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I. EXECUTIVE SUMMARY

A. Continuing Long-Term Systems Failure

Jackson Class members, in general, have multiple diagnoses, have all been institutionalized at either Los Lunas or Fort Stanton, are severely disabled, and have expressive and/or receptive limitations. Their average age is of 59.1 years.

This 2018 Report demonstrates once again a long-term systems failure: to consistently recognize, report, intervene, evaluate and ensure corrective action resulting in improved practice and protections for the individual Jackson class member, at the provider and systems levels. **The urgency is greater now than ever to take collaborative, decisive and effective action which results in improved practice for each class member. This failure is due in large part to the lack of effective leadership and an active and effective Quality Assurance/Quality Improvement system. The system should routinely recognize and reward good practice as well as take swift and effective corrective action when problems and issues are identified. Both data reflecting good practice as well as data identifying problems and issues should be used to plan and implement improved and sustainable practice. That clearly is not broadly or systemically happening. To the extent that it does, the changes planned have not proven to be effective.**

For many years, DOH/DDSD provided limited to no response to Community Practice Review (CPR) data or to the clearly identified Systemic Findings and Recommendations. However, for the 2016 CPR Report, Defendants did respond to each of the14 systemic recommendations made as part of the 2016 CPR findings. This response relied heavily on the update of the 2018 DD Waiver Standards and various processes. DOH/DDSD suggested that revising the DD Waiver Standards would be a major solution to long standing issues. Modifying the 2007 and 2012 Standards did not prove to be an effective intervention as evidenced by the historic and current findings of the CPR/IQR. Changing paper or creating work groups does not, by itself, change practice or behavior and outcomes at the class member level. Identifying and building on good practice along with the identification and remediation of poor practice is an essential ongoing process that must be in place and systemically evaluated for effectiveness.

Unfortunately, for the Systemic Findings and Recommendations identified in the 2017 Report, again Defendants did not respond to the IQR Systemic Findings. Those findings were designed to protect Class Members from harm and improve their quality of life.

Since the publication of the 2017 report and before, senior level systems managers have openly indicated that they have not read the report. This long-standing lack of a coordinated, systemic approach to identifying the cause of poor, and in some cases dangerous practices, crafting interventions, enforcing consistent implementation of those interventions, measuring the outcome(s)of those interventions and modifying practices as required *continues to put JCMs at risk of harm*.

B. Summary of Findings

Several areas of good practice are identified and continue as strengths in 2018. However, *most areas of concern are the same as those which have identified for fifteen years*. Consequently, in 2018 overall conditions for Jackson Class Members have not improved and in too many cases have deteriorated.

The lack of effective action is clearly apparent in the summary of findings which follows. The right-hand column below identifies the year each issue was identified by the Community Practice Review/Individual Quality Review. Information contained in parenthesis refers to Evaluative Components (e.g., S4.1) as issued by the Honorable Judge James A. Parker on April 3, 2015 (Doc. 2035) or if it begins with a "Q" it is referring to the Question asked in the 2018 IQR Protocol.[1]

Years Noted = In CPR and/or IQR Statewide Reports

#	2018 FINDINGS	Years Noted
A. Health		
#1.	This report, in its entirety, coupled with reports provided for the past decade continue to note long term systems failure to recognize, report, intervene, evaluate and ensure corrective action which results in improved health and programmatic practice at the individual, provider and systems level. A few examples follow. (S4.1, S4.2)	
	a. There are current health related issues directly and negatively affecting Jackson Class Members which have been identified as problems by the CPR/IQR for over a decade and continue today.	2004 – present
	b. During the past decade Individual Support Plans have never been found to be adequate to meet more than 35% of individual's needs. In 2007 35% of class members had adequate ISPs (the highest), *in 2017, 0% (the lowest) and, again, in 2018 0% of the ISPs were adequate to meet the person's needs.* (Q#92)	2004 – present
	c. Case Management supports and monitoring which are core individual and systems safeguards have also been identified as urgently needing correction. Only 23% (19 JCMs) of the case manager's record contained documentation that the case manager is monitoring and tracking the delivery of services as outlined in the ISP. (Q#30) From 2004 to 2017, the average percentage of class members reviewed who had evidence of case management monitoring and tracking services as outlined in their ISP is 36.8%.	2004 – present
	d. 29% (24 JCMs) were found to have case management services provided at the level needed (Q#31) a 3% increase from 2017 and again significantly below the 42% found in 2016. From 2004 to 2017, the average percentage of class members who did not have case management providing supports and services needed was 58.8%.	2004 – present
#2.	The Northeast Region had the highest average number of health related issues per person (42.8 per person, up from 10.1 in 2017) followed by Metro region (23.9 per person, up from 14.1 in 2017), then the Southeast region (22 per person, up from 11.6 in 2017), the Northwest (20 per person, up from 7.2 in 2018) and finally, the Southwest (16.9 per person, up from 11 in 2017).	2011 – present
#3.	The Community Practice Review identified 664 health related findings for 86 of the 87 individuals reviewed. Not only did 99% of those reviewed have health related findings which needed review and/or action but 84 (13%) of those findings were "repeat" findings from previous Community Practice Reviews. The detail related to this finding by region and agency is summarized in Appendix A.	2013 - present

[1] The Evaluative Components continue to be referenced in this report as they were in effect at the time of the 2018 IQR Review.

#	2018 FINDINGS	Years Noted
#4.	Only 21% of those reviewed were found to have assessments in all areas needed. (Q.#65). And of those, only 12% of those assessments were found to be adequate for planning. (Q#66) Lack of action to identify, address and/or follow up on individual JCMs health related needs is a frequently identified health issue which puts JCMs at significant risk. 4a. Not following up on recommended medical appointments or evaluations (H1.7.); 4b. Lack of adequate nursing oversight (H1.2); 4c. Needed medication not available (H1.8); 4d. Nurse Uninformed/Giving Incorrect Information (H1.2.); 4e. Needed Therapies were Missing; and 4f. CARMP not being followed (H1.7.a.).	2005 - present
#5.	Health Records are frequently found to be incorrect or contain conflicting health related information (See Chart #8). Information related to specific providers has been summarized in Chart 15. (H1.3., H1.5., H1.6): 5a. Plans, Documents Not accurate, or Information is Inconsistent; 5b. Assessments (contradictory information, guidance unclear, incomplete information, missing); 5c. Medication Administration Record/Issues; and 5d. Data Tracking/Monitoring (not done, not done accurately or consistently, e.g., seizures, weight, fluid tracking).	2004 and 2005; 2010 - present
#6.	46 Jackson Class Members Individuals were identified as having pneumonia of any type (46). The number of "unspecified" pneumonia's is down significantly from 21 in 2017 to 14 in 2018. (Chart #28) The average number of hospitalizations per month was highest for Dehydration/UTI's at 1.67, followed by aspiration/pneumonia at 1.53 and Sepsis at 1.07. (Chart #27). For each of these areas the trend line continues to go up.	2004 and 2013 - present
#7.	Addressing JCM's functional and/or behavioral regression has improved from 2016 but continued improvement is needed. Q#98: 9 (11%) of those reviewed achieved progress in the last year. An Additional 47 (57%) had some more limited areas of progress. Q#127: 33 JCMs (40%) were found to have experienced physical regression in the past year. Q#128: 21 JCMs (26%) experienced behavioral regression in the past year. Q#129: Of the JCMs wo were found to have regression of either type, 30 of the JCM's teams (77%) addressed this regression.	2009 and 2011 - present
B. Individual Service Plan (ISP)		
#8.	18 (22%) of the ISPs were found to contain current and accurate information. (Q#72)	2004 - present
#9.	Issues identified by specific sections of the ISP indicate wide spread problems with almost all sections. (Visions show expectations of growth: 48% (Q#73.); Outcomes address the person's major needs: 55% (Q#83); Action Steps are implemented at a frequency that enables the person to learn new skills: 9% (Q#77); Teaching and Support Strategies are sufficient to ensure consistent implementation of the services planned: 22% (Q#84.); Integrate recommendations and/or objectives/strategies of ancillary providers (e.g., therapists, behavior consultants): 24% (Q#85.)	2004 – present
#10.	30% of those reviewed in 2018 received supports and services adequate to meet the person's needs. That is a significant but totally inadequate increase from the "0" found in 2017. (Q#94b in 2018 and Q#36 in 2017). In 2016, 11 (12%) people were and in 2015, 26% of those reviewed were found to have a program at the level of intensity adequate to meet the person's needs. (S5.3., S3.8)	2004 – present

#	2018 FINDINGS	Years Noted
#11.	Of the 82 people whose ISPs were reviewed and scored, none were found adequate to meet the individuals' needs. (Q#92). None were found to be adequate in 2017 either and only 12% were found to be adequate in 2016.	2004 - present
#12.	4 (5%) of the ISPs reviewed were being fully or consistently implemented. (Q#94a) (S5.3b)	2004 – present
C. Case Management		
#13.	72 of the 82 (88%) class members reviewed had case managers who knew them well. (Q#24)	2010 - present
#14.	23% (19 JCMs) of the case manager's record contained documentation that the case manager is monitoring and tracking the delivery of services as outlined in the ISP. (Q#30.)	2009 – present
#15.	24 (29%) of JCM had case managers who were providing them with the supports and services they need. (Q#31) (26% in 2017; 42% in 2016)	2009 – present
#16.	37 (46%) of JCM's teams convened meetings as needed due to changed circumstances and/or needs (Q#124). 36 (73%) in 2017. (S5.3., S5.3c)	2016 - present
D. Residential Services and Day Services		
#17.	78 (95%) residential staff and 75 (95%) day staff know the JCM well. (Q#42; Q#33)	2004 – present
#18.	71 (100%) of the JCMs reviewed were seen to get along with their residential staff. (11 CND). 66 (100%) were seen to get along with their day/employment staff. (1 N/A; 15 CND) (Q#121; Q#120)	
#19.	34 (41%) of JCMs were integrated into the community. (Q#172)	2004 – present
#20.	64 (78%) of JCMs were viewed as "safe". (Q#112)	
#21.	25 (71%, 47 CND) have the opportunity to make informed choices. (47 CND) (Q#102) 70 (85%) of JCMs reviewed have daily choices/appropriate autonomy over his/her life. (Q#115)	2004 – present
E. Employment Services		
#22.	1 (2%) JCM reviewed was found to have a job that meets agreed criteria. (Q#152)	2004 – present
#23.	4 (8%) of JCMs were found to have teams who assessed their vocational interests, abilities and needs. (Q#135)	2004 – present
#24.	4 (8%) of JCMs were found to have been provided with information about the range of employment opportunities and how to access those options. (Q#143)	
#25.	7 (15%) of JCMs reviewed had teams who addressed how to overcome barriers, if any, to employment. (Q#145)	2017 - present
#26.	8 (17%) of JCMs reviewed Guardians received information regarding the range of employment options available to the individual. (Q#144)	
#27	7 (15%) of JCMs reviewed were engaged in Supported Employment. (Q#151)	2004 to present
#28	15 (30%) of the JCMs reviewed have been offered an opportunity to participate in work or job exploration including volunteer work and/or trial work opportunities. (Q#139)	2004 to present
F. Equipment and Technology		
#29.	33 (60%) of the JCMs reviewed have all of the equipment needed. (Q#162) (5 N/A)	2004 – present
#30.	44 (71%) of the JCMs reviewed have received all of the technology needed. (Q.#163) (20 N/A)	2004 – present
#31.	58 (76%) of the JCMs reviewed have equipment and technology in good repair. (Q#165) (6 N/A)	2004 – present
#32.	51 (66%) of the JCMs reviewed have equipment/technology available in all appropriate environments. (Q#166) (5 N/A)	2004 – present
#33	46 (66%) of the JCMs reviewed received all communication assessments and services. (Q#167) (12 NA)	2004 to present
#34.	70 (90%) of the JCMs reviewed have staff who know how to help them use their equipment appropriately. (Q#164) (6 N/A)	2004 – present

#	2018 FINDINGS	Years Noted
G. Rights		
#35.	78 (95%) of JCMs have their cultural preferences accommodated. (Q#116)	
#36.	55 (67%) of JCMs are protected from abuse, neglect and exploitation. (Q#110)	2004 – present
#37.	34 (62%) of JCMs have all incidents of suspected abuse, neglect and exploitation reported and investigated. (Q#111)	
#38.	28 (34%) of JCMs are treated with dignity and respect. (Q#117)	2004 – present
#39.	64 (78%) of JCMs team members interviewed were trained or knowledgeable on how to report abuse, neglect and exploitation. (Q#105)	2004 – present

C. 2018 Systemic Recommendations

All of the 2016, 2017 and now 2018 Systemic Recommendations which follow have been identified as issues and/or recommendations many times in the past and/or they are included in the Court Ordered Evaluative Components. As stated for the past three years, all of these Systemic Recommendations are made with the expectation that DOH/DDSD will act to address and resolve them quickly and effectively. It is also expected that DOH/DDSD will report on the accomplishment of outcomes identified in each recommendation at least quarterly. However, as in the past two years, there are four recommendations which have outcomes that should be reported on monthly. Those recommendations are: Health #2, #5, #8 and Case Management #12.

#	2018 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
A. Health		
#1.	DOH/DDSD needs to implement and sustain an effective Quality Assurance/Quality Improvement system which identifies, reports, intervenes timely, ensures remedies, and evaluates the effectiveness of the Quality Assurance/Quality Improvement System as it relates to the overall Health Coordination functions which impact outcomes and improve practice at the individual, provider and systems level. Health Care Coordination includes specific responsibilities at the provider, case manager, team, regional and state level (H1.1) [2]The implementation of this system should include: 1a. the examination of the current Quality Assurance and Quality Improvement processes and activities intended to safeguard JCM which results in improved provider performance in relation to quality services for JCM. Including establishing measurable indicators that are consistent with the pertinent standards that address the quality of provider performance. (S4.1.); 1b. the routine and consistent use of existing quality assurance information and tools to identify gaps in the healthcare services to JCMs and, in turn, improve outcomes to JCMs (H4.3a., S1.6.1., S2.1., S3.1., S5.2.,); 1c. Review of IQR findings as a part of every QMB review of all service types and reviewer preparation to inform the QMB survey process; 1d. IQR Individual and Regional Findings being made available to DDSQI for their review and action immediately following issuance of final Regional reports. Actions taken should be evaluated for effectiveness, in part, by IQR Reports. (S3.4)	2004, 2010, 2011, 2014

[2] See December 2015 Health Care Coordination Definition paper agreed to by the Parties and disseminated by the Defendants.

#	2018 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	1e. the investigation of conflicting and/or inconsistent quality assurance information[3] with ensuing corrective action proven to effect desired and long lasting improvements in services, supports and outcomes for JCMs (S3.4) 1f. regulatory reviews of case management agencies by QMB, which include a review of the person's history and preferences, essential services as determined by professional assessments and effectiveness of previous/current interventions (S3.8); 1g. a response from DOH which is proportionate to the seriousness of the contractor's substandard performance[4] when corrective action is not effectively implemented (S4.2.), including. 1.g.i. taking <u>immediate action</u> (the day notified of substandard performance) upon notification of substandard performance when class members health and safety is at risk; 1.g.i. (a): If, within 30 days of notification of substandard performance which affects the health and safety of class members, the provider is unable or unwilling to achieve AND sustain needed improvements which result in measurable and adequate protections of class member's health and safety, DOH/DDSD will take action which immediately ensures the class members' health and safety. 1.g.ii. taking corrective action within 30 working days of notification of substandard performance which does not affect class members immediate health and safety. The corrective action should specify, in measurable terms, what the provider must do and within what timeframes with 30-60-90 day progress reports verifying action taken to resolve the problem. If correction takes longer than 90 days, extensions must be approved by the DDSD Director with justifications provided to DDSQI. 1.g.iii. DDSQI should review substandard performance reports, by provider agency, within 30 days of the reported findings. DDSQI agreed upon corrective action should be taken within two weeks of the DDSQI decision. The Corrective Action applied should be time limited. If the corrective action are quired and/or time limits are not met, contract management action should be taken. 1.g.iv. DDSQI and the IRC should evaluate the effectiveness of their required corrective actions on an annual basis. Based on this assessment, action which results in improved individual outcomes and provider performance should be institutionalized. 1h. <u>providers[5] using identified performance indicators as part of their agency quality assurance system to improve quality (S5.1)</u>	
#2.	The DOH/DDSD Quality Assurance/Quality Improvement System needs to ensure the early identification and effective response to health-related issues including changes in health status of Jackson Class Members. (H4.1) 2a. This should include the prioritization of health-related issues to be addressed, by when and then decisively and swiftly take action to consistently implement interventions which measured resulting outcomes to determine their effectiveness, modified accordingly, in order to result in improved health and safety outcomes for class members. (S5.2a) 2b. Consistent with Health Objective H1.2. this system needs to include nurses who are routinely monitoring Jackson Class Members' (JCMs) individual health needs through face-to-face oversight, face-to-face communication with Direct Support	2004, 2011

[3] From sources such as IR, GER, OOH Placement Reports, RORI's, CPR findings, etc.
[4] Substandard Performance as identified by data sources such as QMB, IQR, Mortality Review, health data, etc.
[5] "Providers" includes providers of day and residential services, case management providers, providers of therapy and dietitian/nutrition services. All DD Waiver contractors for services to JCMs.

#	2018 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	Professionals, and taking corrective actions which ensure that changes in JCMs' health status are responded to timely and overall health needs are being met. 2c. This system needs to be continually improved based on regular and routine reports of effectiveness when monitoring results. 2d. Consistent with S3.4.a. work with service providers and case management agencies that have "repeat findings" or deficiencies or problems to improve and sustain effective interventions. 2e. Consistent with S3.4, Use the findings from the IQR, as well as other available data from DOH/DHI/DDSD, to inform this effort and improve services delivered directly to class members and to improve the system of services for JCM.	
#3.	Oversight, monitoring, modeling and mentoring must be accurately informed and provided (H1.2., H1.4., H1.5, H1.7, H3.3., H4.1., H4.2,): 3a. under the supervision of the DDSD Medical Director who has extensive experience health systems management for people with I/DD: 3.a.i. DDSD expand its medical and health care capacity through a Medical Director charged with the responsibility to, at least: 3.a.i.(a): Provide consultation and policy guidance to DDSD and the regional offices/nurses; 3.a.i.(b) Provide DD Specialty Nursing at the state, regional and provider level; 3.a.i. (c) Supervise and direct the activities of the Clinical Services Bureau; 3.a.i.(d) Provide supervision, consultation and technical assistance to DD regional office nurses; 3.a.i.(e) In concert with DD regional office nurses, intervene as necessary with local practitioners and health care providers (e.g., hospitals, nursing homes) hospitals to protect the health and safety of class members and to improve health outcomes; 3.a.i.(f) Provide leadership, information and guidance to the medical community at large on issues affecting class members. 3b. Evaluate the effectiveness of the Clinical Services Bureau in relationship to quality of health management and health outcomes. 3.b.i. Based on this analysis, modify and integrate CSB functions throughout the policy and service delivery system. 3.c. Evaluate the effectiveness of Regional Office Nurses. 3.c.i. Based on this analysis, enhance resources, provide education and training, modify oversight functions and clarify roles and responsibilities as needed. 3.d. Agency Nurses have regular, direct contact and communication with direct support professionals. 3.d.i. Contact includes record review, training, verification of plan implementation (e.g., HCP, MERP, MAR); 3.d.ii. Communication from and with Direct Support Professionals is documented and includes routinely acquiring information regarding current status, what staff should be watching for and noticeable signs and symptoms. 3e. Agency Nurse caseloads weighted based on the acuity levels of those whom they support.	2004, 2005, 2011, 2014
#4.	Existing reports/systems (e.g., OOH Placement Reports, IRs, GERs, CPR, Therap) should be considered as a potential early warning, tracking, information and monitoring source for providers, Case Managers and DDSD. (S3.4, S4.1., S5.2)	2014, 2016

#	2018 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	4a. Provider QA and DDSD Systems Improvement staff should review, analyze, trend and report on information gathered from these and other sources; 4b. This analysis will be used to identify quality as well as substandard performance with quality indicators and enforcement action taken to improve practice; 4c. The analysis by provider will be used by managers to inform QMB, IQR, regions, contract management and others. This information should be used to measure the longitudinal effectiveness of interventions. 4d. The Regions should assist providers as they develop their QA/QI plans to ensure that findings from evaluative sources are addressed and systemic corrective action taken. (S4.1.b)(S4.1b).	
#5.	The risk factors, health care needs, health care recommendations and changing personal circumstances of Jackson Class Members (JCMs) must: 5a. be timely and accurately assessed; 5b. be known by those who support and provide services to them (H1.6., H3.2., S5.3a), including clinicians and specialists (H1.6). This should include having a list of risk factors identified for each person. This list should be taken to appointments, ER/Urgent care contacts and hospitalizations; 5c. include health care professionals' recommendations which are implemented timely (H1.7c); 5d. be accurately documented in the healthcare record (including health care plans, emergency response plans, aspiration risk management plans, e-Chat, ISP's, etc.) which accurately identify and reflect any recommendations and assessments of the treating and evaluating healthcare professionals (H1.2.a., H1.3.a, H1.5.a., H1.5.b., S5.3a); 5e. include Case Managers identifying significant risks, needed supports, and unmet needs for each JCM; include Case Managers convening the IDT promptly whenever a JCM is at risk or a JCM's needs are not being fully addressed; and include Case Managers seeking assistance from DOH if the IDT is unable to adequately meet a JCM's needs. (S5.3c)	2004, 2005, 2008, 2009
#6.	DOH/DDSD should develop guidance for teams, including the Guardian, for discharge planning. Teams need to know what questions to ask to ensure that they have adequate information to safely facilitate a hospital discharge and lessen the chance of readmission. This includes determining the exact discharge diagnosis, implications of the diagnosis and clear after-care instructions. Teams need to know whether and under which circumstances other options are available that can be coordinated through the hospital, such as home health care or even delayed discharge where the team feels the likelihood of readmission is high. (H3.5a) Guidance might include guidance such as[6]: 1. Initiate communication with hospital discharge planners immediately after hospital admission; 2. Get the guardian's buy-in for the discharge planning meeting and have the guardian contact the discharge planner at the hospital to make the request. Sometimes teams are told only the guardian can request such a meeting. 3. If resistance is encountered, tell the discharge planner this is an unsafe discharge and stress the words "unsafe discharge". 4. If further resistance is encountered, ask for the hospital's patient advocate.	2017

[6] All but #1 taken from suggestions provided by Metro Regional Nurse which were greatly appreciated.

#	2018 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	5. If resistance continues, ask how to file a complaint with Joint Commission about an unsafe patient discharge.	
#7.	Data from Mortality Review, emergency services use, hospital admissions/re-admissions and hospice[7] use should be analyzed and used as a learning opportunity to identify gaps and ineffective health care coordination, learning opportunity which Remediation based on identified gaps and ineffective health care coordination should result in improved practice.	2014, 2016
#8.	Using all source information (e.g., hospital admission and readmissions, hospice, ER use) conduct regular Morbidity Reviews to identify frequently occurring conditions (i.e., dehydration/UTI's, bowel obstructions, aspiration) that are causing people to frequently use emergency services and/or be hospitalized. What is learned should be used quarterly to inform providers, case managers, teams and others about ways to improve health outcomes. (H4.3a; S52). This should include the 2016 recommendation to identify why the upward trend in pneumonia's continues. Based on this analysis, immediate action should be taken to remediate this trajectory. This examination should include a report that identifies trends, findings and recommendations.	2017
B. Individual Services Plan (ISP)		
#9.	The DOH/DDSD ISP Strategic Plan should be informed by and specifically identify strategies which will resolve decade long issues with the ISP as identified by the CPR and now IQR findings and by DOH QA reviews of ISPs. The ISP Strategic Plan should include the development of specific implementation strategies which will systemically and measurably improve practice and outcomes for class members in, at least, each of the four Individual Service Planning areas: ISP Development; ISP (Visions, Outcomes, Action Steps and TSS); ISP Implementation; and ISP monitoring/follow up completed by providers and case managers.	2004, 2007, 2009, 2015, 2016
#10.	DDSD needs to identify and reach agreement on the historic and current barriers to the implementation and enforcement of their ISP standards. These barriers need to be specifically addressed in the DDSD ISP Strategic Plan.	2016
#11.	Consistent with S3.4. Findings from the IQR should be used to inform discussions intended to improve the ISP. Actions taken to improve the ISP should be: 11a. directed towards the achievement of identified Outcomes; 11b. measured, tracked, evaluated and reported to determine their effectiveness; 11c. modified if found to be ineffective; and 11d. memorialized into the system to ensure sustainability when found to be effective.	2004, 2007, 2009, 2015, 2016
C. Case Management		
	Also See Recommendation #9, #10 and #11 above	
#12.	Using IQR and other available data, DOH/DDSD/QMB should identify and prioritize those case management agencies identified to have consistent good practice as well as those with consistent deficiencies (e.g., lack of monitoring and follow up, lack of adequate ISPs, lack of identifying when ISPs are not consistently implemented, not providing CM at the level needed by the individual…). Prioritized agencies with exemplary as well as deficient practice and design interventions intended to: (S3.4) 12a. improve supports, services and safeguards provided to JCMs by recognizing and building off of good practice; 12b. improve the practice of the identified case management agencies;	2004

[7] See the section on "Hospice", page 71 for additional suggestions regarding hospice and palliative care.

#	2018 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	12c. identify why QMB and CPR case management findings are so divergent; and 12d. recommend ways forward in an effort to sustain improved practice.	
#13.	Based on available performance information, develop qualified provider criteria including specific core competencies and core training curriculum. (H4.1; H4.1c)	2017
#14.	Case Management roles, responsibilities and tasks need to be collaboratively reviewed and modified prior to rates[8] being adjusted. The review process should: 14a. include a comprehensive analysis of existing tasks for the purpose of identifying: 14ai. Who has primary responsibility for each task; 14aii. Who has secondary responsibility and what that means which should also clarify roles, responsibilities and authority of other Stakeholders, by task: (e.g., providers, regions, guardians); 14aiii. Who must provide information to complete the task; and 14aiv. What additional training would be needed, if any, to successfully complete the task; 14b. Existing as well as 'required' or 'new' tasks should be included in the analysis (e.g., EC's, CPR findings, etc.); 14c. include a time study to identify Case Management current workload and where time is being dedicated; 14ci. A second time study post 'reforms' should be conducted to determine the effectiveness of planned interventions intended to decrease paperwork and increase categories found to have the most positive impact on an individual's life and outcomes. 14d. Information and agreements made as a result of this process should be used to influence standards, policies/procedures and rates.	2004
D. Supported Employment		
#15.	DOH/DDSD, in conjunction with the Jackson Compliance Administrator and others as needed, should work with providers to ensure: 15a. Individuals and their Guardians have informed choice regarding a wide variety of work and employment options. Informed choice verification needs to include documentation of the following: 15a.i. assessment of the person's vocational interests, abilities and needs; 15a.ii. information has been provided to the individual and guardian about the range of employment opportunities and how to access them including self-employment or developing customized employment; 15a.iii. the person has been able to engage in a variety of individually tailored job exploration opportunities, volunteer work and/or trial work opportunities; and 15a.iv. barriers to employment have been identified and a plan to overcome them has been developed and implemented. 15b. Each year report, by provider, the number of class members who are: 15bi. earning minimum wage or better; 15bii. increasing the average number of hours they work per week; and	2004, 2005, 2016

[8] Outcome based rate model is proposed to be designed by the Human Resource Research Institute and Burns and Associates.

#	2018 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	15biii. who are working in jobs consistent with the Federal Definition of Supported Employment (Supported Employment Objective SE1.2. and JSD. ¶37.d.) 15c. Class members have access to a provider who effectively delivers a wide variety of job options. This variety of job opportunities must be available, experienced and effectively provided to interested class members based on their interests and abilities. In addition, 15ci. Providers need to know the difference between individualized/customized job development vs. putting a person in an existing job slot whether it is a good fit or not. 15cii. Providers need to know the difference between supported employment and customized employment (i.e. creating a reconfigured job that didn't already exist to match the individual's abilities and interests, enabling self-employment and micro enterprises). 15ciii. Providers need to know the difference between contract work and real, integrated competitive employment in the community. 15d. DOH/DDSD should differentiate between supported employment and customized employment by, in part, incentivizing rates and developing rules regarding each.	
16.	Based on available performance information, develop qualified provider criteria including specific core competencies and core training curriculum. (SE1.2)	2017

II. THE PEOPLE BEHIND THE NUMBERS

A. There are people and stories behind these numbers

The Individual Quality Review, like the Community Practice Review before it, evaluates the supports and services provided to individual Jackson Class Members (JCMs). The ensuing individual, regional and statewide reports provide information regarding the findings from those reviews. Behind every number, trend, analysis and observation is a story about a real person. A person who, like all of us, has a history, preferences, strengths interests, good days and bad. But unlike most of us, many JCMs have no people in their lives who are not paid to be there. The things that all of us value most – family, friends and intimate relationships; work and money; mobility and independence; home and privacy; health and wellness – Jackson Class Members frequently do not have. Most of the people in their lives work shifts, are hired, resign and come and go. Most class members do not work or have their own money. Instead, they receive limited public assistance, the bulk of which goes to providers to pay for their housing and food. The place in which they live is not their own so they can be moved at any time into another home, not of their choosing, and frequently with strangers. Likewise, strangers can be moved into their homes with no notice let alone their approval. Given limited communication ability, most JCMs are highly reliant upon staff to know them well enough to identify a change in status – physically, emotionally or mentally – and to act quickly and effectively to ensure a good quality of life and to prevent harm.

Every class member is supported by a Team of people including the individual's guardian, case manager, residential and day service staff and, based on need, therapists such as Physical, Occupational and Speech/Language therapists and Behavioral Support Consultants. Almost every Team can recount powerful stories which illustrate the many positive changes made by the individual since current staff have known the person. For those who have a therapist who has known the person since they lived in the institution, yet more details illustrating personal growth since leaving the institution can be shared. It is not uncommon to hear that individuals who used to hate being in crowds can now go out into the community to the mall, concerts and other social events. Expressive language is also another area in which positive illustrations of change are shared. Hearing staff say things like, 'I never knew he could speak but one day he clearly said….', or, 'she uses her own signs, but you clearly know what she wants' emphasizes what continuing to open experiential doors can enable.

When Team members are asked what they attribute a given story of success to, they inevitably say consistency and persistence. Consistency in staff, in general or consistency and persistence of a particular staff person with whom the class member has a trusting relationship. They may also mention consistency in routine or persistence in offering new and expanded opportunities in spite of initial reluctance on the part of the class member. All of these stories are to be recognized and applauded.

Unfortunately, there are also too many stories and examples of lack of follow through, lack of awareness and lack of timely and effective action which puts class members quality of life and physical wellbeing in jeopardy. Throughout this report, "*The story behind the numbers*" provides personal illustrations of what happens when a part of or the entire system of safeguards does not work as intended. This breakdown, especially in the health arena, can put class members at serious risk of irreconcilable harm or death. Person #11 is an example of what can happen when repeated reports of non-compliance within a given provider are not timely and effectively and sustainably corrected.

The story behind the numbers: Person #11[1]

… is a 62-year-old Hispanic man who lived at one of the Intellectual and Developmental Disability (I/DD) Training Schools and a Mental Hospital beginning at age 25.

… has a large number of diagnoses (30+), 14 of which are listed in his eChat.

… While he has a number of health and mental health issues his health was described as stable at the time of the 2018 IQR. He was discovered to have fractured 2 ribs in June 2018 and a surgery consult in March indicted that he may need surgery for his rectal prolapse.

... has a history of challenging behaviors that include aggression, property destruction, self-injurious behaviors and self-defecation/urination. Though rates of these behaviors remain high, behavioral data does indicate some progress in reducing these behaviors over the past year and the BSC reports, during interview, that current rates are much improved compared to … 's historic levels of challenging behaviors.

… receives services from an agency which has had repeated negative CPR/IQR findings, has been referred to the IRC, and has had an internal monitor temporarily assigned.

Nevertheless, the following represents some of the findings identified for (#11) during the 2018 IQR.

<u>Not following up on ER/Urgent Care Recommendations.</u>

- *Not following Discharge Orders: ER visit 4/4/18, Discharge summary recommended to see PCP in 1 day. Next PCP visit 4/10/18.*
- *Not following up on fractures: x-ray report of 6/21/18 found fracture of 7th and 10th ribs and "possible atelectasis versus infiltrate in the left lateral costophrenic angle" and recommended "correlation with clinical picture. GER for this incident reports FU w/ PCP to occur on 7/5/18. No evidence of this appointment found in documents submitted for this review. Nurse reports, during interview on 7/17/18, indicate that no follow up has occurred as of that date.*
- *Urgent care visit on 12/1/17 (for cough, runny nose) recommended FU w/ PCP. Next PCP visit document provided for this review is from 2/7/18.*
- *Report from … walk in clinic on 3/22/18, where … was seen due to fever, states "Did not complete prescribed Amoxicillin. Needs full 10 days". Amoxicillin for 10 days had been prescribed to treat strep throat on previous visit to clinic on 3/2/18.*

<u>Not following up on Doctor/Specialist Recommendations/Dental issues.</u>

- *Not following up on surgical consult on 3/6/18 indicates that … may need surgery for rectal prolapse. No evidence found of any follow up on this recommendation. Nurse, during interview, was unaware if any follow up had occurred.*
- *Not following PCP and cardiologist recommendations: for low salt diet which have not been included in any plans or instructions to staff who prepare … meals.*
- *PCP recommended, on 4/10/18, that … go on a low-salt diet. Annual Nutrition Evaluation of 4/26/18 does not mention anything about a low-sodium diet.*
- *Cardiologist recommended to limit salt intake on 5/15/18. No evidence of … being on low salt diet.*
- *Not acquiring dental follow up timely: Dental appointment report of 4/3/17 states, "C#31-still missing crown as previously documented." No documentation found of why crown had not been replaced, or if a temporary crown had been placed. Residential nurse did not know why the missing crown had not been addressed for two dental appts.*

<u>Preventative screens and immunizations not acquired:</u>

- *Preventative Screens not acquired per orders: Nurse reports during interview, that …has not received Guaiac stool this year (recommended annually by PCP)*

- *No AIMS documents provided since 9/28/17.*
- *Nurse reports during interview that … has not received pneumonia vaccine that nurse reports is recommended for people over the age of 55.*

Numerous issues indicated that the team may not know and has not adequately discussed …'s diagnoses and health related issues. These include inconsistent and/or incorrect listing of diagnoses.

- *ISP lists only 7 diagnoses of the more than 30 identified on eChat and other documents.*
- *(Assessment) CIA of 7/24/17 lists diagnosis of seizure and indicates … has a helmet to protect from falls during seizure (but refuses to wear it). No evidence found in any other document that …has a diagnosis or history of seizure.*
- *eChat (item 22b) indicates no known hearing impairment. Audiological Assessment of 9/6/16 indicates "high frequency sensorineural hearing loss in each ear"*
- *More than 10 diagnoses are listed in other documents provided for this review that are not listed in eChat including mood disorder, depression, psychosis, depressive disorder with psychotic features, organic brain syndrome, Myopia, bilateral age-related nuclear cataract, high frequency sensorineural hearing loss, Mycoses, thrombocytopenia.*
- *Individual data section of Nursing quarterly and semiannual reports list Developmental Disability: "Autism, other" No diagnosis of autism listed in the eChat diagnosis list or found in any other documents (other than nursing quarterlies) submitted for this review.*

Not Following Health Care Plan:

- *Nurse, during interview, reports that June vital signs/O2 saturation data indicated one day in which O2 sats were 86%. Nurse stated he was not notified and that per HCP staff should have called nurse.*

The Comprehensive Aspiration Risk Management Plan (CARMP) does not provide consistent and accurate information/instructions

- *CARMP of 6/8/18, health monitoring section marks the item Use Pulse Oximeter as "NA". HCP for respiratory treatment (dated 6/6/18) states "take pulse oximetry weekly per protocol ….and more often if needed...If pulse oximetry less than 90% on ordered O2 call on call nursing!"*
- *CARMP indicates "chopped diet" (1/2 inch, uncooked elbow macaroni size pieces) cooked to soft consistency. The SLP assessment of 6/2/17 that … "requires a soft diet". Nutrition assessment of 5/27/17 indicates … should receive "moist pea size ground or chopped meats." Since chopped, ground and soft are all different diet textures, the use of all three terms in various documents makes it unclear what diet texture … should receive and unclear if CARMP accurately reflects the correct diet texture. Nutrition description of pea size meats conflicts with CARMP description of ½ inch uncooked elbow macaroni size pieces.*
- *CARMP of 6/8/18 lists the adaptive eating equipment as, "small (teaspoon) size spoon, divided plate, sippy cup or (straw with DSP support only). Then, under presentation of food, it states … food to be placed "in a dish" rather than a divided plate. Staff report during site visit that ... prefers to eat most food from a bowl.*
- *CARMP oral hygiene strategies section #11 q. #5: "Mouthwash or other prescribed solution (s) such as fluoride or anti-microbial agents: not at this time." MAR of May 2018 indicates Chlorhexidine 12% Mouthwash is prescribed by PCP for oral hygiene.*
- *CARMP Oral hygiene item #4, bullet #2 states that brushing time is for two minutes and item #11 q. #7 states that brushing time is 5 minutes.*

… This person is served by an agency which has been identified as having on-going problems for years and years. While some interventions have been tried, they have obviously not been effective as these many breakdowns illustrate.

B. A Profile of Jackson Class Members (JCM): Diagnostic Information

As of March 31, 2019, there were 245 Jackson Class Members receiving supports and services throughout New Mexico. Understanding the diagnostic and age profile of class members is important to understanding the urgency required to provide diligent and effective healthcare management. As the chart below illustrates, many class members have multiple and long-standing diagnoses which contributes to the need for informed and vigilant oversight of this profoundly challenged group of individuals if harm and deaths are to be prevented.

Chart #1: General Class Member Diagnostic Information

Region	Total Served	Mental Health	Aspiration Pulmonary	Sensory Limits	Mobility	Bowel Kidney	↓ Bone Strength	Cardio-vascular	Eating Esophageal	Epilepsy
Metro	147	252	180	203	176	134	122	92	107	89
NE	23	47	33	23	21	16	16	12	10	7
NW	18	12	24	22	32	25	19	9	13	9
SE	25	43	36	28	33	32	21	40	12	12
SW	33	67	44	45	23	31	22	35	20	8
Total	246	421	317	321	285	238	200	188	162	125

In addition to the many diagnoses attributed to class members, 174 (71%) of the 245 class members fall in the profound (120) or severe (54) range of intellectual disabilities. Level of disability can also influence the person's health-related needs and ability to communicate his/her current or changing circumstances. This in turn impacts on the level of awareness and diligence needed by support professionals to "see", "know" and "act" quickly and effectively.

The age range of Jackson Class Members is from 34 to 95 with the average age being 59.1. The following chart profiles age and service distribution of class members across the state.

C. A Profile of JCMs Demographics and Services Received

Chart #2: Profile of JCM Demographics and Services

Gender		
Females	99	40%
Males	146	60%

Ethnicity		
Hispanic	112	46%
Caucasian	87	36%
Native American	33	13%
Black	12	5%
Asian	1	<1%

Type of Residential Program		
Supported Living	192	78%
Family Living	34	14%
Independent Living	4	2%
Direct Services (Mi Via)	12	5%
ICF/MR	3	1%

Class Members per Region		
Metro	146	60%
Northeast	23	9%
Northwest	18	7%
Southeast	25	10%
Southwest	33	13%

Age		
30-39	3	1%
40-49	32	13%
50-59	98	40%
60-69	79	32%
70-79	27	11%
80-89	5	2%
90+	1	<1%
Average Age:	59.1	
Youngest JCM: 34	Oldest JCM: 95	

Type of Day Program		
Adult Habilitation	170	69%
Community Access	7	3%
Supported Employment	4	2%
Adult Habilitation and Supported Employment	28	11%
Adult Habilitation and Community Access	14	6%
Community Access and Supported Employment	2	1%
Direct Services (Mi Via)	12	5%
ICF/MR	3	2%
None	5	3%

III. INTRODUCTION TO THE 2018 INDIVIDUAL QUALITY REVIEW STATEWIDE REPORT

A. From Community Practice Review to Individual Quality Review

In 2016 The Department of Health (DOH), Developmental Disabilities Supports Division (DDSD) and the Division of Health Improvement (DHI) asked the Community Monitor and the Jackson Parties to consider updating the protocol to make it more contemporary in terms of the type and depth of areas probed as well as the use of more person-centered language. The Parties agreed leading to a collaborative process, led by the Community Monitor but engaging all parties, in developing, testing and implementing a comprehensive person-centered *Individual Quality Review* (IQR) protocol and review process. Input into the 2017 IQR questions asked and scored reflected feedback from providers, case managers, Plaintiffs, Intervenors, Defendants, the Community Monitor and Community Monitor Consultants.

In December 2017, Defendants requested to go back to the previous version of the CPR Protocol document. After many meetings and discussions with all Parties, a revised 2018 Protocol was developed and implemented. These modifications, in part, are expected to enable DHI to conduct a more streamlined IQR and sustain the process. As in the past, the IQR protocol sections are posted at *www.jacksoncommunityreview.org* which enables everyone participating in the review to see the questions which will be asked as well as notes identify what reviewers are probing in advance of every review. For more information related to the transition of the IQR to DHO/DHI see Appendix B.

B. Background for the 2018 Report

During the 2018 Individual Quality Review supports and services provided to eighty-seven[9] citizens who are Jackson Class Members (JCMs) were reviewed. The findings from those individual reviews form the foundation of this report. Over 670 people were interviewed, over 170 observations were conducted, and thousands of documents were reviewed. Before finalizing the findings and recommendations, the Community Monitor met with representatives of each regional office and over 780 representatives from individual teams to review each finding for clarity and accuracy. Information gathered through this multi-level review process was recorded in each individual's IQR protocol, findings and recommendations. That individual data has been aggregated, analyzed and form the basis of the detailed findings in this report.

This report also identifies related objectives which come from Evaluative Components ordered by the Honorable James A. Parker on April 3, 2015 (Doc. 2035). As noted earlier, this order was in effect during the 2018 IQR Review.

The draft of this report was originally distributed by the Community Monitor to the parties on May 3, 2019 for their review and comment. As in the past, the Community Monitor invited the parties to review the report and then schedule a time to meet and discuss the systemic recommendations so that suggestions could be considered. The Community Monitor met with and reviewed the report findings and recommendations with representatives of the Plaintiffs (June 3, 2019) and Arc Intervenors (June 5, 2019). Defendants did not respond to the Community Monitor's invitation.

For the purposes of understanding the detail of this report, it is important to note the difference between findings and issues. Findings relate directly to the number of findings identified for each individual being reviewed. A summary of findings and individual recommendations is issued after every review for each person in the review. Within a given finding there can be more than one issue addressed. For example, Question 64 asks, "Has the individual received all age

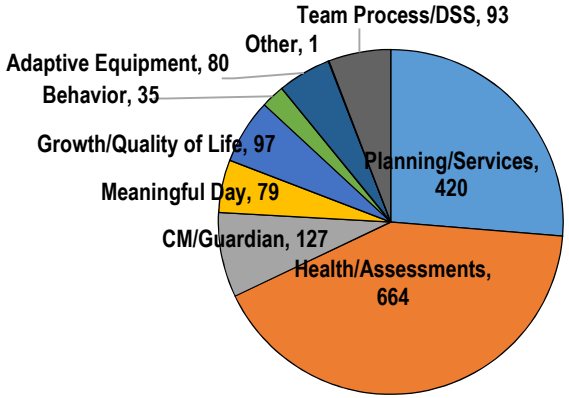
[9] Five JCMs reviewed receive supports and services through the Mi Via Waiver. There are findings and recommendations for these individuals but they are not counted in the scored questions.

and gender appropriate health screenings, in accordance with national best practice and/or as recommended by his/her PCP or other health care professionals." The finding might be: "There was no evidence that Jack has been tested for colorectal cancer, received his flu short or been tested for Hep C."[10] While there is ONE finding there are THREE issues in this finding that Jack and his team and his physician are invited to consider to determine if they are appropriate for him.

C. Most Frequently Identified Findings by Category

In the 2018 Individual Quality Review, statewide, there were a total of 1,596 Findings and Recommendations made. The chart below shows what categories they fall into.

Chart #3: Number of Findings by Category



For at least the past seven years the areas which have the most identified deficiencies/findings are in Health/Assessments and Adequacy of Planning/Individual Support Plan (ISP). Notably, planning findings decreased in 2018 compared to both 2016 and 2017. Health related findings, however, continue on a dangerous upward trajectory. Health and Assessments findings are at an average of 7.6 per person which is up from a previous high of 5.48 in 2017. Both health related and planning related areas will be explored in greater detail in this report, starting with identified health related issues.

The following chart identifies the topical categories where most findings of problem areas were identified during the last seven years. This enables a quick review of trends including areas of improvement, areas of inconsistent results and areas of unacceptable increases.

[10] Issues are identified through use of the healthfinder.gov website adopted as the standard by DDSD for the required screenings and immunizations based on age and gender.

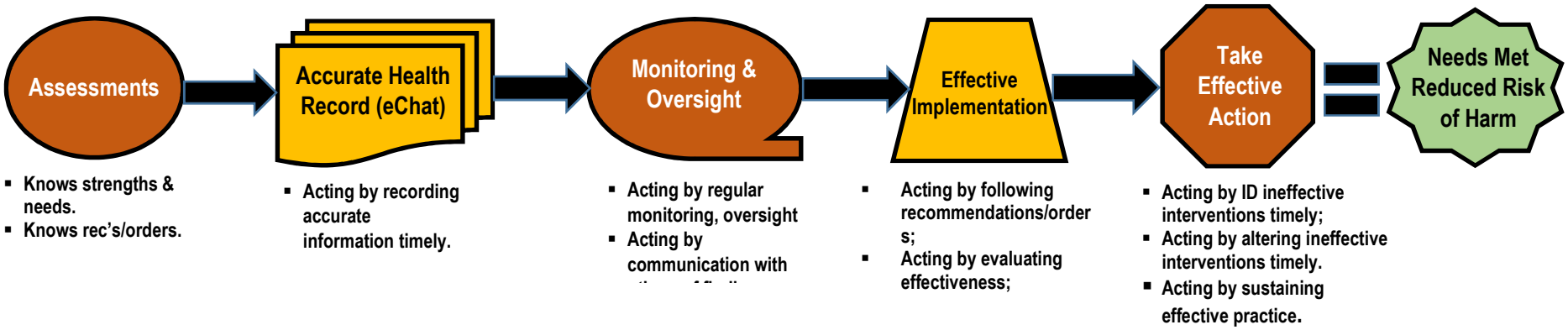
Chart #4: Number of Findings by Topic Category, 6-Year Totals With Average Number of Findings per Class Member Reviewed							
Category area[11] Number in sample	2011/2012[12] 109	2013[3] 103	2014[13] 101	2015[4] 99	2016 93	2017 65	2018 87
Adequacy of Planning/ISP	327 Avg: 3.00	411 Avg: 3.99	439 Avg: 4.25	461 Avg: 4.66	576 Avg: 6.19	607 Avg: 9.34	420 Avg: 4.82
Health/Assessments	370 Avg: 3.39	321 Avg: 3.15	437 Avg: 4.33	414 Avg: 4.18	313 Avg: 3.66	356 Avg: 5.48	664 Avg: 7.63
Case Management and Guardianship	177 Avg: 1.63	188 Avg: 1.83	198 Avg:1.96	166 Avg: 1.68	149 Avg: 1.60	85 Avg: 1.31	127 Avg: 1.46
Direct Care Services / Team Process	171 Avg: 1.57	151 Avg: 1.47	137 Avg: 1.36	152 Avg:1.54	131 Avg: 1.41	38 Avg: .58	93 Avg: 1.07
Expectation of Growth/Quality of Life/Meaningful Day	103 Avg: .94	84 Avg: .82	107 Avg: 1.06	106 Avg: 1.07	95 Avg: 1.02	146 Avg: 2.25	176 Avg: 2.02
Behavior	Not Aggregated	Not Aggregated	Not Aggregated	63 Avg: .64	43 Avg: .46	24 Avg: .37	35 Avg:.40
Adaptive Equipment	81 Avg: .74	62 Avg: .60	70 Avg: .69	50 Avg: .51	46 Avg: .49	60 Avg: .92	80 Avg:.92

[11] Immediate and Special findings are included in their appropriate topic areas for 2014, 2015, 2016 and 2017
[12] The 2011, 2013 and 2014 numbers were provided by DDSD.
[13] The 2015 and 2016 numbers provided by the Community Monitor.

A. Basic Components of Health Care Management

Related Evaluative Components Required for Disengagement include, in part:
Health Objective H1.1. **Expectations for healthcare coordination are appropriate as evidenced by well-defined roles and responsibilities that are carried out and measured at the *provider, region and state level*.**
H1.**c. The definitions of healthcare coordination … must contain *measurable performance indicators* so that DOH can *assess* whether the assigned responsibilities are carried out at the provider, regional and state levels.**
H1.**1e The DOH must *take prompt action* to address healthcare coordination performance that does not meet the measurable performance indicators.**

Healthcare Management involves deliberately organizing individual care activities and communicating information with all involved. This means that the person's needs are known ahead of time and communicated at the right time, to all of the right people, and that this information is used to provide safe, appropriate, and effective care.[14] Basic components of health care management needed to safely and effectively manage the individual's healthcare include:



Healthcare management is everyone's responsibility. At a high level, what is being probed as part of the Individual Quality Review is whether the providers/team knew and whether the providers/team acted based on that knowledge. In basic terms, Team members have a duty to thoroughly know the person and his/her changing circumstances and then to act with reasonable care to, at the very least, prevent harm and, hopefully, to enable the person to flourish. It is through this lens of did we know and did we act that the reader is encouraged to examine the implications of the findings throughout this report but most urgently with respect to health-related findings.

[14] Modified from the United States Department of Health and Human Services, Agency for Healthcare Research and Quality, Care Coordination, Quality Improvement project, http://www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html

This section focuses, primarily, on information gathered through the IQR at the individual and provider (day and residential) levels. Case Management, individual planning, therapy, employment and other important contributors to overall wellness are addressed later in this report.

The IQR explores multiple aspects with respect to the class member's health and resulting health care management which begins with what providers, teams and the system know about the individual. As with all of us, a fact-based understanding of how the person is doing and what his/her needs are begins with *assessments.* Assessment results and recommendations need to be *documented accurately and timely* in the person's *health record* so that others have the same information. In turn, *monitoring and oversight* needs to occur to ensure timely, consistent and *effective implementation of recommendations/orders* and to ensure that any *change in condition is identified quickly*. Briefly, people should *take informed action*, as needed, in a *timely, effective way to prevent harm*.

As evidenced by the information provided throughout this report, ALL of these basic steps required to ensure the health, safety and protection from harm of Jackson Class Members are and have been substantially ineffective for far too many class members.

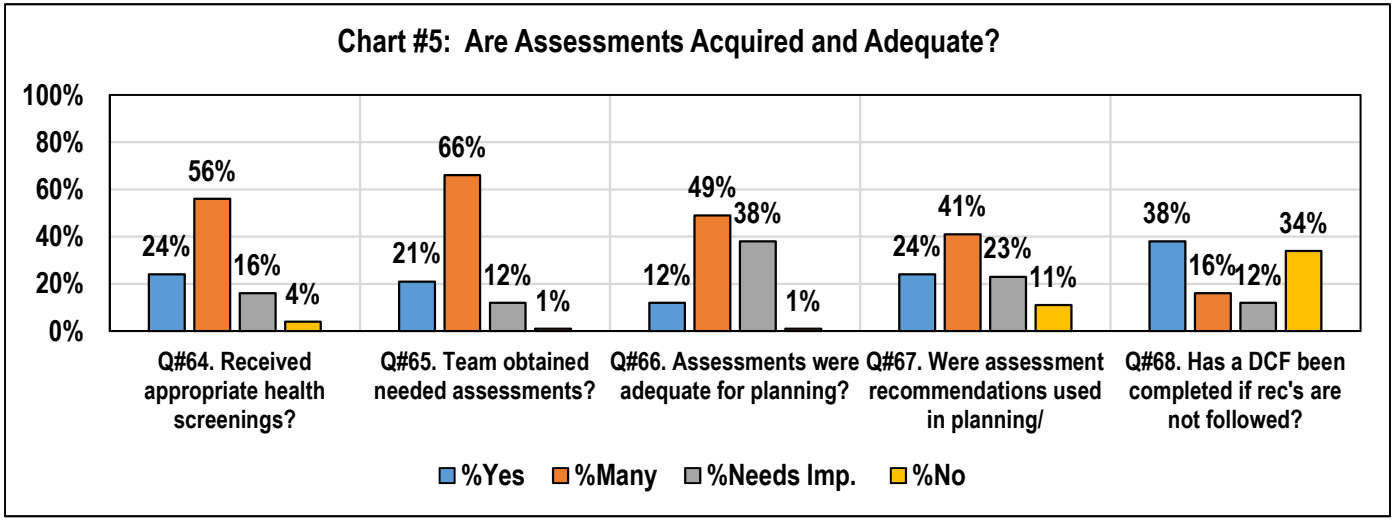
B. Do Class Members Have Needed Assessments/Screenings?

Related Evaluative Components Required for Disengagement include:
H1.7: The team assures recommendations from healthcare professionals are reviewed with the individual and guardian in a manner that supports informed decision making and are either implemented, or documented in a Decision Consultation Form if recommendation is declined.
H1.7a A JCM's IDT must ensure that a healthcare professional's recommendations and assessments (1) are promptly communicated to the nurse, guardian, DSP, and entire health care team, as needed, and (2) are implemented, unless the individual or their healthcare decision maker declines the healthcare professional's recommendations by completing a Decision Consultation form.

The first step in meeting individual needs and reducing risk of harm, is knowing what the individual's health-related needs are as identified by assessments/screenings. Assessments, in this case, refer to both DD Waiver required assessments as well as assessments, tests or screens that are recommended by the individual's Primary Care Physician (PCP), clinical specialists such as gastroenterology, neurology and others to whom an individual may have been referred. The second consideration is whether the assessments provide information that can be used by the Team for planning purposes. Assessments need to provide information that will guide the Team as they work to support the individual and as they develop a comprehensive plan to help the person learn, develop a skill, achieve an outcome, address a medical or behavioral issue and so on. For some individuals, maintaining current skills and level of health may be an appropriate aspiration depending on the individual's personal circumstances (e.g., having been diagnosed with a degenerative disease or in hospice). Finally, the IQR probes whether or not recommendations made as a part of an assessment were used/acted upon by the team. Relevant IQR Questions include:

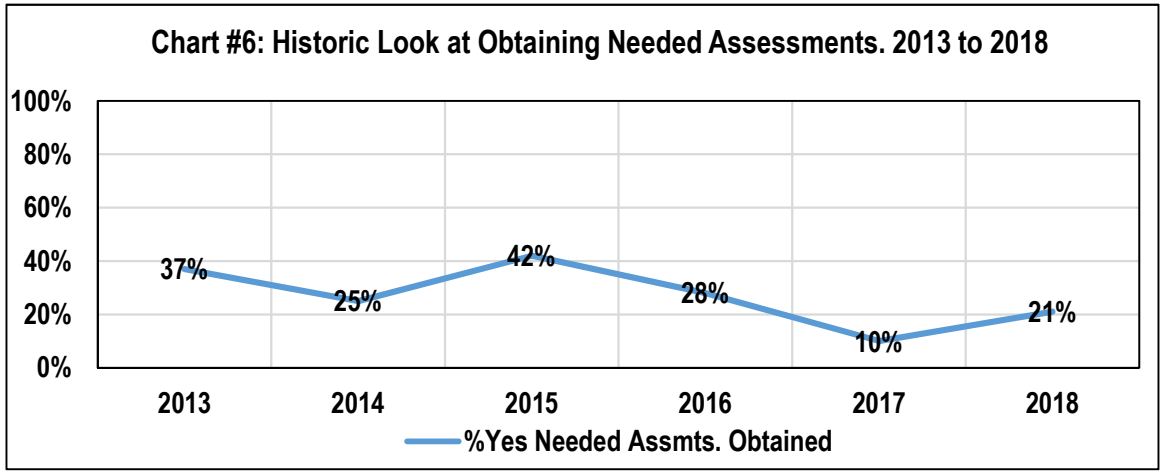
Question #64: Has the individual received all age and gender appropriate health screenings in accordance with national best practice and/or as recommended by his/her PCP or other health care professionals?
Question #65: Did the team arrange for and obtain the needed, relevant assessments?
Question #66: Are assessments adequate for planning?
Question #67: Were recommendations from assessments used in planning?

Question #68: For medical, clinical or health related recommendations, has a Decision Consultation Form (DCF) been completed if the individual and/or their guardian/health care decision maker have decided not to follow all or part of an order, recommendation or suggestion?



Both the previous CPR as well as the current IQR asked questions seeking information related to assessments. When there are comparable questions from the CPR and the IQR 'yes' scores, they have been identified for comparison. This provides one indication of how well class members' needs are assessed and resulting day-to-day services and supports summarized and provided through these assessments and health care plans.

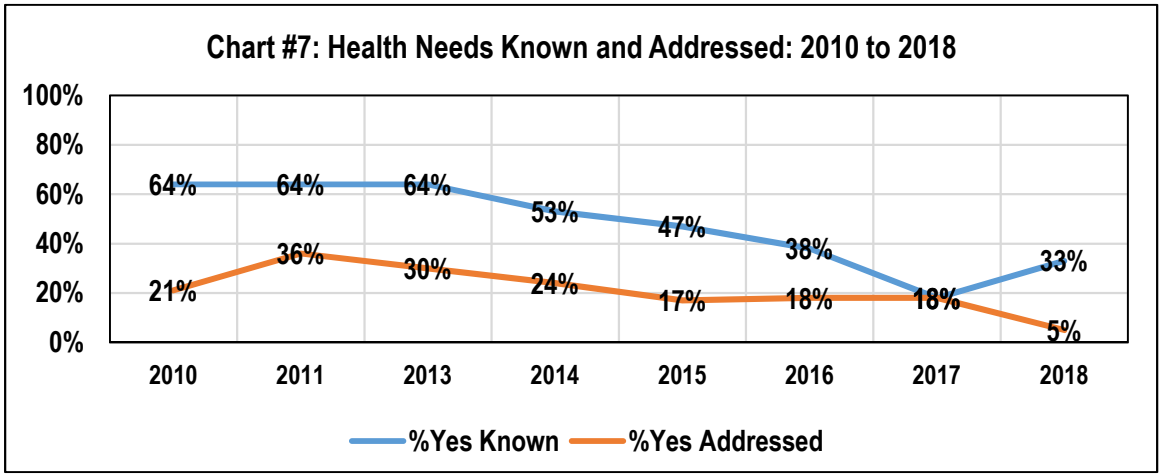
The lack of acquiring needed assessments or their alternatives is a long-standing issue as the following chart illustrates. While there was an increase from 10% to 21% of JCMs reviewed receiving needed, relevant assessments this small increase can bring no level of satisfaction or belief that this issue is understood or being adequately addressed and sustainably resolved. The following chart relates to IQR Q# 65. Did the team arrange for and obtain the needed, relevant assessments?



C. Are Class Members' Health Needs Known and Addressed?

Both the CPR and the IQR asked questions that specifically relate to whether the team (knew) discussed the person's health-related issues and whether those needs were adequately addressed (acted). As Chart #7 below illustrates, since 2010, there has been a steady decline in evidence verifying that team members know the person's health related needs with a small but inadequate increase in 2018. More important, and dangerous, is the continued decline in evidence that providers and team members are adequately addressing the person's health needs.

Question #53. Is there evidence that the IDT discussed the person's health-related issues?
Question #62. Are the person's health supports/needs being adequately addressed?



