuals who met criteria were not consistently referred.

Systemic Recommendations

- Facilities should improve their monitoring to ensure staff implement PNMPs.
- All Facilities should implement systems to ensure individuals who are at increased risk receive services only from staff who have been trained in individual-specific strategies.
- State Office should work with Facilities to develop and implement systems for determining the efficacy (i.e., effectiveness) of PNMPs and PNMT plans/recommendations. Specifically, individuals' IHCPs need to include goals and objectives that, when implemented, generate individual-specific clinical data to substantiate individuals' progress or lack of progress.
- Further work is needed to assist teams and therapists to develop plans (e.g., skill acquisition plans for safe dining, therapy plans for return to oral eating) that clearly establish a goal or objective, and, as appropriate, action steps that detail expected timeframes, and persons responsible.

SECTION P: Physical and Occupational Therapy

Section P addresses physical therapy (PT) and occupational therapy (OT) services and includes four subsections regarding requirements for conducting occupational and physical therapy screening of each individual residing at the Facility; ensuring individuals identified with therapy needs receive a comprehensive assessment; developing, as part of the ISP, a plan to address recommendations of the integrated physical and occupational therapy assessment with individualized interventions; ensuring staff are trained to implement plans; implementing such plans; monitoring and addressing the status of individuals, their physical supports and adaptive equipment, the treatment interventions (including those that address nutritional management needs); and the implementation of interventions.

Substantial progress had been made in addressing several requirements of this Section. This was especially true regarding improvements in timeliness and comprehensiveness of assessments, and in the monitoring of adaptive equipment. One Facility achieved substantial compliance with two subsections; and six Facilities achieved substantial compliance with one subsection.

Areas of Substantial Compliance and/or Progress

Six Facilities had been rated in substantial compliance with development of timely and comprehensive OT/PT assessments. Seven additional Facilities had demonstrated significant progress.

There was improvement in provision of therapies provided directly to individuals by OTs and PTs.

Most Facilities had effective monitoring of cleanliness and condition of wheelchairs and other adaptive equipment, and made repairs on a timely basis when needed.

As reported with regard to Section O, all Facilities required newly hired staff to complete competency-based training on essential aspects of physical and nutritional management before beginning to work with individuals. This training included mealtime practices and positioning. A few Facilities had processes to ensure staff were provided with individual-specific training as needed.

Two practices at Austin SSLC were identified as best practices. The Facility therapists collaborated with the State Office and Facility Administration to add four additional Orientation and Mobility Specialists. This expanded capacity to provide services, such as assessments, training, and engagement for individuals who were visually impaired and/or hearing impaired. A training curriculum was developed and implemented to provide training to clinical staff and direct support professionals in Sighted Guide and Hand-Under-Hand techniques. Staff from numerous departments worked together to develop a work/day program center to meet the unique needs of individuals with visual and hearing impairments.

Obstacles to Substantial Compliance

At most Facilities, recommendations from OT/PT assessments were not integrated into individuals' ISPs. Consistent integration of recommendations was reported at one Facility.

Identification and tracking of measurable and functional outcomes remained a significant weakness.

Many services provided by OTs and PTs should include acquisition of skills as part of therapy and to enhance function. Recommendation or development of skill acquisition plans (SAPs) was not common. OTs, PTs, and IDTs should identify skill acquisition that would be relevant and should then develop and implement SAPs. This had begun to occur at some Facilities.

Attendance by OTs and PTs at ISP annual planning meetings was variable. Disciplines required to attend the ISP planning meeting were determined at the ISP preparation meeting held approximately 90 days prior to the ISP annual meeting. Consistent OT and/or PT attendance, when required (and justification when not required for individuals with PNMPs or other OT/PT needs), was reported for approximately half the Facilities. Lack of consistent attendance was reported for the other half.

There were examples in which individuals who had experienced a change in status either did not have assessment updates and/or consultations completed, or those that were completed did not include the necessary elements.

For individuals who were receiving services provided directly by an OT or PT (as opposed to those planned or monitored by OTs and PTs, such as positioning plans in PNMPs), timely implementation of comprehensive therapy plans, that included listing of measurable and functional outcomes to be tracked, were consistently provided at two Facilities. At several Facilities, therapy plans were provided, but they were not comprehensive. At three Facilities, therapy plans were implemented, but were not consistently implemented timely. Comprehensive monthly progress notes were completed at three Facilities. At most Facilities, such notes were generally completed monthly, but were not comprehensive (for example, they might have indicated whether services were provided, but not assessed progress).

For services provided indirectly, there was little evidence of monitoring of effectiveness. As reported with regard to Section O, there were problems with monitoring of implementation of PNMPs.

Most Facilities did not have comprehensive policies for this section. Although policies existed, numerous important elements were not addressed.

As reported with regard to Section O, although staff received competency-based foundational training, there was not a process in place to ensure staff were provided with individual-specific training prior to working with individuals who were at moderate or high risk.

Systemic Recommendations

- Further work is needed to assist teams and therapists to develop plans (e.g., for direct therapy, return to oral eating.) that clearly establish a goal or objective, and, as appropriate, action steps that detail expected timeframes, and persons responsible.
- When skill acquisition training is determined to be appropriate, SAPs should be developed and implemented.
- Monitoring of effectiveness of interventions must be carried out consistently, must include measures of progress or regression, and must involve addressing lack of progress as needed.

SECTION Q: Dental Services

Section Q.1 requires Facilities to provide individuals with adequate and timely routine and emergency dental care and treatment. Section Q.2 requires Facilities to develop and implement policies and procedures related to the timely and comprehensive provision of assessments and dental services; maintain dental records sufficient to inform the IDT of the specific condition of the individual's teeth and necessary dental supports and interventions; use desensitization programs and other strategies to minimize use of sedating medications and restraints; develop and implement strategies to overcome individuals' refusals to participate in appointments; and track and assess the use of sedating medications and restraints. At most Facilities,

progress had been made with both provisions, but one of the 13 Facilities (8%) was in substantial compliance with Section Q.1, and no Facilities (0%) were in substantial compliance with Section Q.2.

Areas of Substantial Compliance and/or Progress

With regard to Section Q.1, at some Facilities, oral hygiene ratings were improving. Of note, because the State Office had not instituted a system for ensuring the reliability of these scores between Dental Department staff at each Facility and/or across the Facilities, the data should be used cautiously. Even so, these changes were likely due to improvements in the care and treatment Dental Departments and IDTs were providing. For example, at many Facilities, individuals were consistently completing annual dental exams and more frequent dental appointments (i.e., two or more times a year).

At some Facilities, the dental assessment reports were now comprehensive and included assessment of periodontal disease, caries, oral hygiene, and behavior related issues. These changes resulted in improvement in the information that was available to IDTs regarding the status of the individuals' oral health. Some Facilities had oral health care plans that included necessary instructions for living area staff, and in some cases, included monitoring of oral health care status, but not of oral health plan implementation. At some Facilities, work had been done to improve the provision of suction toothbrushing for individuals at risk for aspiration pneumonia or respiratory compromise, but this was not consistent across Facilities, and mechanisms sometimes were needed to determine its efficacy.

Facilities generally demonstrated effective follow-up in response to restorative dental needs. Dental radiography was completed in a timely manner for individuals at most Facilities. At a number of Facilities, documentation of care was improved. The progress notes were typed in subjective, objective, assessment, and plan (SOAP) format and contained adequate information. Some Dental Departments responded rapidly to emergencies.

At many Facilities, individuals were being assessed for use of sedation and total intravenous anesthesia (TIVA)/general anesthesia when needed to complete more extensive work, such as restorations and extractions. As some Facilities, progress had been made in that clinicians met to discuss risk, benefits, and the options available. Some Facilities had begun to provide close monitoring of individuals during and after TIVA anesthesia for dental services. At some Facilities, for those individuals with significant dental disease, who also had severe, comorbid medical conditions, an arrangement was made to have dental care provided at a local area hospital.

