Individual Quality Review
2017 Statewide Report

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I. EXECUTIVE SUMMARY

During the 2017 Individual Quality Review supports and services provided to sixty-five citizens who are Jackson Class Members were reviewed. The findings from those reviews form the foundation of this report. Over 550 people were interviewed, over 100 observations were conducted, and thousands of pieces of paper were reviewed. Information gathered through this process was recorded in the individual IQR protocol, which, at the Defendants request and participation was revised to be, in some areas, a more probing protocol. That raw data and analysis along with detailed findings are provided this report.

The findings continue to show the experiences of Jackson Class Members (JCMs), in large part, remain unchanged, have not improved and in some areas the court has identified for heightened focus, have deteriorated. This pattern of failure of improvement and, in areas, deterioration is also longitudinally demonstrated compared to prior reviews.

See footnote for background.[1]

A. Health

This report, coupled with reports that have been provided for over a decade, continues to document long term and wide spread systems failure to identify, report, intervene, evaluate the effectiveness of the intervention and ensure sustained corrective action designed to result in improved health outcomes for Jackson Class Members. For example, 90% of the class members reviewed did not have health assessments[2] that were found to be accurate and completed as needed. 77% of the class members reviewed did not timely receive the medical treatment they needed.[3] 86% of class members reviewed had Health Care Plans/Documents that were inaccurate; 30% of the class members reviewed were not receiving medication as prescribed.[4]

There has been a marked deterioration of individuals' health care needs being known by members of the JCM's team (38% in 2016; 18% in 2017) and health related assessments being accurate and completed as needed (25% in 2016; 10% in 2017).

[1] The IQR was developed collaboratively involving the Defendants, Plaintiffs, Intervenors and Community Monitor. All questions were agreed to. It is critical that the Defendants, Plaintiffs, Intervenors and all other participants to this action read the entire report. It provides extensive data, findings and recommendations to be used to evaluate and improve the entire system of services for Jackson Class Members, at the individual, provider, regional and state levels. This report is based on data that reports the percentages of *compliance with* any given protocol question. 100% compliance would indicate that for all class members reviewed, the condition/issue would be met. What that fails to make clear is that, even if there is 90% compliance, 10% of the class members reviewed, or 6.3, do not have the support identified as necessary or beneficial to their lives.
[2] See IQR Question #18.
[3] See IQR Question #19.
[4] See IQR Question #19e.

A notable area of improvement has been the timeliness of Mortality Reviews for the purpose of system learning from class member deaths. In 2016 the process of timely Mortality reviews had virtually stopped.[5] By 2017, DDSD reinitiated Mortality Reviews and has continued their effort to become more prompt. Currently there are 9 deaths from calendar year 2017 and 6 from calendar year 2018 that have yet to be heard. There are 3 deaths from 2017 that are not closed but have been heard and closed at the MRC meeting.

B. Individual Service Plan (ISP)

The ISP is a form of a contract, paid for with state and federal money, between the class member and his/her team/provider(s). This contract should identify strengths, needs, challenges and interests as well as what the providers will do to help the person gain skills needed to move towards his/her identified future including as much independence as possible. In 2017 **no ISPs** (0%) reviewed[6] were found to be adequate to meet the JCM's needs. Since 2010 the highest percentage of ISPs found to be adequate to meet the JCMs needs was in 2011 when 28% were found to be adequate. Since that time no more than 13% were found adequate.

37% of JCMs reviewed had experienced functional regression, 70% of their teams had taken action to correct or slow this regression. 13% of JCMs reviewed had experienced regression in their behaviors; 75% of their teams had taken action to correct or slow this regression.[7] It is noteworthy that the majority of class members experiencing functional and/or behavioral regression have had their teams take action to identify the cause and in turn take action to slow or reduce the regression.

C. Residential and Day Services

199 (78%) of all JCMs receive Supported Living (group home) supports. 38 (15%) live with a family and receive Family Living Supports. 177 JCMs (69%) receive Adult Habilitation (day program sites, non-work). In the 2017 review, staff in both Residential (89%) and Day (83%) know the JCM whom they support well[8]. 73% of JCMs were believed to like staff and their home, 97% felt safe in their neighborhood.[9]

Day programs continue to be, primarily, segregated[10] with few meaningful, purposeful activities and do not result in skill building or valued roles for JCMs in the community. 43% of JCMs were found to be engaged in meaningful daily activities; 54% were found engaged in activities that have a stated purpose; 25% of JCMs were found to have valued roles in the community; 34% were found to be decreasing the amount of time they spend in segregated settings.[11]

[5] See 2016 CPR Finding #8.
[6] See IQR Question #7.
[7] See IQR Questions #14a, #14b, #14c and #14d.
[8] See IQR Questions #8a and #8b.
[9] See IQR Questions #23a and #24a.
[10] A site consisting of other people with I/DD congregated together with paid staff.
[11] See IQR Questions #29e, #29f, #29g and #29h.

D. Supported Employment[12]

Enabling people with severe disabilities to find and secure jobs they like and can do all or part of has been a long term challenge. Historic CPR/IQR identified barriers include discriminatory beliefs that people with severe disabilities can't work, lack of agency staff who actually know how to develop and secure jobs, lack of interagency sharing of knowledge and resources along with inconsistent commitment to securing employment for JCM has made for disappointing outcomes.

In 2015 and 2016, 33% of people with I/DD in the New Mexico DD Waiver were reported as working in Competitive Employment.[13] In 2017, less than 1% of Jackson Class Members are working at agreed criteria (*agreed criteria: integrated setting, making at least minimum wage and working at least 10 hours a week*).

From 2010 to 2017 the highest number of Jackson Class Members reviewed who were working at criteria was in 2010 (22%). There has been a steady decline since then. Further, in 2017 no JCMs reviewed were found to have Teams who helped them overcome barriers to employment; 4% were found to have teams that provided them with information and engaged them in a variety of jobs, volunteer and/or trial work experience; 6% of those reviewed had their vocational abilities and needs assessed.[14]

Of those working but not at the agreed criteria: 4% of those reviewed in 2017 were working in a paid position; 2% worked an average of 10 hours a week; and 4% were working in a community, integrated job.[15]

E. Case Management

Case Management services are intended to be person-centered and are key to enabling people to pursue their desired life outcomes while gaining independence and access to needed services and supports. Many case managers in New Mexico continue to know those JCMs whom they support (79%).[16] Many case managers continue to consistently visit class members two times a month, but not always in varying locations where the person receives supports and services (74%)[17]. Case Managers have a great deal of responsibility within the system but not equal authority when it comes to being able to direct or require change where needed. Consequently, their responsibility to monitor, report and act by following up when class members are not receiving a recommended or agreed treatment or service becomes essential criteria when evaluating whether or not case managers are meeting their obligations. For example, only 5% of case managers in the review were found to document and follow up on progress being made on the person's ISP.[18] There are at least two major explanations which impact this score. First, there is limited or inconsistent measurable data being kept by the provider so case managers can't verify progress and/or second, are not consistently checking and recording the data being kept.

26% of JCMs in the review were found to have case managers who provided them with the supports and services needed[19]. Case manager's monitoring should promptly identify issues such as when appointments are not kept, therapy isn't provided as agreed, ISPs are not accurate or implemented, medications aren't given as ordered and, equipment isn't functional and/or used. Equally important, their prompt identification of issues must be accompanied by prompt action which results in improved practice.

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[12] Image taken from Supported Employment: Participant Training Manual, Elizabeth M. Boggs Center on Developmental Disabilities, Robert Wood Johnson Medical School, Department of Pediatrics, University of Medicine and Dentistry of New Jersey.
[13] United Cerebral Palsy (UCP), Case for Inclusion 2015 and 2016 Reports.
[14] See IQR Question #26c and #26a.
[15] See IQR Questions #28a, #28b and #28c.
[16] See IQR Question #8c
[17] See IQR Question #16a.
[18] See IQR Question #16b.
[19] See IQR Question #16c.

F. Therapy, Equipment and Behavioral Consultation

There are good DD Waiver Standards that apply to many of the identified therapeutic supports and services, including policies and procedures. These Standards include an appropriate espoused philosophy around the participatory approach, however, there is poor enforcement of these policies and procedures which results in disappointing outcomes for many people.

With regard to therapy and the equipment needs affiliated with it, 25% of those reviewed have the equipment and technology they need to be safe and comfortable; 57% have the equipment recommended; 56% have the technology recommended; 71% of the equipment/technology is in good repair; 61% of the recommended equipment/technology is available; and 86% of the staff know how to help the JCM use his/her technology.[20]

Findings concerning Behavior Consultation/Supports show that 85% of JCMs taking medication for a behavioral/psychiatric reason receive Behavioral Services; 71% receive these services at the level needed; 76% of JCMs reviewed have behavioral support plans which meet their needs and 71% have a Crisis Prevention Plan that meets their needs. 73% of JCMs had their Behavior Plans and Crisis Plans implemented; 48% of the Behavior Support Services were integrated into the ISP; and 38% of those JCMs reviewed who refused to follow a recommendation had safeguards put in place that met the intent of the original recommendation.[21]

[20] See IQR Questions #25, #25b, #25c, #25d, and #25e.
[21] See IQR Questions #5e, #5f, #5g, #5h, and #5j.