This report aggregates information gathered at the individual level in an effort to both identify individual strengths and challenges as well as enable the identification of trends in good practice as well as in practice that needs improving. These numbers come from real life experiences of class members and impact on the person's quality of life. The level of the impact depends in large part on the nature of the issue and subsequent finding.

The story behind the numbers: Person #22

… is in her 80's and is at risk of aspiration. She was hospitalized for aspiration pneumonia in 2017. Her evaluation at the Supports & Assessments for Feeding and Eating (SAFE) Clinic was completed in May 2017. Her team met to discuss the preliminary report on 6.7.17, the final report was issued 6.19.17 and included 14 recommendations related to her medical, nutritional, oral motor or positioning issues.

Eight months later, February 22, 2018, the IQR found that for 50% of those recommendations there was no evidence that the team acted on or addressed them. For example:

- *The SAFE Clinic recommended either a tilt in space wheelchair or modifications to a standard wheelchair due to increasing postural difficulties which can exacerbate (this person's) aspiration issues. A script for a wheelchair evaluation was provided. The wheelchair was not delivered to (person) until 4.19.18, 10 months later.*
- *Consider offering 6 smaller meals (3 meals and 3 snacks) because of her history of GERD and her (remote) history of rumination. Recommendation not addressed.*
- *Because (person's) kyphosis she is better positioned when her trunk is not completely upright. Recommendation not addressed.*
- When being dependently fed, consider using the bolus loaded spoon to apply pressure to the mid-third of her tongue and waiting for lip closure before removing the spoon. Pressure to the tongue stimulates lip clearance of the spoon. *Recommendation not addressed.*

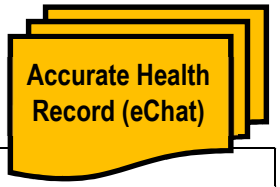
The story behind the numbers: Person #23

… is in her 60's, is interested in everything and was in need of, but did not receive, Physical Therapy and modifications to her wheelchair. As a result of the lack of adequate support to her body, her tendons tightened, her toes curled and she could no longer walk safely. She acquired a blood clot and was put on hospice.

March 2016: Freedom of Choice (FOC) signed to add Physical Therapy (PT)
May 2, 2016: Another FOC was signed to add PT
February 27, 2017: Physician's Order for a new manual wheelchair was written.
March 2017: The PT assessed this person and identified that she did need PT. PT expressed concerns regarding Person #2's wheelchair and its inadequacies.
July 2017: 4 months after the assessment, the PT was given authorization to begin PT services.
December 2, 2017: PT wrote a statement of need regarding the wheelchair.
February 11, 2018: (Person) falls from her recliner, fracturing her right orbital socket.
February 15, 2018: PT, again, indicates that this wheelchair is and has been inadequate… she couldn't reach the foot rests and the back had no support for her.
March 7, 2018: Placed on Hospice
March 15, 2018: During the meeting with the Community Monitor, the PT indicated that because she has gone without foot rests on her chair for so long she now has a deformity of her feet (curled) so the goal of walking for 20 minutes a day is not healthy or safe. An evaluation of her foot, ankle and legs was requested.
April 5, 2018: PT withdraws request for an evaluation of her foot, ankle and legs because she is on hospice.

As of the writing of this report, this person is no longer on Hospice.

D. Are Health Records Accurate and Completed as Needed?



Related Evaluative Components Required for Disengagement include:
Health Objective H1.3 **Teams use accurate health records for Jackson Class Members.**
Health Objective H1.5 **Identified health needs for Jackson Class Members, including daily medical considerations, are addressed in individualized healthcare plans, MERPs, CARMPs, and written direct support instructions as appropriate to the Jackson Class Members. Healthcare plans are reviewed and promptly modified in response to changes in health status.**
Health Objective H1.6 **Current and complete information is provided to the healthcare professionals treating or evaluating the individual.**

One important way for teams and clinical specialists/physicians to protect the individual's health, ensure quality of care and the accuracy of their long-range treatment is to have accurate and comprehensive health records. Health records provide a means of communication about preventative health services, history of examinations, diagnoses, planning and treatment of the individual. The information contained in the person's health record is critical for all providers involved including any subsequent new providers/specialists who assume responsibility for identified health needs of the person.

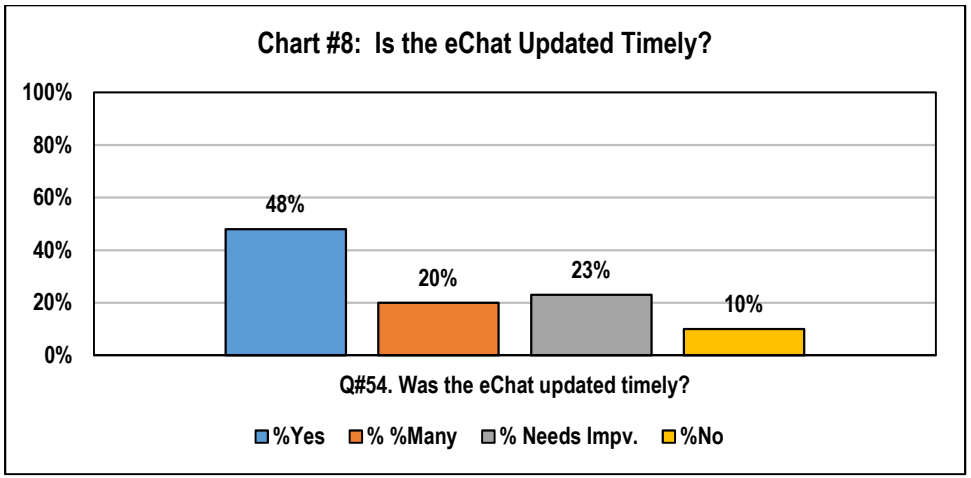
As mentioned above, one of the first steps in knowing the person and having an accurate picture of his/her health status begins with assessments. Based on the outcome of those assessments/screens individual Health Care Plans (HCPs) and Medical Emergency Response Plans (MERPS) may then be developed. Health Care Plans which are required versus those which should be considered are to be noted in the electronic record as are medication administration records and tracking documents to verify that implementation is occurring as intended and/or body functions are occurring safely (e.g., bowel movements, weight stabilization, blood pressure). These health-related records are intended to give guidance to direct support professionals in the day-to-day care of the individual. Team members have a duty to know these documents well and to act with reasonable care in a way which results in early identification, prevention and/or effective and timely treatment. As important as these plans and documents are to the health and safety of the individual, wide spread conflicting and inconsistent information continues to exist within and between them. Such inaccuracies or omissions can put the individual in serious jeopardy and can leave staff confused and conflicted as to what actually should be or has been done. As evidenced by the chart which follows, these issues are long standing and continue at an unacceptable rate.

When considering 'health records' there are a number of documents, plans and tools that make up that record. A few of the most frequently relied upon are listed below along with findings regarding their accuracy, timely availability and use.

The *Health Care Plan (HCP)* is a document developed by a licensed nurse that identifies the individual's health care needs, measurable health related goals, and specific activities to be implemented by licensed nurses, direct support personnel, caregivers or other members of the Interdisciplinary Team (IDT) to address identified health care needs and goals. Health Care Plans addressing constipation/bladder and risk of falls are two examples of common HCP.

A *Medical Emergency Response Plan (MERP)* is a document developed by the agency nurse or other health professional identified by the Interdisciplinary Team (IDT) that provides guidance to staff when an individual has a chronic condition or illness that has the potential to develop into a life-threatening situation. Each Medical Emergency Response Plan (MERP) addresses a single condition/illness.

The *electronic Comprehensive Health Assessment Tool* (eChat) is an in-depth health evaluation of an individual completed by a licensed nurse. The nurse must see the person face-to-face to complete the nursing assessment.[15] It is an online assessment of an individual's health symptoms and history. It also calculates the overall acuity level and publishes a summary with recommendations for where care plans may be required. An eChat is required for people receiving Family Living, Supported Living, Intensive Medical Living Services (IMLS) or Customized Community Supports Group (CCS-Group).[16] It is critical that the information contained in the eChat be accurate and current. The acuity level influences how often the individual is to be seen by a nurse and how often nursing assessments/reports are to be done and the expected level of nursing participation in planning and oversight. An accurate and comprehensive list of diagnoses is required and affect how engagement and/or treatment is designed for a person. The Department expects, through its standards, the eChat to accurately reflect each person's health status and history.



A Comprehensive Aspiration Risk Management Plan (CARMP) is required for people with high or moderate aspiration risk. Individuals identified with high aspiration risk may receive nutrition via tube and have symptoms such as: been hospitalized during the past 2 years for aspiration pneumonia; received outpatient treatment for aspiration pneumonia during the past 12 months; rumination more than 1 x a week; moderate to severe dysphagia coupled with one or more issues such as chronic lung disease, immunosuppression, uncontrolled GERD, rumination or vomiting (weekly). Individuals at moderate aspiration risk have symptoms such as moderate to severe dysphagia *without* chronic lung disease, immunosuppression, uncontrolled GERD, rumination or vomiting along and other identified issues. Aspiration is one of the leading causes of death in individuals with intellectual and developmental disabilities. As a result, this plan must be current, accurate and implemented. The Department has spent a great deal of time developing the Aspiration Risk Screening Tool, the Comprehensive Aspiration Risk Management Plan, Nursing Collaborative Aspiration Risk Assessment Tool and Standards addressing Aspiration. Consistent implementation, oversight and enforcement remain an ongoing challenge for providers and DOH.

[15] NM DD Waiver Standards, Chapter 13. Nursing Services, 13.2.6, Page 161
[16] Ibid.

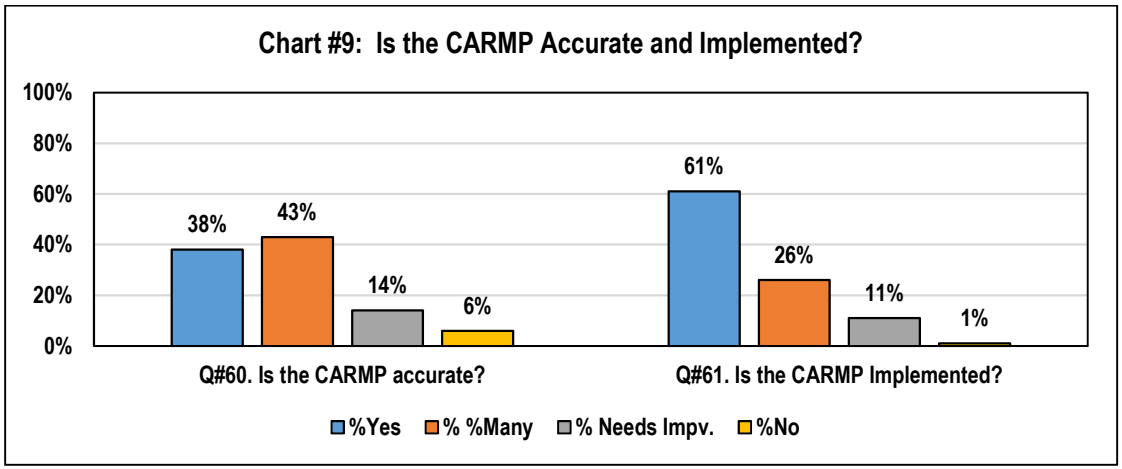


Chart #10: Issues Identified Related to the Accuracy of Health Records				
Issue	**Year**	**# of JCM**	**%**	**# of Issues**
Plans, Documents Not accurate, or Contain Inconsistent Information	2018	79 of 87	91%	750
	2017	*56 of 65*	*86%*	*253*
	2016	*57 of 93*	*61%*	*128*
Assessments: Late, Inaccurate, or Missing	2018	60 of 87	69%	159
	2017	*42 of 65*	*65%*	*85*
	2016	*19 of 93*	*20%*	*29*
Tracking Not Done or is Inaccurate	2018	31 of 87	36%	239
	2017	*14 of 65*	*22%*	*23*
	2016	*7 of 93*	*8%*	*9*
Medication Administration Record/Issues	2018	38 of 87	44%	221
	2017	*18 of 65*	*28%*	*56*
	2016	*16 of 93*	*17%*	*23*

NOTE: The number of issues identified by provider related to health records are identified in Appendix G

The story behind the numbers: Person #5

… at the time of the review, … a 56-year-old woman with an engaging smile and expressive eyes. She has multiple diagnoses which include, in part, breast cancer, dysphagia, seizures, constipation, impaired mobility, osteoporosis, GERD…

Her revised CARMP of November 2017 contains many inconsistencies:

- *It is not clear in the CARMP if … needs to wait 30 secs or 1 minute between each bite. The instructions in the diet texture section states 30 seconds between each bite (in bold and underlined). The instructions in the self-feeding section states "at the moment, waiting the full minute between bites supersedes independence if she is not cooperative" (bolded and underlined).*
- *The CARMP states … needs to maintain 80-90 degrees upright seated position for 2 hours. The Aspiration MERP states for one hour.*
- *The CARMP includes instructions for postural drainage which have been discontinued.*
- *The CARMP identifies the usage of a bite block during oral hygiene. During interview, staff stated that this is not allowed and is not done.*
- *The section of the CARMP for tube feeding includes incorrect times and amounts of the water flushes. The CARMP has flushes occurring at 8 a.m., 12 and 5 p.m. at 200ML HS. It should read 1 hr. after she eats. The amount also changed per Dr.'s order. (The correct instructions are in the nutrition report 12.21.17, Dr.'s orders are 10.10.17.)*
- *The CARMP stated that positioning for ADLs is 30 degrees while the Aspiration MERP identified 15 degrees from lateral as being ideal. This is confusing as different terminology is utilized.*
- *Residual protocol is not clearly defined within the CARMP. Tube feeding support plan stated that less than 60ml residual should be returned and if residuals are greater than 100ml, then on call nurse should be notified. No guidance regarding residuals between 60 and 100ml.*
- *At times … is not safe to eat due to decreased alertness, however, the CARMP does not provide clear guidance regarding how this should be assessed.*
- *There was no evidence found that indicated the nutritionist was involved in the authoring of the revised CARMP (no author contact information).*

The story behind the numbers: Person #13

… is a high aspiration risk and there are issues with the CARMP.

- *The CARMP states that … sleeps with a 30º incline in the head of her bed, however, per observation in the home, the bed was flat and when asked if the head elevated or stayed flat was told that it stays flat.*
- *The CARMP lists liquids should be honey consistency, yet there is no commercial thickener or specific additive identified on the CARMP 6/7/18, the e-chat 6/4/18 or the May, June or July MARs.*
- *The CARMP of 6/7/18, lists honey thickened liquids and an amount of ¼ ounce to be given at a time.*
- *Per the Health Care Reports (quarterly Nursing reports) of 6/4/18 and 2/27/18, it lists Dietary guidelines as "one ounce drinks"; Per the Teaching and Support Strategies for ISP meeting date 7/10/17, Modified to begin implementation 8/30/17 for the WORK outcome pg. 2 states "Drinks need to be in ½ ounce increments."*
- *Per the Health Care Plan for Overweight, drinks are to be limited to one ounce. Per nursing interview, PG is "limited to 1 ounce at a time". Per the Speech Therapist interview PG is given 1 ounce at a time.*
- *No liquid amount is listed on the Nutritional annual report of 5/22/18, or the Modified Barium Swallow report of 10/12/17.*

- *Upon interview and on-site review, the amount of liquid is not measured. The thickened liquid is poured into a cup. Both Residential and Day staff stated that …is given 1 ounce at a time.*

The story behind the numbers: Person #25

… is a 52-year-old man. He had a Swallow Study completed on 2/2/18 which indicated poor mastication of solids placing … at risk for choking and aspiration. The Swallow Study (3.13.18) also indicted esophageal phase dysfunction and recommended a chopped diet.

The CARMP was established (dated 3/15/18) but all staff interviewed on 3/22/18 reported they had not been trained on the CARMP. Day staff was unaware of the new CARMP and reported he receives a regular diet. The Residential Staff indicated that he is chopping the diet consistent with the CARMP. The ARST provide for this review does not reflect current aspiration risk.

The HCP for reactive airway disease, COPD, Asthma makes no mention of how frequently O2 sats are to be checked or of the procedure for increasing O2 to 4L and/or giving DuoNeb Nebulizer treatment if O2 sats are below 88%. It states to notify nurse of sats below 89%. CM interview, site visit note of 6/20/17 and subsequent IR (received 6/20/17) indicate two instances in which …'s O2 sats were below level that HCP requires that nurse be notified, nurse reported she had not been notified (O2 was 80 on 6/11/17 and 83 on 6/16/17, HCP for COPD requires nurse be notified if O2 levels below 90).

E. Is Health Care Monitoring and Oversight Taking Place as Needed?

Monitoring & Oversight

Related Evaluative Components Required for Disengagement include:
Health Objective H1.2 **Nurses routinely monitor Jackson Class Members' individual health needs through**
(1) Oversight,
(2) Communication with DSP (Direct Support Professionals), and
(3) Corrective actions in order to implement the Jackson Class Members' health plans, to ensure that the Jackson Class Members' health needs are being met, and to timely respond to changes in Jackson Class Members' health status.

Health Care oversight and monitoring is a critical function of agency nurses. Others also carry responsibility for implementing, detecting, reporting and acting as well. This section specifically focuses on nurse responsibilities and adequacy of nursing services.

> **Nurses play a pivotal role in supporting individuals receiving services, their guardians, Direct Support Professionals (DSPs), case managers, supervisors and many others within the DD Waiver system and also serve as a key link with the larger Health Care system. DD Waiver Nurses identify and support the person's preferences regarding health decisions; support health awareness, management of medications and health conditions; assess, plan, monitor and manage health related issues; provide education, and share information among the IDT including DSP in a variety of settings.[17]**

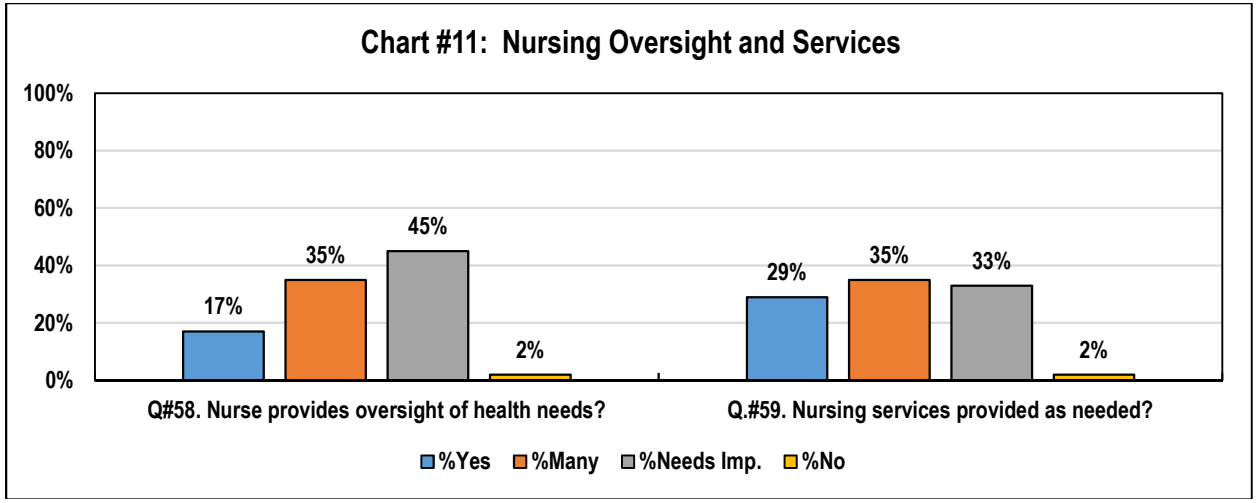
[17] Taken from Chapter 13. Nursing Services, page 157.

Nurses are to respond proactively to chronic and acute health changes and concerns, facilitating access to appropriate healthcare services. This involves communication and coordination both within and beyond the DD Waiver system and typically includes contact and collaboration with the person, guardian and IDT members, which include: Primary Care Practitioners (physicians, nurse practitioners or physician assistants), specialty practitioners, Dentists and the Medicaid Managed Care Organization (MCO) Care Coordinators.[18]

As noted in the 2017 IQR Statewide Report, Nurses and the supports they can provide are essential for the protection and healthy living of class members. In 2017, Nurses identified multiple barriers to their practice including, in part: over-regulation; lack of administrative support from their local provider(s) (e.g., ensuring staff attend scheduled training, effective supervision of provider staff to ensure consistent, and accurate implementation of nursing/health instructions and plans…); nurses being required to do non-nursing documentation/activities; pay; caseload numbers; unrealistic on-call expectations. It is unclear if any meaningful action to address these issues has taken place. All of these issues, as well as oversight, are important and need to be fully addressed in an attempt to ensure a stable and informed nursing workforce. In turn, the expectation is that healthcare services and support to class members improves beyond current experience, some of which is highlighted next.

Answers to the following questions help illuminate our understanding of how the lack of adequate nursing oversight and coordination can contribute to lack of overall health care for class members. Specific nursing responsibilities probed for in the IQR include:

Question #58. Does my nurse provide oversight of health needs (i.e. weight records, vitals, lab reports, PRN medication use, seizure records) in order to ensure accuracy, identify and respond to new issues?
Question #59. Are nursing services provided as needed by the individual?



[18] Ibid.

The story behind the numbers: Person #15

… is a 59-year-old man with multiple diagnoses which include, in part, Seizures, Tourette's, hypothyroidism, depression, PTSD, insomnia… … also has a diagnosis of hypertension.

His blood pressure is to be taken 2 x a day. Examples of blood pressure readings recorded in Vital Signs Tracking from 1.1.18 to 10.24.18 include:

1.14.18: 193/105	*2.24.18: 168/130*	*3.17.18: 177/107*	*4.15.18: 201/119*
5.1.18: 179/103	*6.6.18: 170/112*	*6.7.18: 165/55*	*July 2018: No data*
August 2018: No data	*9.26.18: 145/95*	*10.6.18: 166.67*	*10.25.18: 125/90*

There are other inconsistencies in data tracking provided. The MARS and Tracking sheets do not have consistent tracking information for vital signs. Vital signs tracking from 1/1/18-10/24/18 provided for review is missing dates: only 4 days are tracked in Sept 2018; There is no tracking in July or Aug 2018; June is missing data on the 28, 27, 26, 25, 22, 20, 19, 18, 15, 13; May is missing the 24, 22, 2; Feb is missing the 13, 7: Jan missing 31, 30, 25, 18, 17, 11, 10, 4, 3.

Per the MARs for the months of 1/1/18, through 10/24/18, blood pressure was initialed as completed and as required per the HCP for Decreased Cardiac Output, 4/12/18, which states, Blood Pressure is to be checked before each dose of Prazosin.

The story behind the numbers: Person #26

… is a 65-year-old woman with type 2 diabetes with hyperglycemia along with other diagnoses including, in part: anxiety disorder, asthma, GERD, hypertension and dysphagia.

…'s Health Care Plan for Diabetic/A1C/ fingerstick blood sugar check indicates finger stick blood sugar checks should be completed once a day. Per Blood Sugar Tracking in file it indicated there was missing tracking for every month since January 2018.

Below is a list of months and the number of days when blood sugar checks were not documented.

- *January 2018 - 4 days missed*
- *March 2018 - 16 days missed*
- *May 2018 - 17 days missed*
- *July 2018 - 15 days missed*
- *September 2018 - 8 days missed*
- *November 2018 - 1 day missed*
- *January 1- January 20, 2019 - 4 days missed*
- *February 2018 - 15 days missed*
- *April 2018 - 8 days missed*
- *June 2018 - 17 days missed*
- *August 2018 - 12 days missed*
- *October 2018 - 4 days missed*
- *December 2018 - 4 days missed*

The story behind the numbers: Person #4:

… is a 56-year-old man who has been blind since birth. Other diagnoses include, in part, Autism, anxiety, osteoporosis, GERD, Mood Disorder, insomnia and epilepsy.

The IQR found that …'s nurse did not provide adequate services or oversight of his health needs in order to ensure accuracy and to identify and respond to new issues. For example:

- *Nursing Quarterly Healthcare Reports did not contain discussion of current health-related issues, efficiency of current care plan or goal/changes that may be needed.*
- *The MAR is not updated to show current medication that is being administered, e.g. Ibuprofen 800mg listed that he doesn't take any longer (from 2009).*
- *The MAAT is dated 3/7/18 and states that it was completed by (woman/name), but it is signed by (man/name) and dated 2/17/17.*
- *Vital tracking does not show where …'s pulse is being taken 2x/day, as ordered, and nursing monthlies and quarterlies document days where …'s pulse was recorded only 1x/day (must be 2x/day before medication). There is no documentation to indicate that the nurse followed up on the lack of tracking.*
- *Weight tracking does not note weights taken every month. Weights were recorded 1/18, 6/18, and 9/18 (CARMP and eCHAT state monthly weight). There is no evidence that the nurse has followed up on missing weight data.*
- *BM logs are missing dates throughout 2017 and 2018. There were times documented where … went longer than 3 days without a BM and no evidence to show it was addressed.*
- *The HCP for constipation states says to "know and use MERP for 'Potential for Impaction Related to Constipation,'" but there is no MERP for constipation.*

… has not had a seizure for over a year according to staff. MERP for seizures tells staff to time …'s seizures, but does not tell them how long the seizure should last before calling 911. …'s CARMP indicates that it becomes an emergency if a seizure lasts longer than 4 minutes.

F. Are Individuals' Health Needs Addressed as Needed?

Related Evaluative Components Required for Disengagement include:
Health Objective H1.4 **Teams (including the individual) have information (education, consultant and technical assistance) needed to achieve goals stated in individual Healthcare Plans, MERPs (Medical Emergency Response Plans), CARMPs (Comprehensive Aspiration Risk Management Plans) and written direct support instructions as appropriate to the individual.**
Health Objective H1.8 **Each Jackson Class Member will receive the JCM's medications (1) in the doses prescribed, (2) in the manner and frequency prescribed, and (3) at times prescribed.**
H1.8.b. **Defendants must take prompt action to correct any failure to properly dispense medications to a JCM in accordance with prescriptions.**

Perhaps the most critical role of providers and individual team members is taking informed, timely and effective action. Knowing is the essential first step and acting on that information timely is a non-negotiable. Nowhere is this more important than receipt of recommended and/or needed health care. It is not

enough to have recommendations and orders from clinical specialists – or anyone else – they MUST be implemented unless there is an informed reason why not which is discussed and documented timely. Relevant IQR Questions include:

Question #55. Are all of the individual's needed medical treatments timely received?
Question #56: Does the individual receive routine/scheduled medical treatment?

Another critical area explored as a part of the IQR is receipt of medication as ordered or prescribed by a physician. Most Jackson Class Members receive multiple medications. When reviewing medication storage and administration there are underlying professionally basic expectations. While there are multiple sources that can be used to guide expectations regarding the administration of medication, accepted practice is consistent across sources. *The Nursing Center*[19] has identified 8 Rights of Medication Administration which are informative and are included here.

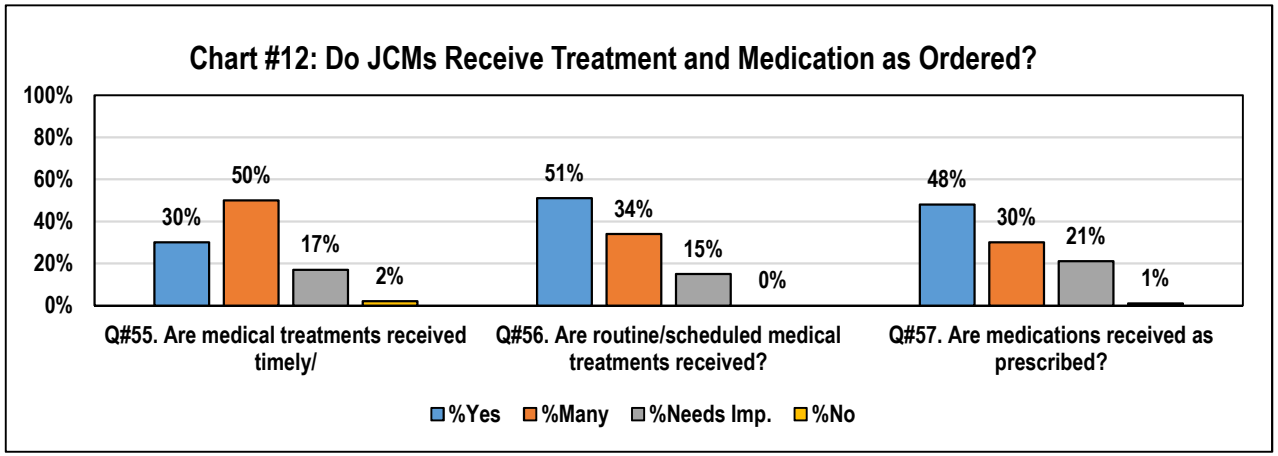
#1: Medication is given to the *right person;*
#2: The individual receives the *right medication*;
#3. The individual receives the *right dose;*
#4. The individual receives medication through the *right route;*
#5. The individual receives medication at the *right time;*
#6. Administration *documentation takes place AFTER giving the ordered medication;*
#7. Medication is given for the *right reason; and*
#8. The medication has the *right response/desired effect.*

As part of the Individual Quality Review, all medications ordered and received by an individual are reviewed. That includes a review of:

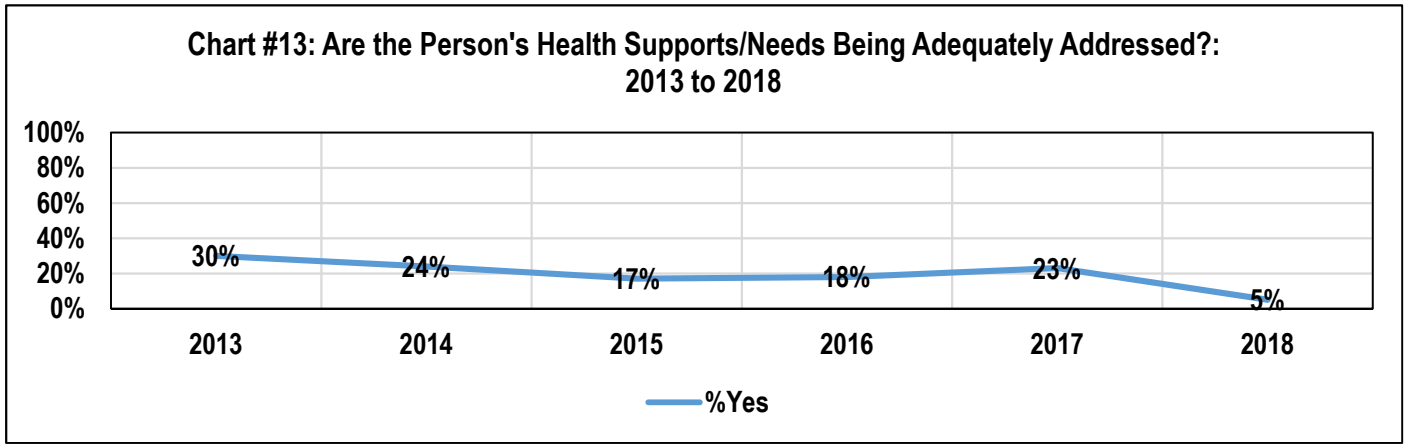
- ✓ **medications identified for each person in Therap/eChat;**
- ✓ **medications listed on the Medication Administration Record in both day and residential environments if paper is kept;**
- ✓ **the actual medication available in day and residential;**
- ✓ **the instructions on the medication container as compared to the physician's order; and**
- ✓ **instructions and delivery identified on the MAR.**

[19] **Reference: Nursing 2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. https://www.nursingcenter.com/ncblog/may-2011/8-rights-of-medication-administration**

The IQR asks: Question #57. Does the individual receive medication as prescribed?



These numbers continue to reflect practices that are inadequate and dangerous for class members. Again, concerns identified in these areas are not new. During the past 6 years, the *highest number* of class members for whom health care needs were seen to be adequately addressed was 30% of those reviewed. As the following chart illustrates, *in 2018 that number dropped to 5%.* IQR Question #62 asks, "Are the person's health supports/needs being adequately addressed?"[20]



The chart below highlights some issues which have been repeatedly identified as risks to class members' health. For example, in 2017, the IQR found that 47 of the 65 people reviewed (72%) had issues with not receiving recommended medical appointments or evaluations. In 2018, that number increased to 87%.

[20] Related CPR Question #56.

Chart #14: Issues Resulting from Lack of Overall Healthcare Management, Nursing Oversight and Follow up				
Issue	**Year**	**# of Class Members Affected**	**%**	**# of Issues**
Not following up on recommended medical appointments or evaluations;	2018	76 of 87	87%	293
	2017	*47 of 65*	*72%*	*157*
	2016	*52 of 93*	*56%*	*98*
Nurse Uninformed/Giving Incorrect Information	2018	3 of 87	3%	6
	2017	*13 of 65*	*20%*	*18*
	2016	*6 of 93*	*6%*	*6*
Lack of Adequate Nursing Oversight	2018	30 of 87	34%	157
	2017	*30 of 65*	*46%*	*130*
	2016	*19 of 93*	*20%*	*26*
Needed Therapies were Missing	2018	5 of 87	6%	16
	2017	*11 of 65*	*17%*	*16*
	2016	*5 of 93*	*5%*	*6*
Needed Medication Not Received/Available	2018	8 of 87	9%	20
	2017	*5 of 65*	*8%*	*8*
	2016	*9 of 93*	*10%*	*9*
CARMP not being followed	2018	7 of 87	8%	7
	2017	*4 of 65*	*6%*	*7*
	2016	*4 of 93*	*4%*	*4*

The story behind the numbers: Person #21

… is a 67-year-old man with multiple diagnoses which include, in part: Epilepsy, Hypothyroidism, anxiety, blind, cerebral palsy, constipation (colostomy), GERD…

… has been losing weight with no identified cause. The 7.31.18 Quarterly Nutritional Evaluation indicates that his Ideal Weight Range is 102 to 137#. In July 2013 his weight is reported to have been 119 lbs. In February 2018 it was reported to have been 112 lbs. At the time of the Team meeting with the Community Monitor, it was reported to be 91 lbs (9.12.18).

… can no longer walk and bare weight as in the past. It was confirmed that he use to walk from his home to the post office box in front of his home, he would stand and pivot, he would be able to stretch his body out and would walk the pool for 5 to 10 minutes during the aquatic PT session. He is no longer walking at

all, he is not able to stretch out, he is not doing daily ROM exercises and he is not participating in aquatic PT (which is hoped to start again). ... has not had aquatic PT in three months during which time his mobility has significantly decreased.

... Urologist recommended that he receive an annual ultrasound. His last reported ultrasound took place 17 months ago (4.11.17).
.. OT indicated that he has had a sensitive area of his mouth (left side) for some time. It is unclear if this sensitivity is due to a cracked tooth (#21), periodontal disease, or a bone issues and whether or not this sensitivity has been reported to his dentist. ... went 10 months between his last 2 dental appointments when, according to Team members, he is to be seen every 6 months.

There were 75 days in the documentation provided (1/1/18 – 7/2/18) with no entry for number of BM's, roughly 42% of this period. He has two Individual Care Plans that direct staff to notify the nurse after 24 hours with no BM. On 7/2/18 he was admitted to the hospital for Seizures Secondary to Constipation and/or Aspiration Pneumonia. There are no entries in the BM tracking log for 6/30/18 and 7/1/18. Per the Nurse's Interview, there are issues because there is a paper log as well as Therap. She did not know if he had BMs on either of those days.

The story behind the numbers: Person #29

... is a 71-year-old woman with multiple diagnoses which include, in part, Cerebral Palsy, blindness, hypothyroidism, OCD, Depression and GERD.

The IQR found numerous inconsistencies with medication administration and/or documentation:

- *The GER dated 1/3/19 stated, "When staff was preparing to give meds, staff noticed that although MAR and bubble Pac were signed, the meds were still in the bubble pack. Nurse was notified and marked meds as missed."*
- *The GER dated 7/30/18 stated, "Staff could not find multivitamin medication so it was not given. Nurse discovered that meds were placed in an area the staff did not have access to." Medication missed.*
- *Per the 12/2017 MAR, there were five missing entries on 12/31/17 for the 8pm dose of medications: Calcium 600-Vit D3 400 Tablet Chlorhexidine 0.12% Rinse, Divalproex Sod ER 500 mg Tab (OCD), Olanzapine 5 mg Tablet (OCD), Omeprazole DR 20 mg Capsule (GERD).*
- *Per the 3/2018 MAR, there were five missing entries on 3/30/18 for the 8pm dose of medications: Calcium 600-Vit D3 400 Tablet, Chlorhexidine 0.12% rinse, Divalproex Sod ER 500 mg Tab, Olanzapine 5mg Tablet, Omeprazole DR 20 mg Capsule.*
- *Per the 4/2018 MAR, there was a missing entry on 4/10/18 for 8pm dose of Calcium 600-Vit D3 400 mg Tablet, there was a missing entry on 4/25/18 for the 12pm dose of Ibuprofen 200 mg, there was a missing entry on 4/26/18 8am dose of Polyethylene Glycol 3350 POWD, and a missing entry on 4/29/18 for 8am dose of Polyethylene Glycol 3350 POWD (constipation).*
- *Per the 5/2018 MAR, there was a missing entry for the 5/30/18 12pm dose of Ibuprofen 200mg and a missing entry for the 5/29/18 8am dose of Prevident 5000 (teeth).*
- *The 7/2018 MAR indicates all meds given/initialed on all dates, <u>including</u> the multivitamin on 7/30/18. The GER of 7/30/18 indicates Multivitamin not given on 7/30/18 due to staff being unable to locate medication.*
- *Per the 8/2018 MAR, there is a missing entry for 8/18/18 pm does of Calcium 600-Vit d3 400 Tablet, two deleted entries on 8/8/18 for the 8pm dose of Olanzapine 5 mg Tablet and 8pm dose of Omeprazole DR 20 mg Capsule, and missing entries for the 8/14/18 6am dose of Tylenol 325 mg Tablet and for the 8/17/18 6am dose of Tylenol 325 mg Tablet.*
- *Per the 9/2018 MAR, there is a deleted entry for 9/10/18 8pm dose of Calcium 600-Vit D3 400 Tablet, no entry for 9/30/18 8pm dose of Calcium 600-Vit D3 400 Tablet , a deleted entry for 9/10/18 8pm dose of Divalproex Sodium ER, no entry for 9/30/18 8pm dose for Divalproex Sodium ER, a deleted entry for 9/10/18*

8pm dose for Olanzapine, no entry for 9/30/18 8pm dose of Olanzapine, a deleted entry for 9/10/18 8pm dose of Omeprazole DR 20 mg, and no entry for 9/30/18 8pm dose of Omeprazole DR 20 mg.

- *Per the 10/2018 MAR, there are missing entries for the 8pm dose on 10/24/18 for the following medications: Calcium 600-Vit D3 400 Tablet Divalproex Sodium ER, Olanzapine 5mg and Omeprazole DR 20 mg. There is also a missing entry on 10/27/18 for the 8am dosage of Divalproex Sodium DR 125 mg.*
- *Per the 11/2018 MAR, there are four missing entries for 11/17/18 8pm doses of: Calcium 600-Vit D3 400 Tablet, Divalproex Sodium ER 500mg, Olanzapine 5mg, and Omeprazole DR 20 Mg.*
- *Per the 12/2018 MAR, there were more than 20 missed medication doses in December. There were no initials for Calcium/vit D3 on 12/31, Divalproex 500 mg on 12/15 and 12/31, Olanzapine on 12/30, Omeprazole on 12/30,*
- *4/5/18 Nursing Report states, "Multiple issues with prescriptions expiring."*

Having information regarding outcomes for class members is not enough. Something actually needs to be done with that information in an effective way that protects people from harm. In an effort to assist the Department in focusing their remediation efforts, IQR information is available and provided by issue, by provider, by region and state wide. Taking medication administration as an example, the following summarizes the most frequently identified issues and providers with the highest number of identified issues. Chart #15 enables an even closer examination of medication issues by provider. It also enables DDSD to identify and recognize providers that did not have issues in the medication administration area identified. All of this information has been and continues to be available to the Department. Obviously, using this and other available data, the Department could provide technical assistance and cooperatively craft effective and sustainable solutions. It does not appear that this has taken place.

Most Frequently Identified Issues:

#1: Medication Administration Record (MAR)/Medication label and the doctor's orders do not match (82 issues identified);
#2: Medication not administered as required (75 issues identified);
#3. Medication not available (20 issues identified);
#4: MAR Charting errors (13 issues identified)

Providers with Highest Number of Identified Issues:
#1: Community Options (3 people in the review, 56 identified issues)
45 issues with medication not being administered as required
10 issues related to MAR/Medication and Dr. Orders not matching
#2: LLCP (9 people in the review, 38 identified issues)
13 charting errors;
10 issues related to MAR/Medication and Dr. Orders not matching
#3. Tobosa (3 people in the review, 32 identified issues)
22 issues related to MAR/Medication and Dr. Orders not matching
#4. Expressions of Life (3 people in the review, 20 identified issues)
12 issues related to MAR/Medication and Dr. Orders not matching

5 Medication not available

#5. Nezzy Care (2 people in the review, 15 identified issues)

8 issues related to MAR/Medication and Dr. Orders not matching

5 Medication not available

This type of examination and prioritization should happen for all of the health-related issues identified in this report with ensuing timely and effective interventions which result in improved practice on the part of providers and outcomes for class members.

Chart #15: Number Issues with Medication Records and Administration, by Residential Agency

Agency	MAAT incorrect/ inconsistent	MAR Charting errors	Meds not administered as required	MAR/ Medication/ Dr. Order do not match	Med delivery instructions unclear	Medication not available (Rx or PRN)	Med found in home but not on MAR	Meds purpose not listed	Medication orders duplicated	Expired meds found in med box/home	Totals
Ability First (1)	0	0	0	0	0	0	0	0	0	0	0
Adelante (9)	0	0	0	2	0	0	0	0	0	0	2
Alegria (1)	0	0	0	1	0	0	0	0	0	2	3
ARCA (7)	0	0	0	0	0	0	0	0	0	0	0
Aspire (1)	0	0	0	0	0	0	0	0	0	0	0
At Home Advocacy (1)	0	0	0	0	0	0	0	0	0	0	0
AWS/ Benchmark (2)	0	0	1	0	0	0	0	0	0	0	1
Bright Horizons (2)	1	0	0	0	0	0	0	0	0	0	1
CARC (1)	0	0	0	0	0	0	0	0	0	0	0
CDD (1)	0	0	0	0	0	0	0	0	0	0	0
Community Options (3)	1	0	45	10	0	0	0	0	0	0	56
Cornucopia (1)	0	0	0	3	0	0	0	0	0	0	3
Dungarvin (7)	0	0	0	3	1	1	0	0	0	0	5
ENMRSH (2)	0	0	0	0	0	0	0	0	0	0	0
Ensuenos (ELADC) (1)	0	0	1	1	0	0	0	0	0	0	2
Expressions of Life (3)	0	0	12	1	2	5	0	0	0	0	20
Family Options (1)	0	0	0	5	0	0	0	0	0	0	5
Leaders (1)	0	0	0	0	0	0	0	0	0	0	0
Lessons of Life (3)	0	0	0	0	0	0	0	0	0	0	0

Agency	MAAT incorrect/ inconsistent	MAR Charting errors	Meds not administered as required	MAR/ Medication/ Dr. Order do not match	Med delivery instructions unclear	Medication not available (Rx or PRN)	Med found in home but not on MAR	Meds purpose not listed	Medication orders duplicated	Expired meds found in med box/home	Totals
LLCP (9)	7	13	0	10	4	1	1	0	0	0	36
MaxCare (2)	0	0	1	0	0	0	0	0	0	0	1
Mi Via (5)	0	0	0	0	0	0	0	0	0	0	0
Nezzy Care (2)	0	0	2	8	0	5	0	0	0	0	15
NNMQC (1)	0	0	0	0	0	0	0	0	0	0	0
Opti Health (2)	1	0	0	8	0	0	0	0	0	0	9
PRS (1)	0	0	0	0	0	0	0	0	0	0	0
Ramah Care (1)	0	0	0	0	0	0	0	0	0	0	0
Su Vida (1)	0	0	0	0	0	0	0	0	0	0	0
The New Beginnings (4)	1	0	3	5	2	1	0	0	0	0	12
TLC (1)	0	0	10	0	0	0	0	0	0	0	10
Tobosa (3)	0	0	0	22	2	3	0	2	1	2	32
Tresco (4)	0	0	0	3	0	4	0	0	0	1	8
Tungland (3)	0	0	0	0	0	0	0	0	0	0	0
Totals	11	13	75	82	11	20	1	2	1	5	221

The story behind the numbers: Person #27

…is a 45-year-old man with multiple diagnoses which include, in part: Bipolar, PTSD, intermittent explosive disorder, cataract secondary to Thorazine use, anterior age-related cataract bilateral, Osteopenia, age-related macular degeneration, obesity.

The IQR found that Healthcare/Nursing oversight needs to significantly improve if it is to function as an effective safeguard for … as identified below.

a. Medication errors: There is no evidence that the following apparent medication errors and issues were noted through healthcare oversight:

- *06.27.2018 – morning meds not signed for*
- *05.30.2018 – evening meds not signed for*
- *03.15.2018 – 8:00 PM Cogentin not signed for*

b. Weights not recorded:

- *Staff failed to document on MAR taking weight monthly for the following months: 09.18; 08.18; 07.18; 05;18; 04.18; 03.18; 02.18; 01.18; 11;17; 10.17.*

c. Lack of recommended follow up, appointments.

- *Upon referral from audiologist … saw a nurse at the PCP's office on 03.02.2017 to have cerumen removed from his right ear. Per follow-up visit report with audiologist (03.10.2017), there was a broken off Q-tip in his ear. No follow-up noted.*
- *Ophthalmology appointment in April 2017 had six-month recall. He did not return to the ophthalmologist until 18 months later, October 2018.*

d. Lack of timely treatment.
- *May 2017 appointment with dentist ended with treatment plan to repair tooth #18 with filling. … did not return to the dentist until 17 months later, 10.29.2018, at which point #18 had gotten so bad it now has to be extracted by oral surgeon. (His consultation with the oral surgeon was scheduled for 12.11.2018.)*
- *…'s most recent Tdap was administered on 02.07.2007 and would have been due again in 2017. There is no evidence that he received the booster.*
- *… saw his ophthalmologist on 10.30.2018. The doctor ordered AREDS II or a multivitamin with Lutein/zeaxanthin, which has not been started as of 12.11.2018. (… does take a regular multivitamin, which has a start date of May 2018).*

e. Lack of needed preventative screens: The only AIMS (tests for tardive dyskinesia) in the record was dated 10.05.2018 (after the sample was announced for this review). It was not signed. Although requested, no earlier AIMS was provided. Thus, it is impossible to verify whether AIMS screening is done at regular intervals.

The story behind the numbers: Person #18
… is a 46 year old man with diagnoses which include, in part: Autism, bruxism, pica, Cerebral Palsy, Dysphagia, kyphosis, GERD, Epilepsy…

The following issues were found regarding this person's current medication orders/MAR:
- *Indication is not listed for Guaifenesin 400 mg tablet.*
- *Indication is not listed for clear skin cleansing pads.*
- *Albuterol 0.083% (PRN), it is not clear whether this medication is given per nebulizer or is an inhaler.*
- *Instruction to clean g-tube site 3 times daily is listed as PRN, but should be done daily.*
- *Oxycodone-Acetaminophen 5-325 (PRN) has no instruction to crush or give per tube.*
- *Keppra bottle indicates that is to be given by mouth on the prescription label. Order of 04.03.2018 also contains this error. MAR says to give per tube.*
- *Tegretol bottle indicates that it is to be given by mouth on the prescription label Order of 04.03.2018 also contains this error. MAR says to give per tube.*
- *Temazepam card indicates that it is to be given by mouth on the prescription label. Order of 04.03.2018 also contains this error. MAR says to give per tube.*
- *has an order for non-alcoholic fluoride rinse. The rinse in the house is Crest 3D White, which is non-alcoholic, but not fluoridated.*
- *has two separate orders for Duoneb currently in effect: one to be administered TID and one for PRN in case of respiratory symptoms. There is only one box in the house for the daily doses. The PRN inhalant appears to be Albuterol, which was also present.*
- *The prescription label on the box of Duoneb say it is to be administered QID. The order/MAR say TID.*
- *The instruction on the prescription label for Lactulose indicates it is to be given once daily PRN. The doctor's order and MAR indicate that it is to be given after no bowel movement for two days.*
- *Order of 04.03.2018 indicates that Nutren is to be given every 2 hours orally. MAR says per tube and it is administered per tube.*
- *Ventolin HFA 9- MCG Inhaler - expired 2.2018*

- *Staff report and record review indicate the team is having issues with the Omeprazole (beads) clogging tube. PCP recommended adding it to an acidy type liquid which staff are doing but still experience clogging.*

G. Is Effective Action Being Taken to Protect Class Members?

Related Evaluative Components Required for Disengagement include:
Health Objective H4.3 **Quality Assurance information is used to improve health outcomes.**
Safety Objective S3.4 **Use the findings from the CPR to improve services for class members and to improve the system of services for Jackson class Members.**

Taking effective action assumes a fact-based understanding of what the primary issues are, identifying the cause of successes/failures timely, altering ineffective interventions timely and putting effective and sustainable interventions in place comprehensively and timely. What does NOT work is not using available data to identify trends and priorities; NOT identifying the cause of ineffective interventions; NOT sharing that learning with the field and NOT enforcing effective interventions timely which appears to be the long-standing trend in New Mexico.

In the 2018 Review 86 of the 87 individuals (99%) had individual health related issues needing review and/or attention.

Chart #16: Number of Health Related Issues Identified by Region
(Based on number of issues found in 2018, 2017 and 2016 Findings and Recommendations)

	Number of Health Care Issues Identified by Class Member																												Total #				Total #				Average #			
Region	0				1-2				3-4				5-6				7-9				10-15				16 - 20				>20				Reviewed				Issues per region				Issues per Person			
Year	'18	'17	'16	'15	'18	'17	'16	'15	'18	'17	'16	'15	'18	'17	'16	'15	'18	'17	'16	'15	'18	'17	'16	'15	'18	'17	'16	'15	'18	'17	'16	'15	'18	'17	'16	'15	'18	'17	'16	'15
Metro	1	1	5	2	0	1	11	6	2	1	16	14	6	3	9	12	4	3	5	10	7	8	4	4	5	5	3	5	23	4	0	0	48	26	50	50	1146	368	195	270	23.9	14.1	3.90	5.40
NE	0	2	2	3	0	1	4	3	1	0	2	1	0	1	3	5	1	1	0	1	2	1	0	0	0	4	0	0	6	0	0	0	10	10	11	13	428	101	30	42	42.8	10.1	2.73	3.23
NW	0	0	2	1	0	0	2	3	1	4	3	2	1	1	0	3	0	2	2	1	1	1	0	0	2	1	0	0	4	0	0	0	9	9	9	10	180	65	29	36	20	7.2	3.22	3.60
SE	0	0	1	1	0	2	3	4	1	0	4	3	0	2	1	1	1	1	0	0	3	4	1	1	2	0	0	1	3	1	0	0	10	10	10	11	220	116	33	52	22	11.6	3.30	4.73
SW	0	0	2	1	0	0	4	3	1	0	4	3	0	1	3	6	1	3	0	2	4	5	0	0	1	1	0	0	3	0	0	0	10	10	13	15	169	110	36	62	16.9	11.0	2.77	4.13
State	1	3	12	8	0	4	24	19	6	5	29	23	7	8	16	27	7	10	7	14	17	19	5	5	10	11	3	6	39	5	0	0	87	65	93	99	2143	760	323	462	24.6	11.7	3.47	4.67

As the chart above illustrates, the number of health-related issues needing to be addressed per person has significantly increased. This year, the average number of health care issues per person is 24.6, double the 11.7 per person in 2017.

In 2017, three class members (5%) were found to have no identified, unaddressed health issues.
In 2018, one class member (1%) was found to have no identified, unaddressed health issues.

In 2017, fifty-three class members (82%) were found to have 5 or more identified health related issues; five of those 53 had over 20 issues per person.
In 2018, eighty class members (92%) were found to have 5 or more identified health related issues; 39 of those 80 had over 20 issues per person.

Again, a closer examination of the issues along with numbers and types by person, provider and region has been and continues to be available and can help the Department determine what action needs to be taken and, overtime, whether that action has proven to be effective. The following chart begins with looking at 'volume', that is, those individuals and providers who were found to have the largest number of issues. This chart summarizes the type and number of issues for 17 people, not 100% of the sample, although that information is available. This provides another way to report and be able to learn from and use data. The majority of the columns are self-explanatory, some may not be. Number of Tracking issues relates to body functions which were to be tracked but were not, e.g., blood pressure, BM's, intake/elimination…; "Issues F/U" refers to those issues identified for that person but no evidence of follow up was found…

Chart #17: Sample of Number and Types of Issues Identified

Region	Person	Res Provider	CM Agency	# ISP Plan Issues	# Tracking issues	Assm'ts	Issues F/U	Recs f/up	Nursing paper	Nurse training	Meds Missing	Med admin	Total
Metro4	1	LLCP	A Step Above	18	12	1	0	4	4	0	0	1	40
Northeast	2	CDD	Visions	17	1	0	0	2	20	0	0	0	40
Northwest	3	Ramah Care	A Step Above	28	0	0	0	8	4	0	0	0	40
Metro4	4	LLCP	UNIDAS	12	0	1	0	2	26	0	0	0	41
Southwest	5	Tresco	SCCM	27	5	1	1	1	2	0	0	5	42
Metro3	6	Dungarvin	PEAK	39	0	2	0	6	2	0	0	0	49
Northeast	7	Community Options	Unidas	22	11	2	0	4	2	0	0	9	50
Northeast	8	Benchmark	Visions	24	2	2	0	2	21	0	0	0	51
Metro3	9	ARCA	A Step Above	13	0	4	0	5	0	0	0	30	52
Metro4	10	Optihealth	PEAK	16	4	0	0	9	22	0	0	7	58
Metro3	11	The New Beginnings	A Step Above	27	0	2	0	5	19	0	0	6	59
Northeast	12	Family Options	Unidas	17	0	1	0	6	35	0	0	5	64
Metro3	13	Optihealth	A Step Above	14	48	0	2	3	3	0	0	1	71
Southeast	14	Tobosa	J&J	10	12	3	1	0	30	0	0	18	74
Metro4	15	Dungarvin	UNIDAS	18	48	1	0	5	1	0	2	2	77
Metro4	16	Expressions of Life	UNIDAS	42	5	1	0	5	3	0	0	21	77
Northeast	17	Community Options	Visions	25	48	6	0	11	19	0	0	45	154

The story behind the numbers: Person #19

… is a 63-year-old man who has been diagnosed with acute renal failure. He also has a number of other diagnoses which include, in part, blindness, dysphagia, constipation, hypertension, osteoporosis, GERD…

The file is missing some tracking for Intake and output including:

Missing intake 2018: 1/25/18, 3/3/18, 3/8, 3/10, 3/12, 3/19, 3/22, 3/23, 3/25/, 3/26, 4/3, 4/8, 4/15, 4/16, 5/4, 5/17, 7/4.
Missing intake and void 2018: 1/29/18, 4/5/18.

The story behind the numbers: Person #28

… is a 72-year-old man with multiple diagnoses which include, in part: diabetes Type II, vascular dementia with behavioral disturbance, hypertension, myopia bilateral, age related cataract, anxiety, constipation, depression…

… has an HCP and MERP for Falls. He also has a sensor in his bedroom to detect movement. Per the Nursing interview, he has fallen 5 times this year. During this review, … fell again, requiring 6 stitches on his head, bringing the number of falls to 6 times in a year.
… has a gait belt on his AT Inventory, but was not wearing it when he fell. Per onsite observation and interviews, … typically refuses his gait belt and staff hold his arm or hand while he is walking. Staff were not next to him when he fell.

… has documented compression fractures in his spine and is diagnosed with Osteopenia. He had a DEXA scan 5/26/17 which showed grade 2 wedge compression L2: mild degenerative disk L1-L2; moderate to severe arthropathy from L1-S1; and a follow-up to be completed in 2 years. He has also had several x-rays and MRI's which document his condition. For pain, he takes Tramadol 50mg 4x a day and he takes Oyster Shell calcium 1000mg 1x a day.

The story behind the person: Person #20

… is a 56-year-old man with multiple diagnoses which include, in part: Cerebral Palsy, cirrhosis of liver NOS, compression fracture, hepatitis C, Osteoporosis, intermittent explosive disorder, epilepsy, history of lower extremity edema…

… weight is not regularly obtained. … has not had regular access to a wheelchair scale. His last accurate weight in the record was taken at his 06.23.2017 physical. (No 2018 weight yet, as of 8.31.18) He was then 111 pounds. His suggested weight range is 112-136 pounds. He is seen quarterly by Registered Dietitian (RD), but she has not been obtaining weights. She reported his weight in her 06.17.2017 assessment as 120 pounds and carried that weight over to her next three assessments (09.24.2017; 12.05.2017; and 03.19.2018.)

… was taken to Continuum of Care on 07.13.2018 and his weight was taken for the first time in over a year. He is down to 95 pounds, BMI of 17.4, which places him in the underweight category. He returned to Continuum of Care on 07.20.2018 and his weight had gone up to 96.88 pounds. During the onsite visit, …'s) relative reported his height is closer to 5'7" than the 5'3" (63") reported on the nutrition reports, meaning that his BMI is lower than what is listed above and his suggested weight range may also be incorrect.

Repeat Findings are another way to evaluate the effectiveness of a remediation intervention. Reviewing findings over time enables the Department to see if an intervention resulted in the desired outcome and if the problem or issue was and remained "fixed". The IQR not only identifies individual issues in a given review year, in this case 2018, but also notes if the finding has been identified for that same class member in previous years. For example, if an individual had an outcome to buy his own home in 2014 but no affirmative action had been taken on the part of his Team to enable that outcome, it would be a finding. If that person was reviewed again in 2018 and was found to continue to have 'buying his home' as an outcome but is no closer to attaining his home, that would be noted as a "repeat finding" as a part of that individuals Findings and Recommendations. When a given issue is identified as a finding, the hope is that the agency will "fix" the issue for both the class member reviewed and for anyone else similarly situated. Unfortunately, that is frequently not the case as evidenced by the number of "repeat findings" identified each review year.

Of the 1,596 Findings and Recommendations in the 2018 IQR, 342 Recommendations (21%) were identified as Findings and/or Recommendations that were "repeat findings/recommendations/issues" from previous years.[21] The category where the repeats are most frequently found is the area of Planning and Services, followed by Health/Assessments.

This Report has a summary of the number of repeat findings by agency from 2013 to 2017 in Appendix E. In addition, each of the individual 2018 Regional Data Reports contains more detail, by residential and case management agency. The following chart identifies the topical areas which were found to have the most repeat findings and/or recommendations by Residential agency.

Chart #18: Repeat Findings by Topic and Residential Provider

Finding/Rec Area Residential Agency	Adaptive Equip./ Aug Comm.	Behavior	CM/ Guardian	Expect Growth/ Quality of Life	Health/ Assessments	Meaningful Day	Planning & Services	Team Process/ DSS	Total
Ability First (1)	0	0	1	0	2	0	2	1	6
Adelante (9)	1	1	3	4	7	4	7	0	27
Alegria (1)	1	0	1	0	1	1	0	0	4
ARCA (7)	0	1	4	3	6	2	9	2	27
Aspire (1)	0	0	0	1	0	0	1	0	2
At Home Advocacy (1)	0	0	1	0	0	0	2	0	3
AWS/ Benchmark (2)	0	0	4	0	3	0	6	1	14

[21] Based on a request from the Department, IQR does not cite 'repeat findings/recommendations' older than 10 years.