With regard to Section Q.2, at some Facilities, refusals and problems related to poor oral hygiene were being addressed through collaborative efforts of the Behavioral Health Services, Active Treatment, and Dental Departments. Similarly, at some Facilities, interdisciplinary efforts had been made to decrease the number of missed appointments with good success.

Of note, some Facilities had effective systems for evaluating the quality of dental treatments. This was important because it allowed these Facilities to self-identify areas requiring improvement, and to act on such information. For example, some Facilities used current and accurate databases to track the main aspects of dental care, and had used this information to improve the dental services.

Obstacles to Substantial Compliance

With regard to Section Q.1, many individuals across the system continued to have poor oral hygiene ratings, and often, effective plans were not in place to change this outcome. At some Facilities, some individuals underwent general anesthesia routinely for preventive cleaning and x-rays, and plans were not in place to reduce the severity of periodontitis in those who had a cleaning under general anesthesia. The lack of programming to improve compliance in toothbrushing, oral hygiene exams, and cleaning indicated a failure to provide basic preventative dental care and services to this population. At other Facilities, significant delays occurred in completing annual assessments and/or providing routine dental services to individuals, and the IDTs were not involved in addressing delays related to difficulty in providing services due to interfering behaviors, or other factors, such as obtaining consent.

Some Facilities were still struggling to ensure that dental emergencies were triaged promptly, including documentation of follow-up appointments, and monitoring parameters for nursing and direct support professionals to follow; radiographs were routinely completed or a rationale for not completing them was provided; and ISPs defined risks and benefits of oral and dental health treatments, and the necessary dental treatments and related supports and services, including plans to address the challenges associated with the provision of dental care and ongoing implementation of comprehensive oral health care plans in the residences. For example, in IRRFs, teams sometimes indicated dental supports were adequate for individuals having recently undergone extractions or having poor oral hygiene ratings. When applicable, the Dental Departments needed to assist the IDTs in identifying additional supports for these individuals who had undesirable outcomes in oral health.

Some Facilities still needed to identify reasons for missed appointments, such as illness, other medical appointments, or hospitalizations, behaviors, and system issues, such as staff shortages, communication issues, and lack of transportation, and take steps to reduce these obstacles to the extent possible.

Problems were noted at some Facilities with regard to a lack of medical or dental policies in place that broadly addressed the use of sedation and anesthesia, such as the level of sedation that was permissible at the Facility and the selection of individuals. In addition, some Facilities had not yet developed and/or implemented a clinically effective mechanism to ensure close monitoring of all individuals following TIVA and other forms of anesthesia, including pretreatment oral sedation.

A significant obstacle to substantial compliance with Section Q.2 was the identification of individuals requiring desensitization or other strategies to reduce the need for dental restraint, including the use of pretreatment sedation (i.e., oral sedation, intravenous sedation, and general anesthesia). Few Facilities had implemented successful plans for individuals that would otherwise be resistant or uncooperative, and even at Facilities where this had occurred for some individuals, additional individuals needed them. For example, many Facilities still needed to develop a program to help individuals become accustomed to the dental milieu, and associated oral treatments, and/or ensure that the program was offered at a frequency that would assist the individual to overcome challenges related to the dental office experience. Facilities also needed to develop measurable goals/objectives to clearly determine whether or not the programs were effective.

A number of Facilities did not have complete sets of dental policies. In addition to concerns noted above regarding the use of anesthesia, some Facilities had insufficient policies and procedures for oral hygiene and suction toothbrushing.

Systemic Recommendations

- The State Office should institute a system for testing the reliability of oral hygiene rating scores between Dental Department staff at each Facility and/or across the Facilities.
- Individuals with moderate to severe periodontitis should have a desensitization/behavioral program with continuous monitoring, service objectives for staff to assist with brushing their teeth, and/or a plan for the Dental Department to teach staff and individuals better toothbrushing skills, with training occurring both in the residence and in the dental chair.
- Each Facility should implement a dental quality assurance process to assess provision of dental services, including efficacy of dental services and care following a dental procedure.

SECTION R: Communication

This Section addresses the provision of speech and communication therapy services. Four subsections address requirements for professional staffing; implementation of a screening and assessment process to identify individuals who would benefit from use of augmentative and alternative communication (AAC) systems, including integration with behavioral supports or interventions; specification in the ISP of information on how each individual communicates, and development of functional assistive communication systems; and development and implementation of a monitoring system to ensure the communication provisions of the ISP address individuals' communication needs and are available.

Continuing improvement was noted. Some processes showed improvement at some Facilities, but not at others. Staffing had improved at many Facilities. A particular area of progress was the timely and comprehensive completion of communication assessments. One Facility had achieved substantial compliance on two subsections; and seven Facilities had achieved substantial compliance with one.

Areas of Substantial Compliance and/or Progress

Seven Facilities achieved an acceptable overall level of speech and language staffing to meet appropriate caseload levels given the acuity of the individuals served. Turnover and vacancies remained problematic at some Facilities. At one Facility, all positions were filled, but caseloads remained excessive. Therapists were appropriately licensed and certified. Therapists provided evidence of completing relevant continuing education.

There was significant improvement in timeliness and comprehensiveness of assessments and updates. This was true for both annual assessments and updates prepared in advance of the ISP annual planning meeting and for assessments provided for individuals who were admitted to the Facilities. At some Facilities, the improvements in comprehensiveness had occurred relatively recently. Although this was an area of improvement, only six Facilities met policy requirements for timeliness of annual assessments and updates and 12 Facilities continued to need improvement in comprehensiveness.

Six Facilities consistently implemented processes for collaboration between behavioral services and speech communication staff in addressing problematic behaviors for individuals with communication difficulties. Most of the remaining Facilities had processes in place, but these were not yet consistently implemented. Nevertheless, this was a significant improvement compared to the baseline monitoring reviews. Specific examples were found at several Facilities of excellent collaboration resulting in communication SAPs for individuals with behavioral concerns and communication deficits. Nonetheless, there were Facilities at which there were few plans showing collaboration, few indications of collaboration (such as participation in program review or planning meetings), and little indication of a process to improve collaboration. Thus, although this was an area of general improvement, there was not improvement across all Facilities.

Competency-based training on communication was provided to new employees prior to working with individuals. Of nine Facilities for which there was review for individual-specific training, four had such training fully in place, while two others did not provide training for all individuals in the sample.

Ten Facilities had comprehensive policies or guidelines for communication services in place. Two additional Facilities had policies that contained most, but not all, expected elements.

Obstacles to Substantial Compliance

As noted above, although there has been significant improvement, further improvement was needed in both timeliness and comprehensiveness of communication assessments.

Integration of communication strategies and therapy plans into ISPs remained variable.

At some Facilities, there were few communication plans and SAPs in place for individuals with communication needs. Even when plans were developed, they were not consistently implemented when opportunities for increased communication were available. When individuals were learning to use Alternative and Augmentative Communication (AAC) devices, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress.

The provision and use of AAC devices provided for individuals varied considerably across Facilities. At some Facilities, there were many devices; at some of these Facilities, training of individuals in use of these devices was evident. However, these devices were rarely available in the settings where they would be used, and the Monitoring Teams' observations confirmed their use at three Facilities. The plans for use of individual-

specific AAC devices, along with training provided to the individuals, needs to be specified in the ISP with goals or objectives.

General use AAC devices were present at most Facilities, with variability in terms of the number available. General use devices, however, were observed in use at only three Facilities. It should be noted that the general use devices had functional uses, and use of those devices by individuals would have been appropriate. Facilities should ensure that individuals are prompted to use these devices, and should also ensure that training on use of the devices occurs for individuals and for staff.

At most Facilities, few individuals participated in direct communication interventions provided by speech clinicians. The number participating ranged from one to 46 per Facility. Thus, there did not appear to be a consistent process to identify who would benefit from direct communication interventions. For those who did participate, programs at six Facilities included measurable goals and objectives that would permit assessment of progress. Monitoring of implementation and progress was limited, and recommendations for revisions to interventions were not consistently made in response to progress or lack of progress.