II. FINDINGS AND RECOMMENDATIONS

While the detail in this year's findings compared to the 2016 CPR Findings Summary has increased the overall number of findings in 2017, the overall findings in identified subject areas remains the same. That is, areas of identified good practice continue as strengths in 2017. Likewise, areas of concern are the same areas of concern that have been identified for many years. Consequently, overall conditions for Jackson Class Members have not improved and in some cases deteriorated. After many years of limited to no response to CPR Systemic Findings and Recommendations, Defendants responded to each of the14 systemic recommendations made as part of the 2016 CPR findings. The response from the Department to the 2016 Systemic Recommendations relied heavily on the update of the 2018 DD Waiver Standards and various processes. DOH/DDSD has suggested that revising the DD Waiver Standards would be a major solution to long standing issues. Unfortunately, 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 groups does not, by itself, change 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.

Years Noted = In CPR and or IQR Statewide Reports

#	2017 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 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) of the ISPs were adequate to meet the person's needs. (Q#7)	2004 – present
	c. Case Management supports and monitoring which are core individual and systems safeguards have also been identified as urgently needing correction. Only 5% (3 JCMs) of the case managers in the review were documenting and following-up on progress on outcomes and action in the ISP. (Q#16b) That is down from 21% in 2016. From 2004 to 2016, the average percentage of class members reviewed who had evidence of case management monitoring and tracking services as outlined in their ISP is 39.5%.	2004 – present
	d. 26% (16 JCMs) of class members were found to have case management provided at the necessary level in 2017. (Q#16c) That is a drop from 42% 2016. From 2004 to 2016, the average percentage of class members who had case management providing supports and services needed was 42.5%.	2004 – present
#2.	The Metro Region had the highest average number of health related issues per person (14.1 per person up from 3.90 per person in 2016) followed by the Southeast (11.6 per person in 2017 up from 3.30 per person in 2016), Southwest (11 per person in 2017 up from 2.77 per person in 2016), Northeast (10.1 per person up from 2.73 per person in 2016 and, finally, the Northwest (7.2 per person up from 3.22 per person in 2016).	2011 – present
#3.	The Community Practice Review identified 356 health related findings for 63 of the 65 individuals reviewed. Not only did 97% of those reviewed have health related findings which needed review and/or action but 47 (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 **Metro** Region who had the highest average number of health related findings per person include:	2013 - present

#	2017 FINDINGS	Years Noted
	○ The New Beginnings had 3 people in the review with 28 health related findings (6 repeats, 8 Immediate) for an average of 9.3 findings per person. Does not match Chart #83. ○ Bright Horizons had 2 people in the review with 17 health related findings (4 repeats, 5 Immediate) for an average of 8.5 per person. ○ LLCP had 3 people in the review with 21 health findings (1 repeat, 4 Immediate, 1Special) for an average of 7 per person. ▪ Case Management Agencies from **Metro** Region who had the highest average number of health related findings per person include: ○ Carino had 5 people in the review with 44 health related findings (4 repeats, 10 Immediate, 1 Special) for an average of 8.8 findings per person. ○ Unidas had 6 people in the review, with 43 health related findings (7 repeats, 11 Immediate) for an average of 7.2 findings per person. ○ A Step Above had 4 people in the review, with 26 health related findings (2 repeats, 3 Immediate, 1 Special) for an average of 6.5 findings per person. ▪ Residential agencies from the **Northeast** Region with the highest average number of health related findings per person include: ○ AWS/Benchmark had 3 people in the review with 18 health related findings (4 Immediate, 3 Special) for an average of 6 findings per person. ○ The two individuals with services provided by the Mi Via had had a combined 5 health related findings for an average of 5.5 findings per person. ▪ Case Management agencies from the **Northeast** Region with the highest average number of health related findings per person include: ○ Visions had 6 people in the review with 29health related findings (2 repeats, 7 Immediate, 3 Special) for an average of 4.8 findings per person. ○ The two individuals with services provided by the Mi Via had had a combined 5 health related findings for an average of 5.5 findings per person. ▪ Residential agencies from the **Southwest** Region with the highest average number of health related findings per person include: ○ Tresco had 7 people in the review with 36 health related findings (3 repeats, 6 Special) for an average of 5.1 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 47 health related findings (6 repeats, 1 Immediate, 7 Special) for an average of 5.9 per person. ▪ Residential agencies from the **Southeast** Region with the highest average number of health related findings per person include: ○ Aspire had 2 people in the review with 10 health related findings (1 repeat, 1 Special) for an average of 5 findings per person. ○ Tobosa had 3 people in the review with 14 health related findings (1 repeat, 2 Special) for an average of 4.7 findings per person. ▪ Case Management Agencies from the **Southeast** Region with the highest average number of health related findings per person include:	

#	2017 FINDINGS	Years Noted
	○ J&J had 9 people in the review with 46 health related findings (7 repeats, 3 Immediate, 3 Special) for an average of 5.1 findings per person. ▪ Residential agencies from the **Northwest** Region with the highest average number of health related findings per person include: ○ Ramah Care had 3 people in the review with 11 health related findings (3 repeats, 2 Special) for an average of 3.7 findings per person. ○ Dungarvin had 3 people in the review with 10 health related findings (2 Special) for an average of 3.3 findings per person. ▪ Case Management agencies from the **Northwest** Region with the highest average number of health related findings per person include: ○ Excel had 3 people in the review with 15 health related findings (4 repeats, 2 Special) for an average of 5 findings per person. ○ Peak had 2 people in the review with 7 health related findings (1 Special) for an average of 2.5 findings per person.	
#4.	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. 62% were found to have assessments in all areas needed (Q.4a) but none of the assessments were found to be both timely or have adequate content. (Q.4) 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.	Incorrect or conflicting health related information in the record was a frequently identified issue and included (Chart #8) (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.	Total instances of Class Members with pneumonia of any type (47) was up sharply for 2016. Although the total is down for 2017 (42) the upward trend continues (Chart #28). Class Members most frequently hospitalized have dehydration/urinary tract infections (25), next highest are bowel issues (23) (e.g., bowel obstructions/impactions); followed by Aspiration Pneumonia (21), enteral tube issues (9) and Sepsis (8). (Chart #26)	2004 and 2013 - present
#7.	Addressing JCM's functional and/or behavioral regression has improved from 2016 but continued improvement is needed. 7a. 23 JCMs (37%) were found to have experienced regression in their ability to function in the past year. 16 of these JCMs (70%) had teams take action to correct or slow this regression. (38 N/A, 1 CND). In 2016 57% had the regression adequately addressed. 7b. 8 JCMs (13%) experienced behavioral regression in the past year. 6 JCM's (75%) team addressed this regression. (54 N/A). In 2016 63% of JCMs experiencing behavioral regression had the regression adequately addressed.	2009 and 2011 - present

#	2017 FINDINGS	Years Noted
#8.	A notable area of improvement has been the timeliness of Mortality Reviews for the purpose of system learning from class member deaths. In 2016 the process of timely Mortality reviews had virtually stopped.[22] By 2017, DDSD reinitiated Mortality Reviews and has continued their effort to become more prompt. Currently there are 9 deaths from calendar year 2017 and 6 from calendar year 2018 that have yet to be heard. There are 3 deaths from 2017 that are not closed but have been heard and closed at the MRC meeting. (S5.3a)	2016 - present
B. Individual Service Plan (ISP)		
#9.	11 (18%) of the ISPs were found to contain current and accurate information. (Q#6)	2004 - present
#10.	Issues identified by specific sections of the ISP indicate wide spread problems with almost all sections. (Visions adequate: 53% (Q#7a., Q#7b., See also Q#7c.); Outcomes: 45% (Q#7d., See also Q#7e., Q#7f., Q#7g.); Action Steps: 6% (Q#7h); T&SS: 15% (Q#7i., See also Q#7j.); Incorporate ancillary providers: 16% (Q#7m.); Address live, work/learn, Fun/relationships: 82%. (Q#7o.)	2004 – present
#11.	No one in the 2017 Review was found to receive supports and services adequate to meet their needs (Q#36). 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 (26% in 2015).[23] (S5.3., S3.8)	2004 – present
#12.	Of the 62 people whose ISPs were reviewed and scored, none were found adequate to meet the individuals' needs. (Q#7) That is down from the 12% found to be adequate in 2016.	2004 - present
#13.	2 (3%) of the ISPs reviewed were being fully or consistently implemented. (Q#12) (S5.3b)	2004 – present
C. Case Management		
#14.	49 of 62 (88%) class members reviewed had case managers who knew them well. (Q#8c.);	2010 - present
#15.	74% of case managers for 45 people reviewed are visiting at least twice a month, and in varying locations where the person receives services and supports. (Q#16a.) (1 N/A)	2010 – Present Noted Ind. Findings
#16.	5% (3 JCMs) of the case managers were found to be documenting and following-up on progress on outcomes and action steps. (Q#16b.) 8% in 2016.	2009 – present
#17.	16 (26%) of JCM had case managers who were providing them with the supports and services they need. (Q#16c.) 42% in 2016.	2009 – present
#18.	36 (73%) of JCM's teams meet when there is a major change in the person's life. (Q#17d.) (S5.3., S5.3c)	2016 - present
D. Residential Services and Day Services		
#19.	54 (89%) residential staff and 50 (83%) day staff know the JCM well. (Q8b. Q#8a.)	2004 – present
#20.	7 (11%) of residential and 6 (10%) of day assessments were found to be adequate. (Q#4i., Q#4k)	
#21.	37 (73%) of JCMs like their home, staff… (Q#23a.)	
#22.	40 (67%) of JCMs live in an integrated neighborhood. (Q#32a.)	2004 – present
#23.	37 (64%) of JCMs are comfortable where they live and work. (Q#23.)	
#24.	38 (62%) of JCM feel safe. (Q#24.)	
#25.	20 (34%) of JCMs teams are taking steps to decrease the amount of time spent in congregate, segregated settings. (Q#29h.)	
#26.	13 (21%) of JCMs were found to be involved in activities that were meaningful outside of work. (Q#29.)	
#27.	29 (47%) of JCM's were found to make their own choices. (Q#30.)	2004 – present
#28.	12 (19%) of JCMs were found to have close personal connections. (Q#31.)	
#29.	37 (62%) of JCMs were found to have connections in their neighborhood. (Q#32.)	