Finding/Rec Area Residential Agency	Adaptive Equip./ Aug Comm.	Behavior	CM/ Guardian	Expect Growth/ Quality of Life	Health/ Assessments	Meaningful Day	Planning & Services	Team Process/ DSS	Total
Bright Horizons (2)	0	0	4	0	0	0	0	0	4
CARC (1)	0	0	0	0	0	0	2	0	2
CDD (1)	0	0	1	0	2	1	4	1	9
Community Options (3)	1	0	4	0	3	0	5	1	14
Cornucopia (1)	1	0	1	0	1	1	3	0	7
Dungarvin (7)	4	0	4	0	10	3	12	1	34
ENMRSH (2)	0	0	0	0	0	0	0	0	0
Ensuenos (ELADC) (1)	1	0	0	0	3	0	0	0	4
Expressions of Life (3)	1	0	1	0	3	1	6	0	12
Family Options (1)	0	0	1	0	3	1	2	0	7
Leaders (1)	0	0	1	2	2	0	0	0	5
Lessons of Life (3)	3	0	3	1	2	3	3	2	17
LLCP (9)	0	0	1	1	16	4	11	1	34
MaxCare (2)	0	0	1	0	1	0	3	0	5
Mi Via (5)	1	0	0	0	4	0	0	0	5
Nezzy Care (1)	0	0	1	0	6	1	6	1	15
NNMQC (1)	0	0	0	0	1	0	0	0	1
Opti Health (2)	0	0	2	0	3	1	3	0	9
PRS (1)	0	0	0	0	2	0	1	0	3
Ramah Care (1)	1	0	0	0	1	0	1	0	3
Su Vida (1)	1	0	0	0	0	1	1	0	3
The New Beginnings (4)	0	2	0	1	5	1	12	0	21
TLC (1)	0	0	1	0	1	0	2	0	4
Tobosa (3)	1	1	4	0	4	1	4	0	15
Tresco (4)	0	0	2	0	3	1	5	0	11
Tungland (3)	2	0	1	1	3	2	4	2	15
Total	19	5	47	14	98	29	117	13	342

Chart #19: Repeat Findings by Area and Case Management Agency

Finding/Rec Area CM Agency	Adaptive Equip./ Aug Comm.	Behavior	CM/ Guardian	Expect Growth/ Quality of Life	Health/ Assessments	Meaningful Day	Planning & Services	Team Process/ DSS	Total
A New Vision (3)	0	0	3	1	3	0	5	2	14
A Step Above (9)	2	2	5	1	9	4	17	0	40
Amigo (4)	1	1	1	1	3	2	8	0	17
Carino (6)	1	0	1	1	5	3	6	0	17
DDSD (1)	0	0	0	0	0	0	2	0	2
Excel (6)	2	0	3	2	5	3	8	3	26
J&J (7)	1	1	6	2	9	1	8	1	29
Mi Via (5)	1	0	0	0	4	0	0	0	5
NMQCM (2)	0	1	1	1	1	2	4	0	10
Peak (8)	5	0	8	1	8	2	11	3	38
Rio Puerco (1)	1	0	0	0	2	0	2	0	5
SCCM (8)	0	0	3	0	8	4	12	1	28
Unidas (18)	3	0	9	4	30	6	20	1	73
Unique Opportunities (2)	0	0	0	0	1	1	2	0	4
Visions (6)	2	0	7	0	10	1	12	2	34
Total	19	5	47	14	98	29	117	13	342

Individual and program level findings roll up into systems findings if extended periods of time go by and the issue does not get resolved. As the following chart illustrates, *some of the health-related Evaluative Component Objectives identified as a part of the 2015 Remedial Plan/Order have been issues for 13 to 14 years* and continue to be identified as issues in the 2018 IQR Report(s). As represented above, the number of Health/Assessments findings per person reviewed is at an all-time high. As has been repeatedly noted in past reports, many of the health findings reflect, minimally, failure of practice to protect class members from harm and in some instances actual harm.

Chart #20: 2015 Court Ordered Remedial Plan Health Related Objectives Which Correspond to Previous CPR and Current IQR Findings including the Year the Issue was First Identified by the CPR/IQR

Evaluative Component/ Objective #	Evaluative Component	Year Issue Was First Identified
H1.1	Expectations for healthcare coordination are appropriate as evidenced by well-defined roles and responsibilities that are carried out and measured at the provider, region and state level.	2004 to present
H1.2	*2* Nurses routinely monitor Jackson Class Members' individual health needs through (1) oversight, (2) communication with DSP (Direct Support Professionals), and (3) corrective actions in order to implement the	2005 to present

Evaluative Component/ Objective #	Evaluative Component	Year Issue Was First Identified
	Jackson Class Members' health plans, to ensure that the Jackson Class Members' health needs are being met, and to timely respond to changes in Jackson Class Members' health status.	
H1.3	Teams use accurate health records for Jackson Class Members.	2004 to present
H1.4	Teams (including the individual) have information (education, consultant and technical assistance) needed to achieve goals stated in individual Healthcare Plans, MERPs [Medical Emergency Response Plans], CARMPs [Comprehensive Aspiration Risk Management Plans] and written direct support instructions as appropriate to the individual.	2005 to present
H1.5	Identified health needs for Jackson Class Members, including daily medical considerations, are addressed in individualized healthcare plans, MERPs, CARMPs, and written direct support instructions as appropriate to the Jackson Class Members. Healthcare plans are reviewed and promptly modified in response to changes in health status.	2005 to present
H1.6	Current and complete information is provided to the healthcare professionals treating or evaluating the individual.	2005 to present
H1.7	The team assures recommendations from healthcare professionals are reviewed with the individual and guardian in a manner that supports informed decision making and [are] either implemented, or documented in a Decision Consultation Form if recommendation is declined.	2005 to present
H1.8	Each Jackson Class Member will receive the Jackson Class Member's medications (1) in the doses prescribed, (2) in the manner and frequency prescribed, and (3) at the times prescribed.	2005 to present
H2.1	JCM receive age appropriate preventative/early detection screening/immunizations for health risk factors.	2005 to present
H3.1	Jackson Class Members receive increased intensity of services during acute episodes or illnesses.	2004 to present
H3.2	Direct Service Personnel/supervisors are able to identify subtle signs of change/acute symptoms.	2004 to present
H3.3	When informed of signs of change in health status (including chronic and acute pain) agency nurses take immediate action.	2004 to present
H3.4	When an individual is receiving healthcare in an out of home setting critical health and functional information will be provided and individual's existing adaptive equipment that can be used in that setting will be offered.	2005 to present
H3.5	When a JCM is receiving healthcare in an out-of-home setting, the IDT will plan for a smooth transition back to the JCM's home as soon as medically feasible.	2005 to present
H4.1	Competent personnel (nurses, DSP, front line supervisors, ancillary providers, and case managers), who have received and passed competency based training related to prevention and early identification, provide services to JCM. (Ashton #6, 7, 8)	1998 to present

Evaluative Component/ Objective #	Evaluative Component	Year Issue Was First Identified
H4.2	IDTs provide for the changing health supports class members need as they age including advanced care planning and have access to palliative care consistent with their individual needs.	2005 to present
H4.3	Quality Assurance information is used to improve health outcomes.	2005 to present

H. Results of Ineffective Health Care Coordination/Management: JCMs Found with Immediate and Special Needs

Issues Identified for Those with Immediate and/or Special Needs[22]

Definition of those with Immediate Needs: Class Members identified as "*needing immediate attention*" are persons for whom urgent health, safety, environment and/or abuse/neglect/exploitation issues were identified which the team is not successfully addressing in a timely fashion.

Definition of those with Special Attention Needs: Class Members identified as "*needing special attention*" are individuals for whom issues have been identified that, if not effectively addressed, are likely to become an urgent health and safety concern, in the near future.

On average, 101.5 class members have been reviewed each year for the six years leading up to the IQR transition from the Community Monitor's Office to DHI. This is approximately one third of the class members. The numbers were lower the past two years due to the lack of an adequate number of available and approved state reviewers. The following Chart shows the number of active JCMs, the number of individuals included in the sample by year and of those reviewed, the number who were identified with Immediate and/or Special Findings. From 2011 to 2016 there were, on average, approximately 27% of the sample identified with Immediate and/or Special Needs. As the following Chart illustrates, 2017 showed a dramatic jump (62%) in percentage of the sample who were identified with Immediate and/or Special Needs. *That increased trend has continued in 2018.*

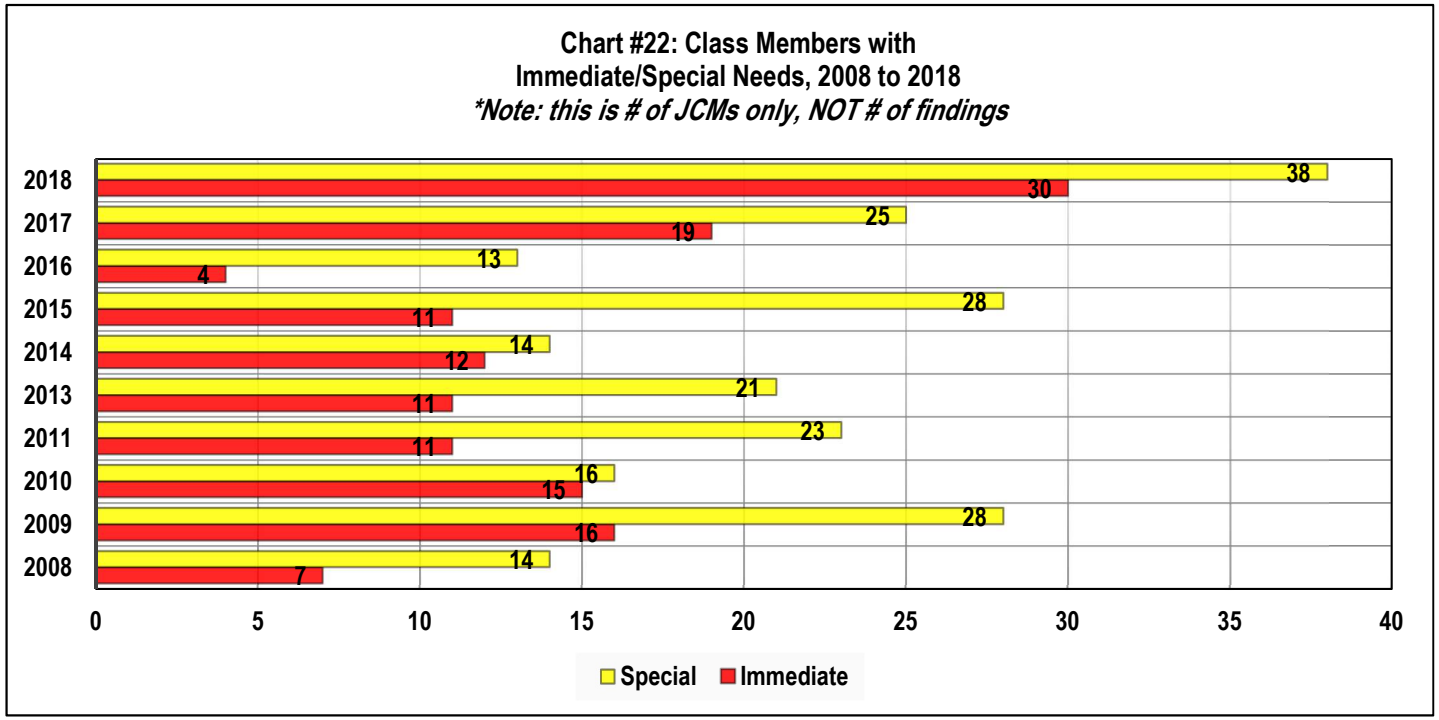
Thirty-two of the 87 individuals reviewed had no Immediate and/or Special Needs identified. *Fifty-five of the 87 were identified as having Immediate and/or Special Needs.* A closer break down follows:

- **30 individuals were identified to have Immediate Needs, 53 different Immediate Findings were identified for these 30 people.**
- **13 of the individuals with Immediate Needs were found to also have Special Needs identified 19 special findings were identified for these 13 people.**
- **25 individuals were identified with Special Attention Needs, 36 different findings were identified for these 25 people.**
- **There were 53 Immediate Findings and 55 Special Needs Findings.**

[22] **See Also Appendix D for more detail regarding type of Immediate and Special findings by provider and case management agency.**

Chart #21: Unduplicated Count of JCMs with Immediate and/or Special Findings			
Year	Active JCMs	Sample Size	# JCM (% of Sample)
2018	256	87	55 (63%)
2017	262	65	40 (62%)
2016	269	93	18 (19%)
2015	283	99	33 (33%)
2014	295	97	24 (25%)
2013	309	103	29 (28%)
2011	317	110	32 (29%)
2010	330	107	30 (28%)

A comparison of the numbers of individuals identified with Immediate and/or Special Needs since 2008 follows. The trend line for the number of Immediate and Special Needs findings continues to go up.



In order for the regions to have a better understanding of Immediate and Special findings, the following breakout may be helpful. As these numbers illustrate, Metro has the largest increase from 2017 to 2018. The NW Region has had no individuals identified with Immediate needs for four consecutive years.

Chart #23: JCMs with Immediate and Special Findings 2014 to 2018 YTD by Region

	2014		Sample	2015		Sample	2016		Sample	2017		Sample	2018		Sample
Region	Immd	SP	Size	Immd	SP	Size	Immd	SP	Size	Immd	SP	Size	Immd	SP	Size
Metro	5 (11%)	6 (13%)	47	10 (20%)	16 (32%)	50	2 (4%)	9 (18%)	49	9 (35%)	9 (35%)	26	17 (35%)	20 (42%)	48
SW	2 (14%)	2 (21%)	15	0	3 20%	14	1 (7%)	2 (14%)	13	3 (30%)	7 (70%)	10	3 (30%)	3 (30%)	10
SE	1 (7%)	2 (14%)	14	1 (9%)	2 (20%)	11	0	1 (10%)	10	1 (10%)	5 (50%)	10	5 50%	3 (30%)	10
NW	2 (20%)	1 (9%)	9	0	3 (30%)	10	0	0	9	0	3 (30%)	9	0	4 (40%)	9
NE	2 (14%)	2 (14%)	14	0	3 (23%)	13	1 (9%)	1 (9%)	11	4 (44%)	3 (30%)	9	5 (50%)	5 (50%)	10
Total	12 (12%)	13 (13%)	99	11 (11%)	27 (27%)	98	4 (5%)	13 (16%)	82	17 (27%)	27 (42%)	64	30 (34%)	35 (40%)	87

In addition to looking at data by region, information can also be identified by provider and by topic area. This information was provided in more detail to the regions following each of their reviews. This information should be used to help the regions prioritize agencies who need technical assistance/remediation and also identify specific priority issues upon which to focus, such as Health Related Oversight, in an effort to use resources wisely.

Chart #24: Immediate and Special Identified Issues by Person, Topic Area and Region

(Details regarding each finding have been provided in previous regional reports)

Grey highlighting indicates that class members is now deceased

Yellow highlighting identifies the topic area along with the number of findings in that area (e.g., Health Related Oversight) and of that number, how many were Immediate and Special issues

Immediate/Special Identified Individual Issues – 2018 IQR						
Reg	CM	Res	Day	Immd	Spec	IR
Health Related Oversight Issues (28 findings; 14 Immediate; 14 Special)						
SW	SCCM	Tresco Deceased	Tresco	X		
SE	J&J	Tobosa	Tobosa		X	
SE	J&J	Tobosa	Tobosa	X		
SE	J&J	Leaders	Leaders		X	

Immediate/Special Identified Individual Issues – 2018 IQR						
Reg	CM	Res	Day	Immd	Spec	IR
Metro3	A Step Above	Optihealth	Optihealth		X	
Metro3	Unidas	Cornucopia	Cornucopia		X	
Metro3	Unidas	Cornucopia	Cornucopia		X	
Metro3	A Step Above	Bright Horizons Deceased	Bright Horizons		X	
Metro3	A Step Above	The New Beginnings	The New Beginnings	X		
Metro3	A Step Above	The New Beginnings	The New Beginnings	X		
Metro3	A New Vision	LLCP	LLCP	X		
Metro3	A New Vision	LLCP	LLCP		X	
M4	Peak	Optihealth	Optihealth	X		
M4	Unidas	Dungarvin	Dungarvin	X		
M4	Unidas	Expressions of Life	Share Your Care	X		
M4	Unidas	Expressions of Life	Share Your Care	X		
M4	Unidas	Expressions of Life	Share Your Care	X		
M4	Unidas	Expressions of Life	LLCP		X	
M4	Carino	LLCP	LLCP		X	
M4	Unidas	LLCP	LLCP		X	
M4	Unique Opp.	LLCP	LLCP	X		
M4	Unique Opp.	LLCP	LLCP		X	
M4	Unidas	LLCP	LLCP		X	
M4	Unidas	LLCP	LLCP		X	
NE	Unidas	Community Options	Community Options	X		
NE	Visions	AWS	AWS	X		
NE	Visions	ELADC	ELADC	X		
NE	Visions	AWS	Phame		X	
Aspiration/CARMP Issues (20 findings; 2 Immediate with IR; 10 Immediate; 8 Special						
Metro1	Unidas	ARCA Deceased	Adelante		X	
Metro1	Peak	Adelante	Adelante		X	
Metro1	Unidas	Alegria	A Better Way	X		X
SW	SCMM	Nezzy Care	Nezzy Care	X		X
SW	SCCM	Tresco Deceased	Tresco	X		
SW	SCCM	Tresco Deceased	Tresco	X		
SW	SCCM	PRS	PRS		X	
SE	J&J	Leaders	Leaders	X		
SE	J&J	Tobosa	Tobosa	X		
SE	J&J	Tobosa	Tobosa	X		

Immediate/Special Identified Individual Issues – 2018 IQR						
Reg	CM	Res	Day	Immd	Spec	IR
SE	J&J	Tobosa	Tobosa		X	
Metro3	A Step Above	Optihealth	Optihealth	X		
Metro3	A Step Above	The New Beginnings	The New Beginnings	X		
Metro3	Peak	Dungarvin	Active Solutions		X	
Metro3	A Step Above	The New Beginnings	The New Beginnings	X		
M4	Carino	LLCP	LLCP		X	
NE	Mi Via	Mi Via	Mi Via		X	
NE	Visions	ELADC	ELADC	X		
NE	Visions	ELADC	ELADC		X	
NE	Visions	AWS	Phame	X		
Not following orders/recommendations (11 Findings; 1 Immediate with IR; 4 Immediate; 6 Special)						
Metro1	Peak	Adelante	Adelante		X	
Metro1	Peak	Abilities First	Adelante		X	
SW	SCCM	Community Options	Community Options		X	
SW	SCMM	Nezzy Care	Nezzy Care	X		X
SW	SCCM	PRS	PRS		X	
SE	Peak	Aspire	Aspire		X	
Metro3	A Step Above	The New Beginnings	The New Beginnings	X		
Metro3	A New Vision	LLCP	LLCP	X		
Metro3	Amigo	Dungarvin	Dungarvin	X		
M4	Unidas	Expressions of Life	Share Your Care	X		
M4	Unique Opp.	LLCP	LLCP		X	
Medication/Side Effects (10 findings; 3 Immediate; 7 Special)						
Metro1	Peak	Adelante	Adelante		X	
SE	J&J	Tobosa	Tobosa		X	
SE	J&J	Tobosa	Tobosa	X		
Metro3	Carino	Arca	None		X	
Metro3	A Step Above	The New Beginnings	The New Beginnings	X		
M4	NMQCM	The New Beginnings	The New Beginnings		X	
M4	NMQCM	The New Beginnings	The New Beginnings		X	
M4	Unidas	Expressions of Life	Share Your Care	X		
M4	Unidas	LLCP	LLCP		X	
NE	Visions	Community Options	Community Options		X	
Symptoms/Issues not being followed up (8 findings; 5 Immediate; 3 Special)						
Metro1	A New Vision	Arca	Adelante		X	

Immediate/Special Identified Individual Issues – 2018 IQR						
Reg	CM	Res	Day	Immd	Spec	IR
SE	Mi Via	Mi Via	Mi Via	X		
Metro3	Carino	LLCP	LLCP	X		
Metro3	Carino	LLCP	LLCP	X		
Metro3	A New Vision	LLCP	LLCP		X	
Metro3	Amigo	Dungarvin	Dungarvin	X		
NW	A Step Above	Ramah Care	Empowerment		X	
M4	Unidas	Dungarvin	Dungarvin	X		
DNR issues (7 findings; 5 Immediate, 2 Special)						
SE	J&J	Nezzy Care	Nezzy Care	X		
Metro3	Amigo	Arca	Adelante	X		
Metro3	A Step Above	Optihealth	Optihealth	X		
Metro3	Carino	Arca	None	X		
NW	Excel	Tungland	Tungland		X	
NE	Visions	Community Options	Community Options	X		
NE	Visions	NNMQC	None		X	
Missing/Gap in Therapy (6 Findings; 1 Immediate with IR; 1 Immediate; 4 Special						
Metro1	Unidas	Adelante	Adelante	X		X
Metro1	Unidas	Alegria	A Better Way		X	
Metro3	A Step Above	MaxCare	MaxCare		X	
Metro3	Unidas	MaxCare	MaxCare		X	
Metro3	A New Vision	LLCP	LLCP	X		
NW	Mi Via	Mi Via	Mi Via		X	
Equipment Issues (5 findings; 1 Immediate with IR; 2 Immediate; 2 Special						
Metro1	Unidas	Adelante	Adelante	X		X
Metro1	Peak	Adelante	Adelante	X		
Metro1	Unidas	Alegria	A Better Way		X	
SW	SCCM	Tresco	Tresco	X		
SW	SCCM	PRS	PRS		X	
Falls/Fractures/Safety (4 findings; 2 Immediate, 2 Special)						
Metro1	A Step Above	Adelante	Adelante	X		
SW	SCCM	Tresco	Tresco	X		
SW	Peak	Lessons of Life	Lessons of Life		X	
NE	Mi Via	Mi Via	Mi Via		X	
Case Management issues (2 Special findings)						
Metro3	Unidas	Cornucopia	Cornucopia		X	

Immediate/Special Identified Individual Issues – 2018 IQR						
Reg	CM	Res	Day	Immd	Spec	IR
M4	Unidas	LLCP	LLCP		X	
HCP/MERPs/eChat discrepancies (2 Special findings)						
Metro3	Unidas	Arca	Adelante		X	
NW	A Step Above	Ramah Care	Empowerment		X	
Other (6 Findings; 3 Immediate, 3 Special)						
Metro3	Amigo	Dungarvin	Dungarvin		X	
Metro3	Amigo	Dungarvin	Dungarvin	X		
NW	Peak	Dungarvin	Dungarvin		X	
M4	Peak	Optihealth	Opihealth	X		
M4	Unidas	Expressions of Life	LLCP		X	
NE	Mi Via	Mi Via	Mi Via	X		

Lack of adequate Health Care Management, Nursing Oversight and effective interventions contribute to the issues identified throughout this report including inaccurate/conflicting information in medical records, orders not being followed, recommended tests/follow up not occurring as ordered and more. Examples of issues identified for individual Jackson Class Members have been identified throughout this report. The following summarizes the number of identified issues that relate to a specific category of findings.

Health Oversight Issues (29)
- Nursing Assessments/Service Information Missing and/or Inaccurate
- Nursing not providing oversight of healthcare tracking
- Nurse not visiting at required frequency
- Bowel tracking/HCP issues
- Issues with weight loss
- Missing required ensure supplement for a week
- Nursing Staff have not provided oversight

Aspiration/CARMP Issues (20)
- Nursing not monitoring as required
- CARMP is not followed/Inconsistent
- Issues were observed with implementation
- Staff Not Trained on CARMP
- CARMP contains inconsistencies/inaccurate

Not following orders/recommendations (11)
- SAFE Clinic Recommendations Not Implemented
- Follow-up appointments and/or lab work were not completed
- HCP Not Being Followed
- Staff Unaware of MERP Instructions
- OT services not provided as recommended

Medication Issues (10)
- Medication Allergy not Identified
- Medication orders/MAR do not match
- Medication has applicable warning

Do Not Resuscitate issues (9)
- Staff have conflicting information about whether or not a DNR Exists
- DNR/Advanced Care Plan not available (2)
- DNR signing in question or in contradiction to Guardian wishes
- DNR/DNI information not included on MERPs

Symptoms not recognized/acted upon (8)
- Ongoing GERD Issues; No GI consult
- Lack of follow up on uterine mass
- Enlarged prostrate causes pain; not treated

- Known pain, not treated

Falls/Fractures/Safety (4)
- ROM being done incorrectly
- Confusion regarding DNR
- Staff Cannot Read Plans (ISP, CARMP, HCP) (Not Translated into Spanish)

Missing/Gap in Therapy (6)
- PT Services missing/delayed
- Gap in OT Services
- BSC discontinued; still has need

Equipment Issues (5)
- Wheelchair is inadequate
- Wheelchair not timely obtained
- Dining Equipment was not available
- Artificial Manual Breathing Unit/Ambu Bag not available
- Air Mattress Needs Replaced

Case Management issues (2)
- CM does not fulfill duties

HCP/MERP/Echat plan discrepancies (2)

Other (4)
- Transition meetings/planning not completed
- Need to reduce possible blood clot
- Alternate Positioning not available
- Funding for Ensure

Chart #25: Number of Immediate and/or Special Findings Identified by Residential/Day Agency									
RESIDENTIAL ( ) = number in review	# Immd Findings	# Special Findings	IR Filed	Avg # I/S/IR Findings	DAY Agency ( ) = number in review	# Immd Findings	# Special Findings	IR Filed	Avg # I/S/IR Findings
Agencies with 10 or more People in the Sample									
					Adelante (17)	5	7	2	0.8
					LLCP (10)	6	13	0	1.9
Agencies with 6 to 9 People in the Sample									
Adelante (9)	4	3	2	1	Dungarvin (6)	5	2	0	0.8
LLCP (9)	6	11	0	1.9					
ARCA (7)	2	4	0	0.9					
Dungarvin (7)	5	3	0	1.1					
Agencies with 4 to 5 People in the Sample									
Mi Via (5)	2	3	0	1	Mi Via (5)	2	5	0	1.4
The New Beginnings (4)	6	2	0	1.5	Tresco (4)	5	0	0	1.3
Tresco (4)	5	0	0	1.3					
Agencies with 2 to 3 People in the Sample									
Community Options (3)	2	2	0	1.3	Lessons of Life (3)	0	1	0	0.3
Expressions of Life (3)	5	2	0	1.7	None (3)	1	2	0	1
Lessons of Life (3)	0	1	0	0.3	The New Beginnings (3)	6	2	0	2.7

Chart #25: Number of Immediate and/or Special Findings Identified by Residential/Day Agency									
RESIDENTIAL ( ) = number in review	# Immd Findings	# Special Findings	IR Filed	Avg # I/S/IR Findings	DAY Agency ( ) = number in review	# Immd Findings	# Special Findings	IR Filed	Avg # I/S/IR Findings
Tobosa (3)	4	3	0	2.3	Tobosa (3)	4	3	0	2.3
Tungland (3)	0	1	0	0.3	AWS/Benchmark (2)	1	0	0	0.5
AWS/ Benchmark (2)	2	1	0	1.5	CFC (2)	0	0	0	0
Bright Horizons (2)	0	1	0	0.5	Community Options (2)	2	2	0	2
ENMRSH (2)	0	0	0	0	ENMRSH (2)	0	0	0	0
MaxCare (2)	0	2	0	1	LifeRoots (2)	0	0	0	0
Opti Health (2)	3	1	0	2	MaxCare (2)	0	2	0	1
					Nezzy Care (2)	3	0	2	2.5
					Phame (2)	1	1	0	1
					Share Your Care (2)	5	0	0	2.5
					Su Vida (2)	0	0	0	0
					Tungland (2)	0	1	0	0.5
Agencies with 1 person in the Sample									
Ability First (1)	0	1	0	1	A Better Way (1)	1	2	1	4
Alegria (1)	1	2	1	4	Active Solutions (1)	0	1	0	1
Aspire (1)	0	1	0	1	Advocacy Partners (1)	0	0	0	0
At Home Advocacy (1)	0	0	0	0	Aspire (1)	0	1	0	1
CARC (1)	0	0	0	0	Bright Horizons (1)	0	1	0	1
CDD (1)	0	0	0	0	CARC (1)	0	0	0	0
Cornucopia (1)	0	3	0	3	CDD (1)	0	0	0	0
Ensuenos (ELADC) (1)	2	1	0	3	Cornucopia (1)	0	3	0	3
Family Options (1)	0	0	0	0	Empowerment (1)	0	2	0	2
Leaders (1)	1	1	0	2	Ensunos (ELADC) (1)	2	1	0	3
Nezzy Care (1)	3	0	2	5	Family Options (1)	0	0	0	0
NNMQC (1)	0	1	0	1	Leaders (1)	1	1	0	2
PRS (1)	0	3	0	3	Optihealth (1)	4	1	0	5
Ramah Care (1)	0	2	0	2	PMS/Shield (1)	0	0	0	0
Su Vida (1)	0	0	0	0	PRS (1)	0	3	0	3
TLC (1)	0	0	0	0					

Chart #26: Number of Immediate and/or Special Findings Identified by CM Agency				
CM Agency ( ) = number in review	Immd Findings	Special Findings	IR Filed	Avg # I/S/IR Findings
CM Agencies with 9 or more people in the Sample				
Unidas (18)	11	15	3	1.6
A Step Above (9)	9	5	0	1.6
CM Agencies with 6 to 8 people in the Sample				
Peak (8)	3	8	0	1.4
SCCM (8)	7	4	2	1.6
J&J (7)	6	5	0	1.6
Carino (6)	3	3	0	1
Excel (6)	0	1	0	0.2
Visions (6)	5	4	0	1.5
CM Agencies with 4 to 5 people in the Sample				
Mi Via (5)	2	3	0	1
Amigo (4)	4	1	0	1.3
CM Agencies with 2 to 3 people in the Sample				
A New Vision (3)	3	3	0	2
NMQCM (3)	0	2	0	0.7
Unique Opportunities (2)	1	2	0	1.5
CM Agencies with 1 person in the Sample				
DDSD (1)	0	0	0	0
Rio Puerco (1)	0	0	0	0

I. Prevalent Causes of Hospitalization

Related Evaluative Components Required for Disengagement include:
Health Objective H3.1 **Jackson Class Members receive increased intensity of services during acute episodes or illnesses.**
Health Objective H3.2 **Direct Service Personnel/supervisors are able to identify subtle signs of change/acute symptoms.**
Health Objective H3.4 **When an individual is receiving healthcare in an out of home setting, critical health and functional information will be provided and the individual's existing adaptive equipment that can be used in that setting will be offered.**
Health Objective H3.5 **When a JCM is receiving healthcare in an out-of-home setting, the IDT will plan for a smooth transition back to the JCM's home as soon as medically feasible.**

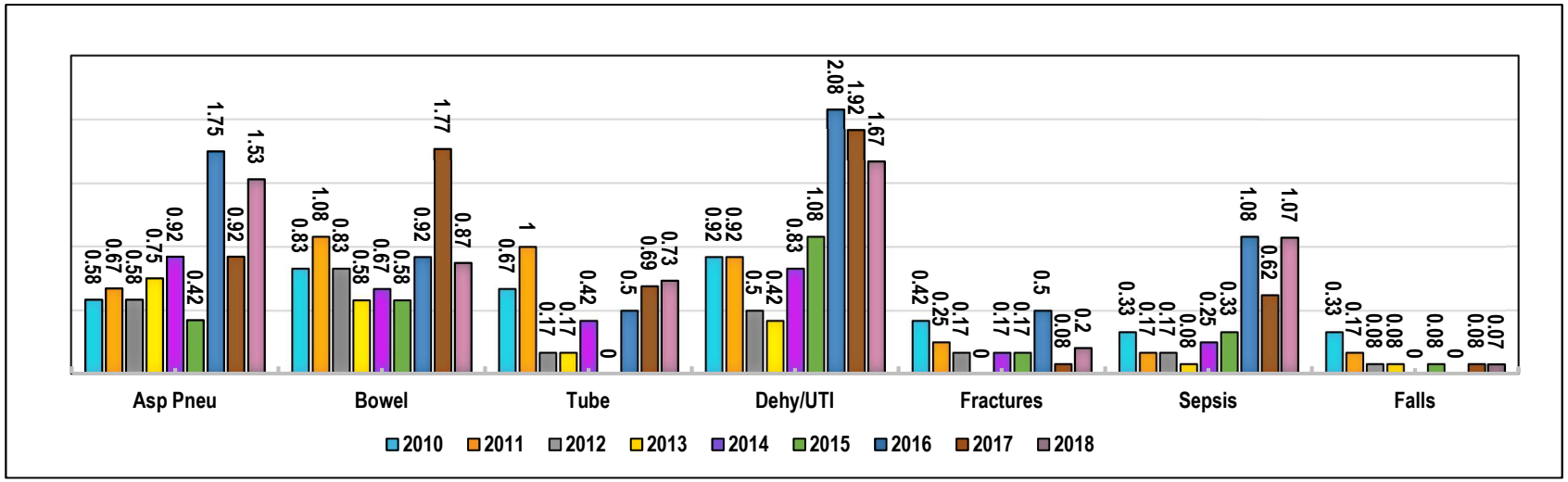
In addition to looking at what people know, what information is contained in the record, what action has been taken and health related outcomes, other facts inform our understanding of overall class member health status and receipt of prompt care. This section examines the most frequently identified health issues based on the Out of Home Placement Report.[23]

For 2018, numbers listed below reflect those Out of Home Placement Reports received after last year's cutoff date (December 29, 2017) through March 31, 2019, a period of fifteen months. Primary causes of hospitalization are described in the chart that follows. Dehydration and urinary tract infections once again accounted for the highest number of hospitalizations, followed by aspiration pneumonia. Bowel-related issues as a contributing cause of hospitalizations (obstructions, impactions, constipation, ileus and volvulus) are down significantly from their high of 2017. Diagnosed cases of sepsis once again increased, with a monthly average nearing the high seen in 2016.

When reviewing these data, be aware that class members often experienced more than one of the tracked diagnoses during a single out of home placement. When sepsis is diagnosed, for example, there was almost always an underlying infectious process, such as pneumonia or urinary tract infection. Dehydration was often associated with constipation and/or bowel obstruction.

As the reporting periods for 2017 and 2018 are longer than the twelve-month periods examined for prior years, diagnoses are examined as a monthly average rather than raw totals, as had been the case in previous years. Comparative analysis conducted here is based upon the monthly average.[24]

Chart #27: Monthly Average of Primary Causes of Hospitalization by Reporting Period



[23] The Out of Home Placement Report is provided by DOH/DDSD weekly and identifies, in part, class members by name who have been moved out of their home, where they were moved, why and some information regarding follow up. The great majority of out of home placements are acute care hospitalizations. This information is current regarding all out of home placements reported through March 31, 2019.

[24] Reporting periods are based on timing of this Community Practice Review. Reviews of Out of Home placements for 2010 – 2016 were limited to 12-month periods. The compilation of this Review is impacted by other activity ongoing the case, with the result that the review period for the 2017 report was slightly longer (13 months) and the review period for the current report includes out of home placement reporting covering 15 months.

Explanation of the conditions tracked in the chart above:

Aspiration Pneumonia: **individuals hospitalized with upper respiratory issues that were diagnosed as aspiration pneumonia.**

Bowel: **individuals hospitalized and diagnosed with bowel obstructions/impactions, and conditions of intestinal paralysis (ileus) and twisting (volvulus) that commonly lead to obstruction, if not detected and treated promptly.**

Tube: **individuals hospitalized with issues such as needing a (g or j) tube, pulling out a tube and needing it to be reinserted, infections at the tube site, refusing to have a tube inserted.**

Dehydration/Urinary Tract Infection (UTI): **individuals hospitalized with diagnoses related to dehydration and/or UTIs.**

Fractures: **individuals hospitalized and diagnosed with broken bones.**

Sepsis: **individuals hospitalized and diagnosed with a life-threatening condition that occurs when an infecting agent such as bacteria, virus or fungus gets into a person's blood stream. The infection activates the entire immune system, which then sets off a chain reaction of events that can lead to uncontrolled inflammation in the body. This whole-body response to infection produces changes in temperature, blood pressure, heart rate, white blood cell count, and breathing.**

Falls: **individuals hospitalized or taken into hospital as a result of falls.**

The following three charts examine the type and prevalence of pneumonia as a contributing factor in out of home placements. Chart #28 identifies the number of pneumonia diagnoses associated with hospital stays by classification. Chart #29 displays the monthly average of out of home placements with pneumonia of any type identified. Chart #30 looks at the number of class members who experienced out of home placements related to aspiration pneumonia, including those class member deaths where aspiration pneumonia is a suspected cause.[25] When these data are examined together, there are several aspects of class members' experience with pneumonia that can be examined.

Over the most recent period, there has been a substantial decrease in the amount of unspecified pneumonias as a portion of the total number of pneumonia diagnoses. Fourteen of the 46 occasions (30%) when a class member was diagnosed with pneumonia contained no additional information as to the type. This is down significantly from the prior reporting period. Out of home placements examined for the 2017 Individual Quality Review identified 39 pneumonia diagnoses, and 52% of these (21 instances) had no type specified. This laudable progress is helpful to teams in planning safe discharges and making necessary changes to supports and services when aspiration has been identified. In the case of community-acquired pneumonia, knowing conclusively that the class member has a communicable type of pneumonia is vital knowledge in preventing others from exposure to the identified pathogen. This important work should continue with a goal of reducing unspecified pneumonia diagnoses to zero.

[25] At the time of this reporting, mortality reviews were available for none of the twelve class members who passed away over this reporting period. In some instances, cause of death is obvious based on diagnoses and hospice admission. However, without the conclusions of mortality review, it is not possible to conclude with certainty whether any additional class members died from complications from aspiration pneumonia.

The trend of increasing admissions related to pneumonia continues into the current reporting period. Last year's average was 3.00 admissions related to pneumonia per month. For the fifteen months examined for the 2018 IQR, the monthly number has increased slightly to 3.07. The highest per-month rate of pneumonia admissions was 3.92, identified in the 2016 Community Practice Review. The 2016 spike in pneumonias resulted in Systemic Recommendation #8:

> "Using all source information (e.g., hospital admission and readmissions, hospice, ER use) conduct regular Morbidity Reviews to identify frequently occurring conditions (i.e., dehydration/UTI's, bowel obstructions, aspiration) that are causing people to frequently use emergency services and/or be hospitalized. What is learned should be used quarterly to inform providers, case managers, teams and others about ways to improve health outcomes. (H4.3a; S52).
>
> This should include the 2016 recommendation to identify why the upward trend in pneumonia's continues. Based on this analysis, immediate action should be taken to remediate this trajectory. This examination should include a report that identifies trends, findings and recommendations".

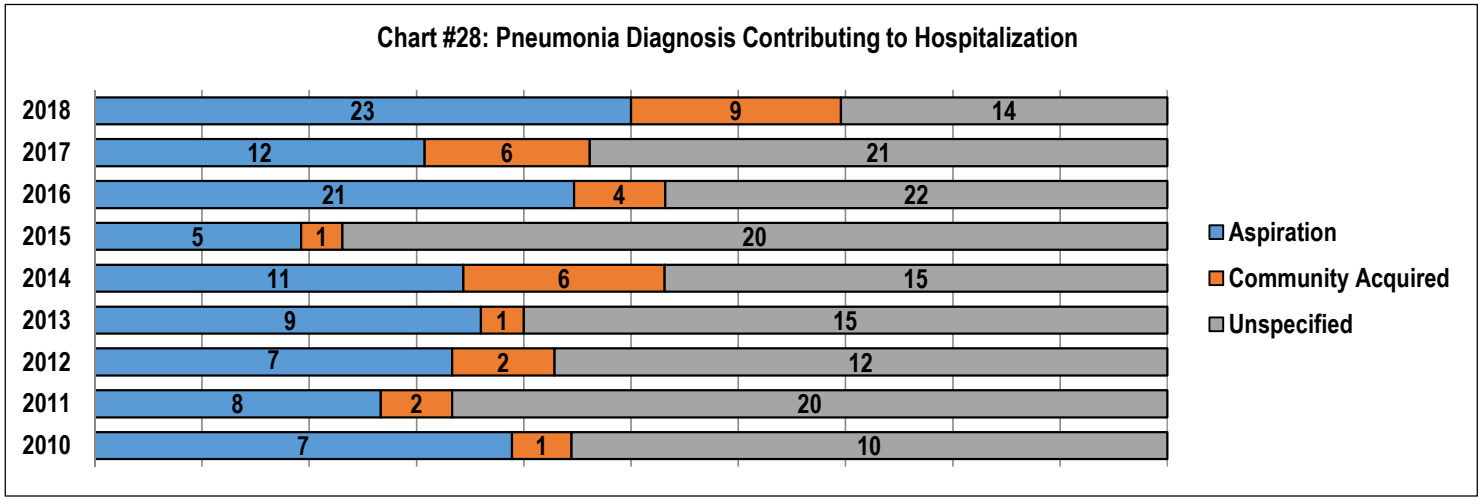


Chart #29: Monthly Average of Reported Pneumonia Diagnoses 2010 to March 2019

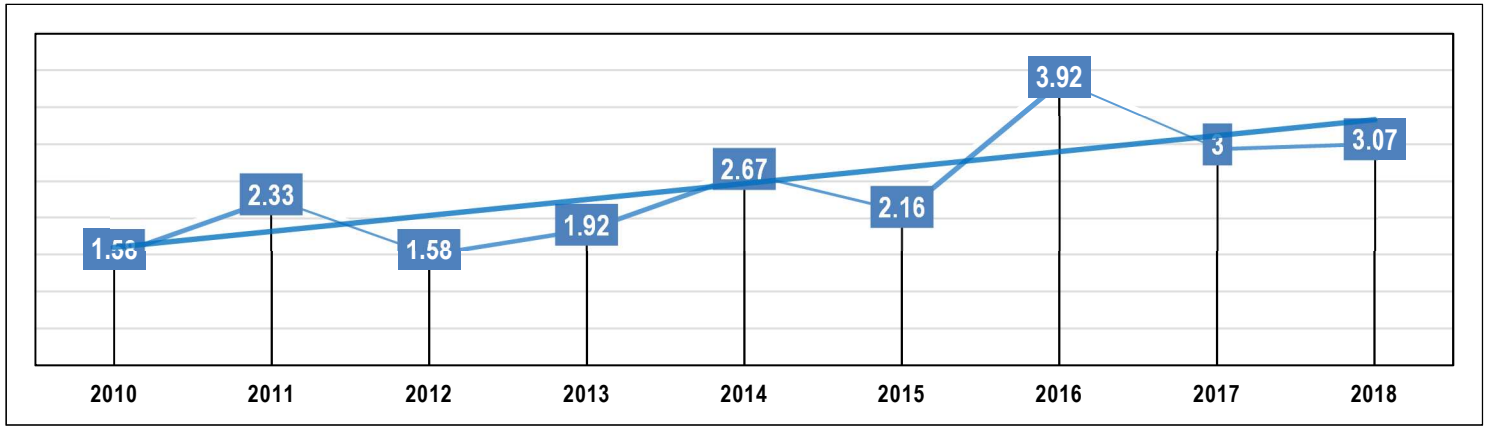


Chart #30: Hospitalizations and Deaths Attributed to Aspiration Pneumonia 2010 to March 2019

( ) = Number of times to hospital	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total
# of Persons who died who had a diagnosis of Aspiration Pneumonia	6	2	0	2	3	1	2	0[26]	1[27]	16
# of Persons hospitalized with a diagnosis of Aspiration Pneumonia	7 (12x)	8 (8x)	7 (10x)	9 (10x)	11	5	17 (21x)	10 (12x)	18 (22x)	73
Total	13	10	7	11	14	4	19	10	21	98[28]

[26] Clinical cause of death and/or accurate diagnosis information was available at the time of this report for only two of the twelve individuals we lost in 2017, and neither of these died of aspiration pneumonia. Thus, accurate reporting for this field is not available.
[27] Clinical cause of death and/or accurate diagnosis information was available at the time of this report for seven of the twelve individuals who passed away during the 2018 reporting period. Aspiration pneumonia was the diagnosis leading to the death of one of the individuals. The reporting in this field is based on data available at the time this report was published, and may not be accurate.
[28] This is a duplicated count. The actual number of individual class members is 61.

J. Readmissions

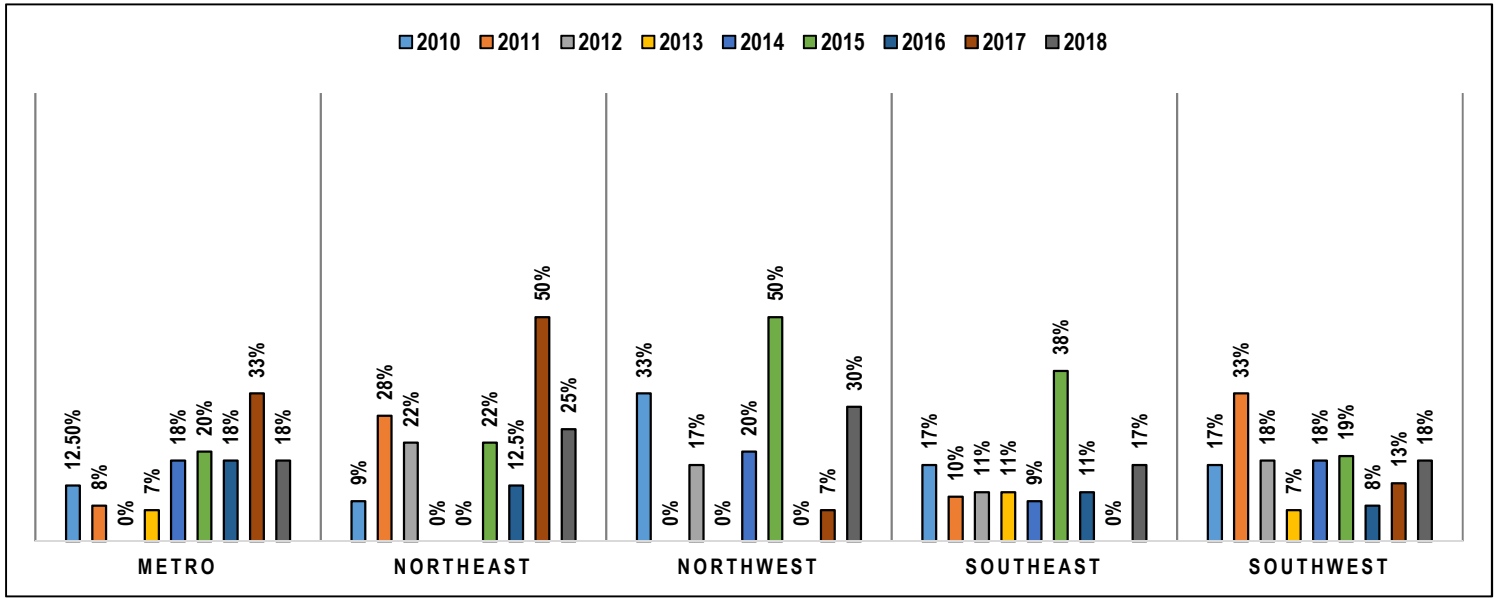
When a person is discharged from the hospital, and then readmitted within 30 days for the same problem or a related problem, this is identified as a readmission. Readmissions are measured nationwide as an indication of quality of care, based upon the presumption that rates of readmission are related to discharges which occur too early, incorrect diagnosis, and/or provision of treatment that is not effective. The risk of hospital readmission is heightened among persons with intellectual disability who have compromised communication skills due to their inability to report symptoms, which designation applies to a large majority of Jackson Class Members,. A total of 150[29] of the 866 (17%) Out of Home Placement records received since 2010 are readmissions. This is the fourth year readmissions have been examined. During 2015 and 2016, the overall percentage of readmissions held steady at 15%. It increased to 17% in 2017 due to a significant increase in readmissions that year pushing the overall number higher. Nineteen percent (19%) of the 127 admissions for the current reporting period were readmissions. The average since 2010 is 17%.

Chart #31: Eight Year Readmission Rate by Region (2010 to March 2019)

Region	Readmissions/Total Admissions	Eight Year % of Total by Region
Metro	80/467	17%
Northeast	21/94	22%
Northwest	13/75	17%
Southeast	13/92	14%
Southwest	23/138	17%
TOTAL	150/866	17%

[29] These numbers do not include any transfers to alternate facilities (e.g., skilled nursing facilities) that occurred during a single period when the Jackson Class Member was out of their home.

Chart #32: Percentage of Hospital Readmissions per Reporting Period by Region



For the 2018 reporting period, a class member who was hospitalized had about a one in five chance of returning to the hospital within 30 days of his or her discharge (19%). It is not always clear why a class member is sent back to the hospital so soon after discharge, but in most instances, Out of Home Records currently contain notes that directly or indirectly identify the cause.

- Most commonly, the class member has not sufficiently recovered from the illness that led to the first hospital stay. In one example, an individual was hospitalized six times over a four-month period, each admission with a diagnosis related to problems with his feeding tube and aspiration.
- Occasionally, the underlying condition for the class member's illness is not identified during the first hospitalization. For instance, one class member had one behavioral health admission and two admissions to an acute care hospital over the course of a month. It was only on the third admission that Depakote toxicity was identified as the underlying cause of her change in mental status.
- Four individuals who experienced hospital readmissions during the current reporting period were nearing the end of a disease process that resulted in death. Three of these class members were discharged to hospice following their last admission.

It is important to note that in the past, readmissions due to lack of timely follow up on discharge orders has been noted. *There is no evidence that this was a concern in any of the 24 readmissions examined for this reporting period.* This significant improvement and protection for class members is noted. Providers, nurses, direct support professionals, case managers, and regional office staff… everyone whose advocacy and diligence on behalf of class members are to be thanked for this important outcome.

Supporters, and indeed, DOH and DDSD, are faced with competing challenges in meeting class members' needs when an acute illness arises. Everyone is charged with the support of a group of individuals with complex medical challenges, frequently further complicated by barriers in communication. This

mandate must be met by relying upon the community resources available. Medical practitioners in the community are faced with their own pressures relating to lack of significant experience in treating individuals with I/DD and significant constraints on resources.

It continues to be important to have a systematic, training-based approach to 'discharge advocacy.' Teams need to know what questions to ask to ensure that they have adequate information to safely facilitate a hospital discharge and lessen the chance of readmission. This includes determining the discharge diagnosis with specificity. If a critical diagnosis is pending (as when biopsy results are awaited), it might be necessary to develop alternative plans for the possible diagnostic outcomes. Teams also need to know whether and under which circumstances other options are available that can be coordinated through the hospital, such as home health care, or delaying discharge for 'observation' where the team feels the likelihood of readmission is high. Strong healthcare advocacy is a non-negotiable in helping individuals live their best and healthiest lives, and an area in which the system must collectively continue to improve.

K. Hospice

> **Related Evaluative Components Required for Disengagement include:**
> ***Health Objective H3.5*** **When a JCM is receiving healthcare in an out-of-home setting, the IDT will plan for a smooth transition back to the JCM's home as soon as medically feasible.**
> ***Health Objective H4.2.*** **IDTs provide for the changing health supports class members need as they age including advanced care planning and have access to palliative care consistent with their needs.**

There continues to be no consistent and routine tracking and reporting of information on the use of hospice. Information regarding hospice is taken from Out of Home Placement Reports, to the extent that information is provided. In a few instances, information on hospice admission came from other sources, such as Comprehensive Health Assessments.

Out of 866 Out of Home Placement Reports which have been filed since 2010, there were reports of 44 class members being referred for hospice. Several of these class members have been referred for hospice services more than once.[30] The availability of Hospice services to Class Members provides an avenue for them to receive comfort care in their final days, and to spend their last hours at home or in a facility dedicated to Hospice care rather than in an acute care hospital setting. The benefit goes beyond members of the Jackson Class to also provide comfort to their family and loved ones.

Of the Class Members who received Hospice referrals during the course of an Out of Home Placement, 32 have died. Twelve Class Members who receive or have received Hospice services remain living. Some class members are referred repeatedly to Hospice for discrete medical events, sometimes separated by months or years. Others appear to remain on Hospice services for multiple years, although there is no separate tracking for Hospice discharges, and these instances are only verified by the Community Monitor incidentally during a Review.

The decision to turn the treatment focus from diagnosis, treatment, and cure to comfort and quality at the end of life is not one to take lightly, and there is substantial documentation that guardians faced with this difficult choice approach it with due gravity and deliberation. It is never an easy decision. The nature of the illness of each individual for whom this is considered is unique, and the variables involved cannot be predicted with any precision. When we are

[30] This number reflects only those Hospice referrals that take place upon hospital discharge. Hospice referrals and intake can also be coordinated through the Class Members' treating physician and may not involve an out-of-home placement. As noted above, not all class members referred to Hospice through hospitalization have died. Thus, these numbers are slightly different than the overall total of Hospice stays considered in the section of this report that evaluates Class Member deaths.

considering treatment decisions for Jackson Class Members, this topic is greatly complicated by compromised communication skills. The individual often cannot express his or her own wishes regarding end-of-life decisions, and in most cases has only a limited ability to communicate their own experience of illness (e.g., I'm feeling better, or I'm feeling worse).

A referral for Hospice should typically follow diagnosis of a terminal illness, one that cannot be cured and is expected to result in death within a short period of time. Yet, about one in four Class Members referred to Hospice have continued to live relatively healthy lives well beyond their referral for that service. This raises several questions:

- **Are there instances where Hospice referrals are made prematurely that have resulted in death because of termination of diagnostics (termination of the search for the potentially reversible cause of functional decline) and/or the removal of treatment that would have been successful if given more time?**
- **Have any Class Members died while receiving Hospice services from a cause of death other than the terminal illness diagnosed, but as a result of the limited Scope of Treatment (e.g., DNR Order) associated with Hospice?**
- **Are people with intellectual and developmental disabilities (I/DD) more likely to be referred to hospice than others without disabilities with the same physical symptoms and/or diagnosis?**

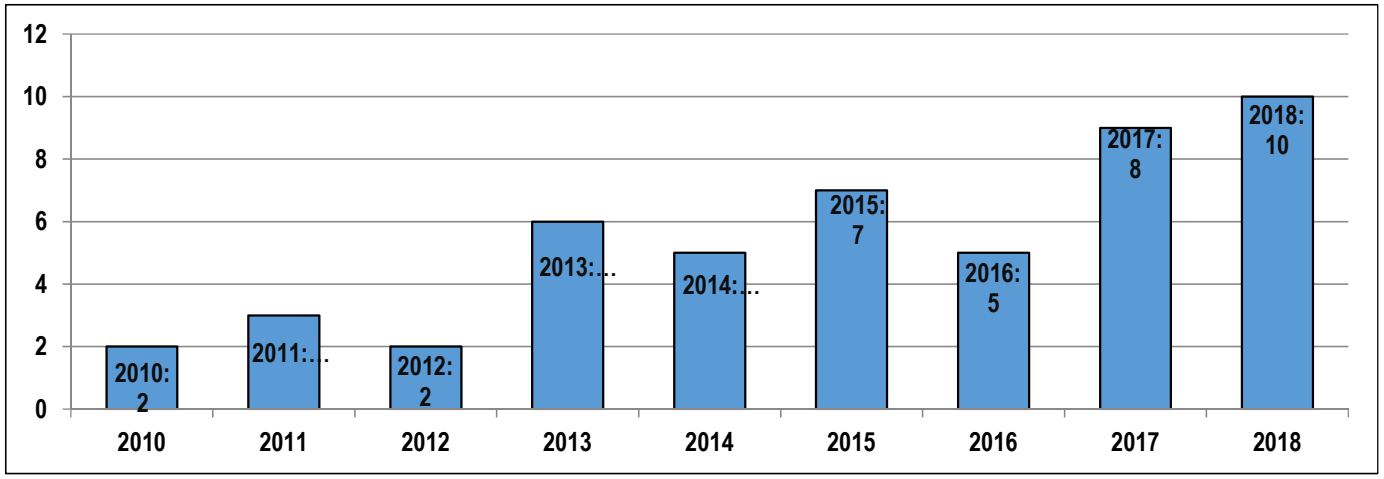
These questions are not intended to raise any sort of accusation for those facing these incredibly complex decisions; rather, the intent is to invite discussion that may lead to learning from the information we already have.

As has been noted in the IQR Statewide Report for, now, three years reviewing available hospice and palliative care information raises systems issues as well. Issues surrounding end of life decisions are going to continue to present themselves as the Jackson Class ages. As more and more individuals and their families consider Hospice, it would be advantageous to everyone concerned to intentionally develop a system of training and data tracking. A few examples follow.

- **It would be helpful to have consistent and routine tracking and reporting of information on the use of hospice including:**
  - **Who goes into Hospice (Out of Home Placement Report provides some of that information now);**
  - **When the person goes into Hospice/Palliative Care (OOH Placement Report sometimes has this information);**
  - **The reason (diagnosis) the person is being recommended for Hospice;**
  - **When the person leaves Hospice/Palliative Care**

- **Individuals, family members and teams would benefit from training related to End of Life Decision making.**
  - **Criteria for Hospice Care vs. Palliative Care;**
  - **What is the role of the individual's team in effectively coordinating care with hospice;**
  - **Expectations of these services . . . what can and can't happen in each in terms of treatment;**
  - **What are the expectations for coordination of care between the hospice and provider nurse;**
  - **Reporting expectations from Hospice and from Palliative Care providers to the DD Waiver provider and vice versa.**
  - **What options exist for Teams to examine a recommendation for Hospice/Palliative Care; and**
  - **What options Teams have if they disagree with a recommendation for Hospice/Palliative Care.**

Chart #33: Statewide Hospice Referral from Hospitals by Reporting Period



L. Class Member Deaths

Twelve class members have died during the 2018 reporting period. In 2013 we experienced the death of seven class members, in 2014 six individuals left us, and we lost an additional twelve in 2015. Thirteen died in 2016 and another twelve passed away in 2017. All will be greatly missed. As discussed as a part of last few years reports, death is a difficult subject for any of us to consider and talk about. Awkwardness, embarrassment, fear, guilt, anger . . . we tend to shy away from the topic or from connecting with those who are dying or those who are grieving. The reality is that we must talk about the death of class members if we are to:

- respect and honor those lives;
- recognize the unexpected longevity of many;
- applaud the examples of sensitive, thoughtful and excellent care that so many receive;
- note the good documentation that was maintained;
- thank those providing long-term relationships during the dying process;
- learn from the good practice of those providing care;
- learn from problems in the provision of care and services so as to improve the system of support for others;
- know how to stop preventable deaths; and
- respect and support those preparing to die even better than we have in the past.

Blame and defensiveness in a litigious environment is common but not helpful if we are to learn from our achievements as well as our failures and in turn improve our performance with and on behalf of class members. The information in this section is provided with the hopes of joining with others to create a 'learning laboratory' of sorts as we examine the information we have surrounding class member deaths. The general profile of those we lost and for whom information has been provided to the Community Monitor follow.