Systemic Recommendations

- Communication interventions should include measurable goals and indicators of progress. Outcomes of interventions should be regularly evaluated and changes made based upon these determinations.
- Facilities should develop a process to identify who would benefit from direct communication interventions.
- Facilities should ensure AAC devices are individualized and used. When general use AAC devices are available, staff should be trained on who is to use them, and how and when they are to be used. Monitoring should be in place to determine whether they are being used, and training provided to staff as needed.
- SAPs for language and communication were few and should be expanded. Communication strategies and programs should be integrated into ISPs.
- For Facilities that had not substantially complied with Section R.1, State Office should work with the Facilities to identify the barriers to maintaining sufficient SLP staffing and address them.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs

This section's provisions focus upon two areas. One is the way in which the Facilities teach new skills, maintain skills already in individuals' repertoires, teach skills in the community, and manage the writing, implementation, and modification of skill training programs. The second area looks at the level of individual engagement in activities throughout the day. None of the Facilities achieved substantial compliance with any of the provisions of this section, however, much progress had occurred in those Facilities where one or more staff took responsibility for overseeing these aspects of service and support.

Areas of Substantial Compliance and/or Progress

In every Facility, there were improvements in the quality of skill acquisition programs (SAPs). SAPs now contained more of the components that one would expect to find in a SAP, such as a rationale, instructions for teaching, documentation requirements, and plans for maintenance and generalization of skills learned. There was some improvement in ensuring that SAPs were chosen based upon individual preferences and needs.

There were other examples of progress and improvement seen at some, but not all Facilities. These included ensuring that SAPs were implemented correctly, developing SAPs for individuals to allow dental procedures to be done, and increasing the number of communication and language related SAPs.

Most improvement occurred in those Facilities that appointed a manager or a team of staff to address improving SAPs, engagement, and community activity. Examples included work groups to improve the way SAPs were created and managed, creating a SAP development curriculum, and training more and more staff. A Behavioral Health Services staff member was added to the SAP team and there was better collaboration between Behavioral Health Services staff and SAP developers in many Facilities. A very promising practice of a peer-review-style SAP committee was initiated at about half of the Facilities.

Few individuals were competitively employed in the community, though some Facilities reported small increases. Similarly, few individuals were working on SAPs in the community, but some Facilities had made efforts to conduct training during already-scheduled outings.

In about half of the Facilities, there were increases in the percentage of individuals who were engaged in activities during observations made by the Monitoring Teams. One Facility established engagement goals for each residential unit based upon the individuals who lived in those homes. One Facility established active treatment daily plans to replace non-functional daily schedules.

Most Facilities struggled with providing meaningful day program activities and with having individuals attend day programming. Unfortunately, addressing this was not a statewide priority at this time, however, many Facilities began focusing on improving day program quality and day program attendance. Examples included collecting and sharing attendance data with senior management; initiating day program attendance projects; looking at scheduling and transportation; creating specialized day programming, such as for individuals with visual impairments, autism, or mobility needs, and special programs for elderly individuals; and programming that allowed individuals to switch between day habilitation and work activities. A best practice was found at El Paso SSLC where day program staff established relationships with a variety of community day centers and other sites to provide integrated day opportunities that almost every individual attended during the week.

Obstacles to Substantial Compliance

The ISP, Personal Focus Assessment, and other assessments were not routinely used to identify or guide decisions about what skills to teach. Direct support professionals sometimes reported that skill acquisition plans were non-functional or addressed skills the person already had. In other words, individualized assessments of preference, strengths, skills, and needs did not seem to impact the selection of all skill acquisition plans. This was identified as a problem at almost every Facility.

Though there were improvements, the content of SAPs was not complete. SAPs continued to lack several components essential to effective teaching: behavioral objectives seldom included objectively defined and measurable goals, and staff instructions were unlikely to result in correct and consistent program implementation. In many circumstances, training opportunities were inadequate, scheduled to occur once per day or less. Plans also lacked strategies for expanding the individual's ability to use the targeted skills outside of the specific training exercise.

More work was needed to ensure SAPs were implemented correctly, as often as required, and had data accurately recorded.

Although some Facilities showed progress, overall, most Facilities needed to improve the way SAPs were used to support individuals who were refusing routine dental/medical exams, and who had communication needs.

Community-based skill training occurred infrequently and was absent for most individuals at almost every Facility. There were no established Facility goals or criteria for the frequency and quality of individuals' participation in community activities, community-based training, or employment.

Although some individuals were employed off-campus either competitively or in enclaves (i.e., the State indicated that in April 2014 this number was 113, which represented approximately 3% of the individuals who lived at SSLCs), many individuals that could have been employed were not, and, moreover, few opportunities even existed.

Every Facility struggled with creating environments in which individuals would be engaged in meaningful and interesting activities. Engagement remained quite limited. The dignity of the individual was not always considered, as adults were often observed seated or lying on the floor of their homes. Activities were often the same from one setting to another with little consideration of individual interests. Apart from vocational settings and some day programs, minimal engagement was observed.

There was a need to operationalize the definition of individual engagement, track engagement across all treatment areas, review trends, and establish acceptable levels of engagement. Engagement targets for each home and day program site should be determined and stated. Concerns remained with the manner in which most Facilities were collecting their own data on engagement. Facility tools usually used a long interval (e.g., three to five minutes) and recorded if engagement occurred at any time. This resulted in Facilities scoring higher rates of engagement than the Monitoring Teams found. A more valid and reliable method is described in each of the Monitoring Team reports.

Systemic Recommendations

- State Office should offer Facilities robust training and/or mentoring on the development, implementation, and evaluation of quality SAPs.
- Staff responsible for the development and oversight of SAPs should be trained to competency. Training and oversight of the process should be the responsibility of Behavioral Health Service BCBAs (as exemplified by the Monitoring Teams' use of BCBAs to monitor this provision), and/or special educators with proven experience in developing teaching plans.
- State Office should establish standards for staff training and management of staff performance in implementing SAPs.
- State Office should provide Facilities with assistance and direction in developing meaningful day activities and day programming.
- Habilitation/training should occur throughout the day, via both formal and informal means.
- State Office should increase expectations for community training/skill acquisition, especially within the ISP.
- Working with State Office, Facilities should make community-based paid employment a more readily available option for individuals.
- Facilities should set engagement goals and work towards achieving them.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs

The 17 subsections of Section T require the State and Facilities to determine whether or not individuals could be supported in more integrated settings, encourage individuals and their guardians to consider transition to the most integrated setting, educate them about options, identify and address obstacles to referral and transition, and for individuals transitioning to the community, develop, implement, and monitor comprehensive Community Living Discharge Plans (CLDPs), and take action when CLDPs are not fully implemented. Section T also includes reporting, as well as quality assurance requirements.

Facilities had made progress in a number of areas, and all Facilities had achieved substantial compliance with some of the subsections. None of the Facilities had obtained substantial compliance with all subsections of Section T.

Since the Settlement Agreement's inception, a number of individuals transitioned to the community. For many individuals, these transitions were successful, their lives were improved, and they and their families were very satisfied. Greater contact with family and more opportunities for independence and integration were some of the positive outcomes experienced by individuals. However, as is discussed in more detail below, Facilities still did not have sufficient transition planning and implementation processes, and community supports for individuals with complex needs were lacking. As a result, a number of individuals' transitions had been disrupted or had potential to be unsuccessful.

Areas of Substantial Compliance and/or Progress

Section T.1.a requires the State to take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account

the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. On a positive note, none of the transitions to the community the Monitoring Teams reviewed were done when an individual or his/her guardian was opposed. Transitions often were occurring at a reasonable pace (i.e., within 180 days of referral), although some significant delays occurred, particularly for individuals with more complex needs. However, as is discussed below, no Facility was in substantial compliance with this subsection, and significantly more work was needed.

Section T.1.c and its three subparts, as well as Sections T.1.d and T.1.e relate to the development of CLDPs, and the confirmation of pre-move required supports. Regarding Section T.1.c.2, 12 Facilities (92%) were substantially compliant with including names/positions responsible and dates due for the action steps included in CLDPs. Ten Facilities (77%) were consistently reviewing CLDPs with the individual and his/her guardian and, thus, were in substantial compliance with Section T.1.c.3.