[22] See 2016 CPR Finding #8.

[23] These individuals scored "Yes" on CPR Q.147 in the protocol.

#	2017 FINDINGS	Years Noted
#30.	10 (16%) of JCMs were found to be contributing members in their community. (Q#33.)	2004 – present
E. Employment Services		
#31.	0% of those reviewed were found to have a job that meets agreed criteria. (Q#28.)	2004 – present
#32.	1 (2%) of JCMs were found to have teams that help them find meaningful employment. (Q#26.)	
#33.	3 (6%) of JCMs were found to have teams who assessed their vocational interests, abilities and needs. (Q#26a.)	2004 – present
#34.	2 (4%) of JCMs were found to have been provided with information about the range of employment opportunities and how to access those options. (Q#26c.)	
#35.	5 (10%) of JCMs had teams who talked with them about becoming self-employed, or developing a customized employment opportunity. (Q#26d.)	
#36.	3 (6%) of JCMs had teams who developed a plan to eliminate any employment barriers. (Q#27b.)	
#37.	2 (6%) of JCMs had their team provide education and information to the guardian if he/she did not agree with employment so the guardian could act with informed choice. (Q#27c.)	
#38.	2 (5%) of JCMs reviewed have acted with informed choice and chosen not to work. (Q#27d.)	
#39.	8 (18%) of JCMs are not working because they consider themselves retired and are over the age of 62. (Q#27e.)	2004 – present
#40.	2 (4%) of JCMs working are in a paid position. (Q#28a.)	2004 – present
#41.	1 (2%) of JCMs working work an average of 10 hours a week. (#Q28b.)	2004 – present
#42.	2 (4%) of JCMs working work in a community, integrated job. (Q#28c)	2004 – present
F. Equipment and Technology		
#43.	15 (25%) of JCMs have the equipment and technology needed to be safe and comfortable. (Q#25.) (1 N/A)	2004 – present
#44.	33 (57%) have all of the equipment that has been recommended by a therapists or medical professional. (Q#25b.) (3 N/A; 1 CND)	2004 – present
#45.	24 (56%) have all of the technology that has been recommended by a therapist or medical professional. (Q#25c.) (18 N/A; 1 CND)	2004 – present
#46.	42 (71%) of JCMs had equipment and technology in good repair. (Q#25d.) (1 N/A; 2 CND)	2004 – present
#47.	36 (61%) of JCMs had equipment/technology available in all appropriate environments. (Q#25e.) (1 N/A; 2 CND)	2004 – present
#48.	50 (86%) of JCMs had staff who know how to help them use their equipment appropriately. (Q#25f.) (1 N/A; 3 CND)	2004 – present
G. Rights		
#49.	11 (18%) of JCMs have their rights respected. (Q#34.)	
#50.	57 (93%) of JCMs are addressed and described using respectful language. (Q#34a.) (1 CND)	
#51.	28 (45%) of JCMs are protected from abuse, neglect and exploitation. (Q#35.)	2004 – present
#52.	30 (48%) of JCMs are treated with dignity and respect. (Q#34c.)	2004 – present
#53.	48 (81%) of JCMs team know how to make a complaint if they believe their rights are being violated. (Q#34d.) (3 CND)	2004 – present

All of the 2017 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. All of these Systemic Recommendations are made with the expectation that DOH/DDSD will act to achieve 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, there are four recommendations which have outcomes that should be reported on monthly. Those recommendations are: Health #2,. #5, #8 and Case Management #12.

#	**2017 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) [24]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) 1e. the investigation of conflicting and/or inconsistent quality assurance information[25] 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 when corrective action is not effectively implemented (S4.2.); 1h. providers[26] using identified performance indicators as part of their agency quality assurance system to improve quality (S5.1)	2004, 2010, 2011, 2014
#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 Professionals, and	2004, 2011

[24] See December 2015 Health Care Coordination Definition paper agreed to by the Parties and disseminated by the Defendants.
[25] From sources such as IR, GER, OOH Placement Reports, RORI's, CPR findings, etc.
[26] "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.

#	2017 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	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. by nurses and direct support professionals, frontline supervisors and ancillary providers; 3b. to direct support professionals, case managers and others who support and provide services to class members; and 3c. on a regular basis so that performance corrections can be made naturally, practically and effectively.	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) 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).	2014, 2016
#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	2017

#	2017 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	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[27]: 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. 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 and re-admissions and hospice 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, bowl 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	2004, 2007, 2009, 2015, 2016

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

#	2017 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	11d. memorialized into the system to ensure sustainability when found to be effective.	
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; 12c. identify why QMB and CPR case management findings are so divergent; and 12d. recommend ways forward in an effort to sustain improved practice.	2004
#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[28] 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;	2004, 2005, 2016

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

#	2017 RECOMMENDATIONS *Related Evaluative Components are listed in parenthesis: e.g., (S4.1)*	Years First Identified &/or Recommended
	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 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

III. TRANSITION TO THE INDIVIDUAL QUALITY REVIEW

A. From Community Practice Review to Individual Quality Review

The protocol used as part of the Jackson Community Practice Review has been in place since 1994. 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 questions to be asked and scored included feedback from providers, case managers, Plaintiffs, Intervenors, Defendants, the Community Monitor and Community Monitor Consultants. Evaluations of reviewer engagement during interviews and onsite observations were requested and received from many of those interviewed including class members, guardians, direct support professionals (day and residential), case managers, nurses, therapists and Behavior Support Consultants. The new IQR and process were adopted by the Community Monitor, Defendants, Plaintiffs, and Intervenors.

B. A Review About Me

The process of developing the new protocol (IQR) began by asking stakeholders what they wanted people with intellectual and developmental disabilities (I/DD) to be able to say about their lives and the supports and services they receive. This is what stakeholders wanted people to be able to say: [29]

I have a good plan and a responsive team

My health is monitored, my wellness needs are met

I am safe and comfortable

My days are productive, I have friends, and I'm a part of my community

My rights are respected and protected

C. Review Process

In addition to changing the protocol, DOH/DHI and DDSD intend to move towards assuming the responsibility for the review process and implementation responsibilities in anticipation of the Jackson litigation coming to an end. Since the Department had no full time DHI/IQR Reviewers hired or available to be trained or work as a reviewer at the beginning of the 2017 Review, the review process experienced little change this first year. The process, in general, includes:

[29] Visual symbols have been used for class members who are non-readers and/or families for whom English is not their first language.

Public Availability of the IQR Protocol and Guidance: The IQR 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 implementation. 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 free 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 evidence accumulated by the Reviewer, findings and recommendations are developed;

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, 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 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 than 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.

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 Review #6, the final Regional report is issued to all of the parties.

D. Follow Up

Ten calendar days following the Regional Status Summary, DDSD assumes responsibility for following up with individual Teams 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 report 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.

E. Examples of CPR/IQR Protocol Differences

The CPR and IQR protocols are different in several ways. When reviewing the issues, findings and scores identified in the IQR it is important to remember:

- The IQR uses more contemporary language;
- The IQR asks specific questions about systems that didn't exist in 1998 (e.g., eChat, CARMP);
- The IQR asks more detailed questions about the quality or adequacy of required services, supports, documents; and
- The IQR is scored in a complementary but expanded way.