Chart #34: Demographic Information for People Who Died 2014 – March 2019

Unclear = Unclear based on available data through the OOH Placement Reports

Demographic	2015	2016	2017	2018 – March 2019
Men	8	9	10	9
Women	4	4	2	3
Age Range/Av. Age	37-67[31] 57 years 6 months	43-83[32] 64 years 8 months	37-77[33] 59 years, 9 months	47-72[34] 58 years
# Receiving Hospice	7	6	3	5
Hospice Diagnosis	1. Pneu & Resp Distress 2. Kidney Failure 3. Renal Failure 4. repeated vomiting? 5. Aspiration Pneu 6. Kidney Failure, Leukemia, Pneumonia & Sepsis 7. Liver Cancer	1. Congestive Heart Failure; 2. Unclear 3. Heart Attack 4. Renal Failure & CHF 5. Cardio-Pulmonary Failure & Seizures 6. Unclear	1. Aspiration, then? 2. Renal Failure; 3. Failure to Thrive?	1. Renal failure, bilateral airspace disease 2. Mass in stomach, likely cancerous 3. Pneumonia 4. Aspiration pneumonia 5. Breast cancer
Average # of days in Hospice	32 days 1 Unknown; 2 @5 days; 2@ 1 day; 1 @ 3 days; 1@208 days (battling cancer)	326.5 days 1@ 1 day; 1@ 2 days; 1 @ 43 days; 1 @ 264 days; 1 @ 331 days; 1 @ 1318 days	514.33 days 1@ 31 days; 1@35 days; 1 @ 1477 days [35]	34.4 days 1@ 10 days; 1@ 3 days; 1@ 4 days; 1@ 26 days; 1@ 119 days
Guardians	2 Arc; 1 Brother; 2 Sisters; 2 Mother; 1 Mother/Father; 2 Quality of Life; 1 Ayudando	2 Arc; 1 Brother/Mother; 1 FLP; 2 Mother; 2 Niece; 2 Quality of Life; 2 Sister; 1 UNIDAS	2 Arc; 1 Agave; 1 Quality of Life; 1 Father; 2 Mother; 1 Aunt; 2 Brother; 1 Niece; 1 Cousin	4: Arc, 1: Brother, 3: parents, 4: sisters
Regions	6: Metro 1: NE 1: SE 4: SW	5: Metro 4: NE 2: NW 2: SE	7: Metro 2: NE 1: NW 2: SE	9: Metro 2: SE 1: SW
Providers	3: Adelante	1: Advantage Communication	1: A Better Way 1: Adelante	2: Adelante

[31] 2015: 1 individual was 37, one 50, one 51, one 52, two were 58, two were 59, one was 61, one was 65, one was 67 and one was 74.
[32] 2016: 1 individual was 43, one 51, one 57, two 59, one 61, one 64, one 68, one 71, one 72, one 73, one 80, and one was 83.
[33] 2017: 1 individual was 37; two 51; two 57; one 59; one 62; two 64; one 66; one 72; one 77
[34] 2018: 1 individual was 47; one 51, one 52 one 55, two 57, two 58, two 60, one 70 and one 72
[35] One individual (#21) was referred to Hospice on 1/24/2013. He died 2/9/2017. Note indicates his mother put him in inpatient Hospice with his 2/2/2017 hospitalization right before he died, but it's not clear that he was ever discharged from outpatient hospice. Depending on which dates are correct, presuming 2/2 as his inpatient hospice admit, he was either on hospice for 1477 days or 7.

Demographic	2015	2016	2017	2018 – March 2019
	2: ARCA 1: Dungarvin 1: ENMRSH 1: Family Options 4: Tresco	3: ARCA 1: AWS 1: CARC 1: ESEM 1: Expressions of Life 1: HDFS 2: Mi Via 1: Ramah Care 1: Tungland	1: Advantage Communications 2: Arca 1: AWS 1: Bright Horizons 1: CDD 2: Dungarvin 2: Mi Via 1: Tresco	2: Arca 3: Bright Horizons 1: Expressions of Life 1: HDFS 1: Private Pay 1: Tobosa 1: Tresco
Case Management	1: A Step Above 1: Amigo 1: J&J 1: NMBHI 1: NMQCM 3: SCCM 3: Unidas	1: A New Vision 1: A Step Above 1: Amigo 1: Excel 2: J&J 2: Mi Via 1: NMQCM 1: Unique Opportunities 1: Unidas 2: Visions	2: Carino 1: Excel 1: Mi Via 1: NMBHI 1: NMQCM 2: Peak 3: Unidas 1: Visions	1: A New Vision 2: A Step Above 2: J&J 3: Peak 1: Private Pay 1: SCCM 2: Unidas

Those involved in the process of dying have a variety of physical, spiritual, emotional and/or social needs. The nature of dying is unique just as the nature of living is unique. Part of person-centered planning has and will need to continue to include being sensitive and responsive to the special requirements of each individual and family through the dying process. Providers, case managers and DDSD are commended for enabling the thoughtful inclusion of hospice services as an option for individuals at the end of life who have a known limited life expectancy. This partnership has enabled individuals to spend their last months at home in a familiar and responsive environment with those who know them best. The addition of hospice services can enable individuals, their families and staff to prepare for death in a way that is satisfactory to them. Thank you all for this demonstration of respect and responsiveness.

As articulated for the past few years, it is worth examining the parameters of the term 'expected' as it pertains to class member deaths. It seems that a death is always considered expected where a Hospice referral is made. In reality, this is not necessarily true and we lose the value of learning when we fail to look into the course of illness that led to the terminal diagnosis. Consider, for example, these fictitious circumstances: if an individual was involved in a car accident caused by reckless driving by their caregiver, was later hospitalized and found to have sustained severe organ damage and not expected to recover, it would be reasonable for Hospice services to be brought in with the team's full understanding and consent. While the eventual death of this person is not unexpected, it was not due to a natural course of illness that has progressed beyond a level of treatment that can be delivered to maintain a reasonable quality of life. All involved would likely agree that there were circumstances leading to the injury and death of a supported person that need to be addressed, and that foregoing this exploration because the death was 'expected' would be a disservice to the life that was lost. Although most of our friends' deaths occur under circumstances that are less cut and dried, our mission of providing the best support and seeking continuous improvement does not end with their deaths. We must do our best to understand what happened and make an objective analysis as to whether something could have been done differently. Perhaps the answer is no, but there are still too many deaths where the question has not been fully asked and answered.

V. INDIVIDUAL SERVICE PLAN (ISP)[36]

A. Individual Planning Context

Each individual has a unique Individual Service Plan (ISP) which serves as a form of a contract between the class member, his/her team and provider. This contract is intended to record what the person's background/experiences have been as well as to identify strengths, needs, challenges and interests. Based on this information, the person, with support from his/her team, details in the ISP what the individual wants to do/accomplish (Vision/Outcomes), then providers develop measurable specifics regarding what they are going to do to enable these wishes to come true (Teaching and Support Strategies (T&SS) and Action Plans). During the Individual Quality Review several areas related to the class member's Individual Service Plan (ISP) are examined and include:

An examination of the *process of developing* the ISP including …

- **Confirming that the individual was offered the *assistance needed* to participate in the development of his/her plan.**
- **Verifying that the *individual's interests and preferences* were *respected and incorporated* into the Plan.**
- **Seeking evidence that *those who know the person best help develop his/her Plan.***
- **Noting if the team *obtained adequate and timely assessments* in areas most likely to lead to the person's greater independence.**

An examination of the *Plan content* including…

- **Ensuring that recommendations from *assessments are incorporated* or explaining why not.**
- **Verifying that the ISP contains *current* and *accurate* information.**
- **Confirming that the ISP contains *sufficient guidance* to achieving the person's vision, outcomes and action steps.**
- **Examining the overall *adequacy* of the ISP to ensure it *addresses* and *meets the person's needs*.**

An examination *of Plan implementation* which includes…

- **Probing team member's knowledge of the person and his/her plan.**
- **Gathering evidence that the plan has been *implemented* as intended and *at a frequency* that enables the person to *gain new or maintain existing skills*;**
- **Verifying that the *person is making progress* and, if not, that the *team addresses identified barriers*.**

The number of findings related to the inadequacy of the ISPs steadily *increased* until 2018 when the number of findings significantly *decreased*. This is a welcome change.

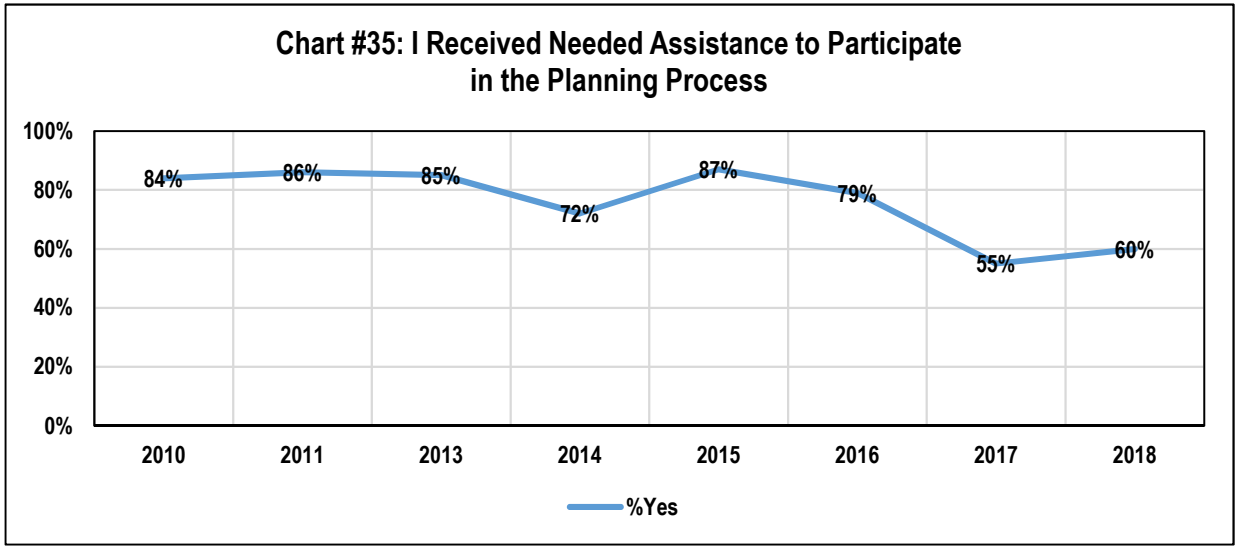
- **In 2013, 103 people had 411 findings identified for the ISP/Planning area; the average number of findings per person was 3.99;**
- **In 2014, 101 people had 439 findings; the average number of findings per person was 4.35;**
- **In 2015, 99 people had 461 findings; the average number of findings per person was 4.66;**
- **In 2016, 93 people had 576 findings; the average number of findings per person was 6.19;**
- **In 2017, 65 people had 607 findings; the average number of findings per person was 9.34;**
- **In 2018, 87 people had 420 findings; the average number of findings person was 4.83.**

[36] **Class Members receiving services through an Intermediate Care Facility for people with Intellectual and Developmental Disabilities (ICF/IDD) have a plan called an Individual Habilitation Plan (IHP). People receiving services through Mi Via call their plans Service and Support Plans (SSP). For the purposes of this report, all individual plans will be referred to as ISPs.**

B. Was the Person Provided with Assistance to Participate in the Planning Process?

The 2018 DD Waiver Standards[37] and New Mexico Administrative code (§ 7.26.5), outlines expectations regarding the development and content of the ISP. With respect to process and preparation for the development of the ISP, DDSD continues to require Case Managers to meet with the person with I/DD and guardian prior to the ISP meeting to review current assessment information, prepare for the meeting, create a plan with the person to facilitate or co-facilitate the meeting if desired, discuss the budget, review current forms and provide supports for greater informed participation in the ISP development by the person. The intended outcome is to ensure that the individual's thoughts and ideas are known and drive the development and ultimate content of the plan. Since the majority of the Jackson Class Members' verbalizations are not always clearly understood by unfamiliar people, knowing how each person communicates his/her preferences, knowing and building on his/her history, strengths and wishes is essential to enabling meaningful engagement of the individual in the planning process.

In the past there has been evidence of assistance so the person can come to ISP meetings and participate as a team member in the ISP planning process. As evidenced by the chart below, from 2010 to 2016 the average "yes" answer to the individual having received assistance to participate in his/her plan was 82%.



In 2017 the speculation was that the drop in the score might be explained, in part, because the questions in the 2017 IQR was more specific about what "assistance and support" is expected and provided in an effort to enable the person to be meaningfully involved in his/her Plan development. However, the 2018 protocol, in question #100, returns to the original question asked by the CPR, specifically, "Was the person provided the assistance and support needed to participate meaningfully in the planning process?"

[37] Which went into effect March 1, 2018.

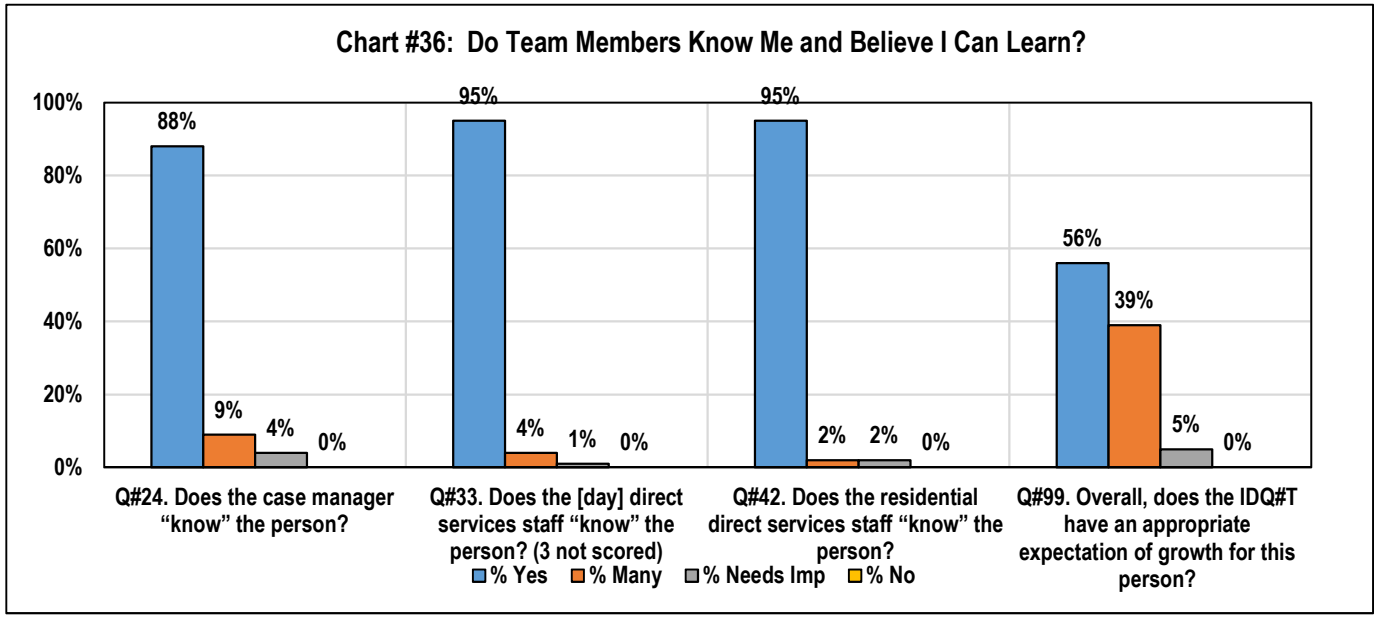
C. Do Team Members Know Me Well and Believe I Can Learn and Gain Skills?

Related Evaluative Component Required for Disengagement:
Safety Objective S5.3a. Case managers must demonstrate that they know the current strengths, needs, preferences, and medical conditions of each JCM they serve and the JCM's ISP must address these factors.

In order for adequate and informed planning to occur, team members need to know the strengths, preferences and challenges which face those whom they support. As the information below shows, many of those who work with the person know him/her well. Unfortunately, only a little over half believe the person can learn and gain skills. Obviously, it is important for people who work with the individual to believe in them and their ability to expand beyond where they are now. Otherwise, there is a danger in the self-fulfilling prophecy coming true, that is, staff may unknowingly cause their low expectations of the person to come true due to the fact that he/she expects it to come true. This is particularly harmful for people with the most severe disabilities due, in part, to their frequently limited ability to articulate their thoughts, feelings and wishes. Unfortunately, all too frequently when staff expectations of individuals are low (e.g., they can't feed themselves, they can't make friends, they can't work….) this causes those expectations to be realized.

Answers to the following related questions were probed and the answers reflected in the following chart.

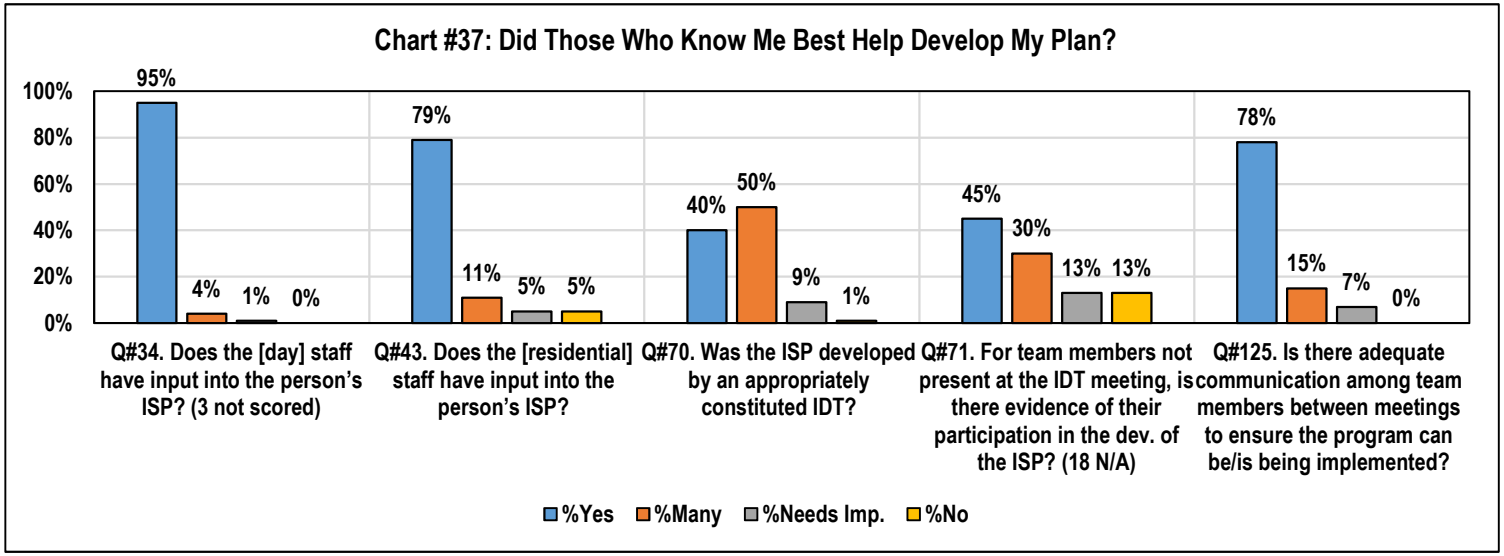
Question #24. Does the case manager "know" the person?
Question #34. Does the [day] direct staff "know" the person?
Question #42. Does the residential direct services staff "know" the person?
Question #99. Overall, does the IDT have an appropriate expectation of growth for this person



D. Do Those Who Know the Person Best Have Input Into the Plan?

Another challenge is the engagement of Direct Support Professionals, who know the person best, in developing the plan. A key component of that includes enabling Direct Support Professionals to actually attend the annual ISP development meeting which may pull them away from their day-to-day job of providing support and assistance to people with I/DD, often 3 or more at a time. Some providers have developed a 'pre-ISP form' intended to gather Direct Support Professionals feedback in advance of the ISP development meeting so their physical presence is not required. This approach has helped alleviate, but not solve, the challenge of ensuring that those who work with the person most and know him best are present at the ISP meeting and/or have direct input into the content of the ultimate plan. Questions probed include:

Question #34: Does the [day] direct service staff have input into the person's ISP? Question #70: Was the ISP developed by an appropriately constituted IDT?
Question #43: Does the [residential] direct service staff have input into the person's ISP?
Question #70: Was the ISP developed by an appropriately constituted IDT?
Question #71: For any team members not physically present at the IDT meeting, is there evidence of their participation in the development of the ISP?
Question #125: Is there adequate communication among team members between meetings to ensure the person's program can be/is being implemented?



From 2010 to 2017, on average, 49% of those who know the person best helped develop the person's plan. 2018 shows a decrease in the percentage of those who know the person best at 40% (Q# 70). During 2010 to 2017, on average, for 44% of those not present there was evidence of their participation in the development of the ISP outside of the meeting. 2018 shows 45%, however, more wide-spread plan development which engages those who know the person best needs to improve.

E. Developing the ISP Based on Timely and Adequate Assessments.

Assessments **are important tools to help identify a person's strengths, interests, possible desired Outcomes and to direct providers toward implementing strategies which assist the individual in meeting their desired Outcomes. However, assessments and evaluations are not a substitute for input from the individual concerning what is meaningful to them and how they perceive their own strengths and weaknesses. The 2018 DD Waiver Standards continue to require provider agencies contributing to annual ISP development by providing *assessment updates* at least 14 days prior to the ISP development meeting to ensure that the ISP addresses the person's assessed needs and personal goals, either through DD Waiver services or other means.[38] *Assessments* are to be completed at least 14 days in advance of the annual ISP[39] Development Meeting so that teams have current, measurable information to guide them in the development of the individual's plan. Assessments completed by day and residential providers as well as needed specialists such as nurses, physical therapists (PT), speech and language pathologists (SLP), occupational therapists (OT), behavior support consultants (BSC), registered dietitians (RD) can provide invaluable information to assure adequate and informed planning which, in turn, enables individuals to be safe and grow their interests and abilities in a way that best assists them in attaining desired outcomes identified in the ISP.**

Acquiring assessments timely is, obviously, essential if teams are to engage in informed planning. Equally important is the content or adequacy of the assessment. When exploring the 'adequacy' of programmatic/therapeutic assessments reviewers are guided to look for things such as:

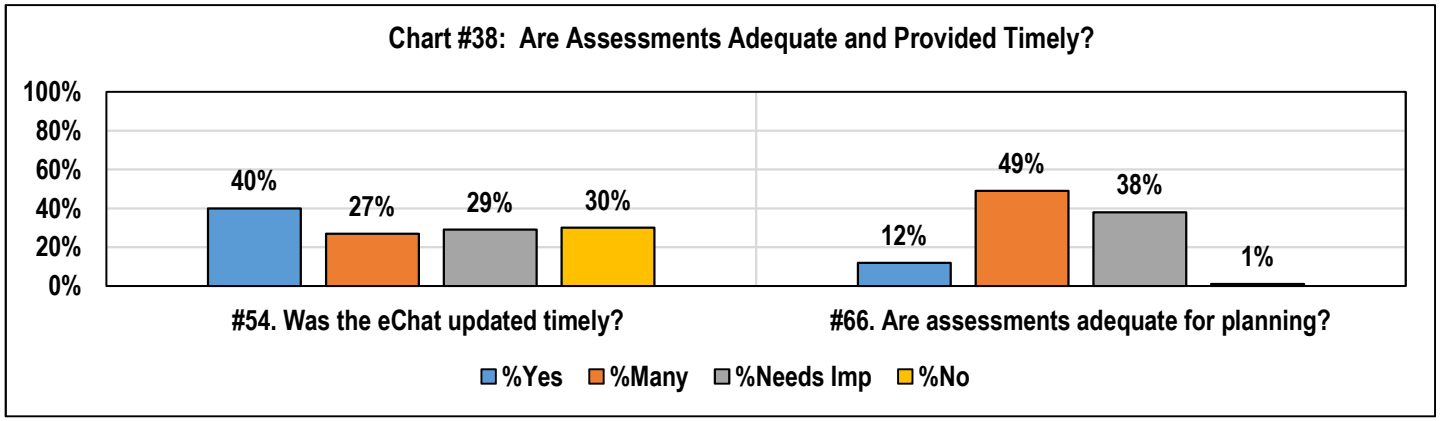
- ✓ **Does the assessment describe where the person started (baseline) in each area? In order for teams to know if their interventions are working, they have to know where the person started, where they are now and if that demonstrates measurable progress/regression/staying the same e.g. maintenance.**
- ✓ **Does the assessment describe how the person is doing in each area?**
- ✓ **Does the assessment describe the person's strengths in each area?**
- ✓ **Does the assessment outline recommendations on what new skills the person might learn and how to the Team can help consistent with my preferences? Those conducting assessments need to give specific recommendations which directly relate to the identified goals and objectives.)**

While what is looked for remains the same, the specific questions related to timeliness and adequacy in the 2018 protocol include:

Question #54: Was the eChat updated timely?

[38] **2018 NM DD Waiver Standards, Chapter 6. Individual Service Plan, 6.3. Page 62,**
[39] **Initial assessments can be completed at any time during the ISP year.**

Question #66. Are the assessments adequate for planning?



The information often found to be missing from assessments is a measurable baseline. In order to know the effectiveness of an intervention, it is critical to know where the individual started, or their 'baseline'. For example, if the Outcome is to walk 100 ft. a day one needs to know how far the individual can walk at the time of the initial assessment (e.g., the baseline) so there is a point from which to measure progress. In this case, let's say the "baseline" or starting point is 50 ft. That is, the person can currently walk 50 ft. a day but wants to walk 100 ft. a day. Now there is a measure FROM which progress can be measured on a daily basis.

Another significant weakness of many assessments is the lack of recommendations for what new skills the person might learn or how they might specifically build on the strengths they currently have. One of the many benefits of having nurses, therapists, and behavioral consultant experts available to the team is the ability to access their knowledge and technical guidance on what can be done, every day, by those who work with the individual the most to enable growth and greater self-reliance.

As is demonstrated above, only 12% of the class members were found to have assessments adequate for ISP planning. The failure to have adequate ISPs is certainly one natural consequence of this finding.

F. Use of Assessment Recommendation, Decision Justification and Decision Consultation Forms

With only 12% of class members found to have assessments adequate for ISP planning, the examination of the use of assessments to guide formation of ISP recommendations begins from an inadequate foundation. Informed ISP content cannot reasonably be expected to be comprehensive, accurate and adequate resting on limited or faulty assessments. Nevertheless, whether or not the recommendations which were provided were used in planning is probed.

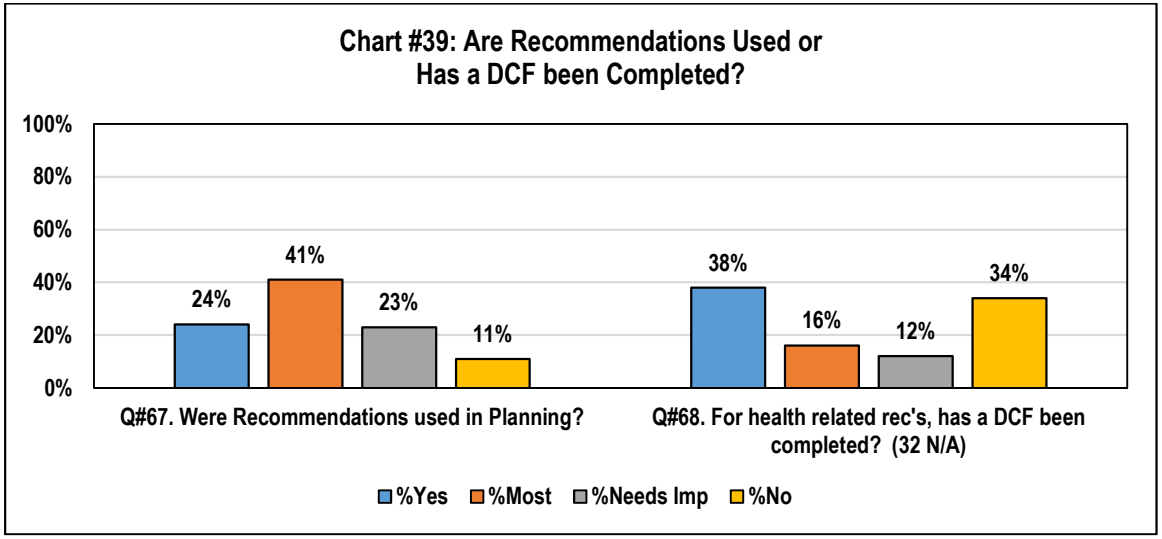
It is important to note that the Team may find some recommendations inappropriate. It might be that specific recommendation has been tried before and found to be ineffective. A Guardian may find the recommendation too intrusive and reject the approach. Teams may reject recommendations. If they do, they are to fill out one of two forms.

The Decision Consultation Form[40]: If orders from licensed healthcare providers are not going to be followed, a Decision Consultation Form is to be filled out. The agency nurse is to contact the ordering practitioner within three business days if the order cannot be implemented due to the person or guardian refusal or if there are other issues delaying implementation of the order. The DCF should contain documentation of the circumstances and rational for this decision and notice should be given to the ordering practitioner no later than the next business day.

The Team Justification Form[41]: If an individual receives a recommendation from a professional or clinician (non-health related) with which they, their guardian and/or the Team disagree, they can use the Decision Justification Form to document their justification for not implementing the recommendation. The Team Justification form documents the discussion and subsequent decision to implement, modify or not implement.

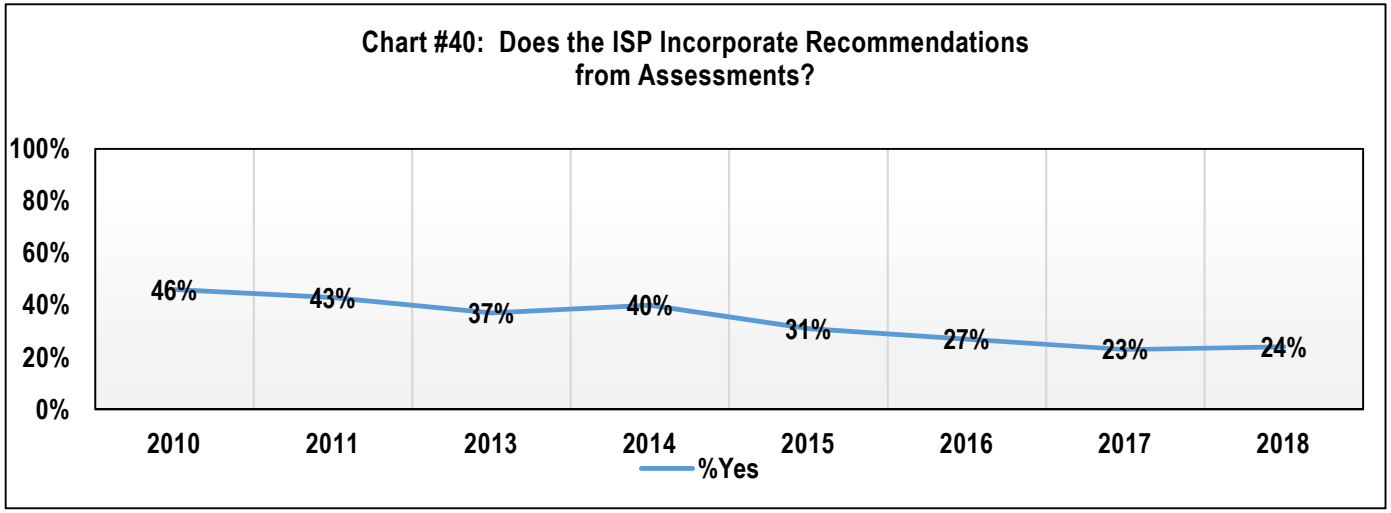
The two relevant questions regarding use of recommendations in planning include:

Question #67: Were recommendations from assessments used in Planning?
Question #68: For medical, clinical or health related recommendations, has a Decision Consultation Form been completed if the individual and/or their guardian/health care decision maker have decided not to follow all or part of an order, recommendation or suggestion?



The following Chart illustrates the continued downward trend of incorporating recommendations from assessments into the person's ISP.

[40] 2018 DD Waiver Standards, Chapter 3 and Chapter 13.
[41] Ibid

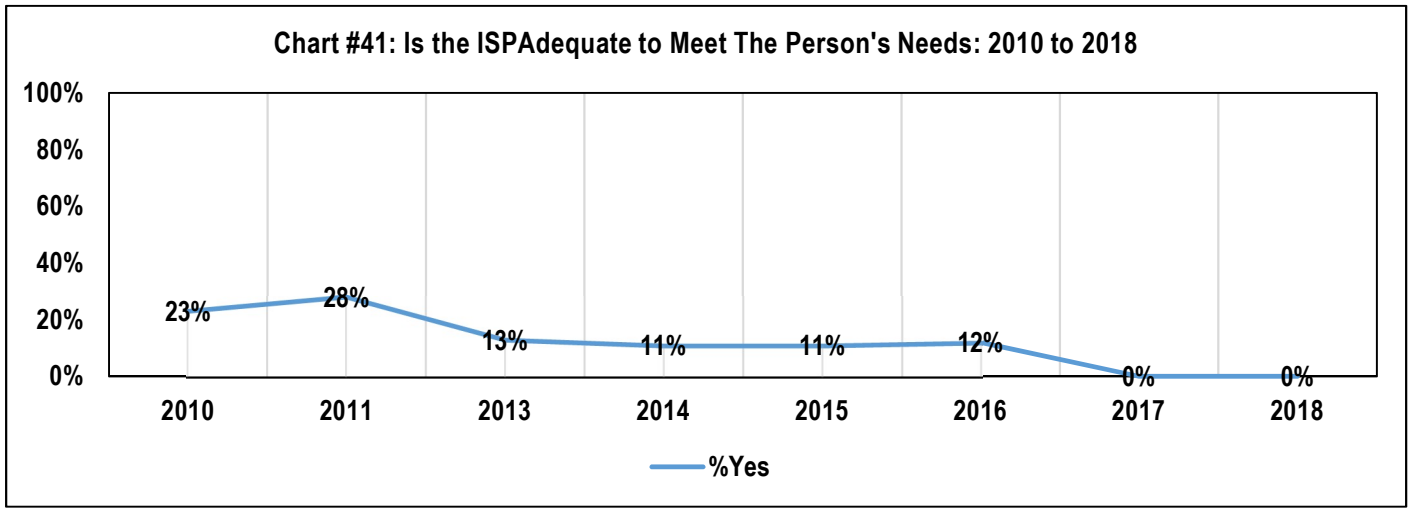


G. Is the ISP Adequate to Meet the Person's Needs?

The adequacy of the person's ISP is probed through multiple perspectives which were identified, in part on page 75 (e.g., development process, Plan content, Plan Implementation). The 37 scored questions[42] which focus in these areas are considered in total when considering the "adequacy" of the ISP. As the following Chart summarizes, the inadequacy of the ISP is long standing.

[42] A summary of all of the ISP questions are in Appendix I.

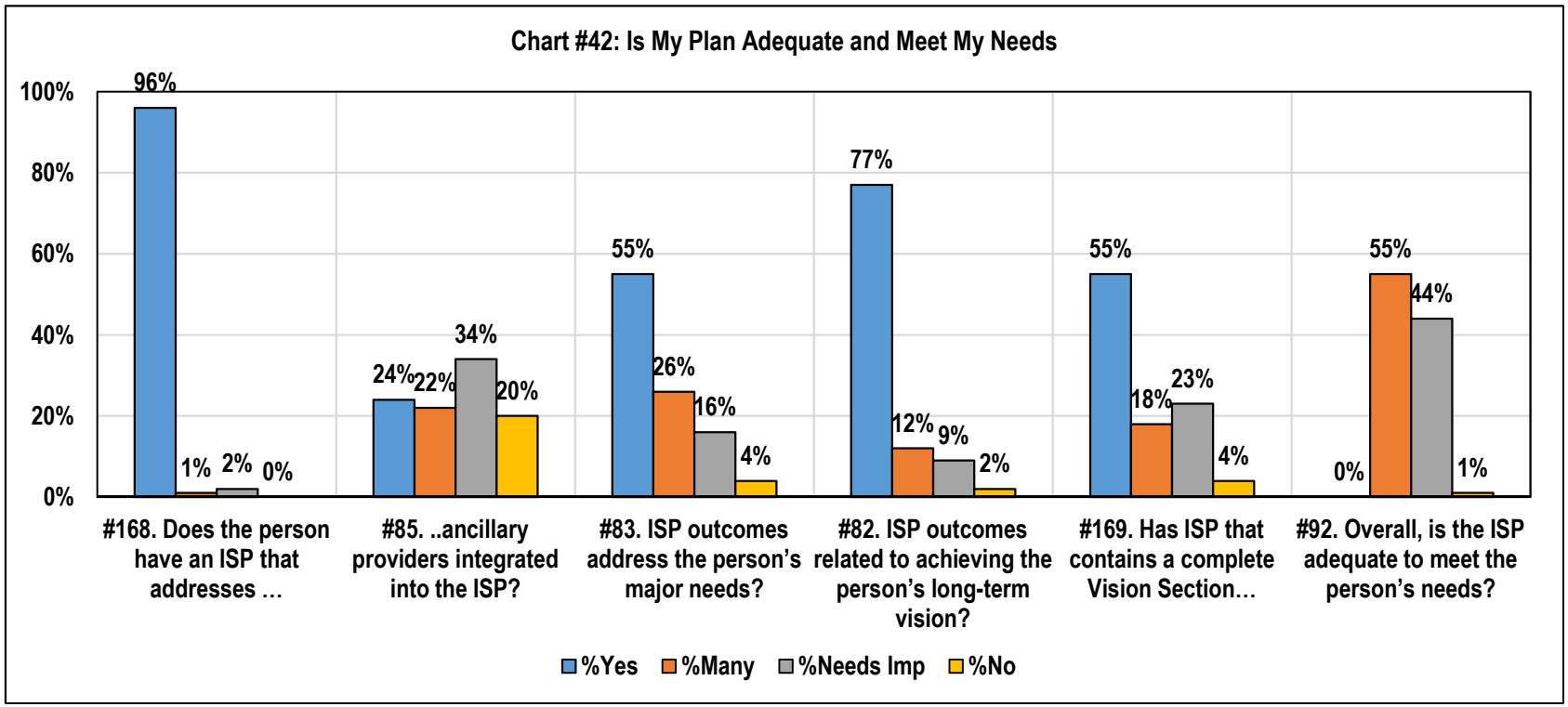
Question #92. Overall, is the ISP adequate to meet the person's needs?



This total failure of adequacy is jarring. Only once since 2010 have even one quarter of ISPs been found to be adequate to meet the person's needs. And for the last two years the adequacy is zero,

Some of the IQR Questions which explore areas of the ISP which influence the findings of adequacy include:

Question #168. Does the person have an ISP that addresses live, work/learn, fun/relationships and health/other that correlates with the person's desires and capabilities, in accordance with DOH Regulations?
Question #85. Overall, are the recommendations and/or objectives/strategies of ancillary providers integrated into the ISP?
Question #83. Overall, do the ISP outcomes address the person's major needs?
Question #82. Overall, are the ISP outcomes related to achieving the person's long-term vision?
Question #169.Does the person have an ISP that contains a complete Vision Section that is based on a long-term view?
Question #92. Overall, is the ISP adequate to meet the person's needs?



H. Is the ISP Consistently Implemented?

Related Evaluative Components Required for Disengagement include: **Safety Objective S5.1a. The DOH must establish measurable quality indicators, including … (2). Implementation of ISPs…** **Safety Objective S5.3b. Case Managers must ensure that each JCM's ISP is properly implemented.**

Inconsistent implementation of the ISP is a long-standing issue. Even if we examine information only going back seven years, consistent implementation of the individual's plan has never been found to be over 54%. The implications of these findings deserve both attention and swift and effective action.

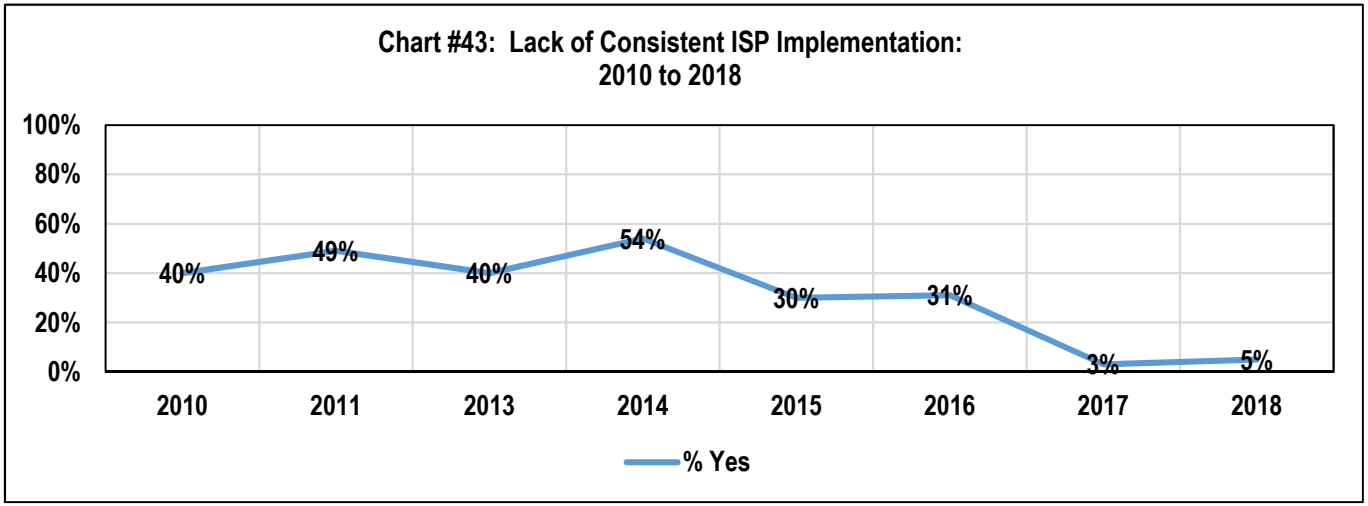
Many individuals with intellectual and developmental disabilities (I/DD) can readily engage in new activities, express a preference or learn a new skill relatively quickly. Other individuals who have had little or no experience with the new task or skill may find it much harder to grasp, enjoy or willingly experience. Those with severe disabilities require a systematic approach in order to fairly and adequately determine personal preferences, gain comfort with new experiences or tools and/or to learn new skills or tasks. This systematic approach needs to include *frequent experience* with *multiple options* and *multiple means* to

systematically assess ability and preference.[43] One of the many reasons frequent experiential engagement is so critical is because of the challenge many people with I/DD have with generalizing information and skills from one situation, setting or environment to another. Consequently, exposing people to new tasks, skills or experiences a few minutes a week (or month, or year) when the person has no personal experience with what these tasks, skills or experiences mean demonstrates a profound lack of understanding of how people with I/DD learn and a startling demonstration of a lack of actual intent to seek the person's real abilities and preferences. *The lack of understanding regarding how critical frequency and consistency of presentation and opportunity is to learning for individuals with I/DD is pervasive throughout the system.*

Additionally, it is assumed that when a JCM funded by the Waiver has a required Outcome, its accomplishment will represent an improvement or positive experience from what currently exists. Otherwise, the purpose of the Outcome becomes unclear. If the person is already doing or has accomplished the identified Outcome there may be obvious value in continuing the activity (e.g. continued reinforcement for a recently learned skill/activity) but that can be done as part of the person's Meaningful Day activities.

In the past (no longer), DDSD emphasized the REQUIREMENT that if a person received DD Waiver funding for residential and day services, they MUST have at least 3 Outcomes identified in their ISP. When the average cost of an individual in the DD Waiver is $73,000[44], requiring providers to support the person in three ISP Outcome areas does not seem unreasonable. Especially if you believe that one of the obligations of the system is to support people to learn and grow to the best of their ability… NOT just provide custodial care.

Question #93/94a. Is the ISP being implemented?

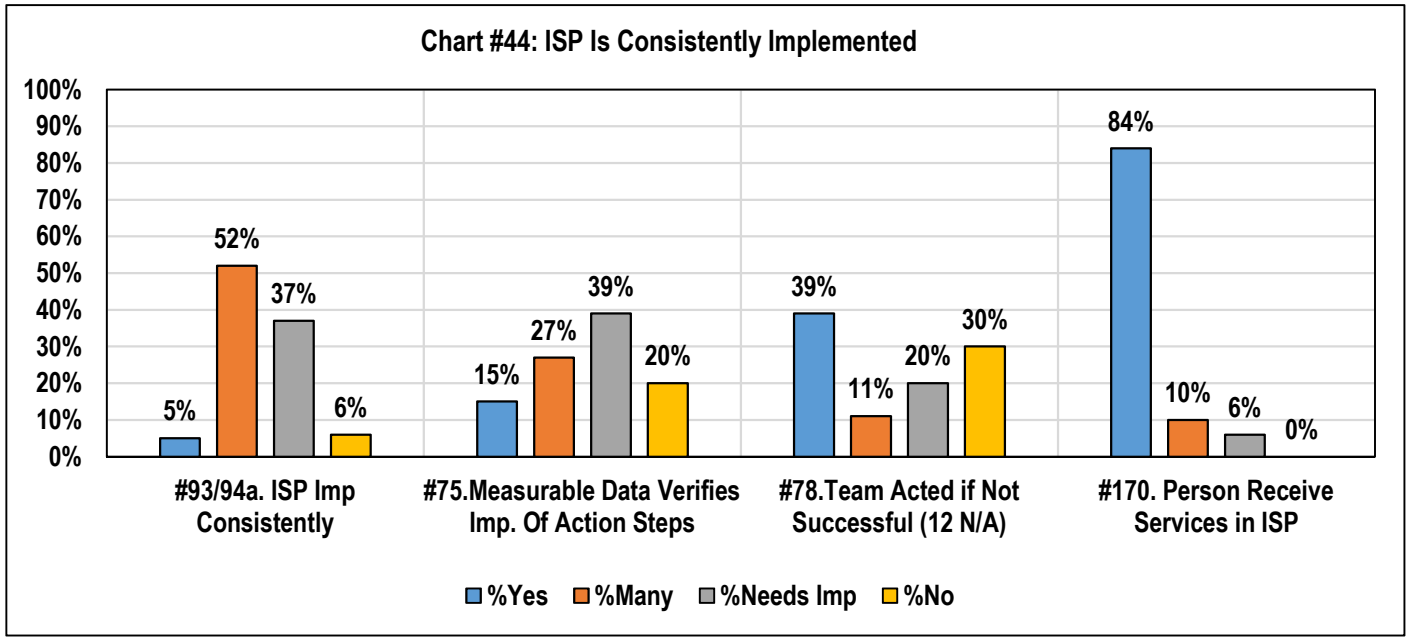


[43] Self-Determination, Michael L. Wehmeyer, Ph.D., University of Kansas, Office of Disability Employment Policy (ODEP).
[44] Report #8-06, New Mexico Legislative Finance Committee Program Evaluation Unit, July 20, 2018 DD Waiver & Mi Via Waiver Report.

An often cited and long-standing reason given for not being able to verify that the ISP is being consistently implemented is the lack of measurable data being kept by the residential and/or day provider. Another frequently identified issue is either not implementing the ISP Action Steps at all, or when the person repeatedly refuses to participate or repeatedly shows no progress, the team does not take timely action to modify the interventions or to change the Action Step or Outcome. There are other cases where the Outcome from previous years continues to be implemented in spite of new ones having been agreed to by the team. All of these examples speak to lack of monitoring on the part of the provider to ensure that staff are implementing and recording implementation consistent with directions in the ISP. It also speaks to the Case Manager not identifying that the ISP isn't being implemented and not 'acting' to report the lack of implementation in an effort to remediate the issue timely.

Reviewers read and gather information from hundreds of documents and data sources. They ask more than 390 questions of the individual, guardian, therapists, nurses, consultants, residential and day staff along with the case manager in an effort to comprehensively gather information which relates to all aspects of the individual's life including knowledge and implementation of the ISP. Some of the contributing factors to being unable to verify the consistent implementation of the ISP follow.

Question #75. Is measurable data kept which verifies the consistent implementation of each of my action steps?
Question #78. If the person is not successful in achieving actions steps, has the team tried to determine why, and change their approach if needed?
Question #170. Does the person receive services and supports recommended in the ISP?



I. Has the Person Made Progress?

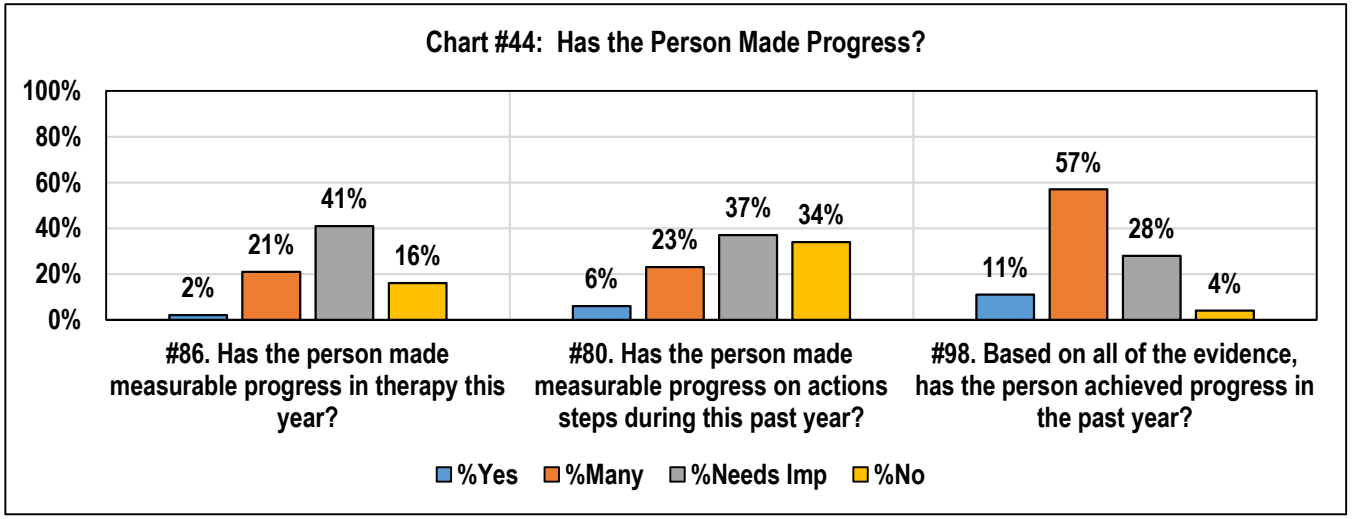
Providers are expected to measure progress individuals are making toward desired outcomes specified in the ISP. ISP activities may include adaptive skill development, adult educational supports, citizenship skills, communication, social skills, self-advocacy, informed choice, community integration and relationship building.
Outcomes from a service such as Customized Community Supports might include an enhanced capacity for self-determination, development of social networks that allow the individual to experience valued social roles while contributing to his or her community and establishing lasting community connections.

Therapists are required to monitor the progress of an individual toward the achievement of therapeutic goals and objectives including those that relate to specific visions and desired outcomes in the ISP. Therapists are also required to monitor the implementation of Written Direct Support Instructions (WDSI)[45] to determine the need for additional training, effectiveness and readiness for fading down or out. Therapists are required to monitor the effectiveness of their skilled therapy interventions and any Assistive Technology (AT) or Personal Support Technology (PST) devices related to that therapist's scope of practice to ensure devices are available, functioning properly and are effective in the settings of intended use.[46]

In order to determine the level of progress an individual is making, if any, the following questions are probed.

Question #86. Has the person made measurable progress in *therapy* this year?
Question #80. Has the person made measurable progress on *actions steps* (in the ISP) during this past year?
Question #98. Based on all of the evidence, has the person achieved progress in the past year? (This question relates to more than just progress on the ISP Outcomes, it enables the reviewer to highlight progress that has occurred as a result of any support formal or informal.)

[45] 2018 NM DD Waiver Standards, Chapter 6. ISP 6.6.3. Page 66.
[46] 2018 NM DD Waiver Standards, Chapter 12. Professional and Clinical Services, Therapy. 12.4.7.8., Page 148.



Team members are asked by reviewers about any progress they have noted outside the ISP. The fact that team members can identify anecdotal examples of progress that individuals have made outside of the ISP is interesting, positive and worth noting as 'perceptions' are important too.

J. Has the Person Experienced Functional and/or Behavioral Regressed, if so, Has the Regression Been Addressed?

Related Evaluative Components Required for Disengagement include:
Health Objective H3.2 Direct Service Personnel/Supervisors are able to identify subtle signs of change/acute symptoms
***Health Objective H3.*1 Jackson Class Members receive increased intensity of services during acute episodes or illnesses.**
***Health Objective H3.2* Direct Service Personnel/supervisors are able to identify subtle signs of change/acute symptoms.**
***Health Objective H3.3* When informed of signs of change in health status (including chronic and acute pain) agency nurses take immediate action.**

When addressing functional regression, the IQR investigates whether or not an individual has lost an acquired function. For example, if an individual used to be able to walk unassisted but now requires a walker or wheelchair, that person has lost function. Loss of function could be due to a number of physical issues which, if addressed, can stop the regression and/or return the person to their original functional ability. What is critical to know is what is causing the regression and when it started. If I am no longer breathing with ease, is it because my wheelchair no longer supports my body to sit properly?

Addressing behavioral regression requires the same level of awareness and urgency to act. Many Class Members have multiple health/mental health diagnoses and medical conditions which may limit their physical movement and overall health or may significantly impact on how the person views and interacts with his/her environment. Regardless, regression of any type for all of us should serve as an alert and result in a close examination to determine the cause. For example, if I am hitting out at staff or hitting myself and this is unusual for me or the frequency of this behavior has spiked, is it because of pain? If

I begin to refuse to sleep in a dark room by myself what's changed? Is it something in the environment (new staff, new bed, new neighbors, TV going longer than normal…) or is it because I am reliving something that happened to me in the past? Or is it because I'm experiencing Reflux and don't want to be alone when I feel like I'm choking?

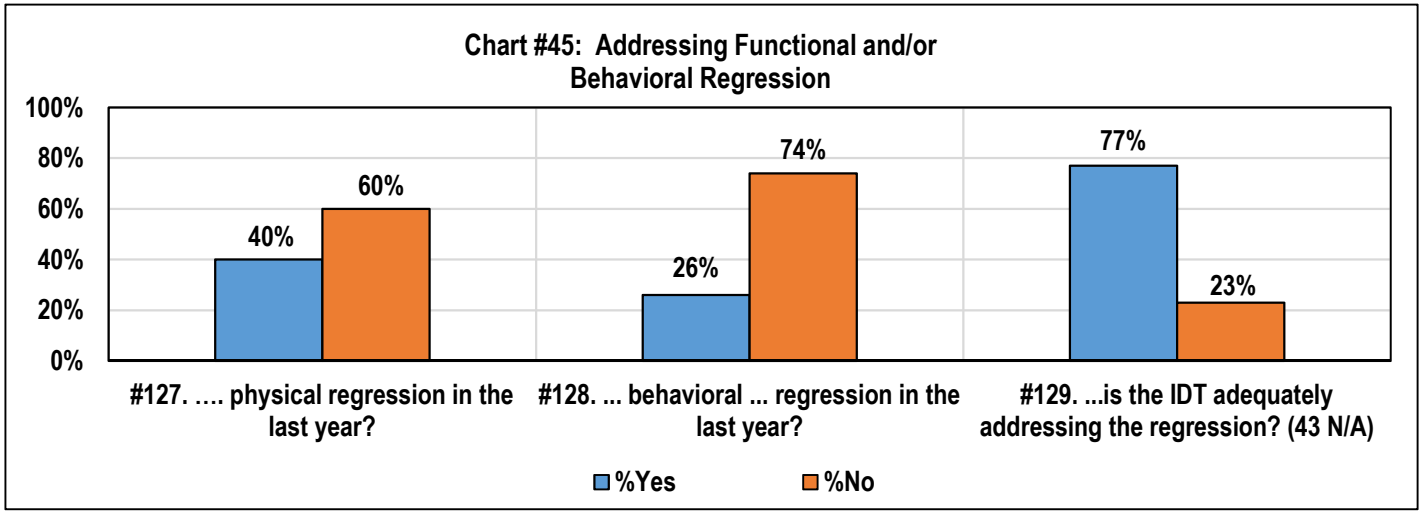
Some regression may be due to lack of adequate services while some might be a natural progression of an identified disease or temporary illness. The key is to recognize the change in circumstance timely and *to act effectively* in an effort to identify the cause and to correct and/or slow further decline, if possible. Some of the IQR Questions which probe this area include:

Question #127. Is there evidence or documentation of *physical regression* in the last year?
Question #128. Is there evidence or documentation of *behavioral or* functional regression in the last year?
Question #129. If #127 OR #128 is scored "Yes", is the IDT adequately addressing the regression?

In terms of numbers of class members affected:

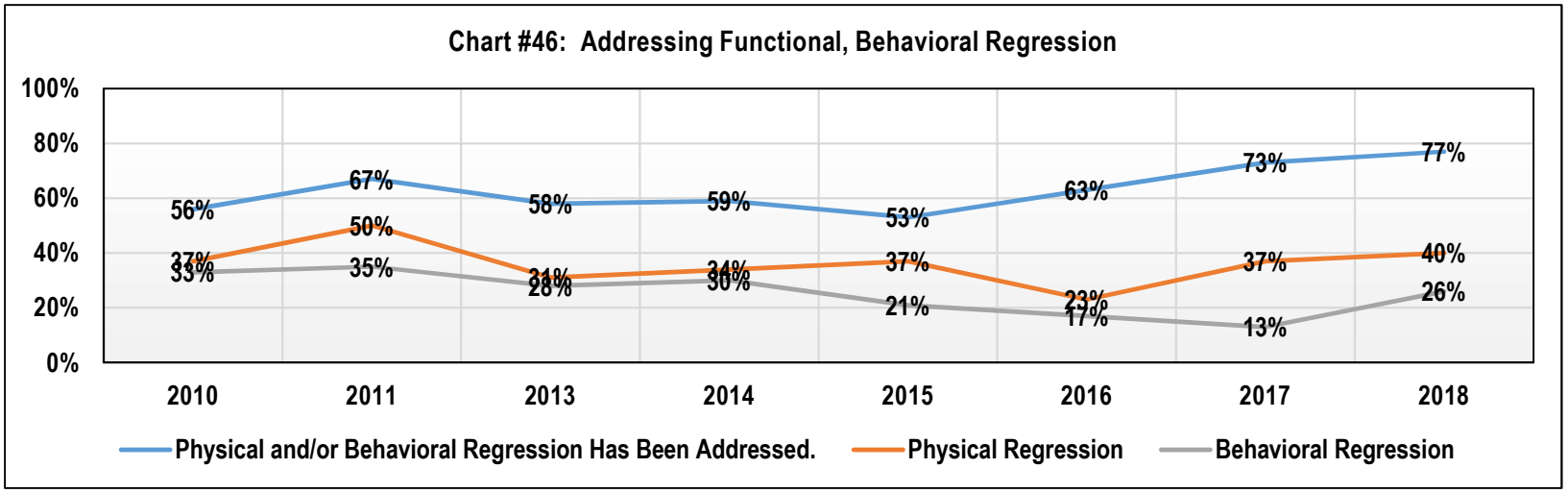
33 individuals were identified as having physical regression in the last year;
49 did not experience regression. (Q# 127).
21 individuals had evidence of behavioral regression in the last year;
61 individuals did not experience behavioral regression. (Q# 128)

Overall, 39 people in the sample experienced physical and/or behavioral regression (48%). Thirty (77%) of those had teams who were addressing the regression.



It is noteworthy and to be celebrated that the majority of class members experiencing functional and/or behavioral regression have had their teams take action to slow or reduce the regression. However, for the 23% of Class Members who experienced functional and/or behavioral regression whose Teams have not addressed the regression, this is not acceptable.

When put into historical context, you can see that when individuals are experiencing functional and/or behavioral regression, in 2018 77% of the time the regression is being addressed. While improvement continues to be needed, the trend is in the right direction.



K. Are Communication and Behavioral Expression and Needs Known?

The ability to communicate and be understood is an essential life skill which impacts on our wellbeing emotionally, economically and socially. Almost all Jackson Class Members have both receptive as well as expressive communication challenges. In addition to challenges in translating messages from others, many JCM's have compounding disabilities which directly affect communication including lack of oral speech, hearing limitations, body positioning which results in being overlooked and visual impairments. Many JCM's use communication devices instead of or as a complement to verbal communication. For others English is not their first language, consequently, it is essential that care givers use the person's primary form of communication.