Every six months, Section T.1.h requires Facilities to submit Community Placement Reports to the Monitors and United States DOJ. All 13 Facilities (100%) were in substantial compliance with this provision.

Section T.2.a requires Facilities to use a standard tool to conduct post-move monitoring visits within 7-, 45-, and 90-day intervals following the individual's move to the community to assess whether supports called for in the individual's CLDP are in place. Section T.2.b allows the Monitoring Teams to observe a sample of the post-move monitoring visits to assess their quality. Seven Facilities (54%) were in substantial compliance with Section T.2.a, and nine out of 12 (75%) (i.e., one Facility was not rated) were in substantial compliance with Section T.2.b. Facilities generally were completing timely post-move monitoring visits. Although over time, the State had modified the standard tool Facilities used, it currently included the necessary components, including an expectation that Post-Move Monitors summarize the evidence they review to support their conclusions about the existence of supports teams had included in CLDPs. At times, Facilities involved clinical staff in the monitoring process to evaluate specific supports. In instances in which problems were noted, Facilities often took action, and remained involved with individuals even past the 90-day post-move monitoring period.

Section T.4 relates to alternate discharges for individuals who, for example, are transferred to other SSLCs or are admitted for short-term respite services. Four SSLCs did not have recent alternate discharges. For the remaining nine, six (67%) had achieved substantial compliance. The other three had not provided adequate post-discharge plans of care that would assist the individual to adjust to the new living environment.

Obstacles to Substantial Compliance

As noted above, Section T.1.a is an overarching provision that requires the State to take action to encourage individuals at the SSLCs to transition to more integrated settings in the community, while taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. Section T.1.g requires each Facility to gather and analyze information related to obstacles to individuals' movement to more integrated settings, and to produce an annual comprehensive assessment of obstacles. Using the aggregate data from Facilities, DADS State Office is then to take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, including as necessary and appropriate seeking assistance from other agencies or the legislature.

On 3/27/14, DADS State Office issued its Annual Report: Obstacles to Transition Statewide Summary. Although the obstacles data remained unreliable, it showed that some of the most significant systemic issues that negatively impacted referrals and transitions were gaps or perceived gaps in supports in the community for individuals with complex behavioral, and/or medical and physical and nutritional management needs, as well as LAR reluctance to transition individuals to the community. Another significant obstacle was the lack of vocational supports, particularly for individuals with the need for behavioral supports.

In its annual report, DADS included a list of strategies and actions, but did not thoroughly address some of these most frequently cited obstacles. Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at

Austin SSLC, and the report did not include updates on last year's strategies. During recent discussion with State Office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies and/or to ensure there were strategies to address the most-often identified obstacles to referral and to transition. Until the State makes significant improvements to the community system's ability to support individuals with complex needs, it will be difficult for the State and Facilities to comply with these requirements of the Settlement Agreement.

Although progress had been made, no Facility (0%) was in substantial compliance with Section T.1.b or its three subparts that require Facilities to:

1) Develop a policy related to the most integrated setting (T.1.b). DADS State Office recently revised the related policy, and it contained many of the necessary components, but not some key ones;
2) Identify and develop plans to overcome obstacles to referral and transition to the most integrated setting (T.1.b.1). Teams were not thoroughly identifying obstacles and developing individualized plans to overcome obstacles to referral or transition. As a result, State Office still did not have a complete list of the obstacles;
3) Provide education about options to individuals and their guardians (T.1.b.2). Facilities consistently offered some educational opportunities, such as provider fairs, community tours, and presentations at self-advocacy and family association meetings. A major issue was the lack of plans to provide individualized education about options to individuals and their guardians to address individuals' specific needs or specific questions that they or their guardians had. At some Facilities, Admissions Placement Department staff and State Office Transition Specialists were beginning to provide more individualized education, and this should be expanded; and
4) Assess individuals' appropriateness for transition to a more integrated setting (T.1.b.3). All 13 Facilities were using the State Office's process for making team determinations about referrals, which required each professional discipline team member to make a recommendation, these team members to make a joint recommendation to the individual and/or guardian, and then the entire team to make a decision. However, often teams did not provide adequate justifications for their decisions, particularly when all assessments indicated the individual could be supported in a more integrated setting, and/or reconciliation between the various team members' written recommendations was not documented. Although at a number of Facilities, referrals had increased, at most Facilities, many additional individuals that should have been referred were not.

Five Facilities (38%) were in substantial compliance with Section T.1.c, which requires timely initiation of the CLDP process, updating of the plan throughout the transition process, and ongoing team involvement. Often, at Facilities that had not achieved substantial compliance, teams were not documenting ongoing updates to the CLDPs, and/or the involvement of the Local Authority. No Facility (0%) was in substantial compliance with Section T.1.c.1, because teams did not clearly identify a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition, including, for example, training community provider staff; collaborating with community clinicians, residential and day program staff, and Local Authority staff; and/or assessing environments in which individuals would be living or working.

As Section T.1.b.1 requires, at no Facility (0%) had teams developed comprehensive ISPs defining the protections, supports, and services individuals needed. This was an essential and still missing piece that stymied teams' ability to develop quality CLDPs, as required by Sections T.1.c.1, T.1.d, and T.1.e. Although improvements were seen with regard to the array of pre- and post-move required supports included, CLDPs continued to lack a number of important supports. As a result, individuals transitioning to the community were potentially at risk. With regard to Section T.1.d, with which one Facility (8%) had achieved substantial compliance, some assessments developed in preparation for CLDP meetings had begun to include more detailed recommendations. Often though, the discharge assessments did not address the specific home, day, and employment sites into which each individual would move. Even when more detailed recommendations were offered, teams often did not translate them into necessary pre- and post-move required supports, nor did prescribed supports consistently provide sufficient detail to ensure appropriate implementation and/or monitoring.

None of the Facilities (0%) were in substantial compliance with Section T.1.f that requires Facilities to implement quality assurance processes related to the development and implementation of CLDPs. Although monitoring activities were occurring, they generally were not producing valid results, because State Office and the Facilities still lacked an understanding of what comprehensive CLDPs entailed, including the staff monitoring them.

In addition, although Facilities were now conducting reviews of poor outcomes that had the potential to disrupt community transitions, they most often were not conducting root cause analyses, critically assessing what was missing from the CLDPs, and using this information to improve future CLDPs. Although many individuals transitioned without incident and were doing well, unfortunately, across the 13 Facilities, a number of individuals experienced various outcomes that disrupted, or had the potential to disrupt, their transitions. These were likely due, in part, to transition planning that did not identify significant support needs and/or important transition activities, as well as to gaps in community services, such as inadequate supports for individuals with complex medical and/or behavioral health needs. Some examples of poor outcomes were police contact and psychiatric hospitalizations, arrests and jail time, returns to the Facilities, medical hospitalizations, and, in some cases, deaths.

It is important to note that the Facilities only conduct post-move monitoring for 90 days, and with the Monitors' prompting, the State began to request information about potentially negative outcomes for a year. The continued lack of strong transition planning is concerning because the goal of transition planning should be the long-term success of individuals' transitions to the community.

Regarding Sections T.2.a and T.2.b, as noted above, close to half of the Facilities remained in noncompliance. The most significant remaining issues were the need for some Facilities to conduct and/or document more thorough reviews, and for Facilities to take action to remediate issues identified, including involving State Office or Local Authorities, as appropriate.

Systemic Recommendations

- State Office should develop and implement comprehensive strategies to address actual and/or perceived gaps in the community system, particularly to address the needs of individuals with complex behavioral and/or medical needs, vocational supports, and the reluctance of LARs to agree to referrals and transitions to the community.
- Given that to-date the State has not produced CLDPs that fully address individuals' needs as well as preferences and it remains unclear that the internal capacity exists to do so, the State should hire consultants to work with all Facilities on the development and implementation of CLDPs that will better assure that individuals have the protections, supports, and services they need to successfully transition to the community.
- The State should focus its efforts on a more organized system of quality assurance, including critical review of outcomes that potentially disrupt community transitions, and use of the resulting information to improve transitions and the outcomes for individuals.