Exploring the third bullet will help explain, in part, why the number of 'findings' and the number of 'issues' are expanded in the IQR. For example, both the CPR and the IQR explore the availability and adequacy of assessments. Assessments are foundational for individuals and Teams to know what people's strengths, preferences, skills and needs; and in turn, identify the right DD Waiver services which need to be provided. The CPR asked two questions regarding relevant assessments and their adequacy, the IQR asks questions specifically identifying what criteria is needed for adequacy by identifying ***where the person 'started' (baseline)*** so the author of the assessment can identify, in measurable terms, whether or not the person is actually making progress, maintaining skills or regressing. The IQR also asks whether or not the assessment ***identifies the person's strengths***. Rather than focus on what the person cannot do, it is essential that the author identify and build on the strengths that the person has; in other words, assessments are not deficit-based or deficit-focused. Also, the IQR asks about whether or not the author ***provides recommendations to the team*** on how they can build on the person's strengths to enable him/her to gain and/or maintain new skills. Those recommendations should be brought to the planning meeting so that action steps and strategies can be developed and reinforced across the person's day to ensure consistency of delivery and frequent opportunities for the person to practice new skills.

The CPR and IQR questions used in this example follow. These questions are not specifically health-related, rather, these 'assessment' questions are more therapy/programmatic related.

CPR Question	IQR Question
57. Did the team consider what assessments the person needs and would be relevant to the team's planning efforts?	

CPR Question	IQR Question
58. Did the team arrange for and obtain the needed, relevant assessments?	4. My team obtained adequate and timely assessments in areas most likely to lead to my greater independence.
	4a. Do I have an assessment in all areas that I need?
59. Are the assessments adequate for planning	4f. Are my assessments adequate for planning?
	4b. Does the assessment describe where I started (baseline) in each area?
	4c. Does the assessment describe my strengths in each area?
	4e. Does the assessment give recommendations to my team on what new skills I might learn and how to help me learn them consistent with my preferences?
60. Were the recommendations from assessments used in planning?	5. My plan incorporates the recommendations from assessments, or explains why recommendations were not included.

Another notable and complementary difference between the CPR and the IQR is the scoring. As the following side-by-side comparison indicates, the 'yes' or 'full compliance' scores are the same between the two as are the 'no' or 'non-compliance' scores. Unlike the CPR, the IQR provides more options between full and non-compliance, that is, the IQR allows for a scoring of "2" which equals "many indicators met" and "1" which means needs improvement. This provides more performance indicators which, in turn, should enable the Department and providers to identify incremental change over time.

CPR Score	IQR Score
0 = Information not present or not adequate (non-compliance)	A rating of 0 = No or No compliance
1 = Information is not completed or partially adequate (partial compliance)	**A rating of 1 = Needs Improvement, few of the indicators are met, many are inconsistently met.**
	A rating of 2 = Many indicators met, but evidence demonstrates that not all were met.
2 = Information present and found to be adequate (full compliance)	**A rating of 3 = Full Compliance or Yes**
NA = Item not applicable to this person	A rating of NA (Not Applicable) represents an item does not apply to the individual being reviewed
CND = Cannot determine based on information available.	A rating of CND = Cannot Determine

Symbols are used to identify scoring results in the 2017 Power Point so non-readers or individuals for whom English is not their first language will be able to identify scoring results more easily. Please note that all of the questions and related scores are identified in the Appendix section at the end of this report.

3 = Full Compliance (Yes). This symbol is used to note Full Compliance (Yes answers)

2 = Many Indicators Met. This symbol means compliance is almost met.

1 = Needs Improvement. This symbol is used to encourage improvement.

0 = No Compliance (No). This symbol notes lack of compliance.

IV. INTRODUCTION TO THE 2017 IQR STATEWIDE REPORT

During the 2017 IQR Reviews, supports and services offered to 65 individuals were reviewed.[30] This report represents a summary of the statewide findings. Separate regional reports and a PowerPoint presentation reflecting the statewide scores for each IQR Question have already been distributed and can be found on the IQR website at jacksoncommunityreview.org.

The website also contains the IQR protocol along with other relevant information so needed reference materials are available to everyone. The protocol contains not only the questions which are ultimately scored but also the questions that reviewers ask the individual, guardian, case manager, residential and day staff. In addition to specific questions that are asked by reviewers, notes identifying specifically what reviewers are to look for are also included. The Guide for Reviewers and Case Judges is also posted online. As previously noted, the IQR, like the CPR, continues to be an 'open book test'. This information has been available online for 9 years.

This report identifies related objectives which come from Evaluative Components ordered by the Honorable James A. Parker on April 3, 2015 (Doc. 2035).

The draft of this report was originally distributed by the Community Monitor to the parties and the Jackson Compliance Administrator May 11, 2018. Since that time, the Community Monitor has met with and reviewed the report findings and recommendations with representatives of the Defendants, Plaintiffs, Arc Intervenors and the Jackson Compliance Administrator. The Final Report reflects the input received.

During the regional reviews approximately 650 people provided input and approximately 700[31] individuals including individuals receiving services/guardians, team members and regional/state DDSD/DHI representatives had an opportunity to review and suggest changes to the individual review findings.

As before, this statewide report differs from the Regional PowerPoint reports in at least three ways. This report:

- identifies related Objectives which come from the Evaluative Components required in the Jackson Case (See Court Order Document. 2035, June 11, 15);
- contains aggregate data based on individual issues and findings identified for the 62 individuals who were reviewed statewide;
- identifies, prioritizes and explains the most frequently identified issues by topic area; and
- identifies the frequency of issues/findings by provider/case management agency in an effort to assist DDSD, providers/case managers and others to focus on areas where technical assistance and corrective action is most needed.

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 18a asks, "Have I received all age and gender appropriate health screenings, in accordance with national best practice and/or as recommended by my 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."[32] 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.

A. Jackson Class Member Demographics

[30] Findings and recommendations for 65 individuals were issued. 62 individuals had scored protocol books. Those who did not have a scored IQR protocol book were the 3 people in the review who were receiving supports through Mi Via.

[31] Some individuals appear more than one time as they sit on more than one team.

[32] 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.

As of December 31, 2017, there were 256 Jackson Class Members. The tables that follow provide information about those Jackson Class Members.

Chart #1: Active Class Member Demographics

Gender	
Male	154
Female	102

Age	
30-39	3
40-49	40
50-59	107
60-69	77
70-79	23
80+	6
Average Age:	58

Ethnicity	
Hispanic	119
Caucasian	91
Native American	33
Black	12
Asian	1

Region	
Metro	153
NE	24
NW	18
SE	27
SW	34

Day Service Type[33]	
Adult Habilitation (AH)	177
Adult Hab/Supp Empl (SE)	31
Adult Hab/Community Access (CA)	14
Community Access	12
Community Access/Supp Empl	2
Supported Employment	5
Mi Via	12
NONE	3

Residential Service Type	
Supported Living	199
Family Living	38
Mi Via	12
Independent Living	4
ICF/I/DD	3

[33] For a definition of Day or Residential Service Type see the Residential and Day Services Section.

B. Most Frequently Identified Findings by Category

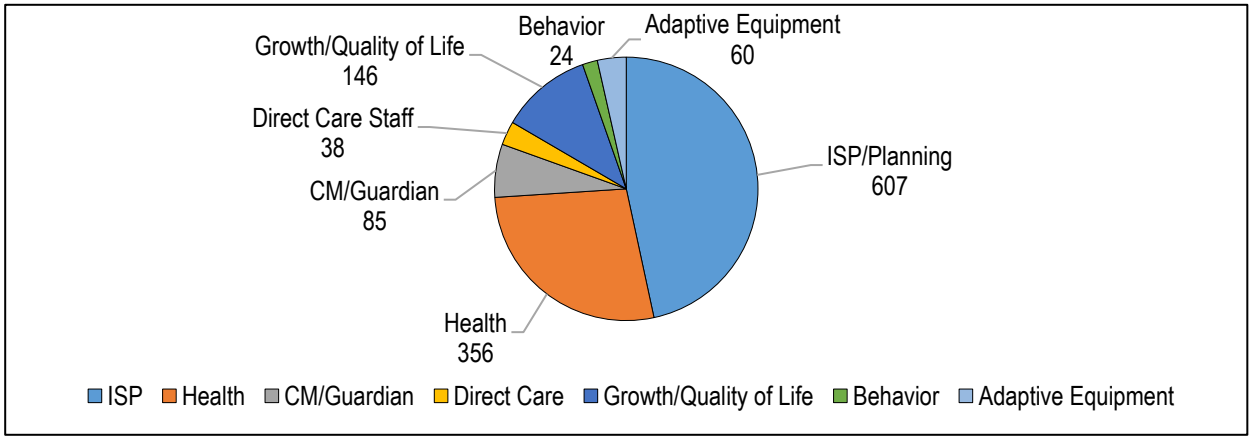
The following chart identifies the topical categories where most findings of problem areas were identified during the last six years.