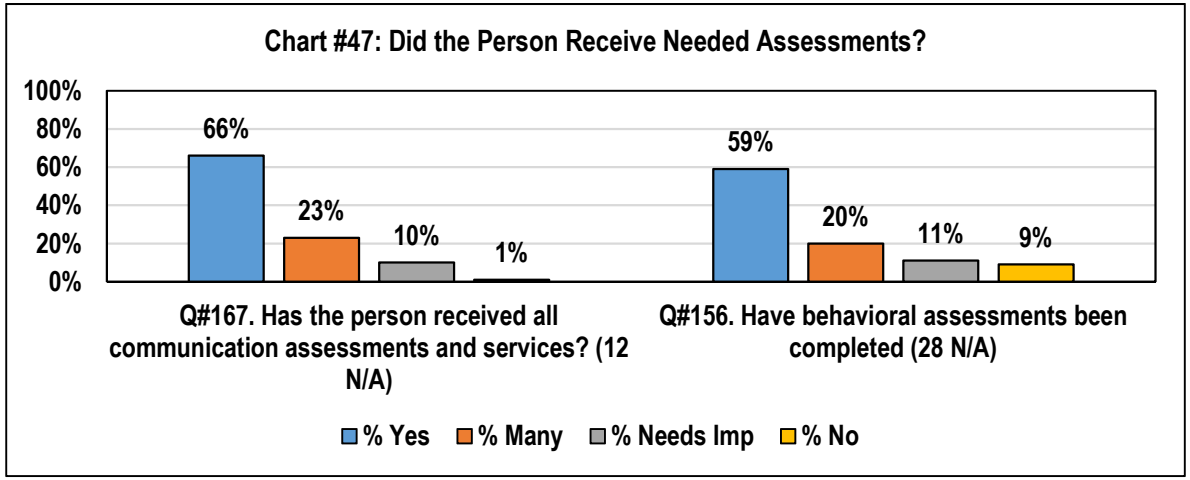
When an individual's verbal communication skills are limited, all of us must rely on the person's non-verbal communication. The good news is that the majority of communication which takes place by all of us is non-verbal. This is true of Class Members as well so being 'tuned into' their facial expressions, voice patterns, gestures, body language, breathing, eye contact, blood pressure, changes in behavioral patterns and habits…is essential.

In order to understand the best way to communicate with an individual, communication assessments are essential. New Mexico has speech and language pathologists (SLPs) in many areas of the state so acquiring assessments and needed equipment and services is frequently possible.

Knowing the person's Behavioral Support Plan and being adequately trained to carry out that Support Plan involves a great deal of "reading" the person's behavior as a form of communication and responding accordingly.

The IQR probes communication and behavioral issues from multiple perspectives. First, are the individual's needs known? In order for someone to be able to socially participate and communicate, their strengths and challenges need to be known (assessments). The IQR asks:

Question #167. Has the person received all communication assessments and services?
Question #156. Have behavioral assessments been completed?



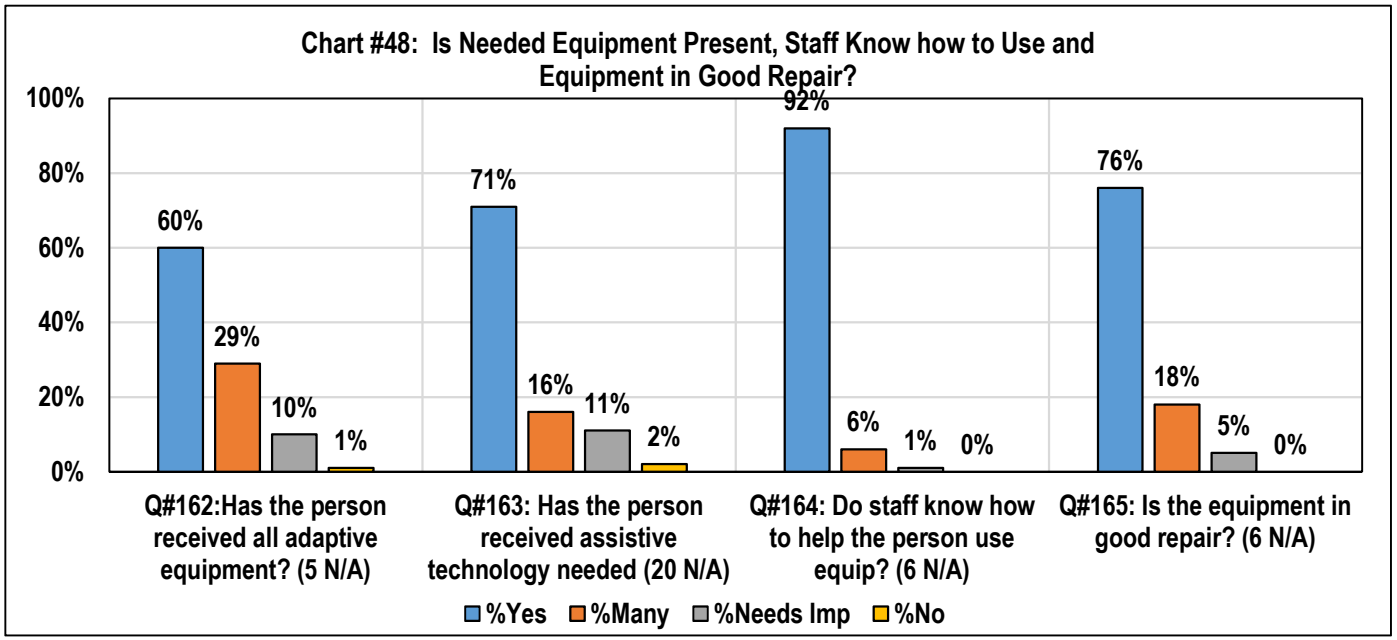
Once the person's strengths and needs are known it is important for them to receive the equipment/devices they need timely, that those who support them know how to use that equipment/device and that the device is functionally appropriate to that person and operates as intended.

For people with structural/physical challenges that means being positioned properly. If I'm not at your eye level and/or can't look you in the eye will you acknowledge my presence? If I can't breathe because I'm folded up on myself, 'talking' is extremely difficult if not impossible. If I can't use my voice and I don't have a device which enables me to express myself in a way that can be understood by others, will I be acknowledged or talked around or about? If certain behaviors prevent me from engaging in my community as a valued member, do those who support me know how to avoid and/or redirect those behaviors? In order to foster respect and social equality, many people with I/DD must have behavioral supports and/or the equipment and other devices to enable them to 'be present' and 'communicate' and 'be engaged with'.

The IQR probes these issues from multiple perspectives. Second, does the person have the equipment/devices needed? Do staff knowhow to use the equipment/device and is the equipment/device functional. The following questions probe these issues.

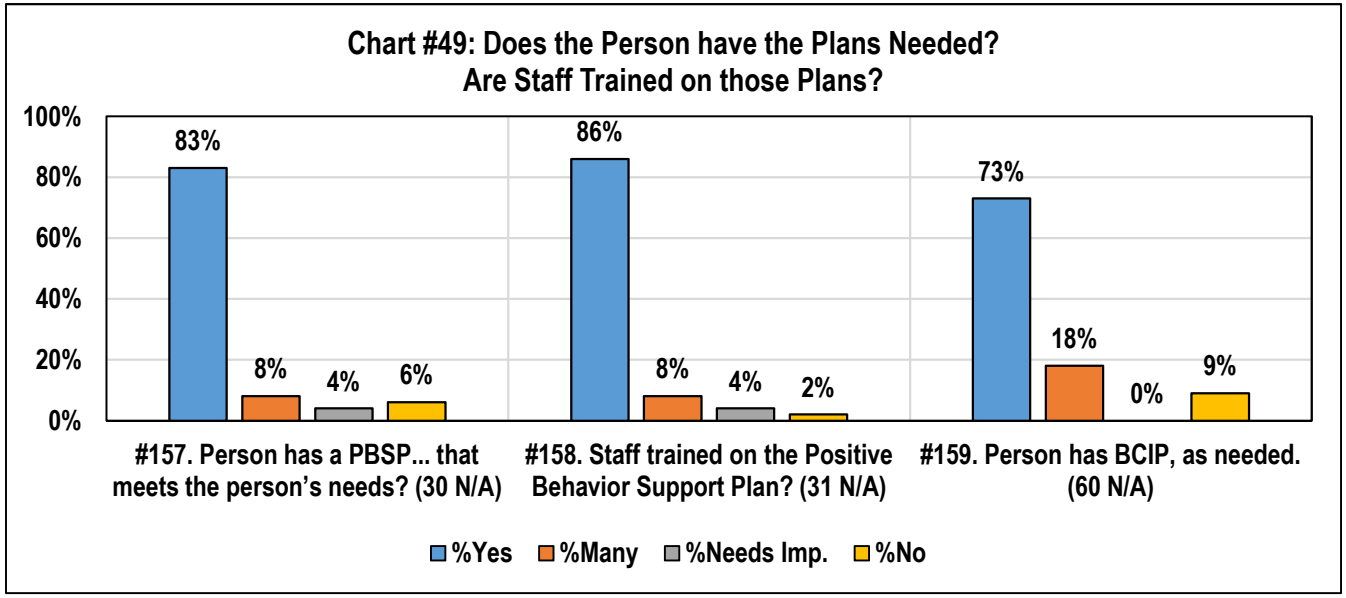
Question #162: Has the person received all adaptive equipment needed?

Question #163: Has the person received all of the assistive technology needed?
Question #164: Do direct care staff know how to appropriately help the person use his/her equipment?
Question #165: Is the person's equipment and technology in good repair?



For people with mental health and/or behavioral challenges, it is critical that needed Positive Behavioral Support Plans (PBSPs) which identify the person's strengths, challenges and his/her engagement with their environment which enables as well as prevents their integration and socialization be well known by those who support them. As the following chart shows, many class members who need PBSPs have them and have staff who have been trained on those plans. The findings become less positive for people who need but do not have Behavior Crisis Intervention Plans.

Question #157. Does the person have a positive behavior support plan developed out of the behavior assessments that meets the person's needs?
Question #158. Has the staff been trained on the Positive Behavior Support Plan?
Question #159. If needed, does the person have a Behavior Crisis Intervention Plan that meets the person's needs?



If the person has assessments, the equipment/devices needed, plans which identify their strengths/challenges including recommendations and staff who are trained on these plans/devices… the next set of probes looks at whether or not the person actually receives services consistent with his/her needs and if those services are integrated into the ISP. The IQR asks:

Question #85: Overall, are the recommendations and/or objectives/strategies of ancillary providers integrated into the ISP? (This focuses on therapies and Behavior Support Consultants recommendations.)
Question #160: Does the person receive behavioral services consistent with his/her needs?
Question #161: Are behavior support services integrated into the ISP?

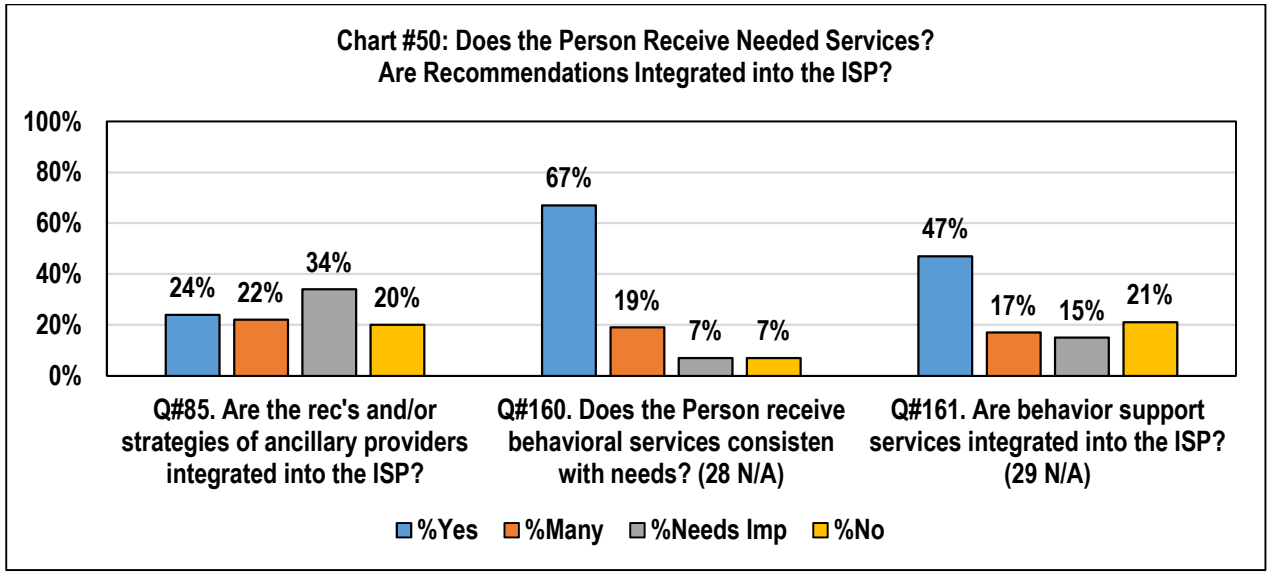


Chart #50: Does the Person Receive Needed Services?
Are Recommendations Integrated into the ISP?
100%
80%
60%
40%
20%
0%
24%
22%
34%
20%
67%
19%
7%
7%
47%
17%
15%
21%
Q#85. Are the rec's and/or strategies of ancillary providers integrated into the ISP?
Q#160. Does the Person receive behavioral services consisten with needs? (28 N/A)
Q#161. Are behavior support services integrated into the ISP? (29 N/A)
%Yes
%Many
%Needs Imp
%No

A. Case Management Essential Elements

Relevant Evaluative Components Required for Disengagement:
Safety Objective S5.3. Implement a responsive and effective case management system as evidenced by the provision of needed supports and services.

Case Management services are to be person-centered and intended to support people to pursue their desired life outcomes while gaining independence and access to needed services and supports. The essential elements of Case Management include activities related to advocacy, assessment, planning, linking, and monitoring.[47] The accomplishment of these essential elements depends on case managers taking informed and timely action with and on behalf of the individual.

The need for advocacy on behalf of class members is woven through each of the case manager's essential elements including, in part: maintaining eligibility; the facilitation and development of the ISP; coordination of and communication with team members; monitoring to ensure that services and supports needed by the individual are received timely and as intended; reporting when there are issues which need attention; and, following up to ensure continuity and effectiveness of services.

In order to understand the challenges facing case management the findings throughout this entire report need to be considered.

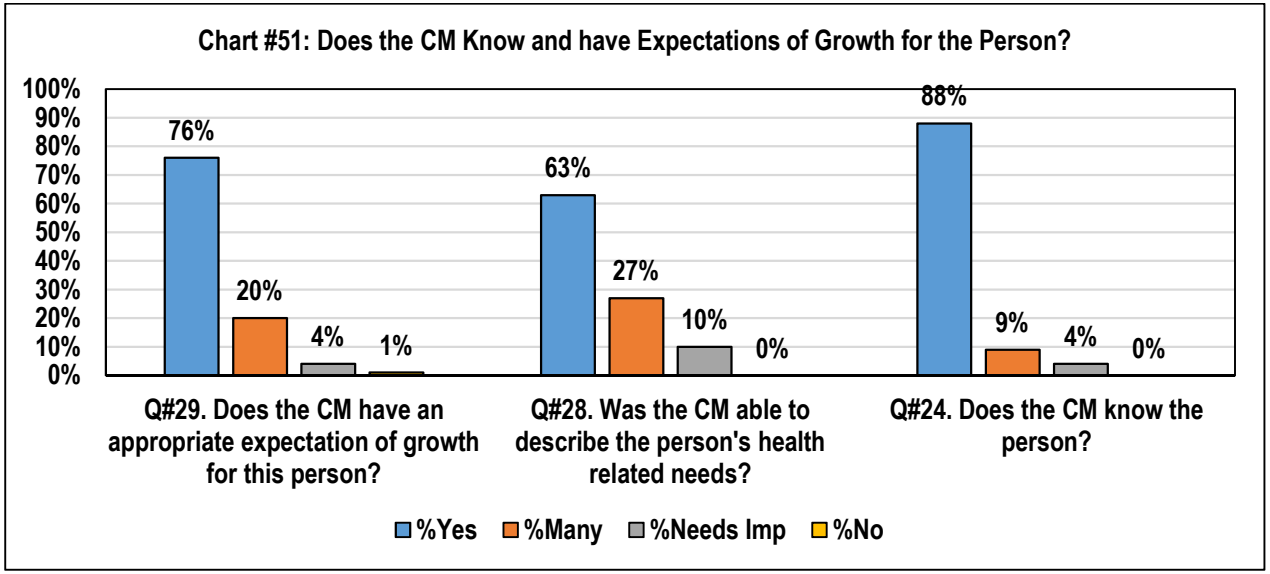
B. Case Managers: Knowing the Individual

Relevant Evaluative Components Required for Disengagement:
Safety Objective S5.3a. Case managers must demonstrate that they know the current strengths, needs, preferences, and medical conditions of each JCM they serve and the JCM's ISP must address these factors.

Central to being an effective case manager is *knowing the individual.* The IQR Question #24 asks, "Does the case manager know the person? Historically, case managers have scored well on this question. Specifically, since 2008 the score for this question has been consistently at or above 88%. In 2017 the score dipped to 79%, but for the 2018 IQR the score has bounced back to 88%. When answering this question, reviewers look to see if the Case Manager thoroughly knows and has described the person's preferences, needs and circumstances; including information describing the individual's personality, likes, dislikes; the individual's general routine; activities; things in the individual's life; significant events that occurred or are occurring which have an impact on the individual; and, what s/he is doing or would like to do. Reviewers also look for a description of strengths, positive attributes, things to build on, such as communication method; work ethic; skills the JCM possesses; willingness to try things; willingness to participate in activities; etc.

[47] NM 2018 DD Waiver Standards, Chapter 8 Case Management.

It is unclear why CMs continue to struggle with knowing the person's health related needs. During interviews all staff, including case managers, are welcome to have the individual's file in front of them for reference. Questions regarding the person's health do not demand a great memory but they do expect case manager to know the file, know where to look and to have a current and accurate picture of the person's health.



Case managers are expected to *visit class members at least twice a month*, once at home and once wherever the person is during the day. The purpose is not the visit per se, but the opportunity to observe what the person is doing, the interaction taking place with staff and others and verify that what the person is supposed to be learning and/or receiving as a part of their ISP is actually taking place as intended. For example, does the person have and is he/she being supported to use their communication system, if any, in line with the ISP/SLP's instructions? Is the person properly seated in their wheelchair, are Action Steps from the ISP being implemented and documented as intended, does the person have the opportunity to interact with non-I/DD persons in their community in a regular and meaningful way and so on?

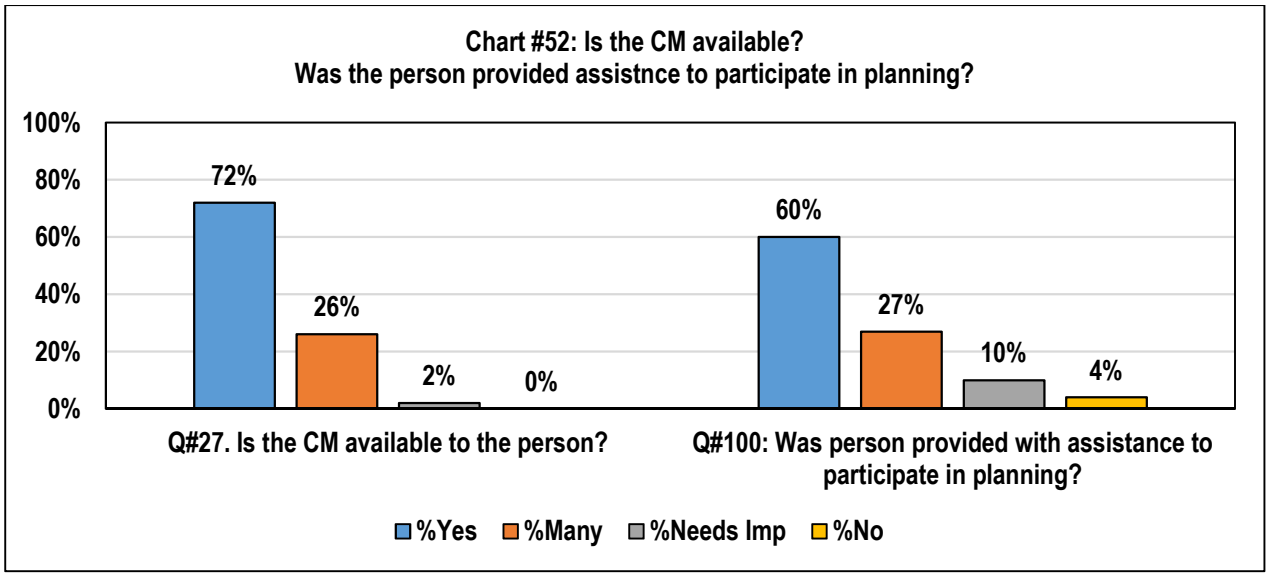
While the NM DD Waiver Standards do not require case managers to visit people on different days each month, in different settings and at different times - that is an expectation when visits are examined as a part of the IQR. In order for case managers to gather a *big picture view* of the person's life, it is helpful to know that case managers are visiting with and observing the person in a variety of locations and at different times each month/during the day. It is challenging to acquire a representative view of the person's life if the case manager always visits the day program in the morning and the home midafternoon. Likewise, if the case manager frequently visits both day and residential on the same day, few insights would be gleaned about the person's level of engagement that month. That *one day snapshot* would not offer insight into what is happening with and for the person at nights, on weekends, in the home, in the community or as a part of day services.

Typically, Case Managers do visit class members at least twice a month. They also visit the person at home and at the day program. Once a quarter a team meeting can count as one of the face-to-face visits for that month. When reviewers make a note regarding visits it is typically because either the case manager conducted both site visits on the same day and/or the case manager is noted to be frequently visiting the home or day program at close to the same time of day each month.

C. Case Management: Areas for Focused Improvement

Relevant Evaluative Component Required for Disengagement:
Safety Objective S5.3b. Case Managers must ensure that each JCM's ISP is properly implemented.
Safety Objective S5.3c. Case Managers must identify significant risks, needed supports, and unmet needs for each JCM; must convene the IDT promptly whenever a JCM is at risk or a JCM's needs are not being fully addressed; must seek assistance from DOH if the IDT is unable to adequately meet a JCM's needs.

The IQR probes many of the essential case management functions beginning with *access and ISP Development*. The CM is required to meet with the person receiving services and their guardian prior to the ISP development meeting to review current assessment information, prepare for the meeting, create a plan with the person to facilitate or co-facilitate the meeting if desired, discuss the budget, review the current Freedom of Choice (SFOC) forms and facilitate greater informed participation in ISP development by the person.[48] In addition to this meeting, easy access to and regular availability of the case manager is a key to being one of the primary safeguards for the individual. Both of these important case management activities are examined through the IQR.



[48] 2018 DD Waiver Standards, 6.4. Preparation for the ISP Meeting, page 62.

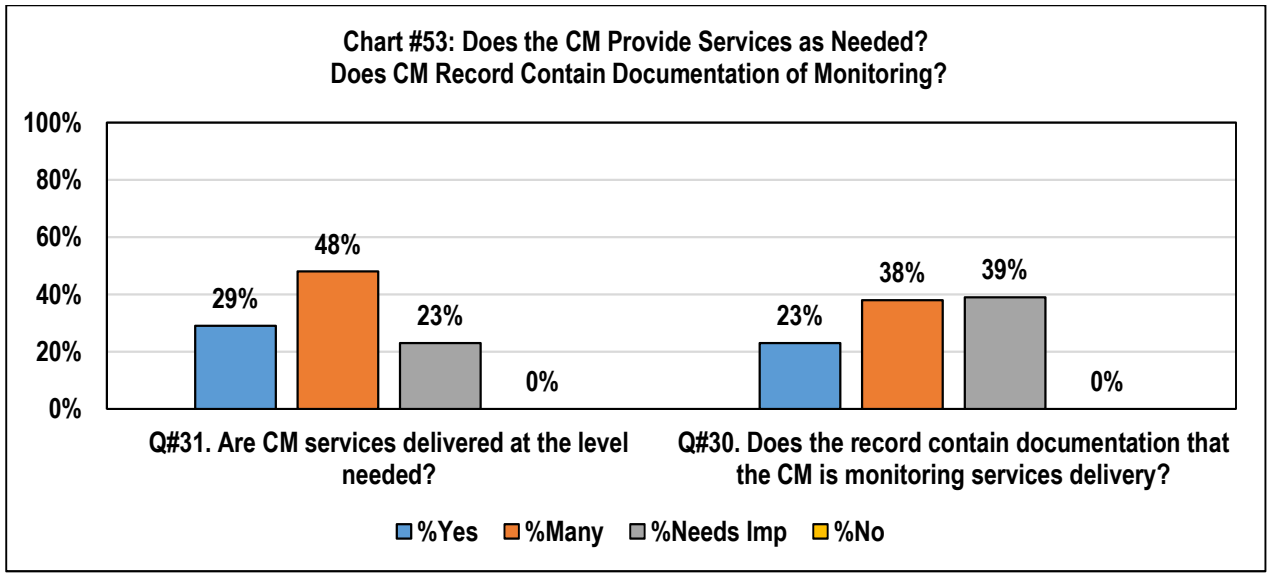
The IQR also focuses on the essential element of ISP implementation which requires, in part, routine and consistent monitoring by the provider and the Case Manager.

The ISP is supposed to play a central role in focusing the supports and services individuals receive, the direction they wish their lives to go and the skills/growth pattern they would like to set. Consequently, case managers play a key role in monitoring and documenting evidence of the implementation of the ISP to ensure it is practiced as intended. Knowing whether or not the person is making progress towards desired outcomes is a requirement of Case Managers and is to be evaluated as part of their twice monthly visits.

As noted earlier in this report, one of the major challenges related to the ISP is that *95% of the ISPs reviewed were not being implemented as intended*. While one of the case manager's primary responsibilities is monitoring to ensure that the ISP is initially implemented as agreed, the case manager also carries responsibility to routinely verify and document that the ISP continues to be implemented as intended and if not, to take action by notifying the provider. If that is not successful, then seeking assistance from the Regional Office through the Regional Office Request for Assistance (RORA) is expected to be initiated. Related IQR Questions include:

Question #30. Does the case management record contain documentation that the case manager is monitoring and tracking the delivery of services as outlined in the ISP?
Question #31. Does the case manager provide case management services at the level needed by this person?

The findings in both areas are troubling. 71% of those reviewed did NOT receive case management at the level needed and 77% did not have a record that verified the case manager was monitoring the delivery of ISP services.



The site visit form that the case manager was required to fill out during the 2018 IQR asks the case manager, at each visit, to verify whether outcomes are being implemented per the ISP based on a review of: outcomes and data collection sheets; Teaching and Support Strategies; and talk with the individual and staff. The form also requires case managers to "note progress, regression or stability" and to answer the question "what follow-up to lack of progress is being taken?"

There are several reasons this question receives such low response. One issue is that Case Managers frequently don't check the source data to verify that outcomes are actually being consistently and accurately implemented. There are times when the case manager asks staff if outcomes are being implemented. If the staff say "yes", or "things are going well" the case manager notes that conversation but does not verify consistent implementation by reviewing the data sheets. Another challenge is access to electronic data that may be kept by the provider. When the case managers are in the home, the provider would have to enable access to the electronic data through a password or having staff 'let them in' to the electronic data base. More and more providers are enabling case managers to access their data. The most challenging for Case Managers includes providers who don't actually keep consistent data so there may be no measurable data for case managers to check. While case managers don't 'control' the providers, they do have great influence which, in this case, might be notifying the provider that data needs to be consistently taken or taken in more measurable ways. If engagement with the provider is unsuccessful, Case Managers can and should engage the assistance of the Regional Office.

Another key to a better grasp of the cause of the low scores for Question #31, is understanding how critically important the role of monitoring is for Case Managers. Providers carry the primary responsibility to ensure that ISP's are consistently implemented. When the Provider fails to implement the ISP as prescribed, the Provider management has the first line responsibility to catch the problem and fix it. However, the case manager also carries responsibility to routinely monitor the implementation of the ISP and to catch when supports and services are not being provided as intended and to then act by notifying the provider that there is a problem. If, after reasonable attempts to resolve the problem have been made and no satisfactory resolution has been implemented the case manager is responsible to act by notifying the Regional Office that their assistance is needed to resolve the issue. Multiply this example many times in virtually every service arena for class members from the implementation of Positive Behavior Support Plans, Comprehensive Aspiration Risk Management Plans, Health Care Plans, attending scheduled specialists/doctor's appointments, receiving medications as ordered and we become more aware of the critical role case managers play as a safeguard for the individual. Without that informed eye consistently watching and, in turn, notifying responsible parties when there is an issue, the systems critical second-level safeguard system becomes ineffective thus putting the person at risk. Advocacy and protection from harm are the responsibility of everyone. Case Managers function, in many ways, as the system's eyes and ears on a daily basis. If case managers do not monitor (see) and act (report) timely, the systems' protections and effective provision of supports and services begins to break down. Scores to these questions, by Case Management Agency, follow.

Chart #54: Scores by Case Management Agency

CM Agency	# in sample	Q# 100	Q# 24	Q# 27	Q# 30	Q# 31
A New Vision	3	100% Yes (3)	100% Yes (3)	100% Yes (3)	33% Yes (1) 33% Many (1) 33% Needs Impv (1)	67% Yes (2) 33% Many (1)
A Step Above	9	55% Yes (5) 44% Many (4)	78% Yes (7) 11% Many (1) 11% Needs Impv (1)	100% Yes (9(	0% Yes 22% Many (2) 78% Needs Impv (7)	11% Yes (1) 33% Many (3) 56% Needs Impv (5)
Amigo	4	25% Yes (1)	75% Yes (3)	50% Yes (2)	0% Yes	0% Yes

CM Agency	# in sample	Q# 100	Q# 24	Q# 27	Q# 30	Q# 31
		25% Many (1) 25% Needs Impv (1) 25% No (1)	25% Many (1)	50% Many (2)	75% Many (3) 25% Needs Impv (1)	50% Many (2) 50% Needs Impv (2)
Carino	6	83% Yes (5) 17% Many (1)	100% Yes (6)	67% Yes (4) 33% Many (2)	33% Yes (2) 50% Many (3) 17% Needs Impv (1)	33% Yes (2) 50% Many (3) 17% Needs Impv (1)
DDSD	1	100% Yes (1)	100% Yes (1)	100% Yes (1)	100% Yes (1)	100% Yes (1)
Excel	6	33% Yes (2) 67% Many (4)	83% Yes (5) 17% Many (1)	83% Yes (5) 17% Many (1)	50% Yes (3) 83% Many (1) 33% Needs Impv (2)	50% Yes (3) 33% Many (2) 17% Needs Impv (1)
J&J	7	86% Yes (6) 14% Needs Imp (1)	86% Yes (6) 14% Needs Imp (1)	57% Yes (4) 43% Many (3)	29% Many (2) 57% Yes (4) 14% Needs Imp (1)	57% Yes (4) 43% Many (3)
NMQCM	3	67% Yes (2) 33% Many (1)	100% Yes (3)	33% Yes (1) 67% Needs Impv (2)	67% Yes (2) 33% Needs Impv (1)	0% Yes 100% Many (3)
Peak	8	63% Yes (5) 13% Needs Impv (1) 25% No (2)	75% Yes (6) 25% Many (2)	38% Yes (3) 50% Many (4) 13% Needs Impv (1)	25% Yes (2) 25% Many (2) 50% Needs Impv (4)	25% Yes (2) 50% Many (4) 25% Needs Impv (2)
Rio Puerco	1	0% Yes 100% Needs Imp (1)	100% Yes (1)	100% Yes (1)	100% Yes (1)	100% Yes (1)
SCCM	8	75% Yes (6) 25% Many (2)	100% Yes (3)	88% Yes (7) 13% Needs Impv (1)	50% Yes (4) 13% Many (1) 38% Needs Impv (3)	50% Yes (4) 38% Many (3) 13% Needs Impv (1)
Unidas	18	44% Yes (8) 39% Many (7) 17% Needs Impv (3)	83% Yes (15) 11% Many (2) 6% Needs Impv (1)	67% Yes (12) 33% Many (6)	0% Yes 72% Many (13) 28% Needs Impv (5)	17% Yes (3) 56% Many (10) 28% Needs Impv (5)
Unique Opportunities	2	100% Yes (2)	100% Yes (2)	100% Yes (2)	0% Yes 50% Many (1) 50% Needs Impv (1)	50% Yes (1) 50% Many (1)
Visions	6	50% Yes (3) 33% Many (2) 17% Needs Impv (1)	100% Yes (6)	83% Yes (5) 17% Many (1)	17% Yes (1) 83% Yes (5)	0% Yes 67% Many (4) 33% Needs Impv (2)

Another way to review the same information is to list agencies based on numbers of individuals in the sample for whom they were responsible and to review their overall scores, e.g., how many 100% ratings they received, how many 75% to 100% ratings and so on.

Chart #55: Case Management Scoring by Number of People in the Sample

CM Agency	# in sample	Q# 100 (%/# Yes)	Q# 24 (%/# Yes)	Q# 27 (%/# Yes)	Q# 30 (%/# Yes)	Q# 31 (%/# Yes)	# of 100%	# 75% to 99%	# 51% to 74%	# 50% or below
Agencies with 8 or more individuals in the sample										
Unidas	18	44% Yes (8)	83% Yes (15)	67% Yes (12)	0% Yes	17% Yes (3)	0	1	1	3
A Step Above	9	55% Yes (5)	78% Yes (7)	100% Yes (9)	0% Yes	11% Yes (1)	1	1	1	2
Peak	8	63% Yes (5)	75% Yes (6)	38% Yes (3)	25% Yes (2)	25% Yes (2)	0	1	1	3
SCCM	8	75% Yes (6)	100% Yes (3)	88% Yes (7)	50% Yes (4)	50% Yes (4)	1	2	0	2
Agencies with 6-7 individuals in the sample										
J&J	7	86% Yes (6)	86% Yes (6)	57% Yes (4)	29% Yes (2)	57% Yes (4)	0	2	2	1
Carino	6	83% Yes (5)	100% Yes (6)	67% Yes (4)	33% Yes (2)	33% Yes (2)	1	1	1	2
Excel	6	33% Yes (2)	83% Yes (5)	83% Yes (5)	50% Yes (3)	50% Yes (3)	0	2	0	3
Visions	6	50% Yes (3)	100% Yes (6)	83% Yes (5)	17% Yes (1)	0% Yes	1	1	0	3
Agencies with 3-5 individuals in the sample										
Amigo	4	25% Yes (1)	75% Yes (3)	50% Yes (2)	0% Yes	0% Yes	0	1	0	4
A New Vision	3	100% Yes (3)	100% Yes (3)	100% Yes (3)	33% Yes (1)	67% Yes (2)	3	0	1	1
NMQCM	3	67% Yes (2)	100% Yes (3)	33% Yes (1)	67% Yes (2)	0% Yes	1	0	2	2
Agencies with 1-2 individuals in the sample										
Unique Opportunities	2	100% Yes (2)	100% Yes (2)	100% Yes (2)	0% Yes	50% Yes (1)	3	0	0	2
DDSD	1	100% Yes (1)	100% Yes (1)	100% Yes (1)	100% Yes (1)	100% Yes (1)	5	0	0	0
Rio Puerco	1	0% Yes	100% Yes (1)	100% Yes (1)	100% Yes (1)	100% Yes (1)	4	0	0	1

A. Jackson Class Members Receiving Residential and Day Services

Living Supports are intended for people 18 years of age and older who need residential habilitation to assure their health and safety. "Habilitation" means that the individual has not just a place to live but also receives services that are provided to increase the person's skills leading towards greater independence and, if possible, the ability to live on one's own or, at least, with the supervision required and no more. There are three models of service included within Living Supports:

1. **Supported Living,**
2. **Family Living, and**
3. **Intensive Medical Living Services (IMLS).[49]**

As the following chart shows, 192, or 78%, of the 245 active Jackson Class Members[50] are receiving *Supported Living* supports. Supported Living is designed to address assessed needs and lead to the accomplishment of individually identified outcomes.[51]

There are 34 JCMs (14%) receiving *Family Living supports* intended for people who are assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family Living is intended to increase and promote independence and to provide the skills necessary to prepare people to live on their own in a non-residential setting. Family Living is designed to address assessed needs and individually identified outcomes. Services and supports are furnished by a Family Living Provider (FLP) who is a natural or host family member, or companion, who meets requirements and is approved to provide Family Living supports. Family Living supports are provided in the person's home or the home of the Family Living provider. The Provider Agency is responsible for substitute care coverage for the primary caregiver when he/she is sick or taking time off as needed. People receiving Family Living supports are required to live in the same residence as the paid FLP.[52]

Likewise, 170 JCMs (69%) receive *Adult Habilitation*, also referred to as "Meaningful Day" or "Community Life Engagement" (CLE). According to the New Mexico Developmental Disabilities Waiver Standards, Community Life Engagement refers to supporting people in their communities in non-work activities. Examples of CLE activities may include participating in clubs, classes or recreational activities in the community, learning new skills to become more independent, volunteering or retirement activities.

The four guideposts of CLE are:

a. **individualized supports for each person;**
b. **promotion of community membership and contribution;**
c. **use of human and social capital to decrease dependence on paid supports; and**
d. **Provision of supports that are outcome-oriented and regularly monitored.[53]**

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[49] 2018 NM DD Waiver Standards, Chapter 10. See 10.3. Living Care Arrangements (LCA), page 96.
[50] Number of active Jackson Class Members as of March 31, 2019.
[51] 2018 NM DD Waiver Standards, Chapter 10. See 10.3.9. Living Supports – Supported Living, Page 102.
[52] 2018 NM DD Waiver Standards, Chapter 10. Living Care Arrangements (LCA), Living Supports Family Living, See 10.3.8.2.1., Page 100.
[53] 2018 NM DD Waiver Standards, Chapter 11. See 11.3.2. Community Life Engagement, page 116, 117

Community Life Engagement is also sometimes used to refer to "Meaningful Day" or "Adult [or] Day Habilitation" activities.

Chart #56: Type of Residential and Day Services Received by JCMs

Residential Service Type	# JCM	% of JCM
Supported Living	192	78%
Family Living	34	14%
Independent Living	4	2%
Direct Services (Mi Via)	12	5%
ICF/MR	3	1%

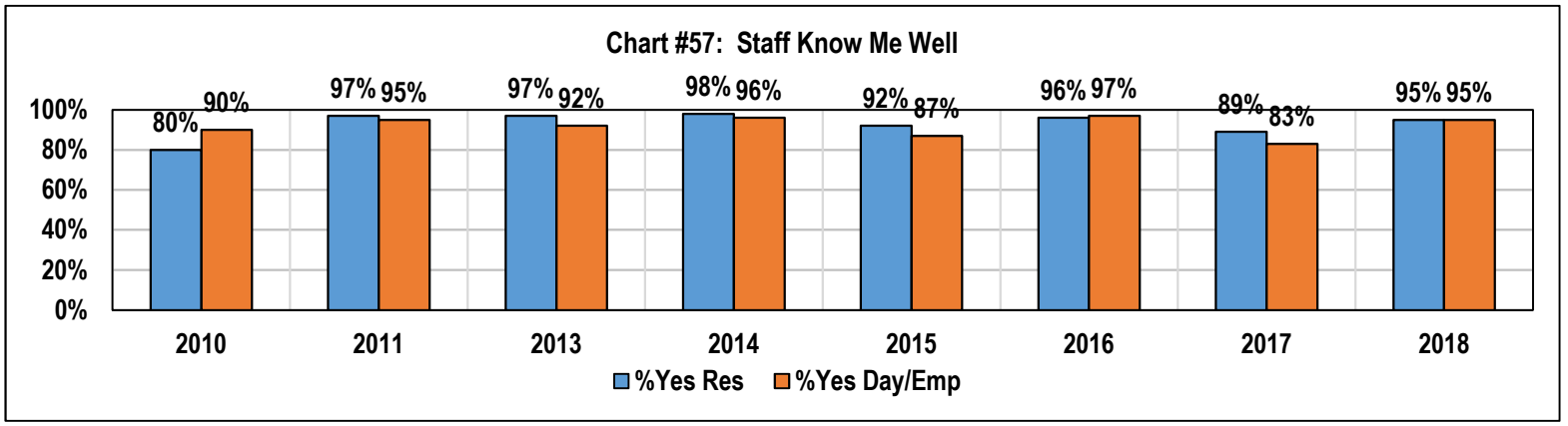
Day Service Type	# JCM	% of JCM
Adult Habilitation	170	69%
Community Access	7	3%
Supported Employment	4	2%
Adult Habilitation and Supported Employment	28	11%
Adult Habilitation and Community Access	14	6%
Community Access and Supported Employment	2	1%
Direct Services (Mi Via)	12	5%
ICF/MR	3	2%
None	5	3%

B. Do Direct Support Professionals Know the Person Well?

As the historical chart which follows points out, both residential and day staff have a history of demonstrating that they know the persons whom they support well.
Since 2010 the scores regarding how well residential staff know the individual they serve have never been below 89%, with the highest percentage being 97% and 98% for 2010, 2011 and 2013. These data points reflect the knowledge of the residential or day staff person identified for the Reviewer as the person who "knows the person best." Likewise, day staff knowing the individual being reviewed has never scored lower than the 83% received this year. Prior to 2017 the lowest score was 87% and ranged as high as 97% in 2016. For 2018 that number is higher than last year, at 95%.

Question #42. Does the residential direct services staff "know" the person? (left bar for each year)

Question #33: Does the Day/Employment staff "know" the person? (right bar for each year)



C. Do Those who Know the JCM Best Have Input into the Person's Plan? (See ISP Section)

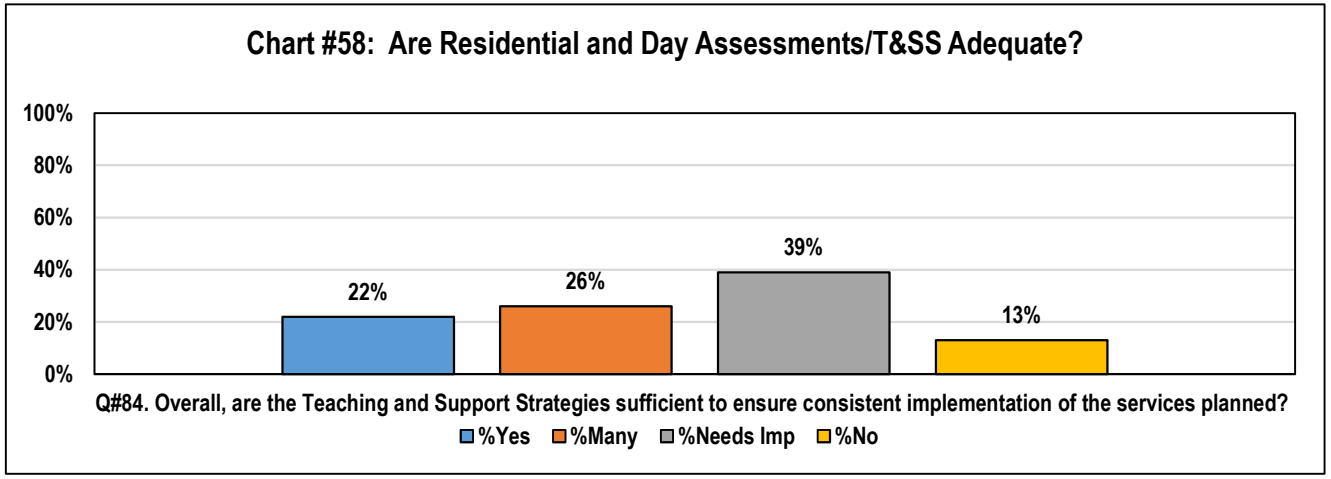
D. Are Residential and Day Assessments and Teaching and Support Strategies Adequate?

As discussed in the ISP Assessments Section, **assessments are important tools to help identify a person's strengths, interests, desires and to identify ways to assist the individual in meeting their desired Outcomes. However, assessments and evaluations are not a substitute for input from the individual concerning what is meaningful to them and how they perceive their own strengths and weaknesses. For provider agencies contributing to annual ISP development, assessment updates must be provided at least 14 days prior to the ISP development meeting to ensure that the ISP addresses the person's assessed needs and personal goals, either through DD Waiver services or other means.[54]**

After the ISP development meeting, Team members should conduct a task analysis and any other assessments necessary to create effective *Teaching and Supports Strategies (T&SS)* and *Written Direct Support Instructions (WDSI)*[55] to support Action Plans developed as part of the ISP. Teaching and Support Strategies are essential guidance to staff so they know how to present new information/experiences to the individual, how often and what to do to ensure the most likely path to success for the person. T&SS should be developed by the residential and/or day provider responsible for implementing the T&SS. Input from others such as therapists should be included as needed. WDSIs are developed by therapists as a complement to the T&SS. All T&SS and WDSI should support the person in achieving his/her Vision.[56] The IQR asks:

Question #84. Overall, are the Teaching and Support Strategies sufficient to ensure consistent implementation of the services planned?

[54] 2018 NM DD Waiver Standards, Chapter 6. Individual Service Plan, 6.3. Page 62,
[55] Therapists develop strategies to support activities of daily life through development of WDSIs addressing a variety of topics including health and safety needs. The WDSIs are utilized by Direct Support Professionals during routine activities, and by IDT-members to create T&SS that further integrate therapy strategies into implementation of the ISP. 2018 NM DD Waiver Standards, Chapter 12. Professional and Clinical Services, Therapy, page 142.
[56] 2018 NM DD Waiver Standards, Chapter 6. Individual Service Plan, 6.6.3.2, Page 66

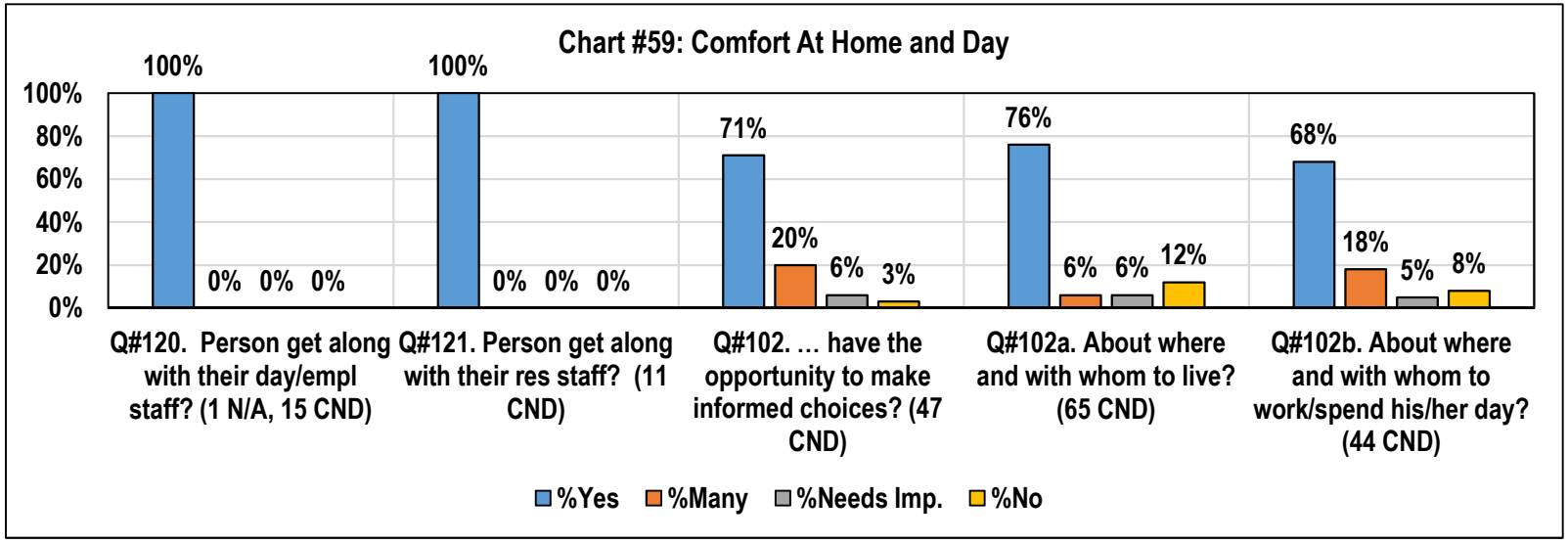


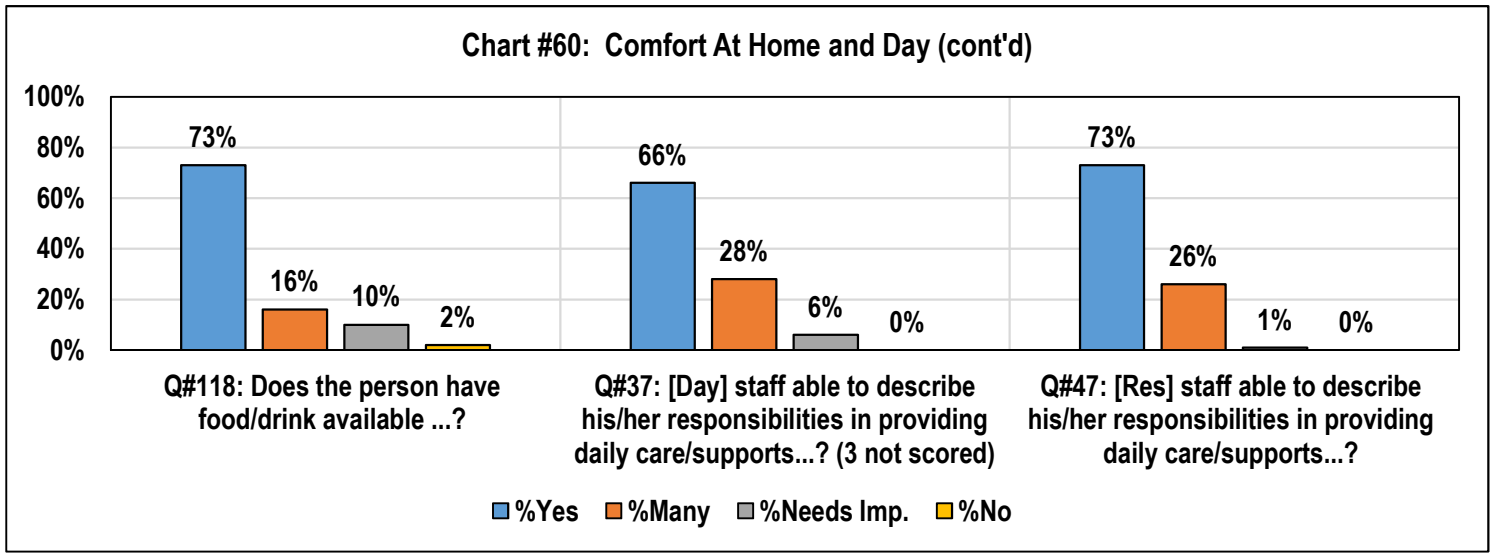
E. Do JCMs Feel Comfortable Where They Live and Work?

In addition to learning new skills, maintaining/expanding relationships and experiences through the ISP, the IQR probes for information regarding the individual's level of choice and comfort as it relates to home and day services. The following questions help give us insights into those reviewed.

Question #120. Does the person get along with their day program/employment provider staff?
Question #121. Does the person get along with their residential provider staff?
Question #102. Does the person have the opportunity to make informed choices?
Question #102a. About where and with whom to live?
Question #102b. About where and with whom to work/spend his/her day?
Question #118. Does the person have food and drink available according to their specific nutritional needs and recommendations?
Question #37. Was the [day] direct service staff able to describe his/her responsibilities in providing daily care/supports to the person?

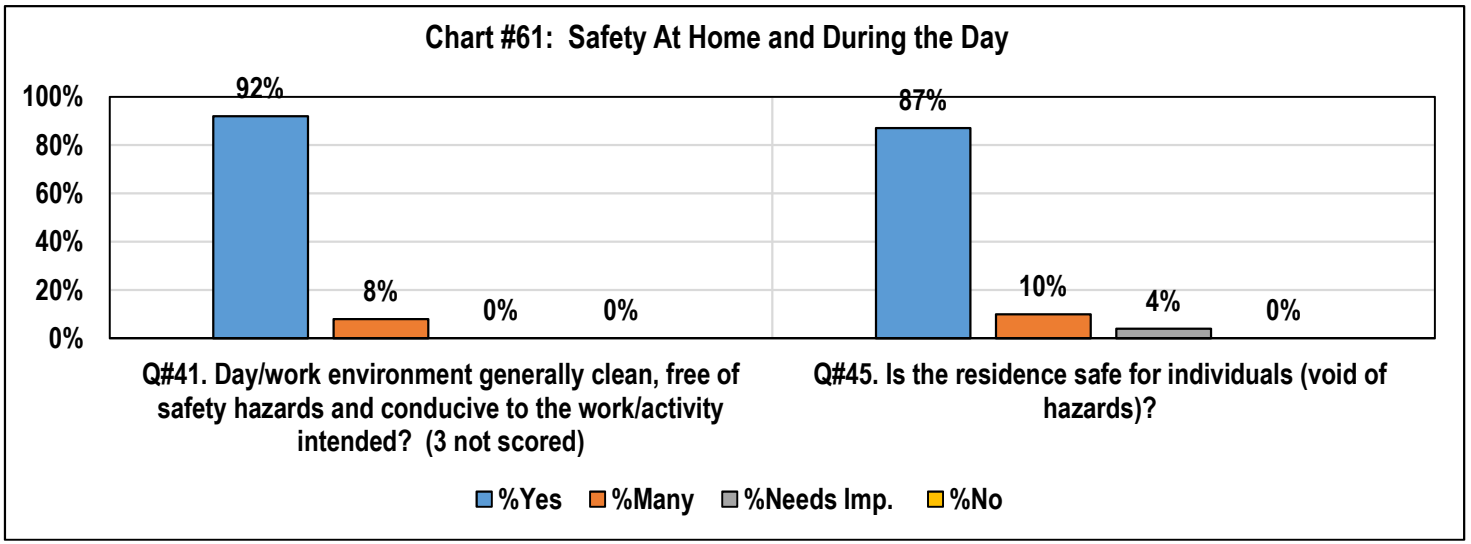
Question #47. Was the direct service staff able to describe his/her responsibilities in providing daily care/supports to the person?





F. Are Residential and Day Sites Safe?

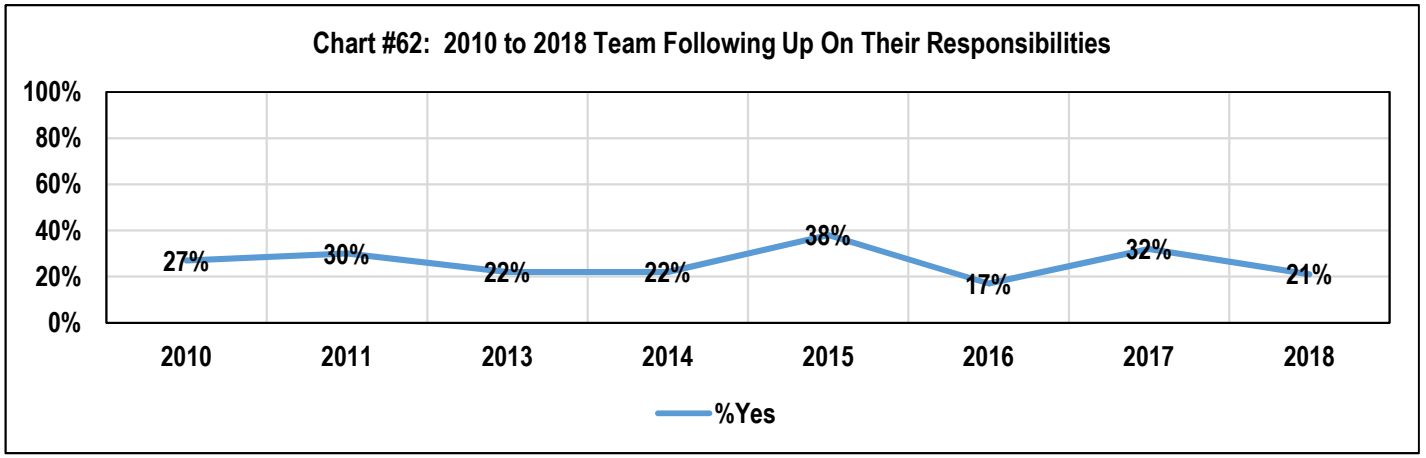
Question #41. Does the person's day/work environment generally clean, free of safety hazards and conducive to the work/activity intended?
Question #45. Is the residence safe for individuals (void of hazards)?



G. Are Team Members Consistently Following Up on Their Responsibilities?

There is a long and consistent pattern of residential and day team members not following up on their programmatic responsibilities which, for example, includes implementing the ISP, identifying and acting on changes in personal circumstances, ensuring appointments are kept, enabling individuals to use recommended equipment and assistive technology, getting them to work timely, etc. The relevant IQR question is:

Question #122. Are the individual members of the IDT following up on their responsibilities?



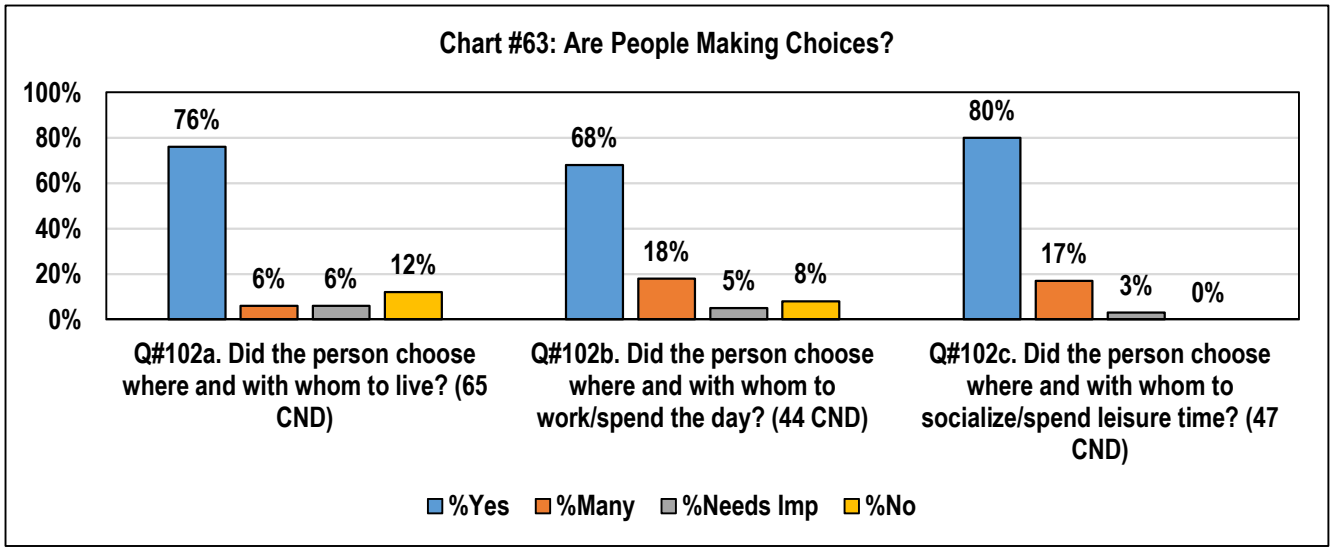
H. Are JCMs Integrated and Experiencing Meaningful Community Engagement?

All people, regardless of disability, deserve the opportunity for a full life in their community where they can live, learn, work and play through all stages of life. People with intellectual and/or developmental disabilities need varying degrees of support to reach personal goals and establish a sense of satisfaction with their lives.[57] Like employment, community participation and engagement with non-disabled community members plays a major role in developing self-esteem, relationships that are not paid to be in your life, natural networks of support, skill-building… the list goes on. Even though very few class members could be interviewed so that their actual choices and experiences could be confirmed, those for whom a score was identified are listed below.