SECTION U: Consent

Section U is an area in which very limited progress was made. Section U relates to consent, and specifically, the development and implementation of a process to determine individuals' functional decision-making capacity, development of a prioritized list of individuals needing guardians, and reasonable efforts to identify guardians. Initially, this was an area of low priority because, for individuals lacking guardians or capacity to make decisions, Facility Directors are authorized by state law to make decisions. However, this represents a conflict of interest, given that the Facility Directors supervise staff responsible for recommending and implementing decisions guardians typically would make (e.g., medical decisions). The Facilities largely have depended on State Office to provide guidance and resources, but at this juncture, little advancement has occurred. None of the Facilities were in compliance with either of the two subsections.

Areas of Substantial Compliance and/or Progress

Section U.1 requires each Facility to maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision, and prioritize such individuals according to specific factors, including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.

Although many Facilities were maintaining prioritized lists, they were not based on standardized processes to accurately determine individuals' functional capacity to render decisions, or their priority need for a guardian. However, IDTs at some Facilities were holding more in-depth discussions at the annual ISP meetings to determine if individuals had the ability to make decisions and give informed consent. At one Facility, the Guardianship Coordinator met with teams to discuss the use of some existing assessments, such as the psychological, psychiatric, and speech/communication assessments. One Facility had a novel internal protocol for assigning priority that drew from the Integrated Risk Rating Form process. These were good initial efforts that would benefit from additional structure.

For some individuals, some Facilities were taking steps to identify alternatives to guardianship, which is the most restrictive form of decision-making assistance. For example, some Facilities were identifying individuals that would benefit from an advocate and taking steps to identify volunteer advocates. All Facilities had active self-advocacy groups, and some of these groups had staff advisors that provided opportunities to expand individuals' knowledge about their right to make decisions, and to practice the related skills.

Section U.2 requires Facilities to use the prioritized lists, and make reasonable efforts to find guardians for individuals that need them. In early 2012, State Office issued a policy on Guardianship, which required Facilities to develop Guardianship Committees. All Facilities had Guardianship Committees, and in addition to assisting in prioritizing the list of individuals needing guardians, some of them were involved in attempting to identify guardianship resources. For example, some Guardianship Committees had members from the community that were aware of resources, and others were involved in developing brochures describing the need for, and process to become, a guardian. Some Facilities had identified potential funding resources for the guardianship application process, such as one Facility that had a grant from the Family Association, and others that were using earned income from individuals' social security funds. Others identified attorneys that offered reduced rates. One Facility had a strong relationship with the local probate court, and this had a number of benefits to assist in obtaining and maintaining guardians for individuals that needed them.

Obstacles to Substantial Compliance

As noted above, State Office had not provided Facilities with a standard process, using objective data to screen/assess individuals' ability to make and communicate a variety of decisions related to their health and welfare, with or without support. A draft decision-making tool State Office recently developed as part of the Rights Assessment was not adequate. In April 2014, the Monitors provided comments to the State on the draft tool.

At a number of Facilities, efforts had resulted in guardians being appointed for individuals, with other individuals in some phase of the process. However, this was being done without a good process to even determine who might need a guardian, and who could make some or all decisions with other less restrictive alternatives to support them. Without such delineation, courts tended to appoint full guardians.

Although individuals at some Facilities had access to nonprofit guardianship agencies, most Facilities had trouble identifying viable guardianship or advocacy resources for individuals needing them. At most Facilities, staff were making efforts to identify family members or others with whom individuals had relationships to petition for guardianship. It will be essential that the State identify adequate resources to address this need.

Systemic Recommendations

- State Office should develop a process for screening individuals' functional decision-making capacity. Such a process should: a) be based on current assessment results (i.e., data driven) and should state the specific assessments and results that influenced the decisions, and not just consist of teams' subjective review; b) reflect specific areas of decision-making in which actual decisions need to be made (e.g., surgery versus the addition of a new medication); c) specifically address individuals' ability to make informed decisions as well as communicate their decisions; and d) identify alternatives to guardianship, which is the most restrictive alternative. State Office should: a) hire a consultant with expertise in this area; and/or b) develop improved guidelines for teams to complete the Rights Assessment. Such guidelines should be detailed and address all of the above areas.
- State Office should identify resources for guardians and advocates for individuals that need them across the State, including, where appropriate, identifying or providing funding for independent nonprofit guardianship agencies and/or funding to assist potential guardians to complete the application and appointment process.

SECTION V: Recordkeeping and General Plan Implementation

This Section covers two distinct areas. Sections V.1, V.3, and V.4 relate to recordkeeping and the use of records to make decisions. Section V.2 relates to the development and implementation of policies needed to implement all requirements of Part II of the Settlement Agreement, which establishes the requirements the Facilities must meet. Section V.1 requires the Facility maintain a unified record for each individual. Section V.3 requires quality assurance procedures that include random reviews of records and corrective action to limit possible reoccurrence of deficiencies. Section V.4 requires that the Facility routinely utilize records in making care, medical treatment, and training decisions. Two Facilities achieved substantial compliance with two of the subsections; four Facilities achieved substantial compliance with one.

Areas of Substantial Compliance and/or Progress

All Facilities maintained a Unified Record that included an Active Record, which was a comprehensive record with the most recent documents, such as assessments, treatment plans, and progress notes/reports; an Individual Notebook that accompanied the individual or was maintained in program areas with information, such as service plans and instructions; and a Master Record that included historical and legal information. All Facilities had a system providing computer access to documents used in the interdisciplinary planning process, and there was movement into some aspects of electronic recordkeeping.

The organization, quality, and usefulness of the Unified Records had improved significantly since the baseline observations, and while improvements were still needed, some Facilities had made good progress. DADS had developed, and Facilities implemented, a standardized table of contents to ensure required documentation was filed and available. Improvement occurred in the presence of current documents in the records. At several Facilities, at least 90% of documents were present and current. Improvement had also occurred at most Facilities in meeting the requirements of Appendix D, such as filing in correct order, using legends when documents required initials, and signing and dating entries. As noted below, additional improvement is needed.

Twelve Facilities were auditing a minimum of five unified records each month (at least the Active Record and Individual Notebook and, at some Facilities, the Master Record). At 11 of these Facilities, a random sample of records was audited; at one Facility, records were audited for all individuals who had an individual support plan (ISP) annual planning meeting the prior month (resulting in audits of 100% of records annually). One Facility had a random audit process, but had not consistently completed at least five audits per month.

The audits reviewed documents in the Active Record and Individual Notebook to determine whether they were present, current, in the correct location in the record, and met the requirements of Appendix D. They included a process to notify appropriate staff of corrections that needed to be made, or other corrective actions when the record could not be modified. Recordkeeping Department staff followed up to determine whether the required corrections and corrective actions were done. Results provided information for quality assurance/quality improvement review by the Facility to determine whether systemic actions should be initiated. At least three

Facilities had developed spreadsheets or databases to aggregate audit data. For these, data could be reported across the Facility, or by living unit, discipline, individual record, or document.

All Facilities provided staff training on recordkeeping and documentation during new employee orientation. Some Facilities reported having refresher training for incumbent staff.

There was improvement in the availability and, although variable, in the use of data and other information from the records at interdisciplinary meetings. This was frequently the case at meetings of the PNMT, at psychiatric treatment reviews, and at annual ISP planning meetings, but as noted below, there was variability in use of information from the records.

The development of policies at Facilities and at the State level was ongoing. Numerous policies were developed, revised, and implemented. At most Facilities, a process had been implemented to ensure policies were available as necessary to guide implementation of all requirements in the Settlement Agreement, with crosswalks or numbering systems to connect policies with the Settlement Agreement. Only a few policies remained needed at most Facilities.