Chart #2: Number of Findings by Topic Category, 6-Year Totals With Average Number of Findings per Class Member Reviewed						
Category area[34] Number in sample	**2011/2012[35] 109**	**2013[3] 103**	**2014[36] 101**	**2015[4] 99**	**2016 93**	**2017 65**
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
Health Care/Health Care Coordination[37]	370 Avg: 3.39	321 Avg: 3.15	437 Avg: 4.33	414 Avg: 4.18	313 Avg: 3.66	356 Avg: 5.48
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
Direct Care Services	171 Avg: 1.57	151 Avg: 1.47	137 Avg: 1.36	152 Avg:1.54	131 Avg: 1.41	38 Avg: .58
Expectation of Growth/Quality of Life	103 Avg: .94	84 Avg: .82	107 Avg: 1.06	106 Avg: 1.07	95 Avg: 1.02	146 Avg: 2.25
Behavior	Not Aggregated	Not Aggregated	Not Aggregated	63 Avg: .64	43 Avg: .46	24 Avg: .37
Adaptive Equipment	81 Avg: .74	62 Avg: .60	70 Avg: .69	50 Avg: .51	46 Avg: .49	60 Avg: .92

From 2012 to and including 2017, the two areas where the most issues continue to be identified are Adequacy of Planning/Individual Services Plan (ISP) and Health Care/Health Care Coordination. In both areas the findings per class member reviewed are at their highest ever. Adequacy of Planning/Individual Services Plan is at an average of 9.34 findings per person, from a previous high of 6.19 in 2016. Health Care is at an average person of 5.48, up from a previous high of 4.33 in 2014. These two areas will be explored in greater detail, starting with identified health related issues.

[34] Immediate and Special findings are included in their appropriate topic areas in 2014, 2015 and 2016
[35] The 2011, 2013 and 2014 numbers were provided by DDSD.
[36] The 2015 and 2016 numbers provided by the Community Monitor.
[37] DDSD uses the terminology "Health and Wellness" which matches the Findings and Recommendations Form in the Community Practice Review.

Chart #3: Most Frequently Identified 2017 Findings by Topic Area



C. CPR and IQR Historical Perspective

The current Community Monitor has been conducting the Community Practice Review (CPR) since 2004. The Individual Quality Review (IQR) began in 2017. During the past fourteen years the Department of Health, Developmental Disabilities Supports Division has developed and refined standards, policies and procedures; created the Clinical Services Bureau; attempted to keep a Medical Director engaged and in place; and initiated coordinated activities intended to address aspiration. In addition, individual findings and recommendations identified during the CPR 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.
It is worth noting the foundation upon which CPR/IQR historical and current information rests. CPR/IQR fact finding and reporting during the past 14 years has included:

9,285 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.

78 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.

1,305 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.

78 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.

13 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.

As evidenced here, detailed facts which have been reviewed by hundreds of people prior to finalization have been gathered and are available by person, by provider, by case management agency, by Region and statewide for over a decade.

Yet, 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 12 to 13 years and continue to be identified as issues in the 2017 IQR Report(s). As represented above, the number of Health Care/Health Care Coordination 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, this subject area is the beginning focus of this 2017 report.

Chart #4: 2015 Remedial Plan Health Related Objectives Which Correspond With Previous CPR and Current IQR Issues including the Year the Issue was First Identified by the CPR

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 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.	2005 to present
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

Evaluative Component/ Objective #	Evaluative Component	Year Issue Was First Identified
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
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

The average age of a Jackson Class Member is 58 years old. This is a diminishing group. The urgency to take collaborative, decisive and effective action which results in improved practice is as high or higher now than ever. It is generally not productive to expend energy by engaging in arguments and/or justifications as to why things have or have not happened in the past. However, it cannot continue to go unnoticed that there has been and continues to be long-term system failure to consistently recognize, report, intervene, evaluate and ensure corrective action resulting in improved practice and protections which are sustained at the individual, provider and systems level. This breakdown is due in large part to the lack of an active and effective Quality Assurance/Quality Improvement system. Such a system would routinely recognize and reward good practice as well as take swift and effective corrective action which results in improved and sustainable practice when problems and issues are identified.

V. HEALTH AND OVERALL WELLNESS

A. Health Care Coordination

Related Evaluative Components Required for Disengagement include:
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.
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.

Healthcare Coordination 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.[38]

Healthcare coordination is everyone's responsibility. At a high level, what is being probed as part of the Individual Quality Review is whether the Team knew and whether the 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.

Effective healthcare coordination involves having well defined roles and responsibilities that are consistently carried out at the individual, provider, region and state level. This section focuses, primarily, on information gathered through the IQR at the individual and provider (day and residential) level. Case Management, individual planning, therapy related and other important contributors to overall wellness are addressed later in this report.

The IQR identifies **expectation statements** in the first person with accompanying questions. In the health arena the overall expectation statements are as follows:

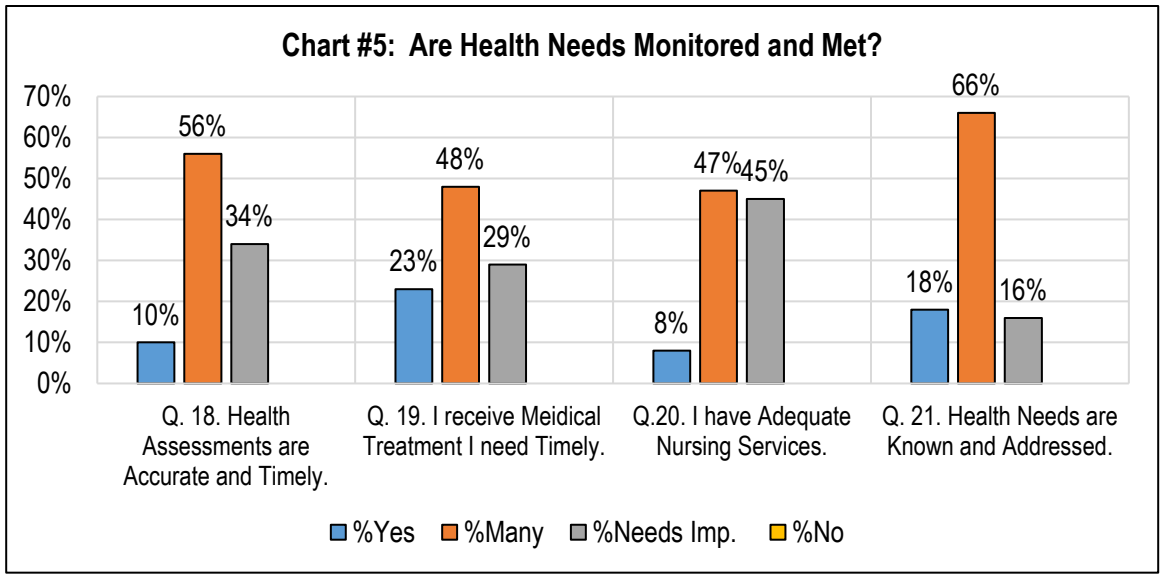
Broad Expectation: "My Health is Monitored and My Medical Needs are Met".

In order to inform the answer to this expectation, other expectations are explored as part of each person's review, including the IQR Questions in the chart below. A closer examination of information which influenced these findings follows, starting with the relevant scored questions asked as part of the IQR.

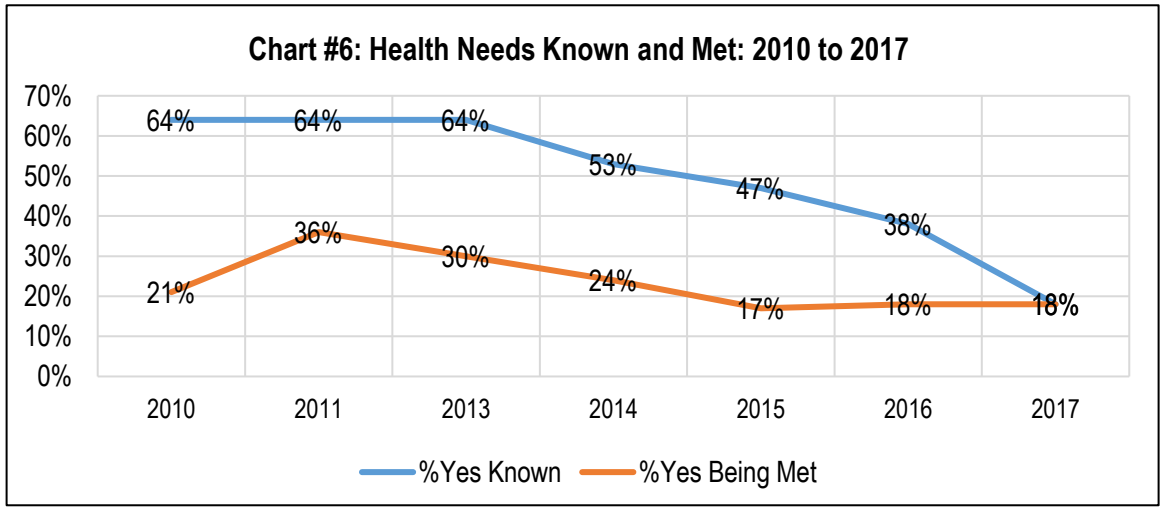
Question #18: My health assessments are accurate and completed as needed.
Question #19. I receive the medical treatment I need timely.
Question #20. I have adequate nursing services.
Question #21. My team is familiar with and addresses my health needs.[39]

[38] 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

[39] CPR Questions #55. Is there evidence that the IDT discussed the person's health-related issues? And CPR Question #56. Are the person's health supports/needs being adequately 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. As Chart #6 illustrates, since 2010, there has been a steady decline in evidence verifying that teams know/discuss the person's health related needs and, in turn, act to adequately address those needs.