Looking at class members experiences in the community include questions such as:

Routinely making choices about:
Question #102a. where and with whom to life?
Question #102b. where and with whom to work/spend the day?
Question #102c. where and with whom to socialize/spend leisure time?

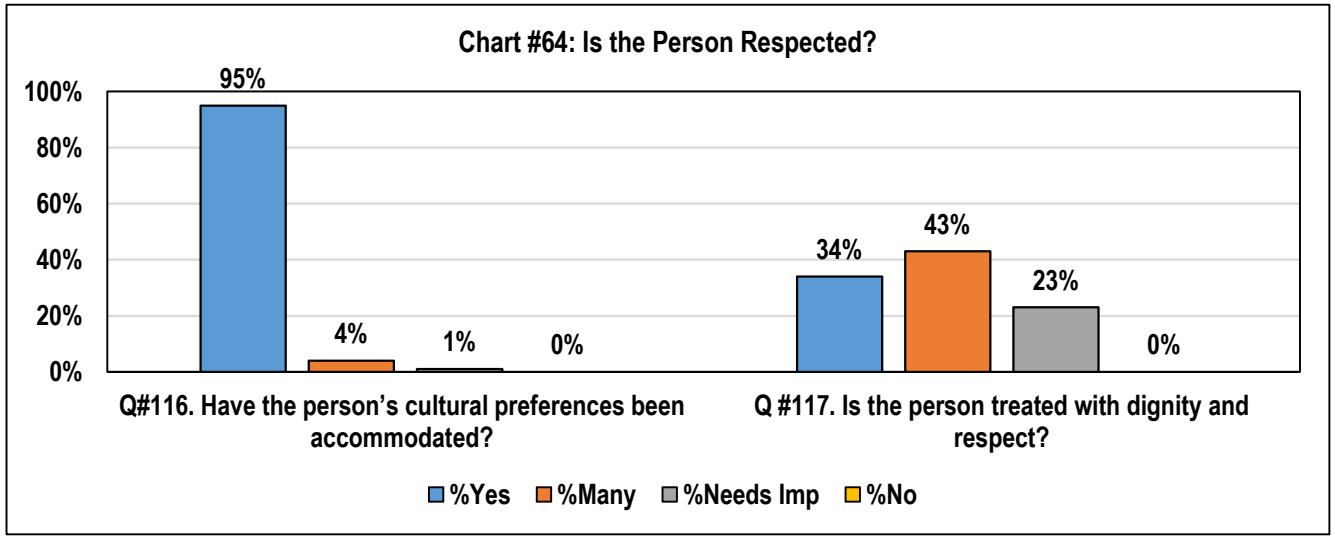
[57] The Arc, Life in the Community. https://www.thearc.org/who-we-are/position-statements/life-in-the-community



Having abilities, needs and preferences known and respected.

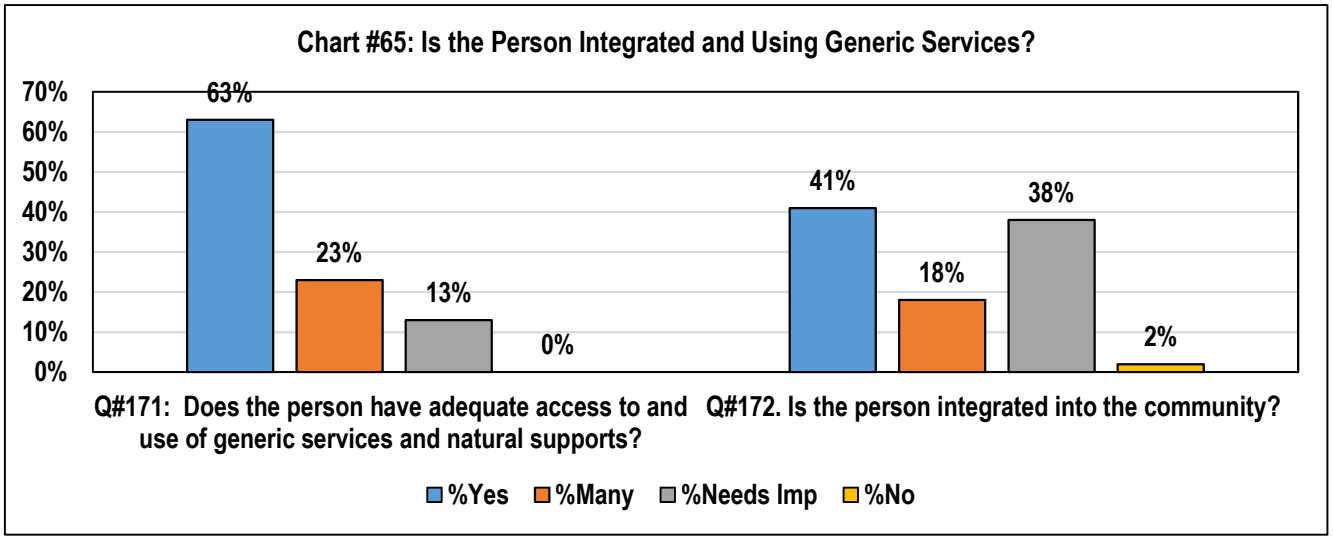
Question #116. Have the person's cultural preferences been accommodated?

Question #117. Is the person treated with dignity and respect?



Being integrated into their community

Question #171: Does the person have adequate access to and use of generic services and natural supports?
Question #172. Is the person integrated into the community?



VIII. SUPPORTED EMPLOYMENT

The DDSD adopted an Employment First Policy in 2016 to establish procedures for supporting working age adults to have access to valued employment opportunities as the preferred service in New Mexico. Access to competitive integrated employment enables the person to engage in community life, control personal resources, increase self-sufficiency and receive services in the community. When engaging in person-centered planning, team members must first look to community and natural supports to assist people to attain their employment goals and Desired Outcomes. As such, supported employment activities are a planning priority for all working age adults. Employment should be the first consideration. If someone does not choose employment, the decision should be based on informed choice.

Making an informed choice about employment is an individualized process. All people have unique histories and backgrounds, which means that some people may have limited experiences and will require more information to make an informed decision about employment while others may have a rich and varied employment history and can make an informed choice based on that history.[58]

A. Components of Informed Choice: Assessment

The expectation is that the Team will work together to determine and provide opportunities for activities that support making an informed choice about employment and clearly document the person's decision-making process in the ISP.[59] The test for whether or not the individual and guardian, if there is one, have been offered informed choice has several components.

> ***Assessment:*** **The first step in making an informed choice about employment starts with the assessment process. Vocational assessment is the process of determining an individual's interests, abilities, and aptitudes and skills to identify vocational strengths, needs and career potential. There are a variety of approaches, but for people with no or limited experience with work, situational assessments are highly effective.**
>
> ***Situational assessment*** **involves placing the person in an actual work situation to assess their performance. Situation assessments are commonly used to assess work behaviors, work tolerance, ability to follow instructions, work with others, etc. If a situational assessment is coordinated with specific job analysis (a checklist of sorts that outlines all the requirements of a particular job) it can be most effective in determining a person's ability in a given job.[60]**

Per the 2018 DD Wavier Standards, The Person-Centered Assessment (PCA) is the process teams are expected to use. Provider Agencies must adhere to the following requirements related to a PCA and Career Development Plan:

a. **A person-centered assessment should contain, at a minimum: information about the person's background and status;**
b. **the person's strengths and interests;**
c. **Conditions for success to integrate into the community, including conditions for job success (for those who are working or wish to work); and**

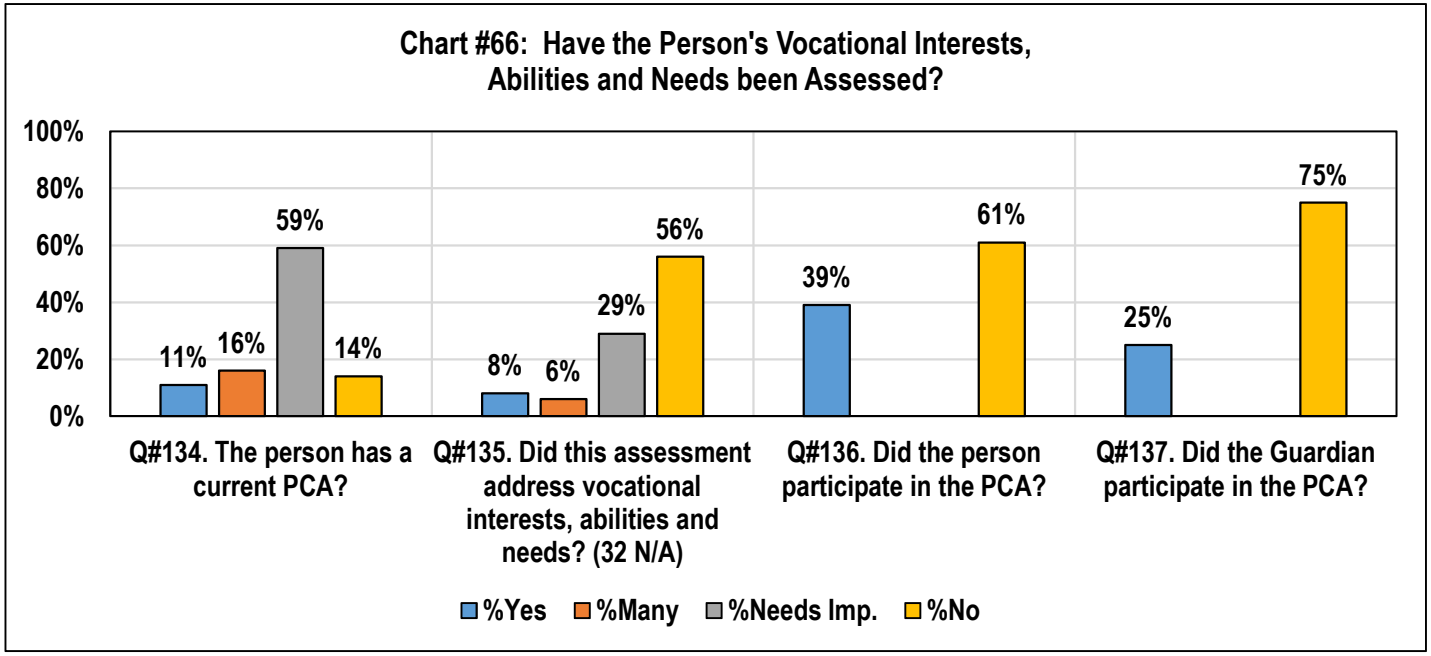
[58] 2018 NM DD Waiver, Chapter 11. 11.2, Page 115
[59] 2018 NM DD Waiver Standards, Chapter 11, 11.2 Employment First, Page 115.
[60] www.ilo.org/public/english//region/asro/bangkok/ability/.../voc_assessment.pdf

d. Support needs for the individual.

Considering vocational interests, abilities and skills is optional for those who are not working and have not expressed a wish to work. If you are working or wish to work then conditions for job success can and should be explored. Many Jackson Cass Members have had few or no job exploration opportunities. Some of the work opportunities which have been offered are limited (e.g., shredding paper for a service agency). Therefore, having the first step of informed choice limited to those who are working or wish to work is illogical when the entire purpose of an assessment is to determine job interests, aptitude and skills.

The IQR asks questions regarding the support class members receive in assessing and determining their interests in work. For example:

Question #134. Does (person) have a current Person-Centered Assessment?
Question #135. Did this assessment address vocational interests, abilities and needs?
Question #136. Did the person participate in the Person Centered Assessment?
Question #137. Did the Guardian participate in the Person-Centered Assessment?



B. Components of Informed Choice: Experience

If a person has no volunteer or employment history, then the individual and guardian should consider trying new discovery experiences in the community to determine interests, abilities, skills and needs. It is the responsibility of the provider to offer these experiences. These new experiences must be clearly documented in the ISP Work, Education and/or Volunteer History section, as well as any reason(s) not to pursue new experiences.[61]

Opportunity for Trial Work or Volunteering: **The guardian and team must also offer/provide the individual with access to job exploration activities including volunteer work and/or trial work opportunities, if the individual and guardian are interested. Employment Provider Agencies can assist in accessing these opportunities. These opportunities must be documented by the CM in the ISP in the Work, Education and/or Volunteer History section.[62]**

IQR questions which help inform us with respect to information and experience offered to class members include:

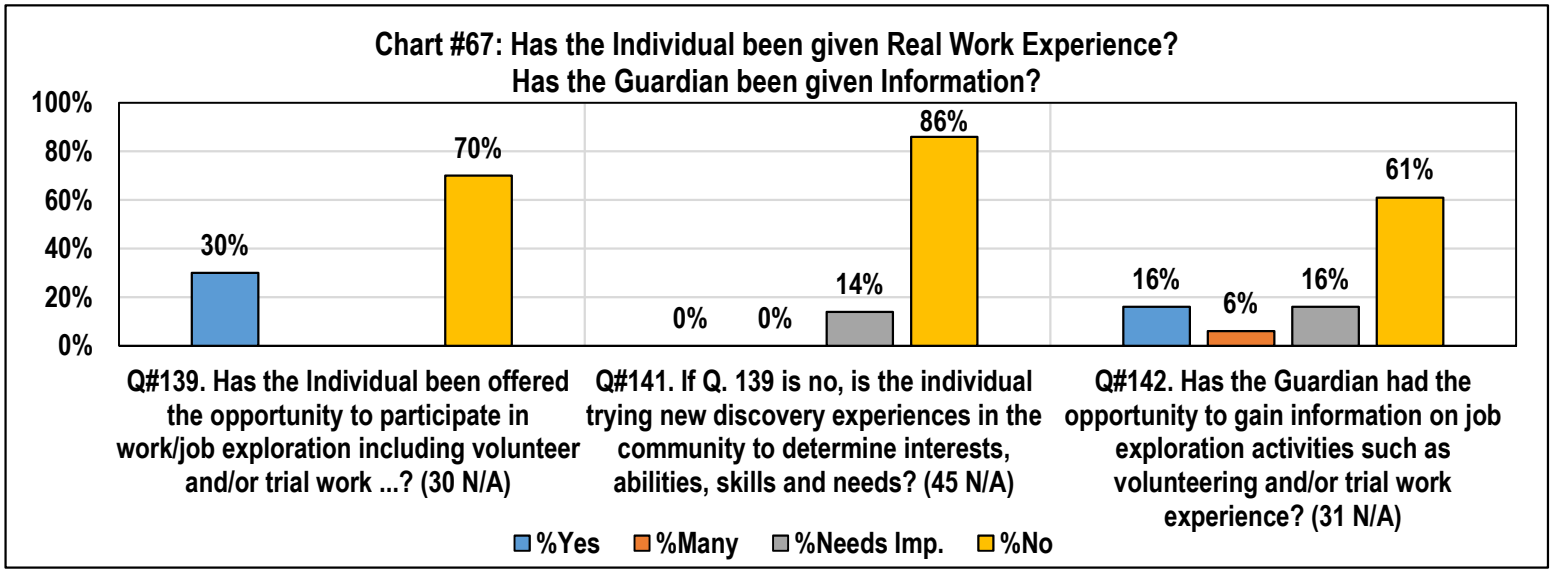
Question #139. Has the Individual been offered the opportunity to participate in work or job exploration including volunteer work and/or trial work opportunities?
Question #141. If Q. 139 is no, is the individual trying new discovery experiences in the community to determine interests, abilities, skills and needs?
Question #142. Has the Guardian had the opportunity to gain information on how the Individual responded during job exploration activities such as volunteering and/or trial work experience?

Once the first three steps have been fulfilled**, then the individual, in conjunction with a legal guardian, if appropriate, can determine whether employment shall be pursued.[63]**

The challenge identified as a part of the IQR Review is that the first three steps are, typically NOT completed before a decision is made that the person does not want to work. Some teams are clear about why they believe the person does not want to work, e.g., these people can't work, they are too severely disabled,

does not understand the significance of money, tried work years ago and it didn't work, guardian does not want him/her to work, etc. Others indicate they have or will "explore" work but the "exploration activity" from the point of view of the class member is difficult to define other than meetings. Some have engaged DVR or a local Tribal Council and have great success stories but as these numbers illustrate, those numbers are small.

[61] 2018 NM DD Waiver Standards, Chapter 11. Community Inclusion, Page 116.
[62] Ibid.
[63] NM 2018 DD Waiver Standards, Chapter 11. Community Inclusion, Page 116.



C. Components of Informed Choice: <u>Employment Barriers</u>

Knowing why people don't work or don't want to work is an important component of Informed Choice. Research has shown that besides earning a paycheck, people work for a variety of reasons including self-worth, self-confidence, purpose or direction in life, and to learn about personal skills, abilities and potential. Similar studies have shown the reasons why people do not work to include retirement, attending school, chronic illness or disability, laid off, taking care of someone else, or not being interested in working. Of all individuals who reported not working, less than 5% indicated they were not interested in working.[64]

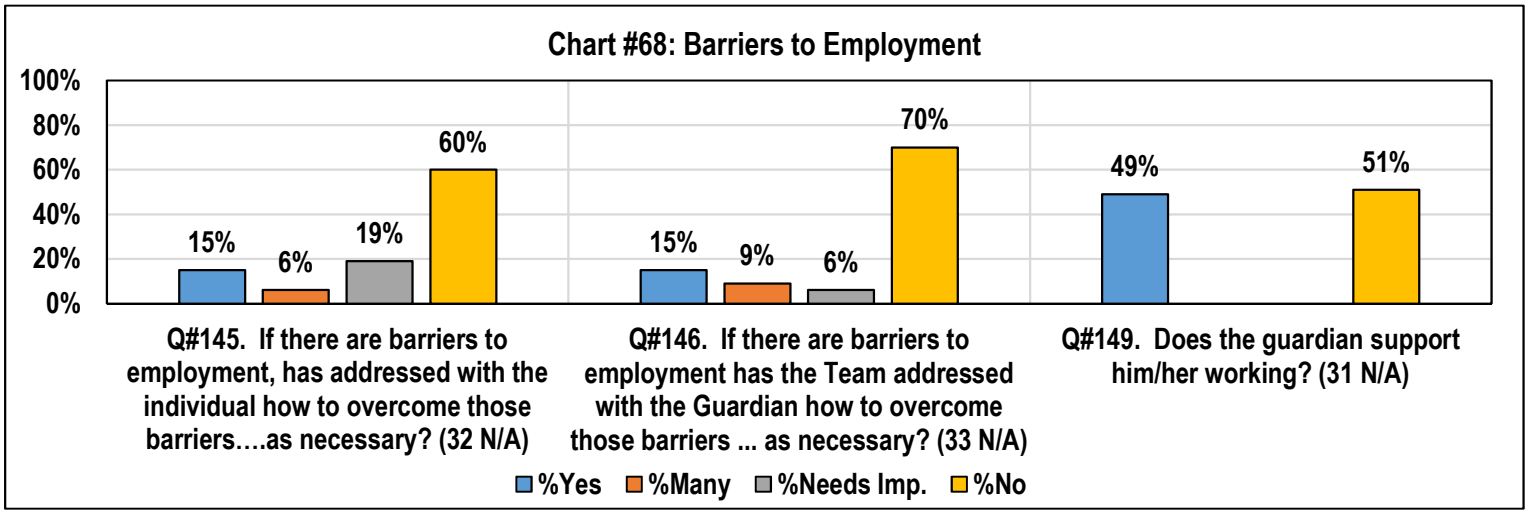
In New Mexico, the 2018 IQR also probed for information regarding why people are not working and what supports they have received to overcome identified employment barriers. For example:

Question #145. If there are barriers to employment, has the Team, including the individual, addressed how to overcome those barriers to employment and integrating clinical information (e.g., AT, Therapies) as necessary?

Question #146. If there are barriers to employment has the Team addressed with the guardian how to overcome those barriers to employment and integrating clinical information (e.g., AT, Therapies) as necessary?

[64] Supported Employment: Participant Training Manual, Elizabeth M. Boggs Center on Developmental Disabilities, Robert Wood Johnson Medical School, Department of Pediatrics, University of Medicine & Dentistry of New Jersey.

Question #149. Does the guardian support him/her working?



D. Jackson Class Members who are working

The criteria agreed to by the Parties which is to be applied when determining if someone "is working" includes the following:

- The person is working at least 10 hours per week;
- The person is making at least minimum wage; and
- The person is receiving a paycheck from a business.

New Mexico reported that 33% of people with I/DD in NM Waiver are working in competitive employment.[65] New Mexico data shows that 2 (.08%) of JCM are working at criteria.

For the 2017 IQR Review sample, no class members reviewed were working at the agreed criteria. For the 2018 IQR Review sample, 1 person (2%) was working at criteria.

The following summarizes those individuals who have been working, *some not at criteria*, as reported by DDSD's Wage and Hour Reports. For 2017 the reports for October 13, 2017 and February 2, 2018 were used. For this report the April 11, 2019 Wage and Hour Report was used. In 2017, 16 individuals were working 2 at criteria. In 2018, 13 individuals are working, 3 at criteria.[66] In 2018, 7 individuals from 2017 are no longer being reported. In 2018, 4 new people were added to the report.

[65] United Cerebral Palsy (UCP), Case for Inclusion 2015 and 2016 Reports.

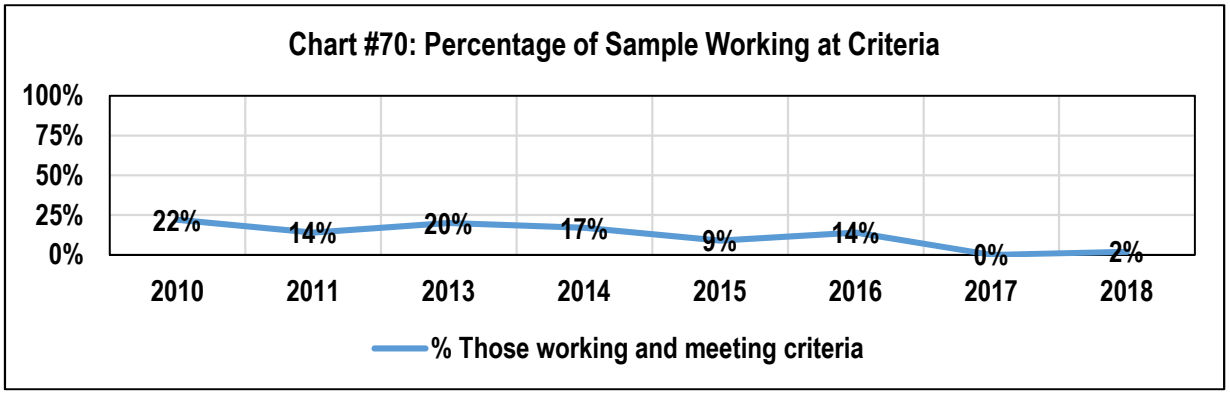
[66] Only 1 individual in the 2018 IQR Sample was found to be working at criteria. Chart #65 speaks to ALL Jackson Class Members as reported by DDSD Wage and Hour Report of 4.11.19.

Chart #69: 2017 and 2018 Summary of Individuals Working							
#	Person	2017 Hours Per Week	2018 Hours Per Week	2017 Hourly Rate	2018 Hourly Rate	2017 Paycheck Source	2018 Paycheck Source
Working at Criteria							
1	#41		27.5		$9.20		Business
2	#24	15	16	$12.78	$13.57	Business	Business
3	#25	10	10	$13.21	$13.75	Business	Business
Close to Criteria							
4	#44		9.75		$7.50		Self Employed
5	#23	11.38	9.25	$7.50 (ABQ $8.75)	$7.50	Business	Business
Below Criteria							
6	#30	4	6	$9.01	$9.21	Business	Business
7	#28	5	4.5	$8.71	$8.89	Business	Business
8	#29	4.5	4	$8.50	10.10	Business	Business
9	#42		3.13		$10.10		Business
10	#43		3		$7.50		Business
11	#33	3	2.5	$7.50	$7.50	Business	Business
12	#26	8.5	2	$9.00	$9.00	Business	Business
	#27	6		$8.50		Business	
	#31	4		$8.48		Business	
	#32	3		$7.50		Business	
	#34	3		$9.00		Business	
	#40[67]	2		$8.88		Business	
	#39[68]	1		$8.80		Business	
13	#36[69]	1.5	.75	$8.58	$9.00	Business	Business
	#37	.75		$8.75		Business	

Historically, the numbers of Jackson Class Members working continues to go down as the following chart shows.

[67] #40 was not on the 10.13.17 Report but was on the 2.21.18 Report.
[68] #39 was not on the 10.13.17 Report but was on the 2.21.18 Report
[69] #36 was on the 10.13.17 Wages and Hours Report but not on the 2.21.18 Report.

Question #152: Is the individual working in accordance with criteria?



IX. RIGHTS AND PROTECTIONS

The 2018 NM DD Waiver Standards, The Medicaid Home and Community-Based Services (HCBS) Consumer Rights and Freedoms offers a good introduction to this section. The HCBS Consumer Rights and Freedoms are summarized below in total and applicable portions are reproduced in relevant sections which follow.

"As a person with an intellectual and/or developmental disability (I/DD), and a person receiving services, I have the same basic legal, civil, and human rights and responsibilities as everyone else. My rights should never be limited or restricted unnecessarily; without due process and the ability to challenge the decision, even if I have a guardian. All my rights should be honored through any assistance, support, and services I receive.

Some Examples of My Rights Include:

- ***Get paid competitive wages to work in an inclusive setting***
- ***Contribute to my community***
- ***Access services in the community the same way people who don't receive services do***
- ***Full inclusion in community and cultural life***
- ***Have access to education and information in a way I can understand***
- ***Choose where I live based on what I can afford***
- ***Choose who I live with***
- ***Lock my doors and home, and choose those who may come in***
- ***Access common places in my home***
- ***Exercise tenant rights in accordance with state law***
- ***Accessibility wherever I go***
- ***Choose to be alone and my privacy respected***
- ***Privacy and confidentiality***
- ***Access to all my personal information (financial, medical, programmatic, behavioral, legal)***
- ***Receive information to make informed decisions regarding my health care.***
- ***Choose supports that I need and want***
- ***Choose from all available service Provider Agencies***
- ***Independence***
- ***Choose/develop my own schedule***
- ***Go out at any time***
- ***Develop my own person-centered plan of support***
- ***Be treated with dignity and respect***
- ***Control my money***
- ***Be free from coercion, restraint, seclusion and retaliation***
- ***Have visitors at my home at any time***
- ***Choose when/what to eat, and have access to food at any time***
- ***Choose my clothing***
- ***Be part of a family or start one***
- ***Live with my partner or get married***
- ***Form loving relationships, either platonic or sexual, with whomever I choose***
- ***Be free from abuse, neglect, exploitation***
- ***Have access to advocacy supports and resources***
- ***Participate in any discussion about restricting my right***
- ***Vote***
- ***Exercise religion or belief of my choice***

Any restriction or modification to these rights:

- ***Must demonstrate informed consent by me.***
- ***Must have an assurance that interventions and supports will cause no harm to me.***
- ***Must be the result of a documented health and safety issue.***
- ***Must be reflected in the person-centered plan.***
- ***Must have documented less intrusive supports that were attempted prior to the modification/restriction.***
- ***Will be communicated to me, in a way I can understand.***
- ***Requires regular review to measure and assess effectiveness of restriction/modification.***

- *Requires a fade-out plan for the restriction/modification.*

A. Class Members Are Addressed with Respectful Language and Have Opportunity for Privacy

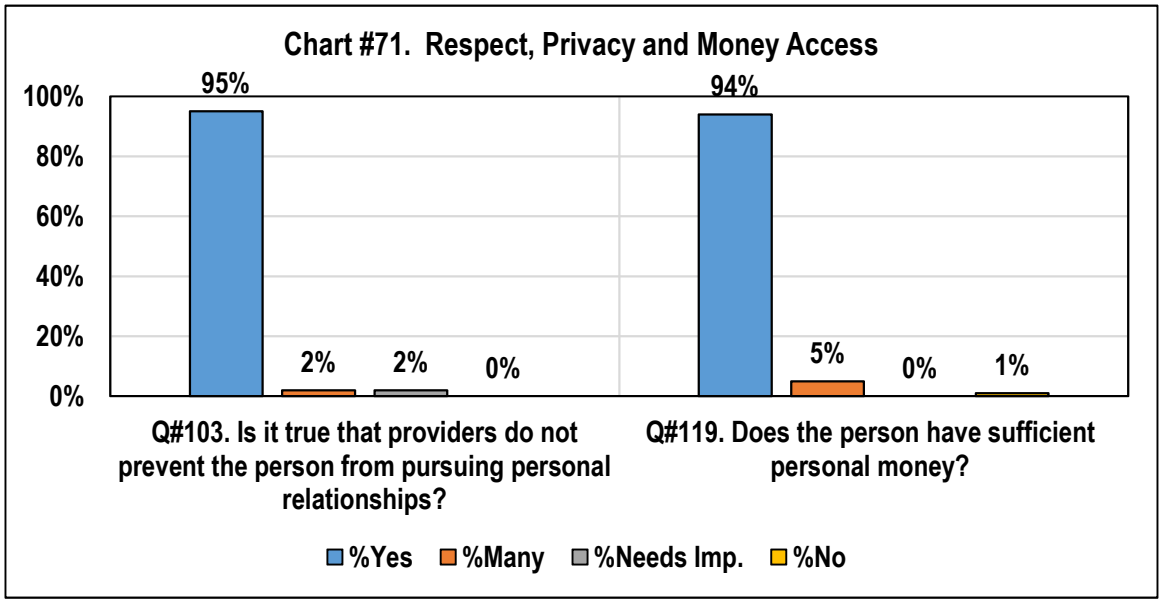
IQR Questions which address these rights include:

Question #102 a-c. Does the person have the opportunity to make informed choices? (See Chart #56)

a. About where and with whom to live?
b. About where and with whom to work/spend his/her day?
c. About where and with whom to socialize/spend leisure time?

Question #119. Does the person have sufficient personal money?

Question #103: Does the evidence support that providers do not prevent the person from pursuing relationships and are respecting the rights of this person?

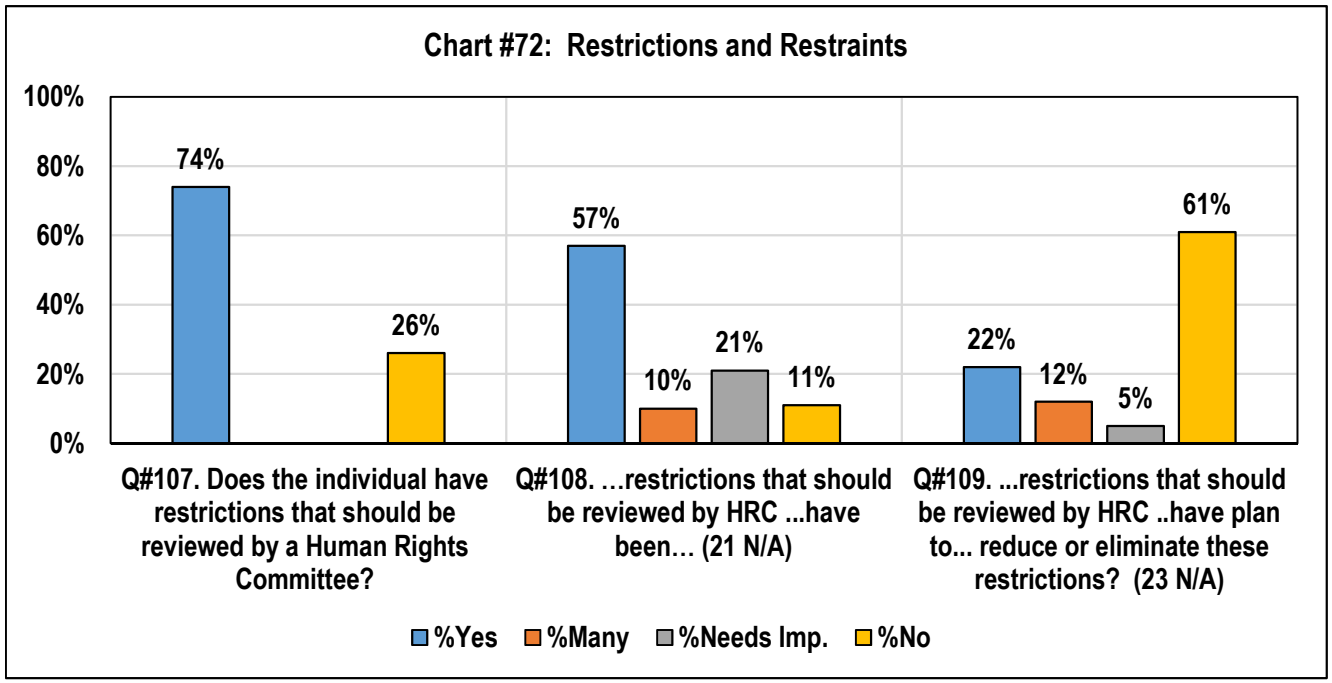


B. Restrictions, Restraints and Reviews

Question #107. Does the individual have restrictions that should be reviewed by a Human Rights Committee?

Question #108. If there are restrictions that should be reviewed by HRC, have the restrictions been reviewed (quarterly) and approved (annually) by the HRC?

Question #109. If there are restrictions that should be reviewed by HRC, is a plan to enable the individual to regain his/her rights and reduce or eliminate these restrictions?



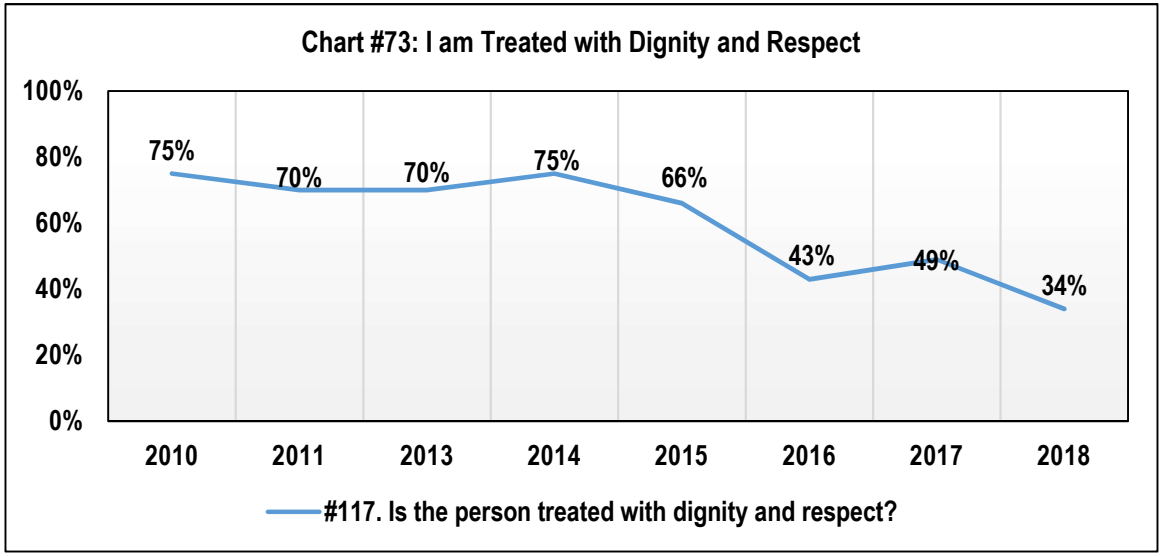
C. Being Treated with Dignity and Respect is on a Concerning Decline.

Question #117. Is the person treated with dignity and respect?

Being treated with dignity and respect is a question that has been part of the CPR Protocol since 1993. Some of the rights that are part of the 2018 standards are included in the test of whether or not someone is treated with dignity and respect, but there are more. If appointments are made but not kept, that does not demonstrate respect. If symptoms show I am not well but those changes are not recognized and acted upon, that does not demonstrate respect.

Some of My Rights Include:

- ✓ Get paid competitive wages to work in an inclusive setting;
- ✓ Contribute to my community.
- ✓ Access services in the community the same way people who don't receive services do.
- ✓ Full inclusion in community and cultural life. Being free from coercion, restraint, seclusion and retaliation.
- ✓ My rights should never be limited or restricted unnecessarily; without due process and the ability to challenge the decision, even if I have a guardian.



D. Instances of Abuse, Neglect and Exploitation (ANE) Are Not Always Reported or Investigated.

Relevant Evaluative Components Required for Disengagement:
Safety Objective S1.1.4 **ANE is reported immediately.**
Safety Objective S4.1a. **The DOH must provide timely information regarding ANE reports, investigations, and findings to JCMs, stakeholders (families, guardians providers, case managers), and other individuals or staff who need that information to ensure the safety of JCMs.**

An Incident Management System (IMS) is a critical part of an agency's practice to ensure swift and appropriate response to any allegations or substantiated findings related to abuse, neglect and exploitation (ANE), suspicious injury, environmental hazard or death. All DD Waiver Provider Agencies shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. A comprehensive IMS for DD Waiver Provider Agencies involves training, monitoring, cooperation with DOH- DHI, reporting and continuous risk management activities.[70]

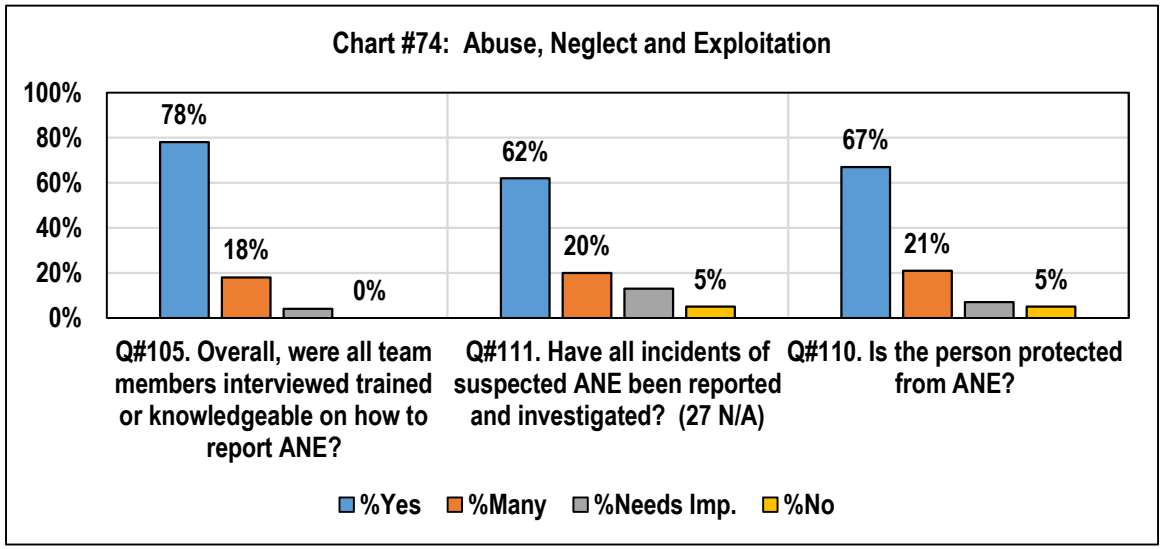
Some of My Rights Include:

- ✓ **Being free from abuse, neglect, and exploitation.**

[70] **2018 NM DD Waiver Standards, Chapter 18. Incident Management System, Page 229**

The IQR probes for information related to the following questions:

Question #105. Overall, were all team members interviewed trained or knowledgeable on how to report abuse, neglect and exploitation?
Question #111. Have all incidents of suspected abuse, neglect and exploitation been reported and investigated?
Question #110. Is the person protected from abuse, neglect and exploitation?



X. GOOD NEWS: OVERALL CONSISTENT AND IMPROVING AREAS

The 2018 Individual Quality Review in many areas reflect positive findings identified during the past seven Community Practice Reviews. Many regions show consistently high scores in specific areas. These areas include whether the person has the opportunity to make *informed choices* and if the individual *finds their case manager, day and residential support staff knows them well.* Day to day issues, such as *honoring cultural preferences and, providing adequate food and drink* are also reviewed, and have been found over the years to score high in many regions, as well as statewide. There are additional positives results to report in the areas of *Safety, Personal Safeguards and Rights*; and while not every region scored over 80% every single time in the most current IQR and the past seven CPRs, there are areas to be recognized and appreciated when it comes to the support of the Jackson Class.

A. Statewide

More detail has been provided by region, but the obvious care that staff show for individual Jackson Class Members is an ongoing positive in the lives of the individuals served by DDSD in New Mexico. Specifically, statewide it was shown that 95% of the day staff and 95% of the residential staff do know the individuals reviewed (Q#33 and Q#42). Statewide, 89% of day direct care staff and 94% of residential staff were able to describe their responsibilities in providing daily care/supports (Q#37a, Q#47a.)

The living and work places of the class members is something also examined in depth by the IQR. 87% of the individuals were found to have safe residences (Q#45). For individuals who required any assistive technology or devices, 92% of staff were found to know how to appropriately and safely help with the use of their equipment (Q#164). Overall, 93% of the sample statewide were found to have appropriate, sufficient, safe, healthy and nutritious food and drink (Q#118).

Ensuring the rights of the Jackson class was also an area of focus during the 2018 IQR; how the rights of individuals were reviewed, as well as honoring their preferences and choices. For 95% of the individuals, statewide, individual cultural preferences were accommodated (Q#116). For 95% of the sample, it was found that providers did not prevent the pursuit of relationships and the rights of the person were being respected (Q#103)

B. Metro Region

Direct Care Staff: 94% of the residential staff and 96% of the day knew the individuals reviewed (Q#42, Q#96). In the Metro region, 93% of day direct care staff and 91% of residential staff were able to describe specific information regarding the individuals' activities (Q#37a, Q#47a).

Case Management: 85% of Case Managers knew the person well (Q#24).

Services and Plan: In the Metro region, 100% of individuals have ISPs that address live, work/learn, fun/relationships and health/other that complements their desires and capabilities (Q168). 81% of individuals who needed a behavior support plan had one that was based on their behavior assessment and met their needs (Q#157).

Living and Work Places: 93% of the day/work environments of the individuals in the region were clean, free of safety hazards, and conducive to the person's activity (Q#41). The homes of 87% of the Metro sample were found to be safe (Q#45). For the individuals who required any assistive technology or devices, 93% of staff were found to know how to appropriately and safely help with the use of their equipment (Q#164). Overall, 94% of the individuals in the region were found to have appropriate, sufficient, safe, healthy and nutritious food and drink (Q#118).

Individuality, Rights and Social Connections: For 94% of the individuals, cultural preferences were accommodated (Q#116) and 100% of the sample, for whom it could be determined, were provided with choices regarding where and with whom to socialize and spend leisure time (Q#102c). 91% of the individuals reviewed in the Metro region were found to have daily choices and appropriate autonomy over their lives (Q#115).

C. Northeast Region

Direct Care Staff: 86% of day services staff and 100% of residential services staff in the Northeast region knew the individual they support well (Q#33, Q#42). 86% of day services staff and 100% of residential services staff could also provide specific information about the person's daily activities. (Q#37a, Q#47a). Staff were also found to have expectations that the person they supported could learn and progress, as 86% of day staff 88% of residential staff had appropriate expectations of growth (Q#40, Q#50).

Case Management: For 100% of the individuals reviewed, their case managers were noted to know them well (Q#24), and 100% of them also had appropriate expectations of growth for the person (Q#29). 88% of case managers were found to be available to the person as needed.

Services and Plan: In the Northeast region, 100% of individuals had ISPs that address live, work/learn, fun/relationships and health/other that complements their desires and capabilities (Q#168). The ISP outcomes for 100% of the individuals reviewed were related to achieving their long-term vision (Q#82).

Living and Work Places: 86% of the day/work environments of the individuals in the region were clean, free of safety hazards, and conducive to the person's activity (Q#41). The homes of 88% of the Northeast sample were found to be safe (Q#45). For the individuals who required any assistive technology or devices, 88% of staff were found to know how to appropriately and safely help with the use of their equipment (Q#164). Overall, 88% of the individuals in the region were found to have appropriate, sufficient, safe, healthy and nutritious food and drink (Q#118).

Individuality, Rights and Social Connections: For 88% of the individuals in the Northeast region, cultural preferences were accommodated (Q#116) and 100% of the sample, for whom it could be determined, were provided with choices regarding where and with whom to work and spend their day (Q#102b).

D. Northwest Region

Direct Care Staff: 100% of day services staff and 100% of residential services staff in the Northwest region were noted know the individual they supported well (Q#33, Q#42). 100% of residential services staff could also provide specific information about the person's daily activities. (Q#47a). Day staff were found to have expectations that the person they supported could learn and progress, as 100% had appropriate expectations of growth (Q#40).

Case Management: For 100% of the individuals reviewed, their case managers were noted to know them well (Q#24), and 100% of them also had appropriate expectations of growth for the person (Q#29). 100% of case managers were also found to be available to the person as needed.

Services and Plan: 100% of individuals in the Northwest region had ISPs that address live, work/learn, fun/relationships and health/other that complements their desires and capabilities (Q#168). The ISP outcomes for 88% of the individuals reviewed were related to achieving their long-term vision (Q#82), and 88% of the ISP outcomes addressed the person's major needs (Q#83).

Living and Work Places: 100% of the day/work environments of the individuals in the region were clean, free of safety hazards, and conducive to the person's activity (Q#41). The homes of 88% of the individual were found to be safe (Q#45). For the individuals who required any assistive technology or devices, 100% of staff were found to know how to appropriately and safely help with the use of their equipment (Q#164). Overall, 88% of the individuals in the region were found to have appropriate, sufficient, safe, healthy and nutritious food and drink (Q#118).

Individuality, Rights and Social Connections: In the Northwest region, 100% of the individuals' cultural preferences were accommodated (Q#116) and 88% of the sample were found to have daily choices and appropriate autonomy over their lives (Q#115).

E. Southeast Region

Direct Care Staff: 100% of day services staff and 100% of residential services staff in the Southeast region knew the individual they support well (Q#33, Q#42). 89% of day services and residential services staff could also provide specific information about the person's daily activities. (Q#37a, Q#47a). Staff were also found to have expectations that the person they supported could learn and progress, as 89% of day and residential staff had appropriate expectations of growth (Q#40, Q#50).

Case Management: The individuals in the Southeast region have case managers who were found to have expectations that the person they supported could learn and progress, as 89% had appropriate expectations of growth for them (Q#29).

Services and Plan: In the region, 89% of individuals had ISPs that address live, work/learn, fun/relationships and health/other that complements their desires and capabilities (Q#168). 89% of individuals were also found to have adequate access to and use of generic services and natural supports (Q#171).

Living and Work Places: 89% of the day/work environments of the individuals in the region were clean, free of safety hazards, and conducive to the person's activity (Q#41). For the individuals who required any assistive technology or devices, 86% of staff were found to know how to appropriately and safely help with the use of their equipment (Q#164). All of the individuals in the region (100%) were found to have appropriate, sufficient, safe, healthy and nutritious food and drink (Q#118).

Individuality, Rights and Social Connections: For 100% of the individuals in the Southeast region, cultural preferences were accommodated (Q#116). For 100% of the sample, it was found that providers did not prevent the pursuit of relationships and the rights of the person were being respected (Q#103)

F. Southwest Region

Direct Care Staff: 90% of both day and residential services staff in the region knew the individual they support well (Q#33, Q#42). 80% of day services staff and 100% of residential services staff could also provide specific information about the person's daily activities. (Q#37a, Q#47a).

Case Management: For 90% of the individuals reviewed, their case managers were noted to know them well (Q#24), and 80% of case managers were found to be available to the person as needed.

Services and Plan: In the Southwest region, 80% of individuals had ISPs that address live, work/learn, fun/relationships and health/other that complements their desires and capabilities (Q#168). 88% of individuals who needed a behavior support plan had one that was based on their behavior assessment and met their needs (Q#157).

Living and Work Places: 90% of the day/work environments of the individuals in the region were clean, free of safety hazards, and conducive to the person's activity (Q#41). The homes of 90% of the individuals in the sample were found to be safe (Q#45). For the individuals who required any assistive technology or devices, 89% of staff were found to know how to appropriately and safely help with the use of their equipment (Q#164). Overall, 90% of the individuals in the region were found to have appropriate, sufficient, safe, healthy and nutritious food and drink (Q#118).

Individuality, Rights and Social Connections: For 100% of the individuals in the Northeast region, cultural preferences were accommodated (Q#116) and 100% of the sample, for whom it could be determined, were provided with choices regarding where and with whom to socialize and spend leisure time (Q#102c).

APPENDIX A: HEALTH RELATED FINDINGS BY AGENCY

The Community Practice Review identified 664 health related findings for 86 of the 87 individuals reviewed. Not only did 99% of those reviewed have health related findings which needed review and/or action but 84 (13%) of those findings were "repeat" findings from previous Community Practice Reviews.

The following are examples, by providers with more than one person in the review: (S4.2)

- **Residential agencies from the Northeast Region with the highest average number of health related findings per person include:**
  - **Community Options had 2 people in the review with 32 health/assessment findings (3 repeat, 2 Immediate, 1 Special) for an average of 16 findings per person.**
  - **AWS had 2 people in the review with 20 health/assessment findings (3 repeat, 2 Immediate, 1 Special) for an average of 10 findings per person.**
- **Case Management agencies from the Northeast Region with the highest average number of health related findings per person include:**
  - **Unidas had 2 people in the review with 25 health/assessment findings (5 repeat, 1 Immediate) for an average of 12.5 findings per person.**
  - **Visions had 6 people in the review with 64 health/assessment findings (10 repeat, 5 Immediate, 4 special) for an average of 10.7 findings per person.**
- **Residential agencies from Metro Region who had the highest average number of health related findings per person include:**
  - **Dungarvin had 3 people in the review with 31 health/assessment findings (6 repeat, 4 Immediate, 3 Special) for an average of 10.3 findings per person.**
  - **Expressions of Life had 3 people in the review with 30 health/assessment findings (3 repeat, 4 Immediate, 1 Special) for an average of 10 findings per person.**
  - **LLCP had 9 people in the review with 86 health/assessment findings (16 repeat, 6 Immediate, 11 Special) for an average of 9.6 findings per person.**
  - **The New Beginnings had 4 people in the review with 38 health/assessment findings (5 repeat, 7 Immediate, 1 Special) for an average of 9.5 findings per person.**
  - **Arca had 7 people in the review with 53 health/assessment findings (3 repeats, 1 Immediate, 4 Special) for an average of 7.6 findings per person.**
  - **Bright Horizons has 2 people in the review with 13 health/assessment findings (1 Special) for an average of 6.5 findings per person.**
  - **Adelante had 9 people in the review with 54 health/assessment findings (2 Immediate, 3 Special) for an average of 6 findings per person.**
  - **MaxCare had 2 people in the review with 9 health/assessment findings (1 repeat) for an average of 4.5 findings per person.**
- **Case Management Agencies from Metro Region who had the highest average number of health related findings per person include:**
  - **Peak had 5 people in the review with 55 health/assessment findings (3 repeat, 1 Immediate, 8 special) for an average of 11 findings per person.**
  - **A New Vision had 3 people in the review with 30 health/assessment findings (3 Immediate, 2 Special) for an average of 10 findings per person.**
  - **Carino had 6 people in the review with 47 health/assessment findings (5 repeat, 3 Immediate, 3 special) for an average of 7.8 findings per person.**
  - **A Step Above had 8 people in the review with 56 health/assessment findings (7 repeat, 8 Immediate, 2 special) for an average of 7 findings per person.**
  - **NMQCM had 3 people in the review with 21 health/assessment findings (1 repeat, 1 Immediate, 1 special) for an average of 7 findings per person.**
  - **Amigo had 4 people in the review with 27 health/assessment findings (3 repeat, 3 Immediate, 3 special) for an average of 6.8 findings per person.**
- **Residential agencies from the Southeast Region with the highest average number of health related findings per person include:**
  - **Tobosa had 3 people in the review with 27 health/assessment findings (4 repeat, 4 Immediate, 4 Special) for an average of 9 findings per person.**

- **ENMRSH had 2 people in the review with 7 health/assessment findings for an average of 3.5 findings per person.**

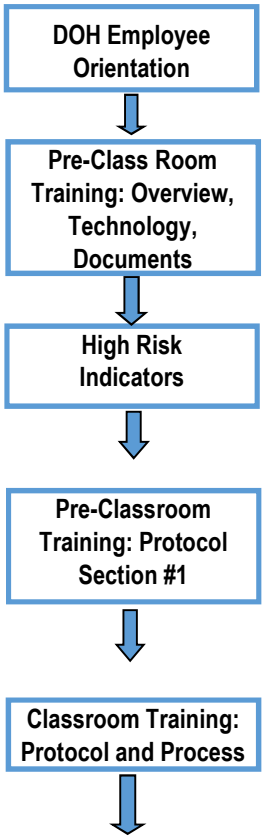
- **Case Management Agencies from the Southeast Region with the highest average number of health related findings per person include:**
  - **J&J had 7 people in the review with 51 health related findings (9 repeats, 6 Immediate, 3 Special) for an average of 7.3 findings per person.**
- **Residential agencies from the Northwest Region with the highest average number of health related findings per person include:**
  - **Tungland had 3 people in the review with 19 health/assessment findings (3 repeat, 1 Special) for an average of 6.33 findings per person.**
  - **Dungarvin had 4 people in the review with 25 health/assessment findings (3 repeat, 1 Special) for an average of 6.25 findings per person.**
- **Case Management agencies from the Northwest Region with the highest average number of health related findings per person include:**
  - **Excel had 5 people in the review with 34 health related findings (4 repeats, 1 Special) for an average of 6.8 findings per person.**
- **Residential agencies from the Southwest Region with the highest average number of health related findings per person include:**
  - **Tresco had 4 people in the review with 24 health/assessment findings (3 repeat, 4 Immediate) for an average of 6 findings per person.**
  - **Lessons of Life had 3 people in the review with 17 health/assessment findings (2 repeat) for an average of 5.7 findings per person.**
- **Case Management agencies from the Southwest Region with the highest average number of health related findings included:**
  - **SCCM had 8 people in the review with 62 health/assessment findings (8 repeat, 7 Immediate, 1 special) for an average of 7.8 findings per person.**
  - **Peak had 2 people in the review with 13 health/assessment findings (2 repeat) for an average of 6.5 findings per person.**

APPENDIX B: TRANSITION OF THE IQR TO DOH/DHI

DOH/DHI IQR Reviewers Begin to be Hired and Trained

In addition to changing the protocol, DOH/DHI and DDSD intend to move towards assuming responsibility for implementation of the review process in anticipation of the Jackson litigation coming to an end. At the beginning of the 2017 IQR process, the Department had no full time DHI/IQR Reviewers hired or available to be trained or work as an IQR reviewer. At the beginning of the 2018 IQR process, the Department had hired five new employees identified to be IQR Reviewers. Four of these individuals,[71] along with two additional staff hired during the 2017 IQR year, began to be trained. The training process, in general, includes the following steps.

There are several phases of training for the Trainee/Reviewer. Those include:



Phase #1: DHI/DDSD New Employee Orientation: This includes internal DOH and DHI orientation as well DDSD required trainings on, for example, the DD Waiver Standards, program and service provision and visits to the field, etc.

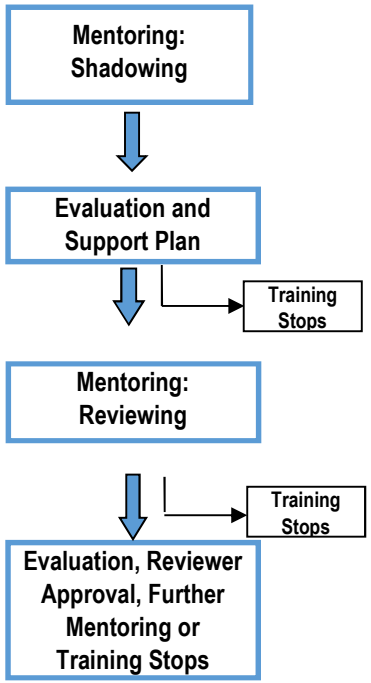
Phase #2: Community Monitor's Office: Overview of IQR Process, Reviewers Guide, demonstrated competency in using WebEx, SCOMMs, navigation of protocol sections, knowing when to send what and to whom, including deadlines.

Phase #3: Community Monitor's Office: This test provides information and then a test to determine the level of understanding of the reviewer on the following 'high risk' topics: Aspiration/ Choking; Constipation/Bowel Obstruction; Dehydration; GERD; Seizures and Something's Not Right/Change in Condition. This test is scored and returned to the potential reviewer.

Phase #4: Community Monitor's Office: Section #1 of the Protocol contains a great deal of evidence documentation upon which many parts of Section #7 depend. As a result, it is critical for the potential reviewer to understand the requirements of Section #1 as early as possible. This training consists of a 5 to 6 hour orientation regarding what information is to be documented, where and why. Demonstrated competency is expected in finding information in the files and entering detailed information in the protocol.

Phase #5: Community Monitor's Office and DDSD: This multi-day training includes a detailed walk through each section of the protocol so reviewers understand what is being sought, where information is to be recorded, how the process works, timelines which are to be met and other specific deliverables. Tips from experienced reviewers are shared. Practice time is integrated throughout.

[71] One new employee took a different position shortly after being hired as an IQR Surveyor and before significant training had occurred.



Phase #6: Community Monitor's Office: The Trainee/Reviewer begins by shadowing an approved and experienced reviewer. Experienced reviewers serve as mentor(s) throughout the entire review process. During the initial stages of this process, the Mentor functions as the Reviewer so the Trainee/Reviewer can 'shadow'/observe initially and later complete identified sections of the protocol. As the Trainee/Reviewer gains experience, protocol sections are exchanged with the Mentor who provides guidance and feedback on the content to ensure accuracy and inter-rater reliability.

Phase #7: Community Monitor's Office: After a The Trainee/Reviewer completes a self-evaluation, the mentor, Case Judge, and Community Monitor complete relevant portions of the same evaluation. This is reviewed with the Trainee/Reviewer and his/her supervisor. The intent is to identify strengths and areas where further training is required. Based on this evaluation, a support plan for the reviewer's next review is developed. Training of the Trainee/ Reviewer may be stopped at any point.

Phase #8: Community Monitor's Office: The Trainee/Reviewer conducts Review(s) as lead. The experienced mentor 'shadows' the Trainee/Reviewer at every stage of a full review. The training of the Trainee/Reviewer may be stopped at any point.

Phase #9: Community Monitor's Office: The Trainee/Reviewer completes a self-evaluation, the mentor, Case Judge, and Community Monitor complete relevant portions of the same evaluation. This is reviewed with the Trainee/Reviewer and his/her Supervisor. After at least two reviews where the reviewer serves as lead, the Reviewer may become "approved" or further mentoring in specified areas may be identified or the training may be stopped.

Throughout the process identified above, additional mentoring/training may be required and provided through additional reviews until such time as the reviewer is approved or training and further reviews by that specific Trainee/Reviewer halted.

Review Process

The review process experienced little change during the past two years even though the protocol changed both years. The long-standing process, in general, includes:

Public Availability of the IQR Protocol and Guidance: The IQR Protocol is published on the web and available to anyone, including those providers and others who will be reviewed, to read or take guidance from as they prepare for the IQR. The protocol includes the bulk of the questions to be asked and notes which identify what the reviewer is looking for. Thus, the live review can be identified as "an open book test" where there should be no surprises.

Setting the Yearly Calendar: DOH/DHI/DDSD and the Community Monitor's Office collaborate on establishing the calendar that it is published at the beginning of the review year. The calendar is published on the Community Monitor's Jackson website so individuals, families, providers, case managers, DHI, DDSD and others are able to have easy access to the information.

Selecting the Sample: The names of individuals to be reviewed are provided to the appropriate region at least 45 days in advance of the review start date by the Community Monitor.