Obstacles to Substantial Compliance

At most Facilities, improvement was needed to ensure current documents were filed correctly in the records. At some Facilities, there were missing documents, and at others, assessments were not filed timely. At most Facilities, improvements were needed in meeting Appendix D requirements (e.g., legibility, accuracy of information in the records, completeness of the record). In addition, although audits of records provided information regarding errors needing correction, corrections were not made consistently at several Facilities. Some errors were corrected, but reoccurred. Some Facilities had initiated improvement actions to address issues identified, such as assigning supervisory staff at living units and departments with the responsibility for improvements, training staff on Appendix D requirements, such as legibility, and changing responsibility for filing documents, but other Facilities had not taken effective action.

Observations at IDT meetings, including annual ISP planning meetings, found that records were consistently present. Use of data and other information from the records, however, was variable. Although generally improved at many Facilities, there were still many times when available data were not used in making care, treatment, and training decisions. A major issue remained with the accuracy of the data available to teams. One improvement was the addition of data on health and behavioral conditions to the draft Integrated Risk Rating Forms and/or Integrated Health Care forms that teams brought to the annual ISP planning meeting, however, reference to these data and the accuracy of the data were observed to be variable.

Tracking of training required for new and revised policies varied across Facilities. Although some had effective processes in place, others either did not clearly specify who needed training or what kind of training needed to be provided uniformly, or they did not have consistent processes across the Facility to determine who received the required training.

Although Facilities had localized and operationalized most DADS statewide policies, there remained a need for more progress. In some cases, Facilities had simply adopted the statewide policies without making the changes needed to operationalize them. For example, there were cases in which the local policies did not indicate which specific staff positions or departments were responsible to carry out actions required by statewide policy, or how broad requirements, such as training or QA processes would occur at the Facility.

Systemic Recommendations

- The State Office should provide guidance on meeting requirements of Section V.4. This should include efforts to increase the accuracy of data available in the records, implementation of monitoring to verify use of information from records in planning supports and services, and addressing requirements for timely documentation of data.
- The Facilities and State Office should determine the policies remaining to be developed or revised, and make a concerted effort to complete those. Facilities should carefully operationalize statewide policies to ensure implementation practices are clear.

Appendix A
Acronyms

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADA	Americans with Disabilities Act
ADR	Adverse Drug Reaction
ANE	Abuse, Neglect, and Exploitation
BCBA	Board Certified Behavior Analyst
CAP	Corrective Action Plan
CLDP	Community Living Discharge Plan
CPE	Comprehensive Psychiatric Evaluation
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DSM-IV	Diagnostic and Statistical Manual – Revision IV
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ID/DD	Intellectual Disabilities and Developmental Disabilities
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IOA	Interobserver Agreement
IPN	Integrated Progress Note
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
LAR	Legally Authorized Representative
MOSES	Monitoring of Side Effects Scale
OT	Occupational Therapy
PBSP	Positive Behavior Support Plan
PCP	Primary Care Provider
PMR	Protective mechanical restraints
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PT	Physical Therapy
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QAQI	Quality Assurance Quality Improvement
QIDP	Qualified Intellectual Disabilities Professional
QPR	Quarterly Psychiatric Review
SAP	Skill Acquisition Program
SSLC	State Supported Living Center

Appendix B
Compliance Findings Chart

The brief descriptions in the chart that follows summarize the Settlement Agreement requirements. Part II, Sections C through V of the Settlement Agreement should be referenced for the full requirements.

Key
SC = Substantial Compliance
Blank = Noncompliance
NR = Not Rated

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
Section C: Protection from Harm – Restraints														
C.1	No prone restraints. Restraint use only if immediate and serious risk of harm; after a graduated range of less restrictive measures; reasons other than punishment or staff convenience			SC		SC		SC						
C.2	Terminate restraint as soon as individual is no longer a danger to self or others		SC	SC		SC		SC		SC	SC	SC	SC	SC
C.3	Policies governing restraints. Restraint must be least restrictive intervention. All staff must have competency-based training on restraint technique		SC	SC	SC	SC		SC	SC	SC	SC		SC	
C.4	Limit use of all restraints, other than medical, to crisis interventions; strategies to minimize the need for medical restraints developed and implemented									SC				
C.5	Restraint monitoring: Face-to-face assessment (15 min) monitor and document vital signs (30 min)													
C.6	Restraint procedure and documentation: check for injury, opportunity for exercise, eat near meals, drink fluids, use toilet/bed pan.									SC			SC	
C.7	Longitudinal assessment of restraint use for each individual (≥ 3 restraints in rolling 30-day period)													
C.7.a	Review adaptive skills and biological, medical and psychosocial factors			SC		NR						NR	SC	SC
C.7.b	Review contributing environmental factors			SC		NR						NR	SC	SC
C.7.c	Review or perform structural assessments of behavior provoking restraints			SC		NR						NR	SC	SC
C.7.d	Review functional assessment of			SC		NR						NR	SC	SC

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	behavior provoking restraints													
C.7.e	Develop and implement PBSP based on individual's strengths			SC		NR			SC			NR		SC
C.7.f	Individual's treatment plan is implemented with high degree of treatment integrity					NR						NR		SC
C.7.g	As necessary, assess and revise PBSP			SC		NR						NR	SC	SC
C.8	Within 3 business days each Facility will review the use each use of restraint, and take necessary action							SC	SC	SC				SC
Section D: Protection from Harm – Abuse, Neglect and Incident Management														
D.1	Policies and procedures: no tolerance of abuse, neglect, and exploitation (ANE); and staff are required to report	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.2	Implement Incident management policies and procedures:													
D.2.a	Immediately report serious incidents and serious injurious	SC			SC			SC	SC			SC		SC
D.2.b	Take immediate action to protect individuals	SC		SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.2.c	Competency-based training on signs and reporting of ANE	SC	SC	SC	SC	SC		SC	SC	SC	SC	SC	SC	
D.2.d	Notification of obligation to report ANE	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.2.e	Mechanisms to educate and support individuals, Legally Authorized Representatives (LARs) and correspondents to identify and report ANE	SC		SC	SC	SC	SC	SC	SC	SC		SC	SC	SC
D.2.f	Postings on rights including information for reporting violations of rights	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.2.g	Procedures for referring ANE to law enforcement	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.2.h	Reporters not subject to retaliation	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.2.i	Audits to determine that significant injuries are reported for investigation					SC	SC	SC		SC	SC	SC	SC	SC
D.3	Timely and thorough investigation of ANE, death, theft, serious injury and other serious incidents, including:													
D.3.a	Investigators are qualified; trained in working with people with ID; outside the direct line of supervision	SC		SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.3.b	Cooperation with outside entities conducting investigations	SC		SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.3.c	Coordinate investigations with law enforcement	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.3.d	Safeguard evidence	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.3.e	Start investigations within 24 hours and complete within 10 calendar days			SC		SC		SC	SC	SC		SC		SC
D.3.f	Investigative reports provide clear basis for its conclusion	SC			SC			SC	SC	SC		SC	SC	

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
D.3.g	Written reports are reviewed by supervisory staff, and corrections made	SC			SC		SC	SC	SC			SC		
D.3.h	Facility also prepares a written report for each unusual incident	SC		SC	SC		SC	SC	SC	SC		SC	SC	
D.3.i	Corrections to prevent a reoccurrence are implemented promptly and thoroughly; such actions are tracked and documented			SC				SC				SC		
D.3.j	Investigation records are maintained to allow easy access	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
D.4	Tracking and trending of unusual incidents and investigation results, and action to correct			SC				SC				SC		
D.5	Background investigation of all staff or volunteers who work with individuals	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
Section E: Quality Assurance														
E.1	Comprehensive Quality Assurance (QA) procedures including: Track data with sufficient particularity to identify trends													
E.2	Analyze data, and when needed, develop corrective action plans													
E.3	Disseminate corrective action plans to all responsible entities	SC	SC			SC	SC	SC	SC			SC	SC	
E.4	Monitor and document corrective action plans to ensure implementation													
E.5	Modify corrective action plans, as necessary, to ensure effectiveness													
Section F: Integrated Protection, Services, Treatment and Supports														
F.1	Interdisciplinary teams for each individual:													
F.1.a	Team facilitated by one person, who ensures members participate in assessing, developing, monitoring, and revising													
F.1.b	Team includes required members													
F.1.c	Conduct comprehensive assessments of sufficient quality, routinely and in response to changes													
F.1.d	Assessment results are used to develop, implement, and revise ISP													
F.1.e	Develop ISP in accordance with Americans with Disabilities Act (ADA) and Olmstead decision													
F.2	Policies and procedures that provide for the development of integrated ISPs, including:													
F.2.a	ISP developed and implemented for each individual:													
F.2.a.1	ISP addresses preferences and													