This report aggregates information gathered at the individual level in an effort to uncover trends. 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 finding. In an effort to constantly remind us all that these findings reflect actual events in people's lives details of specific findings for specific people will be shared. In order to protect the identity of the class member numbers are used instead of names or initials.

Person #1: Example of findings for this one person.

Lack of effective Nursing Oversight and Health Care Coordination:

- Regression not addressed timely**;**
- Clinical Orders/Recommendations not followed or not followed timely (5 findings)**;**
- Falls, lack of intervention to protect (2 findings);
- Not identifying signs and symptoms of potential health issues;
- Not receiving age/gender-appropriate preventative health screens/immunizations in spite of successful screens in past (Repeat Finding from 2008 and 2013);
- Lack of evaluation of effectiveness of medical interventions;
- Lack of accurate and complete Health Care Plans and Emergency Response Plans (2 findings);

Inaccurate, Incomplete or Inadequate Health Records:

- Nursing Reviews;
- Electronic Health Record (eChat) (2 findings);
- AIMS;
- Health Care Plan/Medical Emergency Response Plans;
- Nutritional Assessment (Repeat Finding in 2008, 2010, 2013);
- Lack of tracking (bowl, liquid input, and output) (2 Findings) (Tracking incontinence is a Repeat Recommendation from 2010)

This individual has a diagnosis of Cerebrospinal fluid drainage device, shunt, valve, or other device. The shunt was placed when (#1) was either 9 or 11 days old (depending on what record is reviewed), and was revised multiple times early in life. It appears the shunt has been inactive for many years and the individual was not considered to be actively suffering from fluid buildup.

2015: TEASC[40] made recommendations which were not followed up on until the 2017 IQR Review listed them individually and asked that specific follow up on each recommendation finally be done.
2016: (#1) experienced a significant decline in health which included loss of ability to use one leg and became completely dependent on a wheelchair.
2017: April and May there are several incident reports of the person complaining of headache, and sometimes dizziness and nausea. For over a year the person has been experiencing bouts of increased lethargy and irritability. The person has had multiple falls and one side of their body is not working well. There hasn't been a neurology consult, or the report of a recent MRI or CT scan of head, so it is unsure when it was determined that fluid buildup was not a problem anymore. Important information resulting from interdisciplinary evaluations is missing from the record.

[40] Transdisciplinary Evaluation Support Clinic, funded by NM DOH/DDSD through UNM Department of Family and Community Medicine. They conduct whole-person comprehensive evaluations for people with I/DD at no cost to the individual.

September 2017: IQR Review recommended that the Team/PCP consider, "…an immediate CT Scan or MRI to ensure that the shunt is still intact and there are no other changes with the person's cerebrospinal fluid condition."
December 6, 2017: The person was taken to Med center on 12/6/17 for planned surgery to replace a shunt that Dr. … said had not been working for years and there was an increased amount of fluid around brain. The person tolerated surgery very well.

B. 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 projections/treatment is to have accurate and comprehensive health records. Health records provide a means of communication about preventative health services, history of examinations, diagnosis, 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 earlier, teams must know the person and his/her current and changing needs and teams must act on this information. In this case, acting means documenting information related to the persons health needs accurately and timely in his/her health record. The lack of accuracy of health records has been an identified issue since at least 2004. As the following chart illustrates, the accuracy, comprehensiveness and timeliness of health records continues as a significant issue in 2017. There are a number of records, plans and tools that are heavily relied on with respect to individual records. A few of the most frequently cited are listed below.

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.[41] 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).[42] 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 diagnosis 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.

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

Annual nursing assessments are required for all people receiving any of the Livings Supports (Supported Living, Family Living, IMLS). Nursing assessments are required to determine the appropriate level of nursing and other supports needed within the Living Supports.[43] Nurses are, typically, the employee or sub-contractor of the residential and/or day service agency.

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.

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.

When examining the record, conducting interviews and observations, reviewers look for plans that are required, based on individual need. Plans that are out of date or contain conflicting information are identified as an important area to fix so that it is clear to anyone supporting the individual what the person's needs are and what the expected supports/responses are for that person. Staff should not have to guess what they are to do.

Chart #7: Issues Identified Related to the Accuracy of Health Records

Issue	Year	# of JCM	%	# of Issues
Plans, Documents Not accurate, or Contain Inconsistent Information	2017	56 of 65	86%	253
	2016	*57 of 93*	*61%*	*128*
Assessments: Late, Inaccurate, or Missing	2017	42 of 65	65%	85
	2016	*19 of 93*	*20%*	*29*
Tracking Not Done or is Inaccurate	2017	14 of 65	22%	23
	2016	*7 of 93*	*8%*	*9*
Medication Administration Record/Issues	2017	18 of 65	28%	56
	2016	*16 of 93*	*17%*	*23*

[43] 2018 NM DD Waiver Standards, Chapter 10. Living Care Arrangements, 10.3.2, Page 96

As in the CPR, the IQR seeks specific information regarding the status of the individual as identified by the content of the health record. Team members have a duty to know the person well and then to act with reasonable care in a way which results in early identification, prevention and/or effective and timely treatment. 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 may then be developed. Health Care Plans which are required versus those which should be considered are to be noted in the electronic record. These Health Care Plans are intended to give guidance to direct support professionals in the day-to-day care of the individual.

Both the previous CPR as well as the current IQR asked questions seeking information related to assessments and health care plans. 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.

When probing the accuracy and timeliness of assessments, the following findings were frequently found:

92% of those reviewed were found to have a current and accurate ***Aspiration Risk Screening Test*** (ARST) (Q.18f).

84% of those reviewed had a current ***dental assessment*** (Q18e.).

79% of those reviewed had a current ***vision assessment*** *(Q18c)*. When individuals are unable or unwilling to participate in a 'formal' vision exam, some therapists (usually an OT or an SLP) have been willing to conduct observations during a scheduled assessment and note whether or not there is reason to believe that the person has any functional vision issues. This may also include interviews with staff to incorporate their observations. If there is reason to believe that vision is changing or declining, the team can discuss whether or not further testing should be sought.

Assessments that were less frequently found included:

72% of those reviewed had accurate and complete ***annual physicals*** (Q18a.). Often documents returned from a physical have areas which are left blank, a line is put through them (designation of that is unclear), inaccurate diagnosis are recorded – or accurate diagnosis are not recorded. The lack of a complete systems review is also frequently identified as an issue.

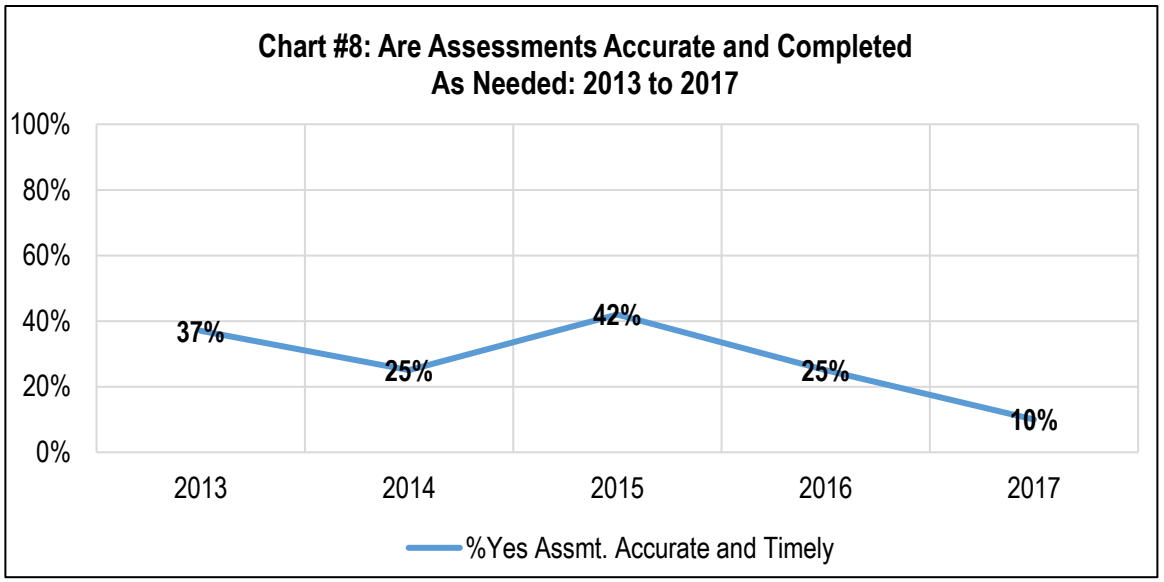
57% of those reviewed had a current ***hearing assessment*** (Q18d). Like vision, when individuals are unable or unwilling to participate in a hearing exam, some therapists have been very helping to conduct observations and interviews with staff so they can make observations as a part of their annual assessments regarding the person's hearing.

49% of those reviewed had their assessments/screens completed as recommended.

40% of those reviewed had an accurate and current Comprehensive Health Assessment Tool (eChat).

29% of those reviewed had received age and gender appropriate health screenings/immunizations in accordance with national best practice and/or as recommended by their PCP/other health care professionals (Q18a.)