Review Weeks

- **Week #1:** File is reviewed by Reviewer.
- **Week #2:** Phone interviews are conducted by the Reviewer with those working with the individual including the Case Manager, Guardian, related therapists, nurse and Behavior Support Consultant. For individuals receiving supports through Mi Via, phone interviews are conducted with the Consultant, Guardian and any other ancillary supports he/she may receive (e.g., therapists, nurses).
- **Week #3:** On-site Review is conducted and includes interview/observation of supports and services offered to the individual being reviewed during the day and in their home. While visiting the home and day locations, the environment is observed, medications reviewed and recommended equipment sought out. The onsite review also includes interviews with direct support professionals who know the person best including employment, if appropriate, day and residential staff.

Recording Evidence and Findings: The individual's IQR protocol serves as the container for accumulated evidence. Based on the evidence collected through file review, interviews and observations, individual findings and recommendations are developed first by the Reviewer.

Reviews to Ensure Accuracy: The evidence, findings and recommendations go through multiple reviews to ensure clarity and accuracy.

- **Review #1:** Based on documented evidence accumulated by the Reviewer, findings and recommendations are developed and written down;
- **Review #2:** The Case Judge reads the entire file, reviews the summary of evidence accumulated and summarized in the protocol which includes summary of all interviews and on-site observations. The Case Judge then reviews the protocol content and the findings and recommendations with the Reviewer. Discrepancies, errors, omissions are reconciled and questions answered between the Reviewer and Case Judge.
- **Review #3:** The Reviewer summarizes his/her findings and recommendations with the Community Monitor. Discrepancies and omissions are reconciled and questions answered.
- **Review #4:** Regional Status Summary. The Community Monitor reviews all of the findings and recommendations with representatives of the Regional Office, DHI and DDSD. Discrepancies, errors and omissions are reconciled and questions answered.
- **Review #5:** The Community Monitor reviews all of the findings and recommendations with each individual's Team which consists of the individual and Guardian, if available, the Case Manager, Day, Employment and Residential provider representatives and related therapists, nurses and behavioral support consultants. Teams are invited to identify discrepancies, errors and questions. If the team has an alternative recommendation to the one provided, they are invited to share those recommendations with the Community Monitor. After each review, the Community Monitor makes appropriate changes to the findings, recommendations and protocol scores.
- **Review #6:** Once the accumulated regional findings are summarized in the Regional Power Point, that summary is sent to the Region for Final review and comment. After this review, the final regional report is issued to all of the parties.
- **Review #7:** A detailed report is then developed and sent to the Region/State which identifies information by provider and by case management agency to enable the region/state to prioritize issues and providers who may need technical assistance/remediation. This report is shared with all of the parties with an invitation to forward further questions.

Follow Up

Ten calendar days following the Regional Status Summary, DDSD assumes responsibility for following up with individual Teams and providers on the Findings and Recommendations. Based on that information, 30-60-90 Day Reports on the recommended corrective action(s) are provided by DDSD to the Community Monitor. These reports continue at 30 day intervals up to a maximum of 180 days after the Regional Status Summary or until the recommendation has been fully implemented. This Finding and/or recommendation follow-up is typically the responsibility of the local provider where a practice deficit had been observed. The DDSD reports the collective follow up of providers.

Corrective action timeline requirements for class members who have been identified as having immediate and/or special needs that put them at risk for significant harm begins immediately upon notification to the Regional Office.

APPENDIX C: IMMEDIATE AND SPECIAL NEEDS BY ISSUE AND REGION

Available by Request: Contains individually identifiable information

Those authorized to receive a copy and who would like one should contact the Community Monitor 785-258-2214 or rpaltd@aol.com

APPENDIX D: NUMBER OF ISSUES IDENTIFIED FOR PEOPLE WITH IMMEDIATE AND/OR SPECIAL NEEDS BY RESIDENTIAL PROVIDER AND CASE MANAGEMENT AGENCY

(Only agencies with Special and/or Immediate findings are listed, this is not the same as Number of Findings)

Agency	Aspiration /CARMP Issues (26)	Not following orders/ recommendations (14)	Symptoms /issues not followed up (7)	Falls/ Fractures /Safety (7)	Equipment Issues (10)	Medication Issues (11)	Nursing Oversight (7)	Team Communication and/or Continuity (10)
Residential								
Adelante	2			2		1		
Advantage Communications	1							
ARCA	2				1	1	2	
Aspire					2			
At Home Advocacy	1							
Benchmark	1	2	2	1	1	1		1
Bright Horizons	3			1			1	
CARC	1							
Community Options	2							1
Dungarvin		1	1					
ENMRSH					2			
ESEM	3	1						
Expressions of Life	1				1			
Expressions Unlimited							1	
Leaders		1	1	1				
LLCP	3	2			1	1		1
Optihealth	1	2	1			1	1	
PRS				1				
Ramah Care		1				1		
R-Way	1					1		
The New Beginnings	1				1	4	2	3
Tobosa	2				1			1
Tresco	1	4	2	1				3
Case Management								
A New Vision				1				
A Step Above	2			1			1	
Amigo	2							
Carino	1	2	1	1	1	2	3	3
DDSD (NERO & SERO)	4	1						
Dungarvin			1					
Excel		1				1		

Agency	Aspiration /CARMP Issues (26)	Not following orders/ recommendations (14)	Symptoms /issues not followed up (7)	Falls/ Fractures /Safety (7)	Equipment Issues (10)	Medication Issues (11)	Nursing Oversight (7)	Team Communication and/or Continuity (10)
J&J	2	1	1	1	5			1
LLCP	2							
NMQCM	3	1			2		1	
Peak	1				1	1	2	2
Rio Puerco		1						
SCCM	2	4	2	1				2
Unidas	3	1		1		5		1
Unique Opportunities	1							
Visions	3	2	2	1	1	2		1
Day Provider (if different from Residential or an additional agency)								
Adelante	4				2	4	1	
CFC	2	2	1	1		1	2	
Cornucopia	2							
Mandy's	1							
Phame	1					1		

APPENDIX E: NUMBER OF REPEAT FINDINGS/RECOMMENDATIONS BY AGENCY – 2011-2017

2018 Repeat Findings are outlined earlier in this report

Note: If the number of Repeat Findings/Recommendations goes up or down it cannot automatically be seen as "improvement" or "decline" for that agency as there are instances of multiple reviews and changes in agencies by JCMs. However, this does provide information that can be used by the Regions to determine 'why' repeat finding/recommendations have been identified. The challenge is to "fix" an issue in a sustainable way for all people in that agency, not just "close" it for one person.

CM # Repeats by CPR	2017	2016	2015	2014	2013	2011
(# in 2016 Sample)		N/A =Agency not reviewed that year				
A New Vision (1)	2	22	14	12	10	5
A Step Above (5)	22	15	15	22	12	1
Agave	N/A	N/A	0	N/A	N/A	N/A
Amigo (1)	3	7	4	9	11	2
Blue Sky	N/A	N/A	N/A	N/A	3	3
Carino (5)	13	15	10	23	7	2
DDSD (2)	13	4	2	3	8	2
Excel (3)	10	20	10	12	15	9
Friends Forever	N/A	N/A	N/A	N/A	3	1
J&J (9)	52	25	27	24	43	15
Keetoni	N/A	N/A	N/A	N/A	3	4
Mi Via (3)	0	1	0	0	N/A	N/A
NMBHI (1)	7	7	4	5	5	6
NMQCM (2)	10	13	19	3	12	11
Peak (9)	33	33	26	22	21	21
PRMC	N/A	N/A	N/A	7	3	8
Purple Cow	N/A	N/A	N/A	N/A	N/A	2
Rio Puerco (2)	10	8	1	5	N/A	N/A
SCCM (8)	41	20	39	25	13	25
Unidas (7)	39	58	61	50	29	23
Unique Opportunities (1)	3	4	13	6	2	1
Visions (6)	20	23	15	47	18	10
TOTAL	278	275	260	275	218	152

RESIDENTIAL # Repeats by CPR	2017	2016	2015	2014	2013	2011
(# in 2017 Sample)	N/A =Agency not reviewed that year					
A Better Way	N/A	3	0	N/A	N/A	1
Ability First	N/A	N/A	5	N/A	N/A	N/A
Achievements	N/A	N/A	N/A	N/A	N/A	8
Active Solutions	N/A	N/A	1	3	N/A	N/A
Adelante (10)	41	36	20	28	12	9
Advantage Communications (1)	3	7	10	3	2	2
Advocacy Partners	N/A	6	N/A	N/A	N/A	1
Alegria	N/A	N/A	9	N/A	5	1
Alianza	N/A	3	N/A	1	1	N/A
Alta Mira	N/A	0	N/A	N/A	N/A	N/A
ARCA (3)	6	13	18	17	4	6
Aspire (2)	14	2	9	N/A	N/A	N/A
At Home Advocacy (1)	1	7	2	4	2	1
AWS/Benchmark (3)	8	16	9	29	10	5
Better Together (1)	0	N/A	N/A	N/A	N/A	N/A
Bright Horizons (2)	12	1	10	1	5	0
CARC (1)	8	N/A	0	3	0	3
Casa Alegre	N/A	N/A	N/A	3	1	3
CDD	N/A	3	1	N/A	4	3
Community Options (1)	11	4	5	10	7	6
Cornucopia	N/A	1	0	N/A	N/A	N/A
Door of Opportunity	N/A	N/A	N/A	N/A	1	1
DSI	N/A	N/A	N/A	12	12	2
Dungarvin (5)	12	23	16	11	8	10
ELADC (Ensuenos) (1)	7	5	3	1	1	0
ENMRSH (3)	17	8	4	5	3	7
ESEM (1)	5	5	3	6	5	3
Esperanza	N/A	N/A	N/A	N/A	7	1
Expressions of Life (1)	2	11	5	5	6	2
Expressions Unlimited	N/A	2	N/A	N/A	3	N/A
Family Options	N/A	4	N/A	5	1	3
HDFS/Better Together	4	5	5	10	15	3
Leaders (1)	8	2	5	1	10	1
Lessons of Life (1)	3	8	3	7	1	3
Life Missions	N/A	6	N/A	N/A	N/A	N/A
LifeQuest	N/A	N/A	N/A	N/A	N/A	5
LLCP (3)	10	20	26	28	19	12
Maxcare	N/A	N/A	N/A	2	N/A	N/A
Meaningful Lives	N/A	N/A	0	N/A	N/A	N/A
Mi Via (3)	0	1	0	0	N/A	N/A
New Pathways	N/A	1	N/A	N/A	1	N/A
Nezzy Care	N/A	4	N/A	N/A	6	N/A
NNMQC	N/A	1	1	7	5	2
Onyx	N/A	7	N/A	N/A	0	N/A
Opportunity Center	N/A	3	N/A	N/A	N/A	3
Optihealth (1)	3	1	0	5	1	5
PRS (1)	4	2	8	8	5	4
Ramah Care (3)	9	3	4	2	3	1
R-Way (1)	1	N/A	4	4	0	3
Safe Harbor	N/A	N/A	N/A	N/A	N/A	2
Santa Lucia (1)	6	N/A	N/A	N/A	N/A	N/A
Silver Linings	N/A	N/A	2	3	N/A	4
Su Vida	N/A	5	4	N/A	2	0
Supporting Hands	N/A	N/A	N/A	N/A	3	N/A
The New Beginnings (3)	20	3	12	11	7	1
TLC	N/A	N/A	1	2	2	2
Tobosa (3)	13	7	7	5	15	6
Tresco (7)	36	25	39	27	7	13
Tungland (1)	4	11	5	6	9	4
ZEE	N/A	N/A	N/A	N/A	5	0
TOTAL	65	275	260	275	218	152

DAY # Repeats by CPR	2017	2016	2015	2014	2013	2011
(# in 2017 Sample)	N/A =Agency not reviewed that year					
A Better Way	N/A	6	1	4	1	4
ABQSFTD	N/A	N/A	N/A	N/A	1	N/A
Active Solutions	N/A	7	6	2	0	2
Adelante (11)	49	57	39	42	25	20
Advantage Communications (1)	3	N/A	N/A	N/A	N/A	N/A
Alegria	N/A	0	1	N/A	5	N/A
Alianza	N/A	3	N/A	N/A	N/A	N/A
ARCA (1)	13	3	7	10	2	N/A
Aspire (2)	14	2	9	N/A	N/A	N/A
AWS/Benchmark (3)	8	8	9	29	12	5
]Bright Horizons (1)	7	N/A	1	1	N/A	N/A
CARC (1)	8	N/A	0	2	0	0
Casa Alegre	N/A	N/A	N/A	N/A	1	3
CDD	N/A	3	1	N/A	3	2
CFC (2)	8	9	10	6	1	2
Community Options (2)	11	4	5	19	7	6
Connections	N/A	9	16	N/A	8	11
Cornucopia (1)	7	1	1	3	1	0
Door of Opportunity	N/A	N/A	N/A	N/A	1	1
DSI	N/A	N/A	N/A	12	11	2
Dungarvin (5)	12	29	13	12	7	5
ELADC (Ensuenos) (1)	7	5	3	1	1	0
Empowerment (1)	0	3	4	1	2	N/A
ENMRSH (3)	17	8	4	5	3	7
ESEM (1)	5	5	3	8	2	3
Esperanza	N/A	N/A	N/A	N/A	7	1
Expressions Unlimited	N/A	2	4	N/A	8	N/A
Family Options	N/A	4	N/A	5	1	3
HDFS/Better Together	4	5	5	10	15	3
La Vida Felicidad	N/A	13	N/A	N/A	2	0
Las Cumbres	N/A	N/A	N/A	3	2	2
Leaders (1)	8	2	5	1	12	1
Lessons of Life (1)	3	8	3	7	1	3
LifeQuest	N/A	N/A	N/A	N/A	N/A	5
Life Roots	N/A	5	9	N/A	5	2
LLCP (4)	13	16	27	29	23	12
Mandy's Farm (1)	4	N/A	N/A	N/A	N/A	N/A
Meaningful Lives	N/A	N/A	4	N/A	N/A	N/A
Mi Via (3)	0	1	0	0	N/A	N/A
New Pathways	N/A	0	0	N/A	N/A	1
Nezzy Care	N/A	4	N/A	3	6	N/A
NONE (1)	0	0	2	2	N/A	N/A
NNMQC	N/A	N/A	0	N/A	N/A	N/A
Onyx	N/A	4	N/A	N/A	N/A	N/A
Opportunity Center	N/A	3	N/A	N/A	N/A	3
OptiHealth	N/A	1	4	2	N/A	N/A
People Centered	N/A	N/A	N/A	4	1	N/A
Phame (1)	1	9	0	N/A	0	3
PMS/Shield	N/A	3	5	2	11	3
PRS (1)	4	2	8	8	5	4
Ramah Care (2)	19	N/A	N/A	1	3	1
RCI	N/A	N/A	N/A	N/A	N/A	1
Safe Harbor	N/A	N/A	N/A	N/A	N/A	2
Santa Lucia (1)	6	N/A	N/A	N/A	N/A	N/A
Share Your Care	N/A	4	15	9	2	7
Silver Linings	N/A	N/A	2	3	N/A	4
Su Vida	N/A	9	4	N/A	4	0
Supporting Hands	N/A	N/A	N/A	N/A	3	N/A
The New Beginnings (1)	4	2	5	8	3	N/A
Tobosa (3)	13	7	7	5	15	6
Tresco (7)	36	25	39	27	7	14
Tungland (1)	4	5	N/A	N/A	N/A	N/A
Very Special Arts	N/A	N/A	N/A	N/A	N/A	1
ZEE	N/A	N/A	N/A	N/A	5	0

APPENDIX F: CPR AND IQR HISTORICAL PERSPECTIVE

The current Community Monitor has been conducting the CPR/IQR since 2004. During the past fifteen years the Department of Health, Developmental Disabilities Supports Division has, in part, developed and refined standards, policies and procedures; created the Clinical Services Bureau; attempted to keep a Medical Director engaged and in place; initiated coordinated activities intended to address aspiration and improve case management monitoring and oversight. In addition, individual findings and recommendations identified during the CPR/IQR have, during the past three years, been consistently addressed and followed up on with each individual's team. The Division reports that it has also tracked and engaged specific providers regarding repeat findings and recommendations. These actions, as well as others not identified here, are recognized.

The foundation upon which CPR/IQR historical and current information rests comes from multiple sources and is reviewed by hundreds of individuals before it becomes final to ensure accuracy and fairness. CPR/IQR fact finding and reporting during the past 15 years has included:

9,955 interviews to inform both historical and current information related to each individual in the review. Interviews enabled reviewers to find as well as verify information. Those interviewed include the individual receiving services, available guardians, day and residential staff identified as knowing the person best, the person's case manager and others such as the nurse, physical therapist, occupational therapist, speech therapist and behavior support consultant working with the individual.

84 regional staff meetings with the Community Monitor to review individual findings and recommendations in advance of initial publication. Regional staff receive copies of the individual findings and recommendations in advance of these meetings. During the meeting, regional staff are provided with the opportunity to challenge findings, provide additional information and suggest different recommendations.

1,304 team meetings with the Community Monitor. Weeks prior to these meetings the team receives a draft copy of the person's findings and recommendations. During the meeting with the Community Monitor, team members have the opportunity to review individual findings and recommendations, challenge the findings, offer additional information, and offer different recommendations.

1,391 individual class member reports issued. These findings include detailed information regarding each person's history and current circumstances as well as issues identified which need attention. These individual findings identify which day, residential and/or case management agency support the individual and, therefore, which agency must be involved in resolving each issue.

90 region specific reports issued. Each region receives a draft report one week in advance of it being issued to the parties as final. That offers the region the opportunity to identify questions and/or challenge aggregate findings prior to the final regional report being issued.

14 Statewide reports issued. This is one of those reports. These reports offer the Department/Division detailed systemic information from which it may initiate corrective action at the provider and/or systems level. The historical information included in these reports provides clear indications of where there has/has not been improvement.

APPENDIX G: ADDITIONAL CHARTS DETAILING JCM ISSUES

Chart #75: Number of Issues with Individual Screen/Assessment by Residential Agency

Agency	Annual Physical not accurate/ complete	AIMS/TD Screen needed	Vision: Not Current/ Missing/ Inaccurate	Audiology: Not Current/ Missing/ Inaccurate	Dental: Assessment missing/ needed	Dental/oral hygiene poor/ undetermined	Various labs missing	F/up with specialist not done	Statin discussion needed	X-Ray, MRI, Ultrasound, other exam not done	CIA incomplete /incorrect	Recommended Swallow study not done	Totals
Ability First (1)	0	0	0	2	0	0	0	3	0	0	0	0	5
Adelante (9)	1	0	1	0	0	0	0	1	0	0	0	0	3
Alegria (1)	0	1	0	0	0	0	0	0	0	0	0	0	1
ARCA (7)	0	1	0	2	2	0	2	2	0	1	0	1	11
Aspire (1)	0	0	1	1	0	0	0	0	0	0	0	0	2
At Home Advocacy (1)	0	0	0	0	0	0	0	0	0	0	0	0	0
AWS/ Benchmark (2)	0	0	0	0	0	0	0	0	0	0	0	0	0
Bright Horizons (2)	0	1	0	0	0	0	0	0	0	0	0	0	1
CARC (1)	0	0	1	1	0	0	0	0	0	0	0	0	2
CDD (1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Options (3)	1	2	0	1	0	4	1	2	0	0	0	0	11
Cornucopia (1)	0	0	0	0	0	0	0	1	0	0	0	0	1
Dungarvin (7)	0	5	0	1	0	0	2	0	0	1	0	0	9
ENMRSH (2)	0	0	0	0	0	0	0	0	0	0	0	0	0
Ensuenos (ELADC) (1)	0	0	1	1	0	0	0	2	0	0	0	0	4
Expressions of Life (3)	0	1	0	0	0	0	0	0	0	0	1	0	2
Family Options (1)	0	0	0	1	0	0	0	0	0	0	0	0	1
Leaders (1)	0	0	0	0	1	0	0	0	0	0	0	0	1
Lessons of Life (3)	0	1	0	2	0	0	0	0	0	0	0	0	3
LLCP (9)	0	2	0	0	2	0	0	7	0	4	0	0	15
MaxCare (2)	0	0	0	0	0	0	0	1	0	0	0	0	1
Mi Via (5)	0	1	0	0	1	0	0	0	1	2	0	0	5
Nezzy Care (2)	1	0	0	0	0	0	0	1	0	0	0	0	2
NNMQC (1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Opti Health (2)	0	0	0	0	0	1	0	2	0	0	0	0	3

Agency	Annual Physical not accurate/ complete	AIMS/TD Screen needed	Vision: Not Current/ Missing/ Inaccurate	Audiology: Not Current/ Missing/ Inaccurate	Dental: Assessment missing/ needed	Dental/oral hygiene poor/ undetermined	Various labs missing	F/up with specialist not done	Statin discussion needed	X-Ray, MRI, Ultrasound, other exam not done	CIA incomplete /incorrect	Recommended Swallow study not done	Totals
PRS (1)	0	0	1	1	0	0	1	0	0	0	0	0	3
Ramah Care (1)	0	0	0	0	0	0	0	1	0	0	0	0	1
Su Vida (1)	0	0	0	0	0	0	0	0	0	0	0	0	0
The New Beginnings (4)	1	2	1	0	3	0	0	0	0	3	0	0	10
TLC (1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Tobosa (3)	2	0	1	1	0	0	1	0	0	0	0	0	5
Tresco (4)	0	0	0	2	0	0	2	0	0	0	0	0	4
Tungland (3)	0	0	0	0	0	0	0	1	0	0	0	0	1
Totals	6	17	7	16	9	5	9	24	1	11	1	1	107

Chart #76: Number Issues with Standard Assessment/Screen/Vaccination Recommended by Healthfinder.org, by Residential Agency

Agency	Bone Density/ Dexa: Not Current/ Missing/ Inaccurate	Hep B/ Hep C vaccine not done	Shingles vaccine not done	Pneumonia vaccine not done	Colon cancer screen not done	TDap not done	HIV Testing not done	Flu vaccine not done	Pap smear /well woman exam not done	Mammogram/ Breast exam not done	Totals
Ability First (1)	0	0	0	0	0	0	0	0	0	0	0
Adelante (9)	1	0	0	0	2	0	0	0	3	1	7
Alegria (1)	0	1	0	0	0	0	0	1	0	0	2
ARCA (7)	0	1	1	1	1	1	0	1	0	0	6
Aspire (1)	0	0	0	0	0	0	0	0	0	0	0
At Home Advocacy (1)	0	1	0	0	0	0	1	0	0	0	2
AWS/ Benchmark (2)	0	1	0	1	0	0	0	1	0	0	3
Bright Horizons (2)	0	1	0	0	0	0	1	0	0	0	2
CARC (1)	0	1	1	1	0	0	1	0	0	0	4
CDD (1)	0	0	1	0	0	1	0	0	0	0	2
Community Options (3)	2	3	2	0	1	1	0	2	1	1	13
Cornucopia (1)	0	0	0	0	0	0	0	0	0	0	0
Dungarvin (7)	2	3	4	2	3	1	3	1	0	2	21
ENMRSH (2)	0	0	0	0	1	1	0	1	0	0	3

Agency	Bone Density/ Dexa: Not Current/ Missing/ Inaccurate	Hep B/ Hep C vaccine not done	Shingles vaccine not done	Pneumonia vaccine not done	Colon cancer screen not done	TDap not done	HIV Testing not done	Flu vaccine not done	Pap smear /well woman exam not done	Mammogram/ Breast exam not done	Totals
Ensuenos (ELADC) (1)	1	1	0	0	1	0	0	0	0	0	3
Expressions of Life (3)	1	3	3	1	0	1	2	1	1	0	13
Family Options (1)	0	1	1	1	0	1	0	0	0	0	4
Leaders (1)	1	1	0	0	1	0	0	0	0	0	3
Lessons of Life (3)	2	2	0	0	1	1	0	0	0	0	6
LLCP (9)	2	5	2	1	5	2	2	0	0	0	19
MaxCare (2)	0	0	0	0	0	0	0	0	0	0	0
Mi Via (5)	2	6	4	3	2	4	2	1	0	0	24
Nezzy Care (2)	0	1	0	1	0	1	0	0	0	0	3
NNMQC (1)	0	1	0	0	0	0	0	0	0	0	1
Opti Health (2)	1	1	2	0	1	0	1	0	2	0	8
PRS (1)	0	0	0	0	0	0	0	1	0	0	1
Ramah Care (1)	0	2	0	0	0	0	0	0	0	0	2
Su Vida (1)	0	0	0	0	0	0	0	0	0	0	0
The New Beginnings (4)	1	0	0	1	2	0	0	0	0	0	4
TLC (1)	0	0	0	0	0	0	0	0	0	0	0
Tobosa (3)	1	1	1	0	0	0	1	0	0	0	4
Tresco (4)	0	1	1	0	1	1	0	0	0	0	4
Tungland (3)	2	1	1	0	2	0	0	0	2	0	8
Totals	19	39	24	13	24	16	14	10	9	4	172

Chart #77: Number Issues with Medication Records and Administration, by Residential Agency

Agency	MAAT incorrect/ inconsistent	MAR Charting errors	Meds not administered as required	MAR/ Medication/ Dr. Order do not match	Med delivery instructions unclear	Medication not available (Rx or PRN)	Med found in home but not on MAR	Meds purpose not listed	Medication orders duplicated	Expired meds found in med box/home	Totals
Ability First (1)	0	0	0	0	0	0	0	0	0	0	0
Adelante (9)	0	0	0	2	0	0	0	0	0	0	2
Alegria (1)	0	0	0	1	0	0	0	0	0	2	3
ARCA (7)	0	0	0	0	0	0	0	0	0	0	0

Agency	MAAT incorrect/ inconsistent	MAR Charting errors	Meds not administered as required	MAR/ Medication/ Dr. Order do not match	Med delivery instructions unclear	Medication not available (Rx or PRN)	Med found in home but not on MAR	Meds purpose not listed	Medication orders duplicated	Expired meds found in med box/home	Totals
Aspire (1)	0	0	0	0	0	0	0	0	0	0	0
At Home Advocacy (1)	0	0	0	0	0	0	0	0	0	0	0
AWS/ Benchmark (2)	0	0	1	0	0	0	0	0	0	0	1
Bright Horizons (2)	1	0	0	0	0	0	0	0	0	0	1
CARC (1)	0	0	0	0	0	0	0	0	0	0	0
CDD (1)	0	0	0	0	0	0	0	0	0	0	0
Community Options (3)	1	0	45	10	0	0	0	0	0	0	56
Cornucopia (1)	0	0	0	3	0	0	0	0	0	0	3
Dungarvin (7)	0	0	0	3	1	1	0	0	0	0	5
ENMRSH (2)	0	0	0	0	0	0	0	0	0	0	0
Ensuenos (ELADC) (1)	0	0	1	1	0	0	0	0	0	0	2
Expressions of Life (3)	0	0	12	1	2	5	0	0	0	0	20
Family Options (1)	0	0	0	5	0	0	0	0	0	0	5
Leaders (1)	0	0	0	0	0	0	0	0	0	0	0
Lessons of Life (3)	0	0	0	0	0	0	0	0	0	0	0
LLCP (9)	7	13	0	10	4	1	1	0	0	0	36
MaxCare (2)	0	0	1	0	0	0	0	0	0	0	1
Mi Via (5)	0	0	0	0	0	0	0	0	0	0	0
Nezzy Care (2)	0	0	2	8	0	5	0	0	0	0	15
NNMQC (1)	0	0	0	0	0	0	0	0	0	0	0
Opti Health (2)	1	0	0	8	0	0	0	0	0	0	9
PRS (1)	0	0	0	0	0	0	0	0	0	0	0
Ramah Care (1)	0	0	0	0	0	0	0	0	0	0	0
Su Vida (1)	0	0	0	0	0	0	0	0	0	0	0
The New Beginnings (4)	1	0	3	5	2	1	0	0	0	0	12
TLC (1)	0	0	10	0	0	0	0	0	0	0	10
Tobosa (3)	0	0	0	22	2	3	0	2	1	2	32
Tresco (4)	0	0	0	3	0	4	0	0	0	1	8

Agency	MAAT incorrect/ inconsistent	MAR Charting errors	Meds not administered as required	MAR/ Medication/ Dr. Order do not match	Med delivery instructions unclear	Medication not available (Rx or PRN)	Med found in home but not on MAR	Meds purpose not listed	Medication orders duplicated	Expired meds found in med box/home	Totals
Tungland (3)	0	0	0	0	0	0	0	0	0	0	0
Totals	11	13	75	82	11	20	1	2	1	5	221

Chart #78: Issues Identified in Relation to Individuals' Tracking needs, by Residential Agency

Residential Agency	Bowel/ Bladder Tracking Issues	Weight not tracked	O2 Tracking not done	Tube residual tracking not provided	Fluid tracking issues	Sodium Tracking inconsistent/ inaccurate	Vitals tracking not consistent /incomplete	Seizure tracking not consistent	Repositioning not completed	Glucose tracking inconsistent	Totals
Ability First (1)	3	1	0	0	0	0	0	0	0	0	4
Adelante (9)	11	1	0	0	0	0	0	0	0	0	12
Alegria (1)	0	0	0	0	0	0	0	0	0	0	0
ARCA (7)	4	0	0	0	0	0	0	0	0	0	4
Aspire (1)	2	0	0	0	0	0	0	0	0	0	2
At Home Advocacy (1)	0	0	0	0	0	0	0	0	0	0	0
AWS/ Benchmark (2)	80	1	0	0	1	0	0	0	0	0	82
Bright Horizons (2)	0	0	0	0	0	0	0	0	0	0	0
CARC (1)	0	0	0	0	0	0	0	0	0	0	0
CDD (1)	0	1	0	0	0	0	0	0	0	0	1
Community Options (3)	37	8	0	0	6	0	0	0	0	0	51
Cornucopia (1)	0	1	0	0	0	0	0	0	0	0	1
Dungarvin (7)	3	0	0	0	0	0	2	0	1	0	6
ENMRSH (2)	0	0	0	0	0	0	0	0	0	0	0
Ensuenos (ELADC) (1)	17	0	0	0	4	0	0	0	0	0	21
Expressions of Life (3)	0	5	0	0	0	0	1	0	0	0	6
Family Options (1)	0	0	0	0	0	0	0	0	0	0	0
Leaders (1)	1	0	0	0	0	0	0	0	0	0	1
Lessons of Life (3)	0	1	0	0	0	0	0	0	0	0	1
LLCP (9)	5	10	0	0	0	0	2	0	0	1	18
MaxCare (2)	0	0	0	0	0	0	0	0	0	0	0
Mi Via (5)	0	0	0	0	0	0	0	1	0	0	1
Nezzy Care (2)	0	0	0	0	0	1	0	0	0	0	1
NNMQC (1)	0	0	0	0	0	0	0	0	0	0	0
Opti Health (2)	6	1	0	0	0	0	0	1	0	1	9
PRS (1)	0	0	0	0	0	0	0	0	0	0	0

Residential Agency	Bowel/ Bladder Tracking Issues	Weight not tracked	O2 Tracking not done	Tube residual tracking not provided	Fluid tracking issues	Sodium Tracking inconsistent/ inaccurate	Vitals tracking not consistent /incomplete	Seizure tracking not consistent	Repositioning not completed	Glucose tracking inconsistent	Totals
Ramah Care (1)	0	0	0	0	0	0	0	0	0	0	0
Su Vida (1)	0	0	0	0	0	0	0	0	0	0	0
The New Beginnings (4)	0	2	0	0	0	0	1	0	0	0	3
TLC (1)	0	0	0	0	0	0	0	0	0	0	0
Tobosa (3)	8	2	0	0	0	0	2	0	0	0	12
Tresco (4)	1	0	1	1	0	0	0	0	0	0	3
Tungland (3)	0	0	0	0	0	0	0	0	0	0	0
Totals	178	34	1	1	11	1	8	2	1	2	239

Chart #79: Issues Identified in Relation to eChats, HCPs, MERPs, ARST and CARMPs, by Residential Agency

Residential Agency	MERPs/HCPs Not found/not specific/incorrect	eChat incorrect/ incomplete	MTP/CARMP not implemented correctly	CARMP inaccurate/ incomplete/not current	Inconsistency between HCP/CARMP/MERP/eChat	ARST contains inaccurate info	Totals
Ability First (1)	3	17	0	6	0	5	31
Adelante (9)	12	22	0	12	0	0	46
Alegria (1)	0	0	0	13	0	0	13
ARCA (7)	19	28	0	10	5	0	62
Aspire (1)	0	2	0	0	0	0	2
At Home Advocacy (1)	0	1	0	1	1	0	3
AWS/ Benchmark (2)	8	9	0	0	8	0	25
Bright Horizons (2)	6	2	0	3	4	1	16
CARC (1)	2	0	0	0	0	0	2
CDD (1)	0	17	0	0	0	0	17
Community Options (3)	20	33	0	5	3	0	61
Cornucopia (1)	4	11	0	0	1	0	16
Dungarvin (7)	25	43	3	4	6	0	81
ENMRSH (2)	0	7	0	2	0	0	9
Ensuenos (ELADC) (1)	7	0	0	9	0	0	16
Expressions of Life (3)	9	42	0	0	8	2	61
Family Options (1)	2	9	1	2	3	0	17
Leaders (1)	0	0	1	0	0	0	1
Lessons of Life (3)	0	3	0	2	0	0	5
LLCP (9)	18	35	0	8	4	4	69
MaxCare (2)	0	8	0	0	0	0	8

Residential Agency	MERPs/HCPs Not found/not specific/incorrect	eChat incorrect/ incomplete	MTP/CARMP not implemented correctly	CARMP inaccurate/ incomplete/not current	Inconsistency between HCP/CARMP/MERP/eChat	ARST contains inaccurate info	Totals
Mi Via (5)	7	0	0	4	8	0	19
Nezzy Care (2)	2	3	0	0	0	1	6
NNMQC (1)	4	4	0	0	0	0	8
Opti Health (2)	9	12	1	3	4	0	29
PRS (1)	1	0	0	3	0	0	4
Ramah Care (1)	7	3	0	0	1	0	11
Su Vida (1)	0	0	0	0	0	0	0
The New Beginnings (4)	8	15	0	6	8	2	39
TLC (1)	5	1	0	0	0	0	6
Tobosa (3)	12	2	1	3	6	0	24
Tresco (4)	14	8	0	8	0	0	30
Tungland (3)	5	3	0	2	3	0	13
Totals	209	340	7	106	73	15	750

Chart #80: Type of Nursing Related Issues Identified by Residential Agency

Residential Agency	Annual/ Quarterly/ Monthly report not timely or missing	Nurse report not accurate/missing information	Nurse not monitoring as required	Nurse not familiar with health needs during interview	Nurse not at IDT Meeting as required	Nursing not providing info to team/ PCP as needed	Totals
Ability First (1)	3	1	4	0	0	1	9
Adelante (9)	8	2	0	0	0	0	10
Alegria (1)	1	0	0	0	0	0	1
ARCA (7)	4	5	3	0	0	0	12
Aspire (1)	0	0	1	0	0	2	3
At Home Advocacy (1)	0	0	0	0	0	0	0
AWS/ Benchmark (2)	10	10	2	0	0	0	22
Bright Horizons (2)	0	0	1	0	0	0	1
CARC (1)	0	0	0	0	0	0	0
CDD (1)	0	12	8	0	0	0	20
Community Options (3)	9	10	2	1	0	0	22
Cornucopia (1)	0	0	0	0	0	0	0
Dungarvin (7)	3	9	3	0	0	1	16
ENMRSH (2)	0	2	0	0	0	0	2
Ensuenos (ELADC) (1)	2	1	0	0	0	0	3

Residential Agency	Annual/ Quarterly/ Monthly report not timely or missing	Nurse report not accurate/missing information	Nurse not monitoring as required	Nurse not familiar with health needs during interview	Nurse not at IDT Meeting as required	Nursing not providing info to team/ PCP as needed	Totals
Expressions of Life (3)	5	4	5	3	0	1	18
Family Options (1)	2	3	30	0	0	0	35
Leaders (1)	0	3	2	0	0	0	5
Lessons of Life (3)	2	0	2	0	0	0	4
LLCP (9)	32	17	15	0	0	1	65
MaxCare (2)	0	0	0	0	0	0	0
Mi Via (5)	0	0	0	0	0	0	0
Nezzy Care (2)	7	1	0	0	0	0	8
NNMQC (1)	0	2	0	0	0	0	2
Opti Health (2)	1	4	11	0	0	2	18
PRS (1)	4	0	1	0	0	0	5
Ramah Care (1)	4	0	0	0	0	0	4
Su Vida (1)	1	0	1	0	0	0	2
The New Beginnings (4)	10	6	2	0	0	7	25
TLC (1)	1	5	3	0	0	1	10
Tobosa (3)	0	2	3	0	0	6	11
Tresco (4)	12	0	3	2	1	2	20
Tungland (3)	2	12	2	0	0	0	16
Totals	123	111	104	6	1	24	369

Chart #81: Issues Found with Therapies, Behavior Support and Nutrition, by Residential Agency

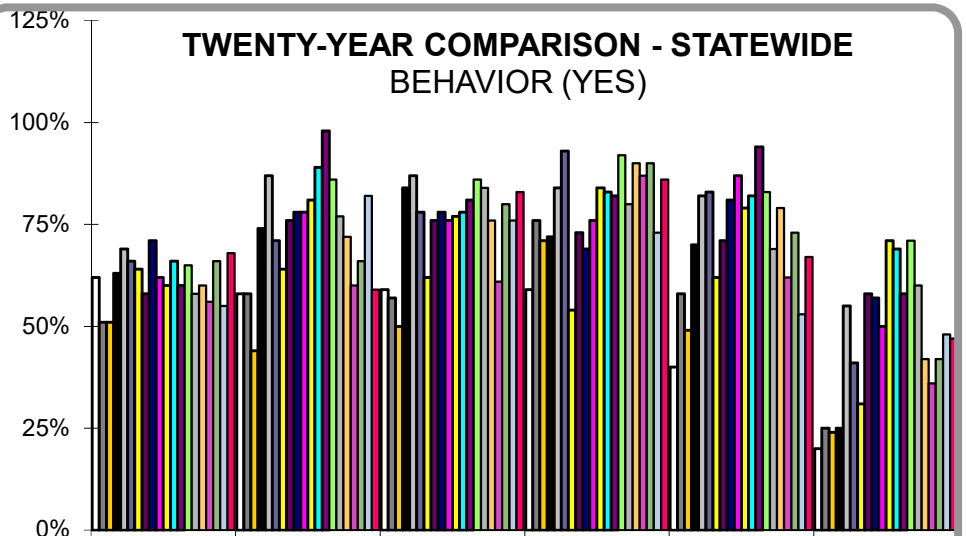
Residential Agency	Evaluation does not identify baseline/ measure progress				Evaluation not provided for review /missing				Report (Annual/Semi) inaccurate/inadequate				Report not found/ provided; missing		Services not consistently provided, are needed				Nutrition Reports late Missing /Inaccurate	Totals
	PT	OT	SLP	BSC	PT	OT	SLP	BSC	PT	OT	SLP	BSC	PT	SLP	PT	OT	SLP	BSC		
Ability First (1)	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2
Adelante (9)	0	2	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	2	6
Alegria (1)	0	1	0	2	0	0	0	1	0	0	1	1	0	0	0	0	0	0	0	6
ARCA (7)	0	0	0	6	0	0	0	4	4	1	3	2	0	1	0	1	0	0	3	25
Aspire (1)	0	0	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3
At Home Advocacy (1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AWS/ Benchmark (2)	0	1	1	1	1	0	0	1	0	0	0	1	0	0	0	0	0	0	1	7

Residential Agency	Evaluation does not identify baseline/ measure progress				Evaluation not provided for review /missing				Report (Annual/Semi) inaccurate/inadequate				Report not found/ provided; missing		Services not consistently provided, are needed				Nutrition Reports late Missing /Inaccurate	Totals
	PT	OT	SLP	BSC	PT	OT	SLP	BSC	PT	OT	SLP	BSC	PT	SLP	PT	OT	SLP	BSC		
Bright Horizons (2)	0	0	3	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	5
CARC (1)	0	0	0	0	0	0	2	0	0	2	0	0	1	0	0	0	0	0	1	6
CDD (1)	2	0	1	0	0	0	0	0	2	0	1	0	0	1	0	0	0	0	0	7
Community Options (3)	1	2	3	1	2	1	0	1	1	2	1	0	2	2	0	0	0	0	5	24
Cornucopia (1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dungarvin (7)	2	5	1	0	0	0	0	1	0	1	0	2	0	0	0	0	0	0	3	15
ENMRSH (2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ensuenos (ELADC) (1)	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	3
Expressions of Life (3)	1	3	1	2	0	0	0	0	1	1	1	1	0	0	0	0	0	0	5	16
Family Options (1)	1	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	3
Leaders (1)	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Lessons of Life (3)	0	0	0	0	0	0	1	0	0	0	2	1	0	0	3	3	2	2	0	14
LLCP (9)	9	3	5	2	0	0	0	8	0	1	4	4	0	0	0	0	0	0	5	41
MaxCare (2)	2	0	1	2	0	0	0	1	1	0	1	3	0	1	0	0	0	1	0	13
Mi Via (5)	0	0	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Nezzy Care (2)	0	0	0	1	1	1	1	0	0	0	0	2	0	0	0	0	0	0	0	6
NNMQC (1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Opti Health (2)	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
PRS (1)	0	1	0	0	0	0	0	0	1	2	1	0	0	0	0	0	0	0	0	5
Ramah Care (1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	3
Su Vida (1)	0	0	0	1	0	0	0	1	0	0	0	3	0	1	0	0	0	0	0	6
The New Beginnings (4)	0	0	0	0	0	0	0	2	0	1	0	0	1	0	0	0	0	0	1	5
TLC (1)	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Tobosa (3)	3	0	2	5	1	1	0	1	2	0	3	0	1	0	0	0	0	0	0	19
Tresco (4)	1	0	0	0	0	0	0	0	2	1	1	3	0	0	0	0	0	0	2	10
Tungland (3)	0	3	2	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	7
Totals	23	24	21	26	9	6	5	21	16	12	24	24	5	6	4	5	3	4	29	267

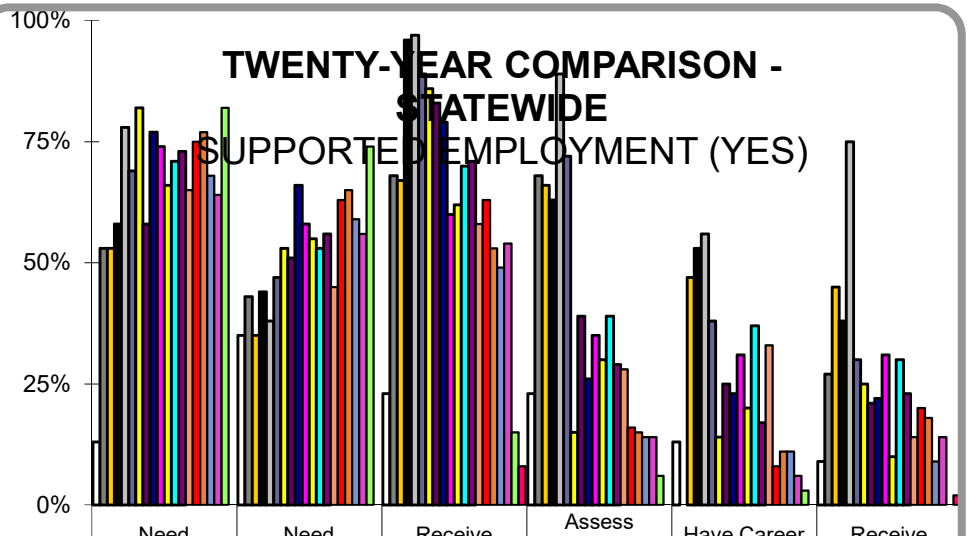
Chart # 82: Number Issues with Medication Records and Administration, by Residential Agency

Agency	MAAT incorrect/ inconsistent	MAR Charting errors	Meds not administered as required	MAR/ Medication/ Dr. Order do not match	Med delivery instructions unclear	Medication not available (Rx or PRN)	Med found in home but not on MAR	Meds purpose not listed	Medication orders duplicated	Expired meds found in med box/home	Totals
Ability First (1)	0	0	0	0	0	0	0	0	0	0	0
Adelante (9)	0	0	0	2	0	0	0	0	0	0	2
Alegria (1)	0	0	0	1	0	0	0	0	0	2	3
ARCA (7)	0	0	0	0	0	0	0	0	0	0	0
Aspire (1)	0	0	0	0	0	0	0	0	0	0	0
At Home Advocacy (1)	0	0	0	0	0	0	0	0	0	0	0
AWS/ Benchmark (2)	0	0	1	0	0	0	0	0	0	0	1
Bright Horizons (2)	1	0	0	0	0	0	0	0	0	0	1
CARC (1)	0	0	0	0	0	0	0	0	0	0	0
CDD (1)	0	0	0	0	0	0	0	0	0	0	0
Community Options (3)	1	0	45	10	0	0	0	0	0	0	56
Cornucopia (1)	0	0	0	3	0	0	0	0	0	0	3
Dungarvin (7)	0	0	0	3	1	1	0	0	0	0	5
ENMRSH (2)	0	0	0	0	0	0	0	0	0	0	0
Ensuenos (ELADC) (1)	0	0	1	1	0	0	0	0	0	0	2
Expressions of Life (3)	0	0	12	1	2	5	0	0	0	0	20
Family Options (1)	0	0	0	5	0	0	0	0	0	0	5
Leaders (1)	0	0	0	0	0	0	0	0	0	0	0
Lessons of Life (3)	0	0	0	0	0	0	0	0	0	0	0
LLCP (9)	7	13	0	10	4	1	1	0	0	0	36
MaxCare (2)	0	0	1	0	0	0	0	0	0	0	1
Mi Via (5)	0	0	0	0	0	0	0	0	0	0	0
Nezzy Care (2)	0	0	2	8	0	5	0	0	0	0	15
NNMQC (1)	0	0	0	0	0	0	0	0	0	0	0
Opti Health (2)	1	0	0	8	0	0	0	0	0	0	9
PRS (1)	0	0	0	0	0	0	0	0	0	0	0

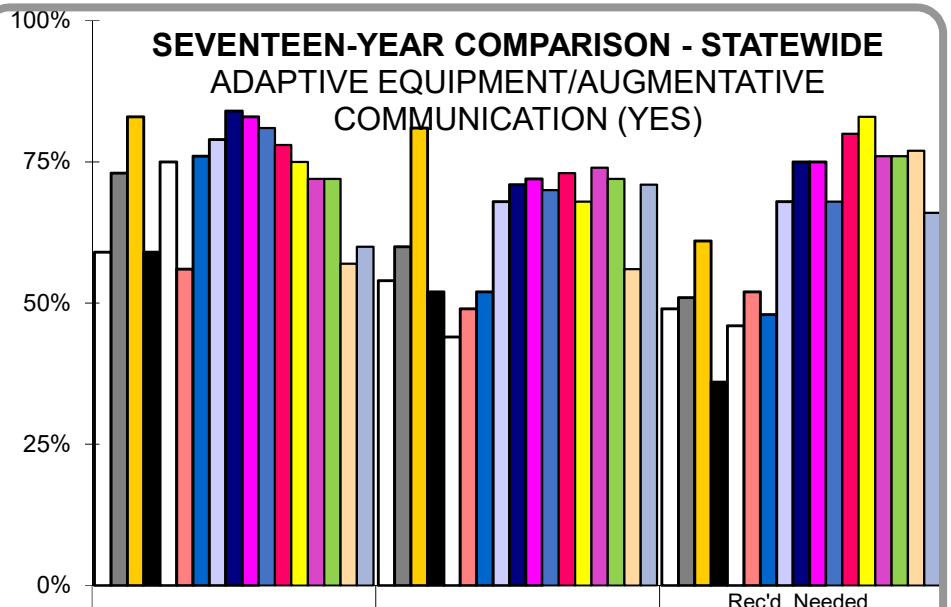
Agency	MAAT incorrect/ inconsistent	MAR Charting errors	Meds not administered as required	MAR/ Medication/ Dr. Order do not match	Med delivery instructions unclear	Medication not available (Rx or PRN)	Med found in home but not on MAR	Meds purpose not listed	Medication orders duplicated	Expired meds found in med box/home	Totals
Ramah Care (1)	0	0	0	0	0	0	0	0	0	0	0
Su Vida (1)	0	0	0	0	0	0	0	0	0	0	0
The New Beginnings (4)	1	0	3	5	2	1	0	0	0	0	12
TLC (1)	0	0	10	0	0	0	0	0	0	0	10
Tobosa (3)	0	0	0	22	2	3	0	2	1	2	32
Tresco (4)	0	0	0	3	0	4	0	0	0	1	8
Tungland (3)	0	0	0	0	0	0	0	0	0	0	0
Totals	11	13	75	82	11	20	1	2	1	5	221



	Need Behavioral Services	Behavioral Assessment Adequate	Have Behavioral Support Plan	Staff Trained on BSP	Receives Behavior Support Svs.	BS Integrated into ISP
1997	62%	58%	59%	59%	40%	20%
1998	51%	58%	57%	76%	58%	25%
1999	51%	44%	50%	71%	49%	24%
2000	63%	74%	84%	72%	70%	25%
2001	69%	87%	87%	84%	82%	55%
2002	66%	71%	78%	93%	83%	41%
2004	64%	64%	62%	54%	62%	31%
2005	58%	76%	76%	73%	71%	58%
2006	71%	78%	78%	69%	81%	57%
2007	62%	78%	76%	76%	87%	50%
2008	60%	81%	77%	84%	79%	71%
2009	66%	89%	78%	83%	82%	69%
2010	60%	98%	81%	82%	94%	58%
2011	65%	86%	86%	92%	83%	71%
2013	58%	77%	84%	80%	69%	60%
2014	60%	72%	76%	90%	79%	42%
2015	56%	60%	61%	87%	62%	36%
2016	66%	66%	80%	90%	73%	42%
2017	55%	82%	76%	73%	53%	48%
2018	68%	59%	83%	86%	67%	47%

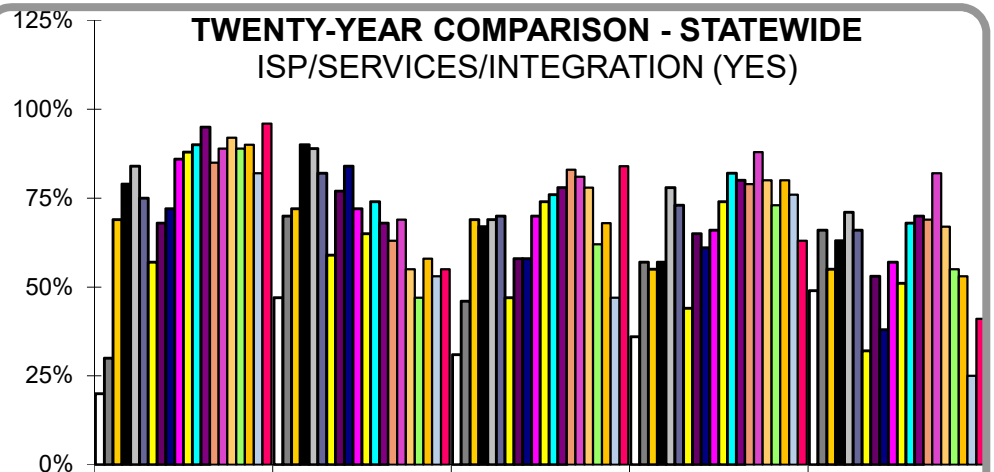


	Need Vocational Assessment	Need Supported Employment	Receive Employment Assessment	Assess Conforms to DOH/DDD Regs	Have Career Development Plan	Receive Employment Services
1997	13%	35%	23%	23%	13%	9%
1998	53%	43%	68%	68%	0%	27%
1999	53%	35%	67%	66%	47%	45%
2000	58%	44%	96%	63%	53%	38%
2001	78%	38%	97%	89%	56%	75%
2002	69%	47%	89%	72%	38%	30%
2004	82%	53%	86%	15%	14%	25%
2005	58%	51%	83%	39%	25%	21%
2006	77%	66%	79%	26%	23%	22%
2007	74%	58%	60%	35%	31%	31%
2008	66%	55%	62%	30%	20%	10%
2009	71%	53%	70%	39%	37%	30%
2010	73%	56%	71%	29%	17%	23%
2011	65%	45%	58%	28%	33%	14%
2013	75%	63%	63%	16%	8%	20%
2014	77%	65%	53%	15%	11%	18%
2015	68%	59%	49%	14%	11%	9%
2016	64%	56%	54%	14%	6%	14%
2017	82%	74%	15%	6%	3%	0%
2018			8%		0%	2%



SEVENTEEN-YEAR COMPARISON - STATEWIDE
ADAPTIVE EQUIPMENT/AUGMENTATIVE COMMUNICATION (YES)

	Rec'd. Needed Adaptive Equipment	Rec'd. Needed Assistive Technology	Rec'd. Needed Communication Assessments And Services
2000	59%	54%	49%
2001	73%	60%	51%
2002	83%	81%	61%
2004	59%	52%	36%
2005	75%	44%	46%
2006	56%	49%	52%
2007	76%	52%	48%
2008	79%	68%	68%
2009	84%	71%	75%
2010	83%	72%	75%
2011	81%	70%	68%
2013	78%	73%	80%
2014	75%	68%	83%
2015	72%	74%	76%
2016	72%	72%	76%
2017	57%	56%	77%
2018	60%	71%	66%



TWENTY-YEAR COMPARISON - STATEWIDE
ISP/SERVICES/INTEGRATION (YES)

	ISP addresses live, work/ learn, fun/ relationship & health/ other…	PTRLTV Based on long-term view	Person receives services & supports recommended in ISP	Adequate Use of Generic Services	Person Integrated into Community
1997	20%	47%	31%	36%	49%
1998	30%	70%	46%	57%	66%
1999	69%	72%	69%	55%	55%
2000	79%	90%	67%	57%	63%
2001	84%	89%	69%	78%	71%
2002	75%	82%	70%	73%	66%
2004	57%	59%	47%	44%	32%
2005	68%	77%	58%	65%	53%
2006	72%	84%	58%	61%	38%
2007	86%	72%	70%	66%	57%
2008	88%	65%	74%	74%	51%
2009	90%	74%	76%	82%	68%
2010	95%	68%	78%	80%	70%
2011	85%	63%	83%	79%	69%
2013	89%	69%	81%	88%	82%
2014	92%	55%	78%	80%	67%
2015	89%	47%	62%	73%	55%
2016	90%	58%	68%	80%	53%
2017	82%	53%	47%	76%	25%
2018	96%	55%	84%	63%	41%