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	strengths, prioritized needs, explains barriers, and encourages community participation													
F.2.a.2	Specifies measureable goals and objectives to attain outcomes to address preferences and meet needs, and overcome identified barriers to living in most integrated setting													
F.2.a.3	Integrates all protections, services and supports													
F.2.a.4	Identifies methods for implementation, time frames, and responsible staff													
F.2.a.5	Provides interventions that effectively address needs, and are functional at Facility and in community													
F.2.a.6	Identifies data to be collected; frequency of collection; person responsible for collection; and person responsible for review													
F.2.b	Coordinate all goals, objectives, anticipated outcomes, services, supports and treatments in ISP													
F.2.c	ISP is assessable and comprehensible to staff responsible for implementing													
F.2.d	Assess progress monthly and take necessary corrective action													
F.2.e	Competency-based staff training on ISP development and implementation													
F.2.f	ISP prepared within 30 days of admission and revised annually; put into effect within 30 days of preparation													
F.2.g	QA processes – ensure ISP developed and implemented consistent with Provision F													
Section G: Integrated Clinical Services														
G.1	Provide integrated clinical services (i.e., general medicine, psychology; psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy)													
G.2	Appropriate clinician review of recommendations from non-facility clinicians; and referral to team as appropriate			SC				SC			SC			
Section H: Minimum Common Elements of Clinical Care														
H.1	Assessments and evaluations done regularly and in response to change in status													
H.2	Diagnoses shall clinically fit the corresponding assessments or	SC	SC		SC		SC	SC	SC	SC		SC	SC	SC

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	evaluations and be consistent with DSM and ICD													
H.3	Treatments and interventions are timely and clinically appropriate based upon assessments and diagnoses													
H.4	Clinical indicators of the efficacy of treatments and interventions are determined in a clinically justified manner													
H.5	System developed and maintained to effectively monitor health status of individuals													
H.6	Treatments and interventions modified in response to clinical indicators													
H.7	Integrated clinical services policies, procedures and guidelines to implement Provision H													
Section I: At-Risk Individuals														
I.1	Regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk													
I.2	Interdisciplinary assessment of services and supports for at-risk individuals (five working days)													
I.3	Implement a plan to minimize risk within 14 days; integrated into ISP													
Section J: Psychiatric Care and Services														
J.1	Provide psychiatric services only by qualified professionals	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
J.2	Psychotropic medications only after evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist	SC	SC		SC	SC	SC	SC	SC	SC		SC		SC
J.3	No psychotropic medications as substitute for treatment, in absence of psychiatric diagnosis, for convenience of staff, or as punishment						SC					SC		
J.4	Pre-treatment sedation for medical and dental care: strategies to minimize or eliminate; coordinate with other supports and services											SC		
J.5	Sufficient board-certified or board-eligible psychiatrists to assure provision of required services	SC	SC	SC		SC	SC	SC		SC	SC	SC		
J.6	Procedures for psychiatric assessment, diagnosis, and case formulation (Appendix B)	SC	SC		SC			SC	SC	SC		SC		
J.7	Use of Reiss Screen for Maladaptive Behaviors to screen for possible psychiatric disorder; all identified	SC	SC		SC	SC	SC	SC	SC	SC	SC	SC		

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	individuals receive a comprehensive psychiatric assessment and diagnosis													
J.8	Integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation						SC	SC	SC			SC		
J.9	Least intrusive and most positive interventions to treat behavioral or psychiatric condition						SC	SC						
J.10	Before psychotropic medications, IDT to conduct risk-benefit analysis, and consider alternative treatment			SC		SC	SC	SC	SC					
J.11	Facility-level review system for monthly monitoring of prescription of polypharmacy	SC	SC		SC	SC		SC			SC	SC		
J.12	System for monitoring, detecting, reporting and responding to side effects of psychotropic medications, such as MOSES/DISCUS	SC		SC	SC	SC	SC	SC	SC					SC
J.13	Psychotropic medication treatment plan includes: clinically justifiable diagnosis or behavioral-pharmacological hypotheses; therapeutic effect timeline; and plan for monitoring. Treatment to be monitored no less than quarterly		SC		SC			SC				SC		
J.14	Informed consent must be obtained prior to administering psychotropic medications or other restrictive procedures	SC	SC	SC	SC	SC		SC	SC					
J.15	Neurologist and psychiatrist coordinate use of medications through the IDT process when they are prescribed to treat both seizures and a mental health disorder	SC	SC	SC	SC	SC	SC	SC			SC			
Section K: Psychological Care and Services														
K.1	Professionals with Master's Degree and BCBA to provide services to individuals needing PBSP and all individuals to maximize regression and loss of skills, reasonable safety, and freedom from undue restraint											SC		
K.2	Qualified director of psychology	SC	SC	SC		SC	SC	SC	SC	SC	SC	SC	SC	SC
K.3	Establish a peer-based system to review the quality of PBSPs			SC		SC	SC	SC	SC	SC			SC	SC
K.4	Develop and implement standard procedures for data collection for PBSPs, monthly review of data, and changes to plans, as appropriate						SC							
K.5	Standard psychological assessment procedures that identify medical, psychiatric, environmental or other								SC				SC	

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	reasons for target behaviors and for other psychological needs that may require intervention.													
K.6	Psychological assessments based on current, accurate and complete clinical and behavioral data								SC					
K.7	Psychological assessments completed for each individual pursuant to the Facility's standard psychological assessment procedures						SC		SC				SC	SC
K.8	Provide individuals needing psychological services other than PBSPs with such services, and measure efficacy of treatment					SC				SC			SC	
K.9	Develop PBSBs, obtain necessary consents and approvals, and implement.												SC	
K.10	Organize and maintain documentation related to PBSPs so progress can be measured to determine efficacy of treatment, including psychiatric treatment						SC							
K.11	PBSPs written to allow understanding for implementation by direct support professionals	SC	SC	SC		SC	SC	SC	SC	SC	SC	SC	SC	SC
K.12	Provision of competency-based training for all direct support professionals and supervisors for PBSPs													
K.13	Maintain an average ratio of psychology professionals of 1:30 and psychology assistants of 1:60.											SC		
Section L: Medical Care														
L.1	All individuals receive routine, preventive and emergency medical care consistent with current, generally accepted professional standards													
L.2	Establish and maintain a medical review system that consists of non-Facility physician case review and assistance													
L.3	Medical quality improvement process to collect data relating to the quality of medical services; assess data for trends; initiate outcome-oriented inquiries, identify and initiate corrective actions, and monitor to assure remedies are achieved										SC			
L.4	Policies and procedures for provision of medical care consistent with current, generally accepted professional standards of care													