The lack of acquiring needed assessments or their alternatives is a long-standing issue as the following chart illustrates.

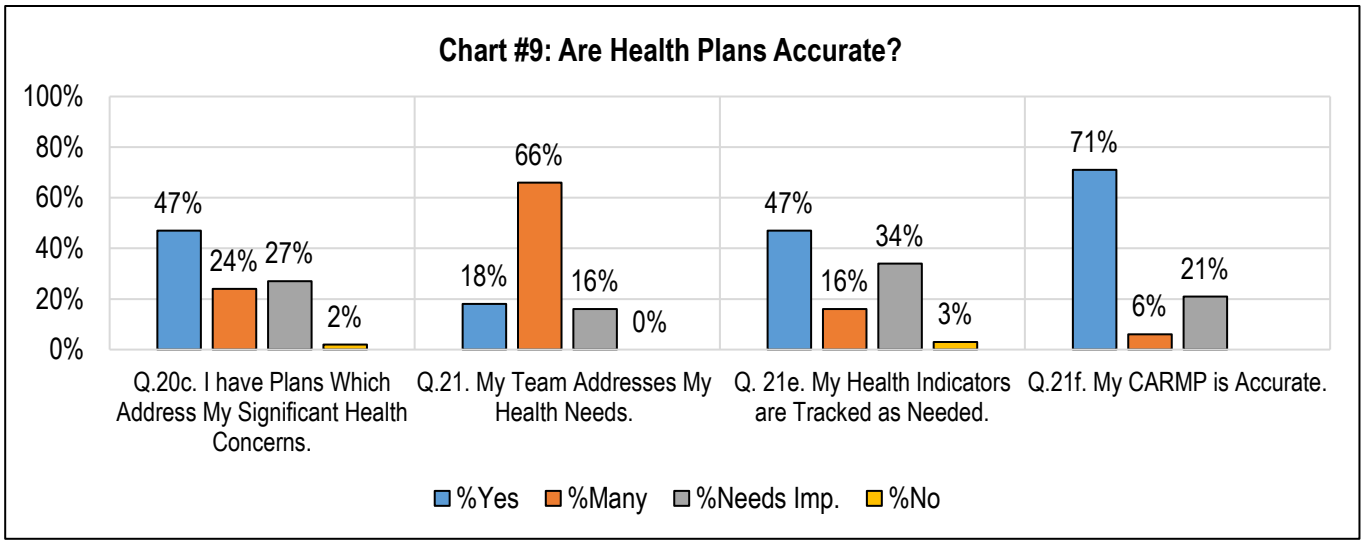


Once assessments have been updated and/or completed, nurses are to determine if Health Care Plans (HCP) and Medical Emergency Response Plans (MERPs) are warranted and if so, develop them, train the staff, and provide ongoing oversight to ensure their accurate and consistent implementation.

Issues with the health record such as inaccurate, conflicting or missing Plans (Health Care, CARMP, MERPS, etc.) has been identified as an issue for over a decade. As the summary and chart which follows emphasizes, inaccurate records continue as a problem today. When reviewing day-to-day practice for class members in DD Waiver Services, the highest full compliance number was only 71% of class members who needed an aspiration risk management plan had one that was accurate and not in conflict with other related documents. Having 29% of those reviewed with inaccurate or conflicting instructions for staff when they are dealing with aspiration risk, one of the leading contributors of death in people with I/DD, is very troubling. If this was a new issue and, therefore, caught people by surprise that would be equally troubling. Risks related to aspiration have been identified as a part of the CPR since, at least, 2004. Continuous and effective diligence MUST complement the policies and procedures put in place by DDSD in order to have safe and effective plans and protections in place.

Specific IQR questions related to HCP and MERPS follow.

Question #20c. Has my nurse developed individualized health care plans (HCP's) and Medical Emergency Response Plans (MERP's) to address my significant health concerns?
Question #21. My team is familiar with and addresses my health needs.
Question #21e. Are my health indicators (such as seizure tracking records, weight records, bowel movements, etc.) tracked as needed.
Question #21f. My CARMP is accurate.



C. Are Individuals Receiving Adequate, Timely Medical Treatment?

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 H2.1 Jackson Class Members receive age appropriate preventive/early detection screening/immunizations for health risk factors.

Perhaps the most critical role of providers and individual team members is taking informed and timely 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.

Question #19: I receive the medical treatment I need timely. Related CPR Questions # *Q#56: … Are the person's health supports/needs being adequately addressed?*

Again, concerns in this area are not new. During the past 5 years, the ***highest number*** of class members for whom health care needs were seen to be adequately addressed was 30% of those reviewed. (See more detailed information regarding the receipt of needed types of medical care/treatment in the charts that follow.)

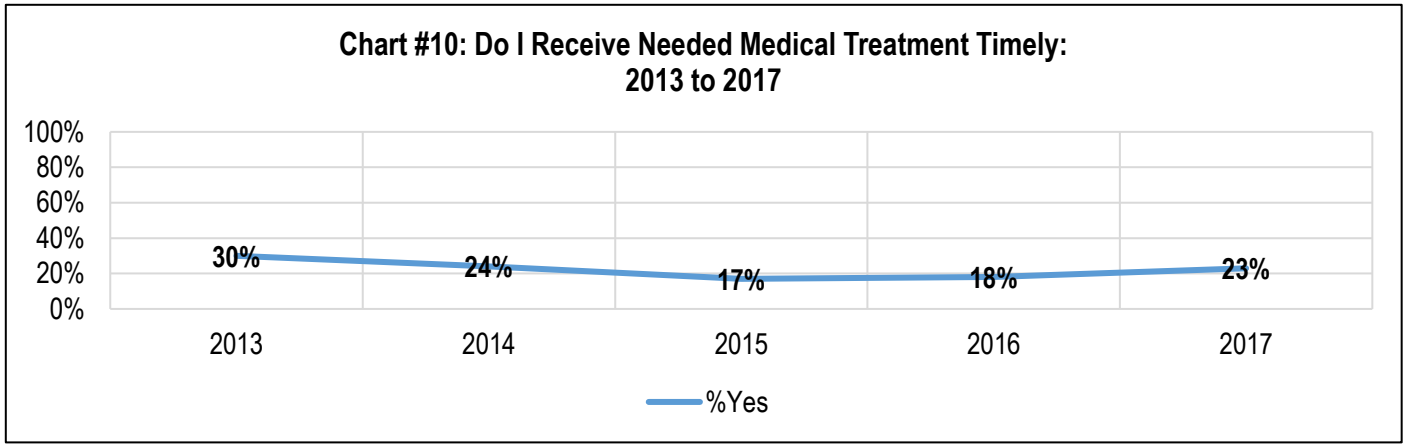


Chart #11 begins to highlight some of the types of issues which impact these findings as well as the number of class members affected by the issue. For example, in 2017, the IQR found that 47 of the 65 people reviewed (72%) had issues with not receiving recommended medical appointments or evaluations. Some of these issues are explored in more detail in the sections that follow.

Chart #11: Issues Related to Lack of Overall Healthcare Coordination, Nursing Oversight and Follow up

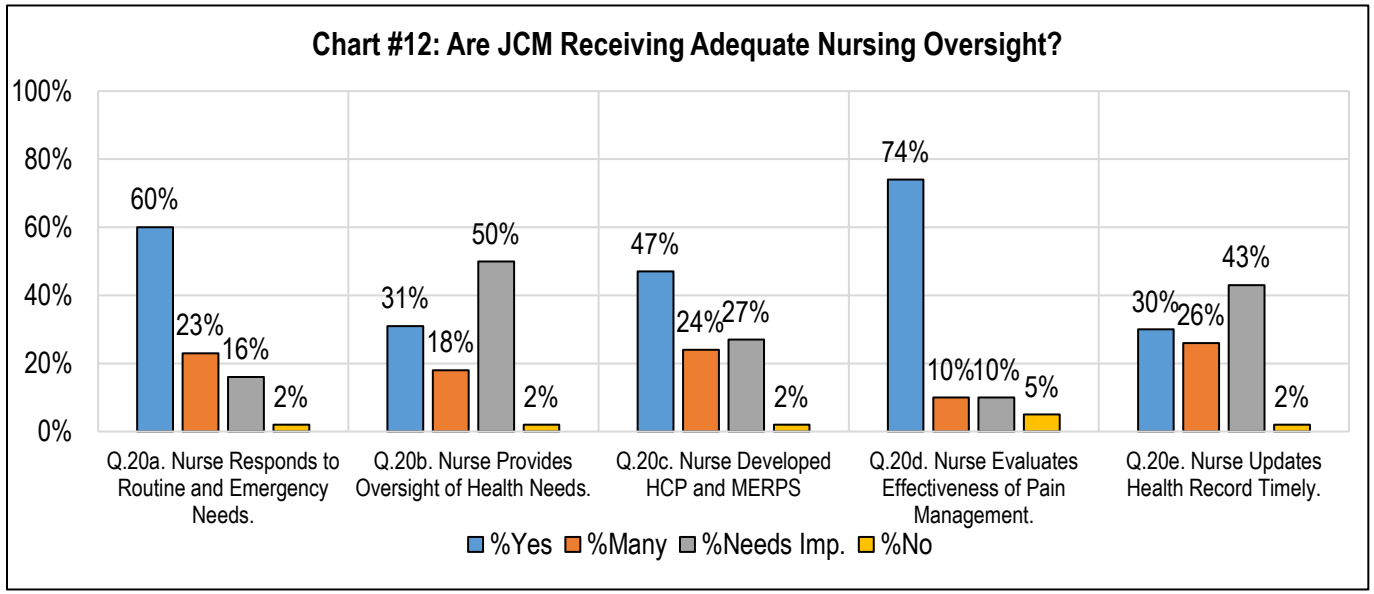
Issue	Year	# of Class Members Affected	%	# of Issues
Not following up on recommended medical appointments or evaluations;	2017	47 of 65	72%	157
	2016	*52 of 93*	*56%*	*98*
Nurse Uninformed/Giving Incorrect Information	2017	13 of 65	20%	18
	2016	*6 of 93*	*6%*	*6*
Lack of Adequate Nursing Oversight	2017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