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
Case Management						
24. Does the case manager "know" the person? CPRQ26; '17IQR#8c	95% Yes (97) 5% Partial (5)	93% Yes (90) 6% Partial (6) 1% No (1)	95% Yes (91) 5% Partial (5)	88% Yes (79) 11% Partial (10) 1% No (1)	79% Yes (49) 19% Many (12) 2% Need Impv (1)	88% Yes (72) 9% Many (7) 4% Needs Impv (3)
25. Does the case manager understand his/her role/job? CPRQ27 '17IQR#16	51% Yes (52) 49% Partial (50)	48% Yes (47) 52% Partial (50)	56% Yes (54) 44% Partial (42)	56% Yes (50) 44% Partial (40)	3% Yes (2) 55% Many (34) 42% Need Impv (26)	33% Yes (27) 45% Many (37) 22% Needs Impv (18)
26. Did the case manager receive training on the topics needed to assist him/her in meeting the needs of this person? CPRQ28	80% Yes (82) 20% Partial (20)	79% Yes (77) 21% Partial (20)	86% Yes (83) 14% Partial (13)	82% Yes (74) 18% Partial (16)		76% Yes (62) 17% Many (14) 7% Needs Impv (6)
27. Is the case manager available to the person? CPRQ29; '17IQR#16a	86% Yes (88) 14% Partial (14)	80% Yes (78) 20% Partial (19)	82% Yes (79) 18% Partial (17)	78% Yes (70) 22% Partial (20)	74% Yes (45) 13% Many (8) 13% Need Impv (8) (1 N/A)	72% Yes (59) 26% Many (21) 2% Needs Impv (2)
28. Was the case manager able to describe the person's health related needs? CPRQ30	72% Yes (73) 28% Partial (29)	63% Yes (61) 37% Partial (36)	66% Yes (63) 34% Partial (33)	78% Yes (70) 22% Partial (20)		63% Yes (52) 27% Many (22) 10% Needs Impv (8)
29. Does the case manager have an appropriate expectation of growth for this person? CPRQ31	64% Yes (65) 35% Partial (36) 1% No (1)	51% Yes (49) 48% Partial (47) 1% No (1)	57% Yes (55) 39% Partial (37) 4% No (4)	67% Yes (60) 31% Partial (28) 2% No (2)		76% Yes (62) 20% Many (16) 4% Needs Impv (3) 1% No (1)
30. Does the case management record contain documentation that the case manager is monitoring and tracking the delivery of services as outlined in the ISP? CPRQ32; '17IQR#16b	25% Yes (25) 75% Partial (77)	30% Yes (29) 69% Partial (67) 1% No (1)	33% Yes (32) 65% Partial (62) 2% No (2)	21% Yes (19) 79% Partial (71)	5% Yes (3) 29% Man (18) 48% Need Impv (30) 18% No (11)	23% Yes (19) 38% Many (31) 39% Needs Impv (32)
31. Does the case manager provide case management services at the level needed by this person? CPRQ33; '17IQR#16c	37% Yes (38) 63% Partial (64)	39% Yes (38) 60% Partial (58) 1% No (1)	44% Yes (42) 55% Partial (53) 1% No (1)	42% Yes (38) 57% Partial (51) 1% No (1)	26% Yes (16) 34% Many (21) 40% Need Impv (25)	29% Yes (24) 48% Many (39) 23% Needs Impv (19)
32. Does the case manager receive the type and level of support needed to do his/her job? CPRQ34	91% Yes (93) 9% Partial (9)	87% Yes (84) 13% Partial (13)	88% Yes (84) 13% Partial (12)	86% Yes (77) 14% Partial (13)		76% Yes (62) 21% Many (17) 4% Needs Impv (3)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
Day/Employment						
33. Does the direct services staff "know" the person? CPRQ35; '17IQR#8a	92% Yes (94) 8% Partial (8)	96% Yes (91) 4% Partial (4) (2 not scored)	87% Yes (82) 13% Partial (12) (2 not scored)	97% Yes (84) 3% Partial (3) (3 not scored)	83% Yes (50) 10% Many (6) 7% Need Impv (4) (2 N/A)	95% Yes (75) 4% Many (3) 1% Needs Impv (1) (3 not scored)
34. Does the direct service staff have input into the person's ISP? CPRQ36	56% Yes (57) 39% Partial (40) 5% No (5)	69% Yes (64) 29% Partial (27) 2% No (2) (4 not scored)	84% Yes (79) 14% Partial (13) 2% No (2) (2 not scored)	80% Yes (70) 18% Partial (16) 1% No (1) (3 not scored)		72% Yes (57) 16% Many (13) 8% Needs Impv (6) 4% No (3) (3 not scored)
35. Did the direct service staff receive training on implementing this person's ISP? CPRQ37	81% Yes (83) 19% Partial (19)	80% Yes (75) 20% Partial (19) (3 not scored)	83% Yes (78) 16% Partial (15) 1% No (1) (2 not scored)	90% Yes (78) 10% Partial (9). (3 not scored)		75% Yes (59) 18% Many (14) 8% Needs Impv (6) (3 not scored)
36. Was the direct service staff able to describe this person's health-related needs? CPRQ38	63% Yes (64) 35% Partial (36) 2% No (2)	61% Yes (58) 39% Partial (37) (2 not scored)	48% Yes (45) 51% Partial (48) 1% No (1) (2 not scored)	76% Yes (66) 24% Partial (21) (3 not scored)		54% Yes (43) 30% Many (24) 14% Needs Impv (11) 1% No (1) (3 not scored)
37. Was the direct service staff able to describe his/her responsibilities in providing daily care/supports to the person? CPRQ39	81% Yes (83) 19% Partial (19)	78% Yes (74) 22% Partial (21) (2 not scored)	72% Yes (68) 28% Partial (26) (2 not scored)	90% Yes (78) 10% Partial (9) (3 not scored)		66% Yes (52) 28% Many (22) 6% Needs Impv (5) (3 not scored)
37a. Was the direct service staff able to provide specific information regarding the person's daily activities? CPRQ39a	93% Yes (95) 7% Partial (7)	86% Yes (82) 14% Partial (13) (2 not scored)	95% Yes (89) 5% Partial (5) (2 not scored)	95% Yes (83) 5% Partial (4) (3 not scored)		89% Yes (70) 10% Many (8) 1% No (1) (3 not scored)
37b. Can the direct service staff describe his/her responsibilities in implementing this person's ISP, including outcomes, action plans, and WDSIs? CPRQ39b	87% Yes (89) 13% Partial (13)	86% Yes (81) 13% Partial (12) 1% No (1) (3 not scored)	76% Yes (71) 23% Partial (22) 1% No (1) (2 not scored)	91% Yes (79) 9% Partial (8) (3 not scored)		68% Yes (54) 18% Many (14) 14% Needs Impv (11) (3 not scored)
38. Did the direct service staff have training in the ISP process? CPRQ40	77% Yes (79) 20% Partial (20) 3% No (3)	66% Yes (61) 32% Partial (30) 2% No (2) (4 not scored)	74% Yes (70) 22% Partial (21) 3% No (3) (2 not scored)	79% Yes (69) 21% Partial (18) (3 not scored)		65% Yes (51) 16% Many (13) 13% Needs Impv (10) 6% No (5)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
						(3 not scored)
39. Did the direct service staff have training on the provider's complaint process and how to report abuse, neglect and exploitation? CPRQ41	85% Yes (87) 14% Partial (14) 1% No (1)	80% Yes (76) 20% Partial (19) (2 not scored)	79% Yes (74) 20% Partial (19) 1% No (1) (2 not scored)	76% Yes (66) 24% Partial (21) (3 not scored)		87% Yes (69) 11% Many (9) 1% No (1) (3 not scored)
40. Does the direct service staff have an appropriate expectation of growth for this person? CPRQ42	75% Yes (77) 23% Partial (23) 2% No (2)	63% Yes (60) 35% Partial (33) 2% No (2) (2 not scored)	74% Yes (70) 21% Partial (20) 4% No (4) (2 not scored)	71% Yes (62) 26% Partial (23) 2% No (2) (3 not scored)		76% Yes (60) 16% Many (13) 5% Needs Impv (4) 3% No (2) (3 not scored)
41. Does the person's day/work environment generally clean, free of safety hazards and conducive to the work/activity intended? CPRQ43	97% Yes (98) 2% Partial (2) 1% No (1) (1 N/A)	92% Yes (87) 8% Partial (8) (2 not scored)	95% Yes (89) 5% Partial (5) (2 not scored)	94% Yes (78) 6% Partial (5) (4 CND) (3 not scored)		92% Yes (73) 8% Many (6) (3 not scored)
Residential/Living Services						
42. Does the residential direct services staff "know" the person? CPRQ44; '17IQR#8b	97% Yes (99) 3% Partial (3)	98% Yes (95) 2% Partial (2)	92% Yes (88) 8% Partial (8)	96% Yes (86) 4% Partial (4)	89% Yes (54) 3% Many (2) 8% Need Impv (5) (1 CND)	95% Yes (78) 2% Many (2) 2% Needs Impv (2)
43. Does the direct service staff have input into the person's ISP? CPRQ45	75% Yes (77) 20% Partial (20) 5% No (5)	74% Yes (71) 24% Partial (23) 2% No (2) (1 not scored)	89% Yes (85) 10% Partial (10) 1% No (1)	84% Yes (76) 16% Partial (14)		79% Yes (65) 11% Many (9) 5% Needs Impv (4) 5% No (4)
44. Did the direct service staff receive training on implementing this person's ISP? CPRQ46	81% Yes (83) 18% Partial (18) 1% No (1)	88% Yes (84) 13% Partial (12) (1 not scored)	89% Yes (85) 11% Partial (11)	91% Yes (82) 8% Partial (7) 1% No (1)		79% Yes (65) 16% Many (13) 5% Needs Impv (4)
45. Is the residence safe for individuals (void of hazards)? CPRQ47	91% Yes (93) 9% No (9)	93% Yes (90) 7% No (7)	99% Yes (95) 1% No (1)	89% Yes (80) 11% No (10)		87% Yes (71) 10% Many (8) 4% Needs Impv (3)
46. Was the residential direct service staff able to describe this person's health-related needs? CPRQ48	66% Yes (67) 33% Partial (34) 1% No (1)	58% Yes (56) 41% Partial (40) 1% No (1)	60% Yes (58) 39% Partial (37) 1% No (1)	79% Yes (71) 21% Partial (19)		59% Yes (48) 35% Many (29) 6% Needs Impv (5)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
47. Was the direct service staff able to describe his/her responsibilities in providing daily care/supports to the person? CPRQ49	77% Yes (79) 23% Partial (23)	81% Yes (79) 19% Partial (18)	84% Yes (81) 16% Partial (15)	88% Yes (79) 12% Partial (11)		73% Yes (60) 26% Many (21) 1% Needs Impv (1)
47a. Was the direct service staff able to provide specific information regarding the person's daily activities? CPRQ49a	96% Yes (98) 4% Partial (4)	94% Yes (90) 6% Partial (6) (1 not scored)	96% Yes (92) 4% Partial (4)	99% Yes (89) 1% Partial (1)		94% Yes (77) 6% Many (5)
47b. Can the direct service staff describe his/her responsibilities in implementing this person's ISP, including outcomes, action plans, and WDSIs? CPRQ49b	79% Yes (80) 21% Partial (21)	83% Yes (80) 16% Partial (15) 1% No (1) (1 not scored)	86% Yes (83) 14% Partial (13)	87% Yes (78) 12% Partial (11) 1% No (1)		72% Yes (59) 26% Many (21) 1% Needs Impv (1) 1% No (1)
48. Did the residential direct service staff have training in the ISP process? CPRQ50	72% Yes (73) 22% Partial (22) 7% No (7)	72% Yes (68) 25% Partial (24) 3% No (3) (2 not scored)	79% Yes (76) 17% Partial (16) 4% No (4)	79% Yes (71) 19% Partial (17) 2% No (2)		63% Yes (52) 21% Many (17) 9% Needs Impv (7) 7% No (6)
49. Did the direct service staff have training on the provider's complaint process and how to report abuse, neglect and exploitation? CPRQ51	84% Yes (86) 16% Partial (16)	87% Yes (84) 13% Partial (13)	78% Yes (75) 21% Partial (20) 1% No (1)	80% Yes (72) 20% Partial (18)		96% Yes (79) 1% Many (1) 1% Needs Impv (1) 1% No (1)
50. Does the residential direct service staff have an appropriate expectation of growth for this person? CPRQ52	68% Yes (69) 32% Partial (33)	60% Yes (58) 36% Partial (35) 4% No (4)	66% Yes (63) 31% Partial (30) 3% No (3)	80% Yes (72) 18% Partial (16) 2% No (2)		77% Yes (63) 16% Many (13) 4% Needs Impv (3) 4% No (3)
51. Does the person's residential environment offer a minimal level of quality of life? CPRQ53	91% Yes (93) 9% Partial (9)	86% Yes (83) 13% Partial (13) 1% No (1)	88% Yes (84) 13% Partial (12)	88% Yes (79) 12% Partial (11)		82% Yes (67) 15% Many (12) 4% Needs Impv (3)
Health						
52. Overall, were the team members interviewed able to describe the person's health-related needs? CPRQ54; '17IQR#21b	39% Yes (40) 61% Partial (62)	31% Yes (30) 69% Partial (67)	33% Yes (31) 67% Partial (64) (1 not scored)	59% Yes (53) 41% Partial (37)	66% Yes (41) 24% Many (15) 8% Need Impv (5) 2% No (1)	33% Yes (27) 60% Many (49) 7% Needs Impv (6)
53. Is there evidence that the IDT discussed the person's health related issues? CPRQ55; '17IQR#21	64% Yes (65) 36% Partial (37)	53% Yes (51) 47% Partial (46)	47% Yes (45) 53% Partial (50) (1 not scored)	38% Yes (34) 62% Partial (56)	18% Yes (11) 66% Many (41) 16% Need Impv (10)	33% Yes (27) 44% Many (36) 23% Needs Impv (19)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
54. Was the eChat updated timely? '17IQR#18g					40% Yes (25) 27% Many (17) 29% Need Impv (18) 3% No (2)	48% Yes (39) 20% Many (16) 23% Needs Impv (19) 10% No (8)
55. Are all of the individual's needed medical treatments timely received? 17IQR#19					23% Yes (14) 48% Many (30) 29% Need Impv (18)	30% Yes (25) 50% Many (41) 17% Needs Impv (14) 2% No (2)
56. Does the individual receive routine/scheduled medical treatment? 17IQR#19a					61% Yes (37) 20% Many (12) 18% Need Impv (11) 2% No (1) (1 CND)	51% Yes (42) 34% Many (28) 15% Needs Impv (12)
57. Does the individual receive medication as prescribed? 17IQR#19e					70% Yes 42) 8% Many (5) 20% Need Impv (12) 2% No (1)	48% Yes (39) 30% Many (25) 21% Needs Impv (17) 1% No (1)
58. Does my nurse provide oversight of health needs (i.e. weight records, vitals, lab reports, PRN medication use, seizure records) in order to ensure accuracy, identify and respond to new issues? '17IQR#20b					31% Yes (19) 18% Many (11) 50% Need Impv (31) 2% No (1)	17% Yes (14) 35% Many (29) 45% Needs Impv (37) 2% No (2)
59. Are nursing services provided as needed by the individual? 17IQR#20					8% Yes (5) 47% Many (29) 45% Need Impv (28)	29% Yes (24) 35% Many (29) 33% Needs Impv (27) 2% No (2)
60. Is the CARMP is accurate? '17IQR#21f					71% Yes (37) 6% Many (3) 21% Need Impv (11) 2% No (1) (7 N/A, 3 CND)	38% Yes (27) 43% Many (31) 14% Needs Impv (10) 6% No (4) (10 N/A)
61. Is the CARMP consistently implemented as intended?						61% Yes (43) 26% Many (18) 11% Needs Impv (8) 1% No (1) (10 N/A, 2 CND)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
62. Are the person's health supports/needs being adequately addressed? CPRQ56; '17IQR#19	30% Yes (31) 66% Partial (67) 4% No (4)	24% Yes (23) 76% Partial (74)	17% Yes (16) 80% Partial (76) 3% No (3) (1 not scored)	18% Yes (16) 82% Partial (74)		5% Yes (4) 55% Many (45) 39% Needs Impv (32) 1% No (1)
Assessments						
63. Did the team consider what assessments the person needs and would be relevant to the team's planning efforts? CPRQ57	45% Yes (46) 55% Partial (56)	40% Yes (39) 59% Partial (57) 1% No (1)	35% Yes (33) 64% Partial (61) 1% No (1) (1 not scored)	51% Yes (46) 48% Partial (43) 1% No (1)		27% Yes (22) 61% Many (50) 12% Needs Impv (10)
64. Has the individual received all age and gender appropriate health screenings, in accordance with national best practice and/or as recommended by his/her PCP or other health care professionals? '17IQR#18a					29% Yes (18) 42% Many (26) 23% Need Impv (14) 6% No (4)	24% Yes (20) 56% Many (46) 16% Many (13) 4% No (3)
65. Did the team arrange for and obtain the needed, relevant assessments? CPRQ58; '17IQR#18	37% Yes (38) 63% Partial (64)	25% Yes (24) 74% Partial (72) 1% No (1)	42% Yes(40) 57% Partial (54) 1% No (1) (1 not scored)	28% Yes (25) 72% Partial (65)	10% Yes (6) 56% Many (35) 34% Need Impv (21)	21% Yes (17) 66% Many (54) 12% Needs Impv (10) 1% No (1)
66. Are the assessments adequate for planning? CPRQ59; '17IQR#4f	34% Yes (35) 66% Partial (67)	41% Yes (40) 57% Partial (55) 2% No (2)	29% Yes(28) 68% Partial (65) 2% No (2) (1 not scored)	14% Yes (13) 84% Partial (76) 1% No (1)	13% Yes (8) 58% Many (36) 29% Need Impv (18)	12% Yes (10) 49% Many (40) 38% Needs Impv (31) 1% No (1)
67. Were the recommendations from assessments used in planning? CPRQ60; '17IQR#5	37% Yes (38) 62% Partial (63) 1% No (1)	40% Yes (39) 57% Partial (55) 3% No (3)	31% Yes (29) 61% Partial (58) 8% No (8) (1 not scored)	27% Yes (24) 69% Partial (62) 4% No (4)	23% Yes (14) 44% Many (27) 34% Need Impv (21)	24% Yes (20) 41% Many (34) 23% Needs Impv (19) 11% No (9)
68. For medical, clinical or health related rec's, has a DCF been completed if the individual and/or their guardian/health care decision maker have decided not to follow all or part of an order, rec, or suggestion? '17IQR#5c					31% Yes (11) 11% Many (4) 23% Need Impv (8) 34% No (12) (27 N/A)	38% Yes (19) 16% Many (8) 12% Needs Impv (6) 34% No (17) (32 N/A)
Adequacy of Planning and Adequacy of Services						

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
69. Is there a document called an Individual Service Plan (ISP) that was developed within the past year? CPRQ61; '17IQR#9	100% Yes (102)	100% Yes (97)	100% Yes (95) (1 not scored)	100% Yes (90)	87% Yes (53) 8% Many (5) 5% Need Impv (3) (1 N/A)	100% Yes (82)
70. Was the ISP developed by an appropriately constituted IDT? CPRQ62; '17IQR#3	48% Yes (49) 52% Partial (53)	44% Yes (43) 56% Partial (54)	56% Yes (53) 44% Partial (42) (1 not scored)	54% Yes (48) 45% Partial (40) 1% No (1) (1 N/A)	39% Yes (24) 37% Many (23) 24% Need Impv (15)	40% Yes (33) 50% Many (41) 9% Needs Impv (7) 1% No (1)
71. For any team members not physically present at the IDT meeting, is there evidence of their participation in the development of the ISP? CPRQ63; '17IQR#3d	31% Yes (24) 56% Partial (44) 13% No (10) (24 N/A)	36% Yes (28) 56% Partial (44) 8% No (6) (19 N/A)	45% Yes (34) 32% Partial (30) 12% No (11) (20 N/A) (1 not scored)	41% Yes (28) 47% Partial (32) 12% No (8) (22 N/A)	52% Yes (25) 10% Many (5) 19% Need Impv (9) 19% No (9) (14 N/A)	45% Yes (29) 30% Many (19) 13% Needs Impv (8) 13% No (8) (18 N/A)
72. Does my ISP contain current and accurate information? '17IQR#6					18% Yes (11) 35% Many (22) 47% Need Impv (29)	22% Yes (18) 49% Many (40) 29% Needs Impv (24)
73. Overall, does the long-term vision show expectations for growth and skill building? CPRQ64; '17IQR#7b	60% Yes (61) 38% Partial (39) 2% No (2)	48% Yes (47) 48% Partial (47) 3% No (3)	45% Yes (43) 49% Partial (47) 5% No (5) (1 not scored)	56% Yes (50) 44% Partial (40)	53% Yes (33) 15% Many (9) 31% Needs Impv (19) 2% No (1)	48% Yes (39) 27% Many (22) 21% Needs Impv (17) 5% No (4)
74. Overall, does the ISP give adequate guidance to achieving the person's long-term vision? CPRQ65; '17IQR#7c	75% Yes (76) 25% Partial (26)	61% Yes (59) 36% Partial (35) 3% No (3)	46% Yes (44) 52% Partial (49) 2% No (2) (1 not scored)	52% Yes (47) 46% Partial (41) 2% No (2)	45% Yes (28) 21% Many (13) 29% Need Impv (18) 5% No (3)	57% Yes (47) 17% Many (14) 18% Needs Impv (15) 7% No (6)
75. Is measurable data kept which verifies the consistent implementation of each of the action steps? '17IQR#12a					18% Yes (11) 21% Many (13) 47% Need Impv (29) 15% No (9)	15% Yes (12) 27% Many (22) 39% Needs Impv (32) 20% No (16)
76. Does the data kept identify what the person does so a determination regarding progress/lack of progress? '17IQR#12b					7% Yes (4) 10% Many (6) 49% Need Impv (30) 34% No (21) (1 N/A)	12% Yes (10) 17% Many (14) 28% Needs Impv (23) 43% No (35)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
77. Is each action step in the ISP implemented at a frequency that enables the person to learn new skills? '17IQR#12c					13% Yes (8) 16% Many (10) 45% Need Impv (28) 26% No (16)	9% Yes (7) 26% Many (21) 38% Needs Impv (31) 28% No (23)
78. If the person is not successful in achieving actions steps, has the team tried to determine why, and change their approach if needed? '17IQR#12d					15% Yes (8) 6% Many (3) 57% Need Impv (30) 23% No (12) (8 N/A, 1 CND)	39% Yes (27) 11% Many (8) 20% Needs Impv (14) 30% No (21) (12 N/A)
79. If the person achieves action steps, does the team move to the next in the progression of steps or develops a new one? '17IQR#12e					17% Yes (7) 7% Many (3) 48% Need Impv (20) 29% No (12) (18 N/A, 2 CND)	15% Yes (10) 10% Many (7) 22% Needs Impv (15) 53% No (36) (14 N/A)
80. Has the person made measurable progress on actions steps during this past year?'17IQR#13b					2% Yes (1) 16% Many (10) 60% Need Impv (37) 23% No (14)	6% Yes (5) 23% Many (19) 37% Needs Impv (30) 34% No (28)
81. Overall, do the outcomes in the ISP include criteria by which the team can determine when the outcome(s) have been achieved? CPRQ67; '17IQR#7e	57% Yes (58) 35% Partial (36) 8% No (8)	43% Yes (42) 57% Partial (55)	38% Yes (36) 58% Partial (55) 4% No (4) (1 not scored)	29% Yes (26) 57% Partial (51) 14% No (13)	31% Yes (19) 8% Many (5) 47% Need Impv (29) 15% No (9)	26% Yes (21) 21% Many (17) 34% Needs Impv (28) 20% No (16)
82. Overall, are the ISP outcomes related to achieving the person's long-term vision? CPRQ68; '17IQR#7d	62% Yes (63) 35% Partial (36) 3% No (3)	69% Yes (67) 30% Partial (29) 1% No (1)	69% Yes (66) 28% Partial (27) 2% No (2) (1 not scored)	66% Yes (59) 33% Partial (30) 1% No (1)	45% Yes (28) 11% Many (7) 42% Needs Impv (26) 2% No (1)	77% Yes (63) 12% Many (10) 9% Needs Impv (7) 2% No (2)
83. Overall, do the ISP outcomes address the person's major needs? CPRQ69; '17IQR#7g	68% Yes (69) 29% Partial (30) 3% No (3)	60% Yes (58) 36% Partial (35) 4% No (4)	39% Yes (37) 57% Partial (54) 4% No (4) (1 not scored)	53% Yes (48) 42% Partial (38) 4% No (4)	32% Yes (20) 27% Many (17) 39% Need Impv (24) 2% No (1)	55% Yes (45) 26% Many (21) 16% Needs Impv (13) 4% No (3)
84. Overall, are the Teaching and Support Strategies sufficient to ensure consistent implementation of the services planned? CPRQ71; '17IQR#7i	29% Yes (30) 64% Partial (65) 7% No (7)	40% Yes (39) 52% Partial (50) 8% No (8)	36% Yes (34) 55% Partial (52) 9% No (8) (1 N/A) (1 not scored)	23% Yes (21) 73% Partial (66) 3% No (3)	15% Yes (9) 25% Many (15) 52% Need Impv (32) 8% No (5) (1 N/A)	22% Yes (18) 26% Many (21) 39% Needs Impv (32) 13% No (11)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
85. Overall, are the recommendations and/or objectives/strategies of ancillary providers integrated into the ISP? CPRQ72; '17IQR#7m	42% Yes (41) 53% Partial (52) 5% No (5) (4 N/A)	34% Yes (32) 59% Partial (56) 7% No (7) (2 N/A)	31% Yes (29) 59% Partial (55) 10% No (9) (2 N/A) (1 not scored)	28% Yes (25) 57% Partial (51) 16% No (14)	16% Yes (10) 25% Many (15) 46% Need Impv (28) 13% No (8) (1 N/A)	24% Yes (20) 22% Many (18) 34% Needs Impv (28) 20% No (16)
86. Has the person made measurable progress in therapy this year? '17IQR#13a					11% Yes (7) 28% Many (17) 54% Need Impv (33) 7% No (4) (1 N/A)	22% Yes (18) 21% Many (17) 41% Needs Impv (34) 16% No (13)
87. If needed, does the ISP contain a specific Medical Emergency Response Plan (MERP)? CPRQ73b '17IQR#20c	73% Yes (71) 26% Partial (25) 1% No (1) (5 N/A)	78% Yes (74) 21% Partial (20) 1% No (1) (2 N/A)	80% Yes (75) 18% Partial (17) 2% No (2) (1 N/A) (1 not scored)	66% Yes (57) 33% Partial (29) 1% No (1) (3 N/A)	47% Yes (29) 24% Many (15) 27% Need Imp (17) 2% No (1)	54% Yes (44) 27% Many (22) 17% Needs Impv (14) 2% No (2)
88. Does the ISP contain information regarding primary health (medical) care? CPRQ74	87% Yes (89) 12% Partial (12) 1% No (1)	93% Yes (90) 7% Partial (7)	85% Yes (81) 15% Partial (14) (1 not scored)	89% Yes (80) 11% Partial (10)		84% Yes (69) 12% Many (10) 2% Needs Impv (2) 1% No (1)
88a. Does the ISP face sheet contain contact information for the PCP? CPRQ74a	93% Yes (95) 6% Partial (6) 1% No (1)	96% Yes (93) 4% Partial (4)	96% Yes (91) 3% Partial (3) 1% No (1) (1 not scored)	94% Yes (85) 4% Partial (4) 1% No (1)		91% Yes (75) 4% Many (3) 5% No (4)
88b. Is the Healthcare coordinator's name and contact information listed in the ISP? CPRQ74b	90% Yes (92) 8% Partial (8) 2% No (2)	99% Yes (96) 1% Partial (1)	88% Yes (84) 6% Partial (6) 5% No (5) (1 not scored)	90% Yes (81) 9% Partial (8) 1% No (1)		94% Yes (77) 4% Many (3) 1% Needs Impv (1) 1% No (1)
89. Does the ISP reflect how the person will obtain prescribed medications? CPRQ76	90% Yes (92) 9% Partial (9) 1% No (1)	92% Yes (89) 8% Partial (8)	88% Yes (84%) 11% Partial (10) 1% No (1) (1 not scored)	91% Yes (82) 8% Partial (7) 1% No (1)		91% Yes (75) 6% Many (5) 2% No (2)
90. Does the ISP reflect how the person will get to work/day activities, shopping, and social activities? CPRQ75	88% Yes (42) 10% Partial (5) 2% No (1) (54 N/A)	81% Yes (35) 12% Partial (5) 7% No (3) (54 N/A)	91% Yes (29) 6% Partial (2) 3% No (1) (63 N/A) (1 not scored)	64% Yes (16) 32% Partial (8) 4% No (1) (65 N/A)		71% Yes (58) 17% Many (14) 5% Needs Impv (4) 7% No (6)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
91. Does the ISP contain a list of adaptive equipment needed and who will provide it? CPRQ77; '17IQR#25a	49% Yes (46) 44% Partial (43) 4% No (4) (9 N/A)	44% Yes (41) 49% Partial (46) 6% No (6) (4 N/A)	53% Yes (46) 43% Partial (37) 5% No (4) (8 N/A) (1 not scored)	61% Yes (49) 34% Partial (27) 5% No (4) (10 N/A)	38% Yes (23) 26% Many (16) 30% Need Impv (18) 7% No (4) (1 N/A)	37% Yes (30) 39% Many (32) 16% Needs Impv (13) 5% No (4)
92. Overall, is the ISP adequate to meet the person's needs? CPRQ78; '17IQR#7	13% Yes (13) 87% Partial (89)	11% Yes (11) 89% Partial (86)	11% Yes (10) 89% Partial (85) (1 not scored)	12% Yes (11) 88% Partial (79)	0% Yes 27% Many (17) 73% Need Impv (45)	0% Yes 55% Many (45) 44% Needs Impv (36) 1% No (1)
93. Is the ISP being implemented? (If 92 is "3") CPRQ79 '17IQR#12	54% Yes (7) 46% Partial (6) (89 N/A)	73% Yes (8) 33% Partial (3) (86 N/A)	20% Yes (2) 80% Partial (8) (85 N/A) (1 not scored)	36% Yes (4) 64% Partial (7) (79 N/A)	3% Yes (2) 19% Many (12) 68% Need Impv (42) 10% No (6)	(82 N/A)
94a. Is the ISP being implemented? (If 92 is "0", "1", or "2") CPRQ80a '17IQR#12	38% Yes (34) 61% Partial (54) 1% No (1) (13% N/A)	51% Yes (44) 49% Partial (42) (11 N/A)	32% Yes (27) 67% Partial (57) 1% No (1) (10 N/A) (1 not scored)	30% Yes (24) 70% Partial (55) (11 N/A)	3% Yes (2) 19% Many (12) 68% Need Impv (42) 10% No (6)	5% Yes (4) 52% Many (43) 37% Needs Impv (30) 6% No (5)
94b. Are current services adequate to meet the person's needs? CPRQ80b '17IQR#11	33% Yes (29) 67% Partial (60) (13 N/A)	41% Yes (35) 58% Partial (50) 1% No (1) (11 N/A)	29% Yes (25) 69% Partial (59) 1% No (1) (10 N/A) (1 not scored)	14% Yes (11) 86% Partial (68) (11 N/A)	3% Yes (2) 53% Many (33) 44% Need Impv (27)	30% Yes (25) 41% Many (34) 27% Needs Impv (22) 1% No (1)
95. Overall, was the direct service staff trained on the implementation of this person's ISP? CPRQ81	69% Yes (70) 31% Partial (32)	73% Yes (71) 27% Partial (26)	74% Yes (70 26% Partial (25) (1 not scored)	81% Yes (73) 19% Partial (17)		74% Yes (61) 18% Many (15) 7% Needs Impv (6)
96. Overall, were the direct service staff able to describe their responsibilities in providing daily care/supports to the person? CPRQ82;	68% Yes (69) 32% Partial (33)	69% Yes (67) 31% Partial (30)	66% Yes (63) 34% Partial (32) (1 not scored)	84% Yes (76) 16% Partial (14)		66% Yes (54) 32% Many (26) 2% Needs Impv (2)
97. Overall, do the progress notes or other documentation in the record reflect the status of the outcomes and services of the key life areas stated in the ISP? CPRQ83	21% Yes (21) 75% Partial (76) 5% No (5)	25% Yes (24) 74% Yes (72) 1% No (1)	12% Yes (11) 83% Partial (79) 5% No (5) (1 not scored)	8% Yes (7) 88% Partial (79) 4% No (4)		4% Yes (3) 41% Many (34) 39% Needs Impv (32) 16% No (13)
Expectation of Growth, Quality of Life and Satisfaction						

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
98. Based on all of the evidence, has the person achieved progress in the past year? CPRQ84; '17IQR#13	68% Yes (69) 30% Partial (31) 2% No (2)	52% Yes (50) 47% Partial (45) 1% No (1) (1 CND)	46% Yes (44) 48% Partial (46) 5% No (5) (1 not scored)	42% Yes (38) 57% Partial (51) 1% No (1)	0% Yes 37% Many (23) 61% Need Impv (38) 2% No (1)	11% Yes (9) 57% Many (47) 28% Needs Impv (23) 4% No (3)
99. Overall, does the IDT have an appropriate expectation of growth for this person? CPRQ85; '17IQR#8d	51% Yes (52) 49% Partial (50)	30% Yes (29) 69% Partial (67) 1% No (1)	39% Yes (37) 61% Partial (58) (1 not scored)	51% Yes (46) 48% Partial (43) 1% No (1)	63% Yes (39) 23% Many (14) 13% Need Impv (8) 2% No (1)	56% Yes (46) 39% Many (32) 5% Needs Impv (4)
100. Was the person provided the assistance and support needed to participate meaningfully in the planning process? CPRQ86; '17IQR#1b	85% Yes (86) 14% Partial (14) 1% No (1) (1 CND)	72% Yes (67) 25% Partial (23) 3% No (3) (4 CND)	87% Yes (80) 13% Partial (12) (3 CND) (1 not scored)	79% Yes (71) 19% Partial (17) 2% No (2)	69% Yes (42) 19% Many (12) 10% Need Impv (6) 2% No (1) (1 CND)	60% Yes (49) 27% Many (22) 10% Needs Impv (8) 4% No (3)
101. Is the person offered a range of opportunities for participation in each life area? CPRQ87	84% Yes (81) 16% Partial (15) (6 CND)	75% Yes (69) 25% Partial (23) (5 CND)	79% Yes (67) 20% Partial (17) 1% No (1) (10 CND) (1 not scored)	79% Yes (59) 20% Partial (15) 1% No (1) (15 CND)		62% Yes (51) 22% Many (18) 11% Needs Impv (9) 5% No (4)
102. Does the person have the opportunity to make informed choices? CPRQ88; '17IQR#30	79% Yes (34) 21% Partial (9) (59 CND)	77% Yes (27) 23% Partial (8) (62 CND)	76% Yes (25) 24% Partial (8) (62 CND) (1 not scored)	47% Yes (9) 53% Partial (10) (71 CND)	47% Yes (29) 44% Many (27) 10% Need Impv (6)	71% Yes (25) 20% Many (7) 6% Needs Impv (2) 3% No (1) (47 CND)
102a. About where and with whom to live? CPRQ89; '17IQR#23c	85% Yes (33) 13% Partial (5) 3% No (1) (63 CND)	89% Yes (24) 7% Partial (2) 4% No (1) (70 CND)	78% Yes (18) 17% Partial (4) 4% No (1) (72 CND) (1 not scored)	70% Yes (7) 30% Partial (3) (80 CND)	50% Yes (3) 33% Need Impv (2) 17% No (1) (56 CND)	76% Yes (13) 6% Many (1) 6% Needs Impv (1) 12% No (2) (65 CND)
102b. About where and with whom to work/spend his/her day? CPRQ90; '17IQR#23d	86% Yes (37) 14% Partial (6) (59 CND)	82% Yes (28) 18% Partial (6) (63 CND)	85% Yes (28) 12% Partial (4) 3% No (1) (62 CND) (1 not scored)	50% Yes (8) 50% Partial (8) (74 CND)	85% Yes (17) 5% Many (1) 10% Need Impv (2) (42 CND)	68% Yes (26) 18% Many (7) 5% Needs Impv (2) 8% No (3) (44 CND)
102c. About where and with whom to socialize/spend leisure time? CPRQ91	90% Yes (36) 10% No (4)	86% Yes (32) 14% Partial (5)	86% Yes (30) 9% Partial (3)	80% Yes (12) 20% Partial (3)		80% Yes (28) 17% Many (6)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
	(62 CND)	(60 CND)	6% No (2) (60 CND) (1 not scored)	(75 CND)		3% Needs Impv (1) (47 CND)
103. Does the evidence support that providers do not prevent the person from pursuing relationships and are respecting the rights of this person? CPRQ92; '17IQR#31f	98% Yes (97) 2% Partial (2) (3 CND)	98% Yes (90) 2% Partial (2) (4 CND)	97% Yes (88) 3% Partial (3) (4 CND) (1 not scored)	99% Yes (88) 1% Partial (1) (1 CND)	92% Yes (34) 8% Need Impv (3) (22 N/A, 3 CND)	95% Yes (78) 2% Many (2) 2% Needs Impv (2)
105. Overall, were all team members interviewed trained or knowledgeable on how to report abuse, neglect and exploitation? CPR 93*; '17IQR#35a	75% Yes (76) 25% Partial (26)	76% Yes (74) 24% Partial (23)	68% Yes (65) 32% Partial (30) (1 not scored)	66% Yes (59) 34% Partial (31)	55% Yes (34) 21% Many (13) 24% Need Impv (15)	78% Yes (64) 18% Many (15) 4% Needs Impv (3)
106. Does this person and/or guardian have access to the complaint processes/procedures? CPRQ94	92% Yes (90) 7% Partial (7) 1% No (1) (4 CND)	92% Yes (85) 8% Partial (7) (5 CND)	90% Yes (83) 8% Partial (7) 2% No (2) (3 CND) (1 not scored)	94% Yes (83) 5% Partial (4) 1% No (1) (2 CND)		91% Yes (75) 4% Many (3) 1% Needs Impv (1) 4% No (3)
107. Does the individual have restrictions that should be reviewed by a Human Rights Committee? '17IQR#34h					73% Yes (38) 4% Many (2) 19% Need Impv (10) 4% No (2) (1 N/A, 9 CND)	74% Yes (61) 26% No (21)
108. If there are restrictions that should be reviewed by HRC, have the restrictions been reviewed (quarterly) and approved (annually) by the HRC? If no, describe why. '17IQR#34i					68% Yes (42) 32% No (20)	57% Yes (35) 10% Many (6) 21% Needs Impv (13) 11% No (7) (21 N/A)
109. If there are restrictions that should be reviewed by HRC, is a plan to enable the individual to regain his/her rights and reduce or eliminate these restrictions? '17IQR#34j					11% Yes (4) 11% Many (4) 23% Need Impv (14) 23% No (14)	22% Yes (13) 12% Many (7) 5% Needs Impv (3) 61% No (36) (23 N/A)
110. Is the person protected from abuse, neglect and exploitation? '17IQR#35					44% Yes (27) 34% Many (21) 21% Need Impv (13) (1 N/A)	67% Yes (55) 21% Many (17) 7% Needs Impv (6) 5% No (4)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
111. Have all incidents of suspected abuse, neglect and exploitation been reported and investigated? '17IQR#35b					67% Yes (33) 14% Many (7) 18% Need Impv (9) (13 N/A)	62% Yes (34) 20% Many (11) 13% Needs Impv (7) 5% No (3) (27 N/A)
112. Is the individual safe? '17IQR#24					62% Yes (38) 20% Many (18) 8% Need Impv (5) (1 CND)	78% Yes (64) 13% Many (11) 9% Needs Impv (7)
113. What is the level of participation of the legal guardian in this person's life and service planning? CPRQ 97; '17IQR#15a	38% Active (39) 43% Moderate (43) 19% Limited (19) (1 N/A)	39% Active (37) 35% Moderate (33) 28% Limited (26) (1 N/A)	32% Active (30) 53% Moderate (50) 12% Limited (11) 3% None (3) (1 N/A) (1 not scored)	33% Active (29) 48% Moderate (48) 19% Limited (17) (2 N/A)	40% Active (25) 31% Moderate (19) 21% Limited (13) 8% None (5)	33% Active (27) 34% Moderate (28) 33% Limited (27)
114. If the person is retired, does he/she have opportunities to engage in activities of interest during the day? CPRQ 100; '17IQR#29b	71% Yes (15) 24% Partial (5) 5% No (1) (80 N/A, 1 CND)	91% Yes (21) 4% Partial (1) 4% No (1) (73 N/A, 1 CND)	83% Yes (20) 13% Partial (3) 4% No (1) (69 N/A, 2 CND) (1 not scored)	63% Yes (17) 37 Partial (10) (63 N/A)	53% Yes (8) 27% Many (4) 13% Need Impv (2) 7% No (1) (47 N/A)	61% Yes (20) 24% Many (8) 15% Needs Impv (5) (49 N/A)
115. Does the person have daily choices/appropriate autonomy over his/her life? CPRQ101 '17IQR#30	79% Yes (81) 18% Partial (18) 3% No (3)	76% Yes (74) 23% Partial (22) 1% No (1)	82% Yes (78) 16% Partial (15) 2% No (2) (1 not scored)	84% Yes (76) 14% Partial (13) 1% No (1)	47% Yes (29) 44% Many (27) 10% Need Impv (6)	85% Yes (70) 7% Many (6) 7% Needs Impv (6)
116. Have the person's cultural preferences been accommodated? CPRQ102; '17IQR#31e	96% Yes (96) 4% Partial (4) (2 CND)	99% Yes (94) 1% Partial (1) (2 CND)	95% Yes (88) 5% Partial (5) (2 CND) (1 not scored)	96% Yes (85) 4% Partial (4) (1 CND)	86% Yes (51) 10% Many (6) 3% Need Impv (2) (1 N/A, 2 CND)	95% Yes (78) 4% Many (3) 1% Needs Impv (1)
117. Is the person treated with dignity and respect? CPRQ103; '17IQR#34c	70% Yes (71) 30% Partial (31)	75% Yes (73) 25% Partial (24)	66% Yes (63) 34% Partial (32) (1 not scored)	43% Yes (39) 57% Partial (51)	49% Yes (30) 20% Many (12) 31% Need Impv (19) (1 N/A)	34% Yes (28) 43% Many (35) 23% Needs Impv (19)
118. Does the person have food and drink available according to their specific nutritional needs and recommendations? CPRQ108; '17IQR#23e	100% Yes (99) (3 CND)	100% Yes (96) (1 CND)	99% Yes (91) 1% Partial (1) (3 CND) (1 not scored)	100% Yes (90)	98% Yes (59) 2% Need Impv (1) (2 CND)	93% Yes (76) 5% Many (4) 2% Needs Impv (2)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
119. Does the person have sufficient personal money? CPRQ110 '17IQR#34f	93% Yes (93) 7% Partial (7) (2 CND)	88% Yes (84) 13% Partial (12) (1 CND)	91% Yes (85) 9% Partial (8) (2 CND) (1 not scored)	91% Yes (82) 8% Partial (7) 1% No (1)	88% Yes (53) 8% Many (5) 3% Need Impv (2) (2 CND)	94% Yes (77) 5% Many (4) 1% No (1)
120. Does the person get along with their day program/employment provider staff? CPRQ111	97% Yes (62) 3% Partial (2) (38 CND)	98% Yes (56) 2% Partial (1) (2 N/A, 38 CND)	100% Yes (57) (1 N/A, 37 CND) (1 not scored)	98% Yes (42) 2% Partial (1) (1 N/A, 46 CND)		100% Yes (66) (1 N/A, 15 CND)
121. Does the person get along with their residential provider staff? CPRQ112	99% Yes (77) 1% Partial (1) (24 CND)	98% Yes (63) 2% Partial (1) (33 CND)	100% Yes (61) (34 CND) (1 not scored)	100% Yes (55) (35 CND)		100% Yes (71) (11 CND)
Team Process						
122. Are the individual members of the IDT following up on their responsibilities? CPRQ 114; '17IQR#10	22% Yes (22) 78% Partial (80)	22% Yes (21) 77% Partial (75) 1% No (1)	38% Yes (36) 62% Partial (59) (1 not scored)	17% Yes (15) 83% Partial (75)	32% Yes (20) 53% Many (33) 15% Need Impv (9)	21% Yes (17) 54% Many (44) 26% Needs Impv (21)
123. If there is evidence of situations in which the team failed to reach a consensus on the person's service and support needs, has the team made efforts to build consensus? CPRQ 115; '17IQR#17c	71% Yes (22) 16% Partial (5) 13% No (4) (71 N/A)	63% Yes (24) 26% Partial (10) 11% No (4) (59 N/A)	58% Yes (11) 32% Partial (6) 11% No (2) (76 N/A) (1 not scored)	85% Yes (11) 15% Partial (2) (77 N/A)	57% Yes (8) 43% No (6) (48 N/A)	81% Yes (17) 10% Many (2) 5% Needs Impv (1) 5% No (1) (61 N/A)
124. Do records or facts exist to indicate that the team convened meetings as needed due to changed circumstances and/or needs? CPRQ 116; '17IQR#17d	74% Yes (67) 26% No (24) (8 N/A), 3 CND)	69% Yes (65) 31% No (29) (2 N/A, 1 CND)	79% Yes (71) 21% No (19) (4 N/A, 1 CND) (1 not scored)	68% Yes (56) 32% No (26) (8 N/A)	73% Yes (36) 10% Many (5) 12% Need Impv (6) 4% No (2) (13 N/A)	46% Yes (37) 41% Many (33) 6% Needs Impv (5) 6% No (5) (2 N/A)
125. Is there adequate communication among team members between meetings to ensure the person's program can be/is being implemented? CPRQ117	77% Yes (79) 22% Partial (22) 1% No (1)	85% Yes (82) 15% Partial (15)	88% Yes (84) 11% Partial (10) 1% No (1) (1 not scored)	88% Yes (79) 12% Partial (11)		78% Yes (64) 15% Many (12) 7% Needs Impv (6)
126. Do you recommend Dispute Resolution for this IDT? CPRQ118	7% Yes (7) 93% No (95)	7% Yes (7) 93% Partial (90)	1% Yes (1) 99% No (94) (1 not scored)	3% Yes (3) 97% No (87)		2% Yes (2) 98% No (80)
127. Is there evidence or documentation of physical regression in the last year? CPRQ119 '17IQR#14a	31% Yes (31) 69% No (70) (1 CND)	34% Yes (33) 66% No (63) (1 CND)	37% Yes (35) 63% No (60) (1 not scored)	23% Yes (21) 77% No (69)	37% Yes (23) 63% No (39)	40% Yes (33) 60% No (49)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
128. Is there evidence or documentation of behavioral or functional regression in the last year? CPRQ120; '17IQR14c	28% Yes (28) 72% No (73) (1 CND)	30% Yes (28) 70% No (66) (3 CND)	21% Yes (20) 79% No (74) (1 CND) (1 not scored)	17% Yes (15) 83% No (73) (2 CND)	13% Yes (8) 87% No (54)	26% Yes (21) 74% No (61)
129. If #127 OR #128 is scored "Yes", is the IDT adequately addressing the regression? CPRQ121;	58% Yes (25) 37% Partial (16) 5% No (2) (59 N/A)	59% Yes (27) 33% Partial (15) 9% No (4) (51 N/A)	53% Yes (23) 37% Partial (16) 9% No (4) (51 N/A 1 CND) (1 not scored)	63% Yes (19) 33% Partial (10) 3% No (1) (60 N/A)		77% Yes (30) 23% No (9) (43 N/A)
130. Has the person changed residential/day services in the last year? CPRQ122	16% Yes (16) 84% No (86)	16% Yes (16) 84% No (81)	9% Yes (9) 91% No (86) (1 not scored)	17% Yes (15) 83% No (75)		21% Yes (17) 79% No (65)
131. If #130 is Yes, was the change Planned by the IDT? CPRQ122a	89% Yes (17) 5% Partial (1) 5% No (1) (83 N/A)	71% Yes (12) 29% Partial (5) (80 N/A)	50% Yes (4) 25% Partial (2) 25% No (2) (87 N/A) (1 not scored)	64% Yes (9) 36% Partial (5) (76 N/A)		76% Yes (13) 24% No (4) (65 N/A)
132. If #130 is Yes, did the change meet the person's needs and/or preferences? CPRQ122b	84% Yes (16) 16% Partial (3) (83 N/A)	71% Yes (12) 29% Partial (5) (80 N/A)	89% Yes (8) 11% Partial (1) (86 N/A) (1 not scored)	80% Yes (12) 13% Partial (2) 7% No (1) (75 N/A)		89% Yes (17) 11% No (2) (63 N/A)
133. Has the IDT process been adequate for assessing, planning, implementing and monitoring of services for this person? CPRQ123; '17IQR#7n	18% Yes (18) 81% Partial (83) 1% No (1)	24% Yes (23) 76% Partial (74)	28% Yes (27) 72% Partial (68) (1 not scored)	22% Yes (20) 78% Partial (70)	3% Yes (2) 34% Many (21) 58% Need Impv (36) 5% No (3)	11% Yes (9) 50% Many (41) 38% Needs Impv (31) 1% No (1)
Supported Employment						
134. Does (Name) have a current Person Centered Assessment?						11% Yes (9) 16% Many (13) 59% Needs Impv (47) 14% No (11) (2 not scored)
135. Did this assessment address vocational interests, abilities and needs? CPRQ126; '17IQR#26a	63% Yes (48) 37% No (28) (26 N/A)	52% Yes (39) 38% No (36) (21 N/A) (1 not scored)	49% Yes (32) 51% No (33) (30 N/A) (1 not scored)	52% Yes (30) 48% No (28) (30 N/A) (2 not scored)	6% Yes (3) 17% Many (9) 32% Need Impv (17) 45% No (24)	8% Yes (4) 6% Many (3) 29% Needs Impv (14) 56% No (27)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
					(9 N/A)	(32 N/A, 2 not scored)
136. Did the individual participate personally in the Person Centered Assessment?						39% Yes (31) 61% No (49) (2 not scored)
137. Did the Guardian participate in the Person Centered Assessment?						25% Yes (20) 75% No (60) (2 not scored)
138. Is the individual engaged in the Informed Choice Project?						10% Yes (8) 90% No (74)
139. Has the individual been offered the opportunity to participate in work or job exploration including volunteer work and/or trial work opportunities? '17IQR#26e					0% Yes 14% Many (7) 31% Need Impv (16) 66% No (28) (11 N/A)	30% Yes (15) 70% No (35) (30 N/A, 2 not scored)
140. If #139 is Yes, are these new experiences clearly documented in the ISP Work, Education and/or Volunteer History section?						27% Yes (4) 33% Many (5) 20% Needs Impv (3) 20% No (3) (65 N/A, 2 not scored)
141. If #139 is No, is the individual trying new discovery experiences in the community to determine interests, abilities, skills and needs?						0% Yes 14% Needs Impv (5) 86% No (30) (45 N/A, 2 not scored)
142. Has the Guardian had the opportunity to gain information on how the individual responded during job exploration activities such as volunteering and/or trial work experiences?						16% Yes (8) 6% Many (3) 16% Needs Impv (8) 61% No (30) (31 N/A, 2 not scored)
143. Has the individual received information regarding the range of employment options available to him/her? '17IQR#26c					4% Yes (2) 8% Many (4) 43% Need Impv (23) 45% No (24) (N/A)	8% Yes (4) 10% Many (5) 15% Needs Impv (7) 67% No (32)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
						(32 N/A, 2 not scored)
144. Has the Guardian received information regarding the range of employment options available for the individual?						17% Yes (8) 4% Many (2) 25% Needs Impv (12) 54% No (26) (32 N/A, 2 not scored)
145. If there are barriers to employment, has the Team, including the individual, addressed how to overcome those barriers to employment and integrating clinical info., AT, & therapies as necessary ... '17IQR#27b					6% Yes (3) 16% Many (8) 24% Need Impv (12) 54% No (27) (12 N/A)	15% Yes (7) 6% Many (3) 19% Needs Impv (9) 60% No (29) (32 N/A, 2 not scored)
146. If there are barriers to employment, has the Team addressed with the Guardian how to overcome those barriers to employment and integrating clinical info., AT, & therapies as necessary ...?						15% Yes (7) 9% Many (4) 6% Needs Impv (3) 70% No (33) (33 N/A, 2 not scored)
147. Has the individual participated in work or volunteer activities during the past year?						20% Yes (10) 14% Many (7) 36% Needs Impv (18) 30% No (15) (30 N/A, 2 not scored)
148. Has the individual identified what type of work or volunteer activities he/she would like to do?						25% Yes (13) 8% Many (4) 20% Needs Impv (10) 47% No (24) (29 N/A, 2 not scored)
149. Does the Guardian support him/her working?						49% Yes (24) 51% No (25) (31 N/A, 2 not scored)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
150. Is (Name) is involved in the DVR Outreach Project?						8% Yes (6) 93% No (74) (2 not scored)
151. Is the individual engaged in Supported Employment? CPRQ129	36% Yes (23) 64% No (41) (38 N/A)	27% Yes (17) 73% No (47) (32 N/A) (1 not scored)	28% Yes (16) 72% No (41) (38 N/A) (1 not scored)	30% Yes (15) 70% No (35) (38 N/A) (2 not scored)		15% Yes (7) 85% No (41) (32 N/A, 2 not scored)
152. Is the individual Working in accordance with the following: CPRQ 130 '17IQR#28	20% Yes (13) 13% Partial (8) 67% No (43) (38 N/A)	17% Yes (11) 11% Partial (7) 72% No (46) (32 N/A) (1 not scored)	9% Yes (5) 21% Partial (12) 70% No (40) (38 N/A) (1 not scored)	14% Yes (7) 12% Partial (6) 74% No (37) (38 N/A) (2 not scored)	0% Yes 11% Many (5) 19% Need Impv (9) 71% No (34) (14 N/A)	2% Yes (1) 8% Many (4) 4% Needs Impv (2) 85% No (41) (32 N/A, 2 not scored)
153. Does the person have a Career Development Plan? CPRQ128 17IQR#26e	7% Yes (5) 34% Partial (23) 59% No (40) (34 N/A)	11% Yes (7) 18% Partial (12) 71% No (46) (31 N/A) (1 not scored)	11% Yes (6) 26% Partial (15) 63% No (36) (38 N/A) (1 not scored)	6% Yes (3) 34% Partial (17) 60% No (30) (38 N/A) (2 not scored)	0% Yes 14% Many (7) 31% Need Impv (16) 66% No (28) (11 N/A)	0% Yes 30% Many (3) 20% Needs Impv (2) 50% No (5) (70 N/A, 2 not scored)
Behavior						
154. Is the person considered by the IDT to need behavior services now? CPRQ131; '17IQR#5d	57% Yes (55) 43% No (41) (6 N/A)	59% Yes (55) 41% No (39) (3 N/A)	61% Yes (55) 39% No (35) (5 N/A) (1 not scored)	68% Yes (60) 32% No (28) (2 N/A)	55% Yes (34) 45% No (28)	63% Yes (52) 37% No (30)
155. Does the person need behavior services now? CPRQ132 '17IQR#11e	58% Yes (55) 42% No (40) (7 N/A)	60% Yes (57) 40% No (38) (2 N/A)	56% Yes (50) 44% No (40) (5 N/A) (1 not scored)	66% Yes (59) 34% No (30) (1 N/A)	58% Yes (36) 42% No (26)	68% Yes (56) 32% No (26)
156. Have behavioral assessments been completed? CPRQ133	77% Yes (44) 16% Partial (9) 7% No (4) (45 N/A)	71% Yes (41) 26% Partial (15) 3% No (2) (39 N/A)	54% Yes (30) 41% Partial (23) 5% No (3) (39 N/A) (1 not scored)	65% Yes (39) 32% Partial (19) 3% No (2) (30 N/A)		59% Yes (32) 20% Many (11) 11% Needs Impv (6) 9% No (5) (28 N/A)
157. Does the person have a positive behavior support plan developed out of the behavior assessments that meets the person's needs? CPRQ134 '17IQR#5g	86% Yes (48) 11% Partial (6) 4% No (2) (46 N/A)	76% Yes (44) 19% Partial (11) 5% No (3) (39 N/A)	62% Yes (34) 33% Partial (18) 5% no (3) (40 N/A) (1 not scored)	81% Yes (48) 19% Partial (11) (31 N/A)	76% Yes (26) 12% Many (4) 9% Need Impv (3) 3% No (1) (28 N/A)	83% Yes (43) 8% Many (4) 4% Needs Impv (2) 6% No (3) (30 N/A)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
158. Has the staff been trained on the Positive Behavior Support Plan? CPRQ135; '17IQR#10d	80% Yes (45) 16% Partial (9) 4% No (2) (46 N/A)	90% Yes (52) 5% Partial (3) 5% No (3) (39 N/A)	87% Yes (48) 11% Partial (6) 2% No (1) (40 N/A) (1 not scored)	90% Yes (53) 10% Partial (6) (31 N/A)	73% Yes (24) 18% Many (6) 6% Need Impv (2) 3% No (1) (29 N/A)	86% Yes (44) 8% Many (4) 4% Needs Impv (2) 2% No (1) (31 N/A)
159. If needed, does the person have a Behavior Crisis Intervention Plan that meets the person's needs? CPRQ 73a; '17IQR#5h	77% Yes (23) 20% Partial (6) 3% No (1) (72 N/A)	88% Yes (28) 13% Partial (4) (65 N/A)	82% Yes (23) 18% Partial (5) (67 N/A) (1 not scored)	81% Yes (21) 19% Partial (5) (64 N/A)	71% Yes (10) 21% Many (3) 7% Need Impv (1) (48 N/A)	73% Yes (16) 18% Many (4) 9% No (2) (60 N/A)
160. Does the person receive behavioral services consistent with his/her needs? CPRQ 136 '17IQR#5i	67% Yes (38) 30% Partial (17) 4% No (2) (45 N/A)	78% Yes (45) 19% Partial (11) 3% No (2) (39 N/A)	56% Yes (31) 36% Partial (20) 7% No (4) (40 N/A) (1 not scored)	73% Yes (43) 27% Partial (16) (31 N/A)	53% Yes (20) 29% Many (11) 13% Need Impv (5) 5% No (2) (24 N/A)	67% Yes (36) 19% Many (10) 7% Need Impv (4) 7% No (4) (28 N/A)
161. Are behavior support services integrated into the ISP? CPRQ 137; '17IQR#11d	59% Yes (33) 34% Partial (19) 7% No (4) (46 N/A)	41% Yes (24) 52% Partial (30) 7% No (4) (39 N/A)	33% Yes (18) 49% Partial (27) 18% No (10) (40 N/A) (1 not scored)	42% Yes (25) 49% Partial (29) 8% No (5) (31 N/A)	48% Yes (16) 9% Many (3) 39% Need Impv (13) 3% No (1) (29 N/A)	47% Yes (25) 17% Many (9) 15% Needs Impv (8) 21% No (11) (29 N/A)
Adaptive Equipment/Augmentative Communication						
162. Has the person received all adaptive equipment needed? CPRQ138; '17IQR#25b	78% Yes (72) 21% Partial (19) 1% No (1) (10 N/A)	75% Yes (67) 24% Partial (21) 1% No (1) (8 N/A)	72% Yes (61) 27% Partial (23) 1% No (1) (10 N/A) (1 not scored)	72% Yes (55) 28% Partial (21) (14 N/A)	57% Yes (33) 22% Many (13) 21% Need Impv (12) (3 N/A, 1 CND)	60% Yes (46) 29% Many (22) 10% Needs Impv (8) 1% No (1) (5% N/A)
163. Has the person received all assistive technology needed? CPRQ139; '17IQR#25c	73% Yes (49) 25% Partial (17) 2% No (1) (35 N/A)	68% Yes (48) 31% Partial (22) 1% No (1) (26 N/A)	74% Yes (49) 23% Partial (15) 3% No (2) (29 N/A) (1 not scored)	72% Yes (48) 25% Partial (17) 2% No (2) (23 N/A)	56% Yes (24) 19% Many (8) 21% Need Impv (9) 5% No (2) (18 N/A, 1 CND)	71% Yes (44) 16% many (10) 11% Needs Impv (7) 2% No (1) (20 N/A)
164. Do direct care staff know how to appropriately help the person use his/her equipment? '17IQR#25f					86% Yes (50) 5% Many (3) 9% Need Impv (5) (1 N/A, 3 CND)	92% Yes (70) 6% Many (5) 1% Needs Impv (1) (6 N/A)
165. Is the person's equipment and technology in good repair?'17IQR#25d					71% Yes (42) 17% Many (10)	76% Yes (58) 18% Many (14)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
					12% Need Impv (7) (1 N/A, 2 CND)	5% Needs Impv (4) (6 N/A)
166. Is the person's equipment/technology available in all appropriate environments? '17IQR#25e					61% Yes (36) 22% Many (13) 15% Need Impv (9) 2% No (1) (1 N/A, 2 CND)	66% Yes 51) 27% Many (21) 6% Needs Impv (5) (5 N/A)
167. Has the person received all communication assessments and services? CPRQ140 ; '17IQR#10b	80% Yes (72) 18% Partial (16) 2% No (2) (12 N/A)	83% Yes (71) 17% Partial (15) (11 N/A)	76% Yes (68) 20% Partial (18) 3% No (3) (6 N/A) (1 not scored)	76% Yes (62) 24% Partial (20) (8 N/A)	77% Yes (44) 7% Many (4) 16% Need Impv (9) (5 N/A)	66% Yes (46) 23% Many (16) 10% Needs Impv (7) 1% No (1) (12 N/A)
Individual Service Planning						
168. Does the person have an ISP that addresses live, work/learn, fun/relationships and health/other that correlates with the person's desires and capabilities, in accordance with DOH Regulations? CPRQ141 '17IQR#7o	89% Yes (91) 10% Partial (10) 1% No (1)	92% Yes (89) 8% Partial (8)	94% Yes (89) 6% Partial (6) (1 not scored)	90% Yes (81) 9% Partial (8) 1% No (1)	82% Yes (51) 8% Many (5) 8% Need Impv (5) 2% No (1)	96% Yes (79) 1% Many (1) 2% Needs Impv (2)
169. Does the person have an ISP that contains a complete Vision Section that is based on a long-term view? CPRQ142 '17IQR#7a	69% Yes (70) 29% Partial (30) 2% No (2)	55% Yes (53) 44% Partial (43) 1% No (1)	49% Yes (47) 42% Partial (40) 8% No (8) (1 not scored)	58% Yes (52) 42% Partial (38)	53% Yes (33) 21% Many (13) 23% Need Impv (14) 3% No (2)	55% Yes (45) 18% Many (15) 23% Needs Impv (19) 4% No (3)
170. Does the person receive services and supports recommended in the ISP? CPRQ143; '17IQR#11a	81% Yes (83) 19% Partial (19)	78% Yes (76) 22% Partial (21)	65 % Yes (62) 35% Partial (33) (1 not scored)	68% Yes (61) 32% Partial (29)	47% Yes (29) 27% Many (17) 26% Need Impv (16)	84% Yes (69) 10% Many (8) 6% Needs Impv (5)
171. Does the person have adequate access to and use of generic services and natural supports? CPRQ144; '17IQR#33f	88% Yes (90) 12% Partial (12)	80% Yes (78) 19% Partial (18) 1% No (1)	77% Yes (73) 23% Partial (22) (1 not scored)	80% Yes (72) 20% Partial (18)	76% Yes (47) 15% Many (9) 10% Need Impv (6)	63% Yes (52) 23% Many (19) 13% Needs Impv (11)
172. Is the person integrated into the community? CPRQ145; '17IQR#29g	82% Yes (84) 18% Partial (18)	67% Yes (65) 31% Partial (30) 2% No (2)	58% Yes (55) 38% Partial (36) 4% No (4) (1 not scored)	53% Yes (48) 46% Partial (41) 1% No (1)	25% Yes (15) 21% Many (13) 43% Need Impv (26) 11% No (7)	41% Yes (34) 18% Many (15) 38% Needs Impv (31) 2% No (2)
173. Overall is the ISP adequate to meet the person's needs? CPRQ146; '17IQR#7	13% Yes (13) 87% Partial (89)	11% Yes (11) 89% Partial (86)	11% Yes (10) 89% Partial (85) (1 not scored)	12% Yes (11) 88% Partial (79)	0% Yes 27% Many (17) 73% Need Impv (45)	0% Yes 55% Many (45) 44% Needs Impv (36)

Question	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)	2018 (sample=82)
						1% No (1)
174. Is the total program of the level of intensity adequate to meet this person's needs? CPRQ147; '17IQR#36	27% Yes (28) 72% Partial (73) 1% No (1)	26% Yes (25) 74% Partial (72)	14% Yes 13) 85% Partial (81) 1% No (1) (1 not scored)	12% Yes (11) 88% Partial (79)	0% Yes 44% Many (27) 56% Need Impv (35)	2% Yes (2) 67% Many (55) 30% Needs Impv (25)