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
Section M: Nursing Care														
M.1	Nurses shall document nursing assessments; identify health care problems; notify physician of health care problems; and monitor, intervene, and keep appropriate records of individuals' health care status sufficient to readily identify changes in status.													
M.2	Update nursing assessments for each individual quarterly or more often as indicated by the individual's health status			SC							SC			
M.3	Develop and implement nursing interventions annually to address each individual's health care needs, including needs related to at-risk conditions, and modify as needed													
M.4	Develop and implement nursing assessment and reporting protocols to address health status of individuals served			SC		SC				SC	SC			
M.5	Develop and implement a system of assessing and documenting clinical indicators of risk for each individual; and teams to discuss status as part of integrated reviews based on individual's needs													
M.6	Develop and implement nursing procedures for administration of medications in accordance with current, generally accepted professional standards of care			SC		SC				SC	SC			
Section N: Pharmacy Services and Safe Medication Practices														
N.1	Pharmacist medication regimen reviews at prescription of a new medication, and as clinically indicated, make recommendations	SC	SC	SC		SC	SC	SC			SC	SC		
N.2	Quarterly comprehensive drug regimen reviews to review lab results	SC	SC	SC	SC		SC	SC						SC
N.3	Collaboration between prescribing medical practitioners and pharmacists for monitoring of use of "stat" medications, chemical restraints, anticholinergics, benzodiazepines, and polypharmacy to ensure clinical justification	SC		SC			SC	SC	SC					SC
N.4	Treating medical practitioners shall consider pharmacist recommendations and document any recommendations not followed noting clinical rationale	SC	SC	SC		SC	SC	SC		SC	SC	SC		SC
N.5	Tardive dyskinesia monitoring using	SC		SC	SC	SC	SC	SC						

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	MOSES or DISCUS													
N.6	Identification, reporting, and follow-up for significant or unexpected adverse drug reactions	SC	SC	SC		SC		SC			SC			
N.7	Regular drug utilization evaluations in accordance with current, generally accepted professional standards of care	SC	SC	SC		SC	SC	SC		SC	SC			SC
N.8	Regular documentation, reporting, data analysis and follow- up remedial action regarding actual and potential medication variances			SC		SC					SC			
Section O: Minimum Common Elements of Physical and Nutritional Management														
O.1	Overarching provision requiring PNMPs for all appropriate individuals, integration with IDTs, and a PNM Team			SC			SC	SC		SC			SC	SC
O.2	Physical and nutritional interventions for individuals with PNM difficulties, and PNMT assessments													
O.3	Maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans for individuals having physical or nutritional management problems					SC				SC				
O.4	Staff engage in mealtime practices that do not pose risk of harm to any individual							SC						
O.5	Competency-based training for all staff working with persons with PNMPs							SC			SC			
O.6	Monitor implementation of mealtime and positioning plans to ensure staff demonstrate competencies to safely and appropriately implement such plans													
O.7	Develop and implement a system to monitor progress of individuals with PNMPs, and revise, as necessary													
O.8	Evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary, and, when appropriate, implement plan to return to oral eating			SC										
Section P: Physical and Occupational Therapy														
P.1	OT and PT screenings of each individual at the Facility, and, as needed comprehensive integrated OT and PT assessment			SC		SC	SC				SC		SC	SC
P.2	As part of ISP, develop and implement plan to address recommendations from comprehensive OT and PT assessments													

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
P.3	Competency-based staff training related to OT and PT plans							SC			SC			
P.4	Systems to monitor and address implementation and effectiveness of OT/PT plans, as well as equipment, and status of individuals with OT/PT needs													
Section Q: Dental Services														
Q.1	Adequate and timely routine and emergency dental care and treatment consistent with current, generally accepted American Dental Association standards								SC					
Q.2	Develop and implement policies and procedures regarding comprehensive, timely provision of assessments to IDTs and dental services; desensitization and other supports to minimize use of sedation; strategies to address refusals; and tracking of sedation													
Section R: Communication														
R.1	Adequate number of speech language pathologists or other professionals with specialized training or experience to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of communication programs			SC		SC	SC	SC			SC	SC	SC	
R.2	Develop and implement a screening and assessment process to identify who could benefit from alternative or augmentative communication systems, including systems involving behavioral supports or interventions				SC			SC						
R.3	Specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings													
R.4	Develop and implement a monitoring system to ensure that the communication provisions of the ISP address communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are revised as necessary													
Section S: Habilitation, Training, Education, and Skill Acquisition Programs														
S.1	Provide adequate habilitation services, including individualized training,													

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	education, and skill acquisition programs developed by IDTs to promote growth, development and independence of all individuals													
S.2	Annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration in the areas of living, working and engaging in leisure activities													
S.3	Use information from assessments and review processes to develop, integrate and revise programs of training, education, and skill acquisition to address each individual's needs that include:													
S.3.a	Interventions that: 1) address needs for services; and 2) are practical and functional													
S.3.b	Training opportunities in the community													
Section T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs														
T.1	Planning for Movement Transition and Discharge													
T.1.a	State shall take action to encourage and assist movement to the most integrated setting for individuals for whom it is not opposed by the individual or LAR													
T.1.b	Facility shall review, revise, or develop, and implement policies, procedures and practices related to transition and discharges													
T.1.b.1	Individuals' ISPs comprehensively describe protections, supports, and services; and identify and develop plans to overcome obstacles to movement to most integrated setting													
T.1.b.2	Education for individuals and their LARs regarding available community options to make informed choices													
T.1.b.3	Assess at least 50% of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge.													
T.1.c	IDT to develop and implement a community living transition plan and coordinate with Local Authority and community provider staff						SC		SC		SC	SC	SC	
T.1.c.1	Implement and coordinate community transition plan with provider staff													
T.1.c.2	Specify staff responsible and	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC		SC	SC

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	timeframes													
T.1.c.3	Review with individual and LAR	SC		SC		SC	SC	SC	SC	SC	SC		SC	SC
T.1.d	Comprehensive assessment of individuals' needs within 45 days prior to individuals' transition						SC							
T.1.e	Pre-move and post-move supports included in assessment are identified and in place at time of move or as identified in transition plan													
T.1.f	Quality assurance processes to ensure community living discharge plans are developed, and implemented by the Facility													
T.1.g	Facility to gather and analyze information related to obstacles to successful community placement and report annually on identification and remediation efforts; and DADS to take steps to overcome obstacles, as appropriate, including requesting assistance of other agencies and the legislature													
T.1.h	Each Facility to develop and issue to the Monitor and to DOJ a Community Placement Report	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC
T.2	Serving persons who have moved from the Facility to more integrated settings appropriate to their needs													
T.2.a	Conduct post-move monitoring visits within each of three intervals of 7, 45 and 90 days respectively following an individual's move to the community, and if concerns are noted with regard to the provision of supports in transition plan, Facility to use its best efforts to ensure provision of support	SC			SC		SC		SC			SC	SC	SC
T.2.b	Monitor may review and participate in post-move monitoring visits for the purpose of assessing the adequacy of the Facility's monitoring	SC	NR		SC		SC	SC	SC	SC		SC	SC	SC
T.3	Non-applicability of procedures at Section T for individuals admitted for court-ordered evaluations													
T.4	Compliance with all CMS-required discharge planning procedures for persons moving out of state; persons discharged from emergency admission; discharged after order of protective custody; individuals receiving respite services for up to 60 days; for individuals determined not to be eligible	NR	SC				NR	SC	SC	SC	NR	NR	SC	SC

Sub-Section	Brief Description	Abilene	Austin	Brenham	Corpus Christi	Denton	El Paso	Lubbock	Lufkin	Mexia	Richmond	Rio Grande	San Angelo	San Antonio
	for admission; individuals discharged pursuant to court order vacating a commitment order; and individuals transferred to another SSLC													
Section U: Consent														
U.1	Facility shall maintain and update semi-annually a prioritized list of individuals lacking both functional capacity to render a decision regarding health or welfare and an LAR to render such decision										NR			
U.2	Starting with individuals with highest priority need, make reasonable efforts to obtain LAR for any individual lacking both functional capacity to render a decision regarding health or welfare and an LAR to render such decision										NR			
Section V: Recordkeeping and General Plan Implementation														
V.1	Maintain a unified record for each individual consistent with Appendix D								SC	SC			SC	
V.2	Develop, review, and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this agreement							SC						
V.3	Implement additional QA procedures to ensure a unified record for each individual consistent with guidelines in Appendix D, including taking corrective actions, as needed					SC			SC		SC		SC	
V.4	Routinely use unified records in making care, medical treatment, and training decisions													