D. Are Individuals Receiving Adequate Nursing 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.

For health care coordination, oversight and monitoring, I/DD services rely heavily on nurses, primary care physicians and referrals to needed specialists. Relevant questions related directly to nursing include:

Question #20a. Does my nurse respond to all of my routine and emergency needs, as appropriate?
Question #20b. Does my nurse provide oversight of my health needs (e.g., weight records, vitals, lab reports, PRN Medication use, seizure records) in order to ensure accuracy, identify and respond to new issues?
Question #20c. Has my nurse developed individualized health care plans and medical emergency response plans to address my significant health concerns?
Question #20d. Does my nurse evaluate the effectiveness of pain management strategies and record the effectiveness in nursing notes or on the MAR?
Question #20e. Does the nurse ensure my healthcare record is promptly updated?

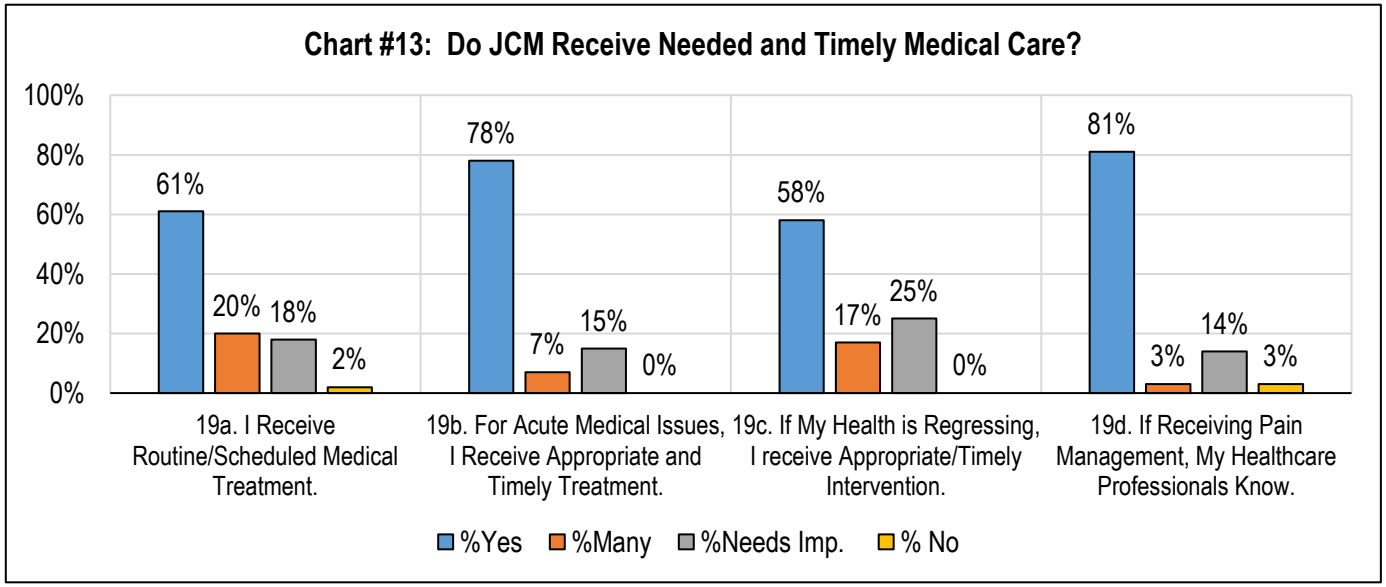


Nurses and the supports they can provide are essential for the protection and healthy living of class members. Nurses have identified multiple barriers to their practice including, in part: over-regulation; lack of administrative support from their local provider(s) (e.g., ensuring staff attend scheduled RN 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. All of these issues 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 can improve 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.

Question #19a. Do I receive routine/scheduled medical treatment? This includes consistent attention to my chronic conditions.
Question #19b. When I have an acute medical issue, do I receive appropriate and timely treatment?
Question #19c. If my health is regressing, do I receive appropriate and timely intervention?
Question #19d. If I am receiving effective pain management the strategies are communicated to all of my treating healthcare professionals?



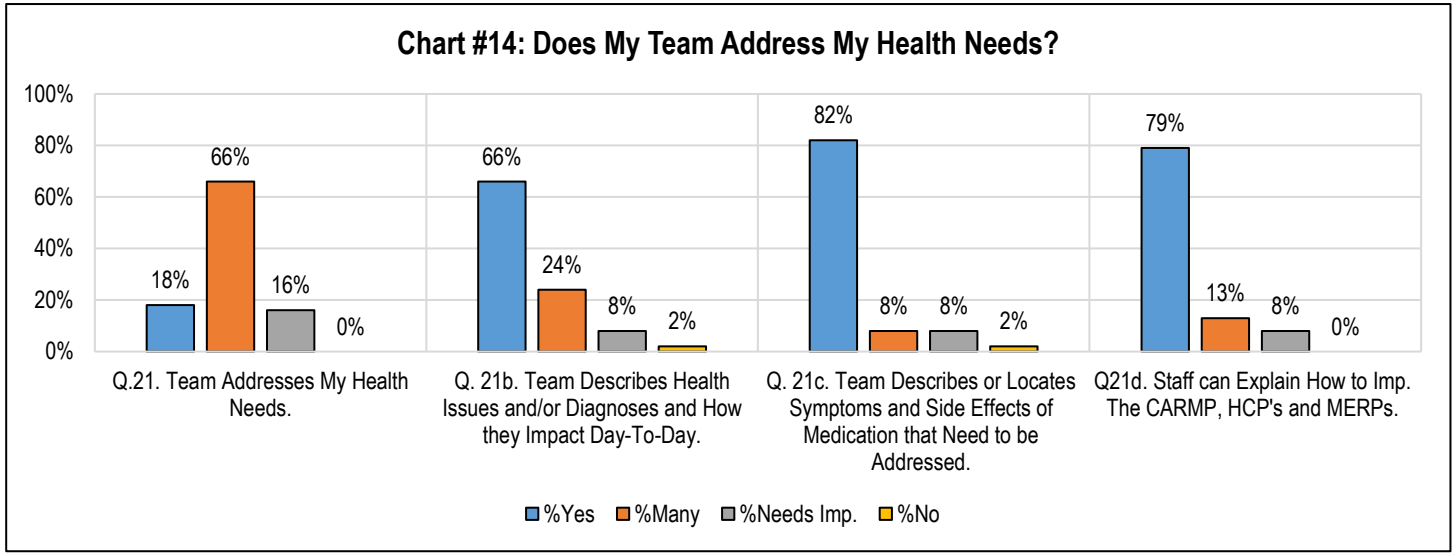
E. Are Teams Addressing JCM Health Needs?

Related Evaluative Components Required for Disengagement include:
Health Objective 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.
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.

In addition to agency nurses, it is everyone's responsibility to recognize and respond when a person has ongoing health needs as well as when a change in health status occurs. Some of the relevant IQR questions which probe whether team members address health needs follow.

Question #21. My Team is familiar with and addresses my health needs.[44]
Question #21b. Can my team members describe my health issues and/or diagnoses and how they impact me on a day-to-day basis?[45]
Question #21c. Can my team members describe or locate symptoms and side effects of medication that would need to be addressed by medical personnel?
Question #21d. Can the people who work with me every day explain how to implement the CARMP, HCPs and MERPs?



F. Are Medications Received As Prescribed?

Related Evaluative Components Required for Disengagement include:
Health Objective 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.
H1.8a Defendants must monitor the accuracy of dispensation of prescription medications to each JCM.
H1.8b Defendants must take prompt action to correct any failure to properly dispense medications to a JCM in accordance with

[44] CPR Question #55.
[45] CPR Questions #30; #38; #48 and #54.

prescriptions."

Another critical area explored with respect to receipt of what has been ordered or prescribed by a physician includes medication. Most Jackson Class Members receive multiple medications. When reviewing medication storage and administration there are underlying expectations that influence the questions asked. While there are multiple sources that can be used as a guide when reviewing medication, accepted practice is consistent.

The Nursing Center[46] has identified 8 Rights of Medication Administration which are informative and are included here.

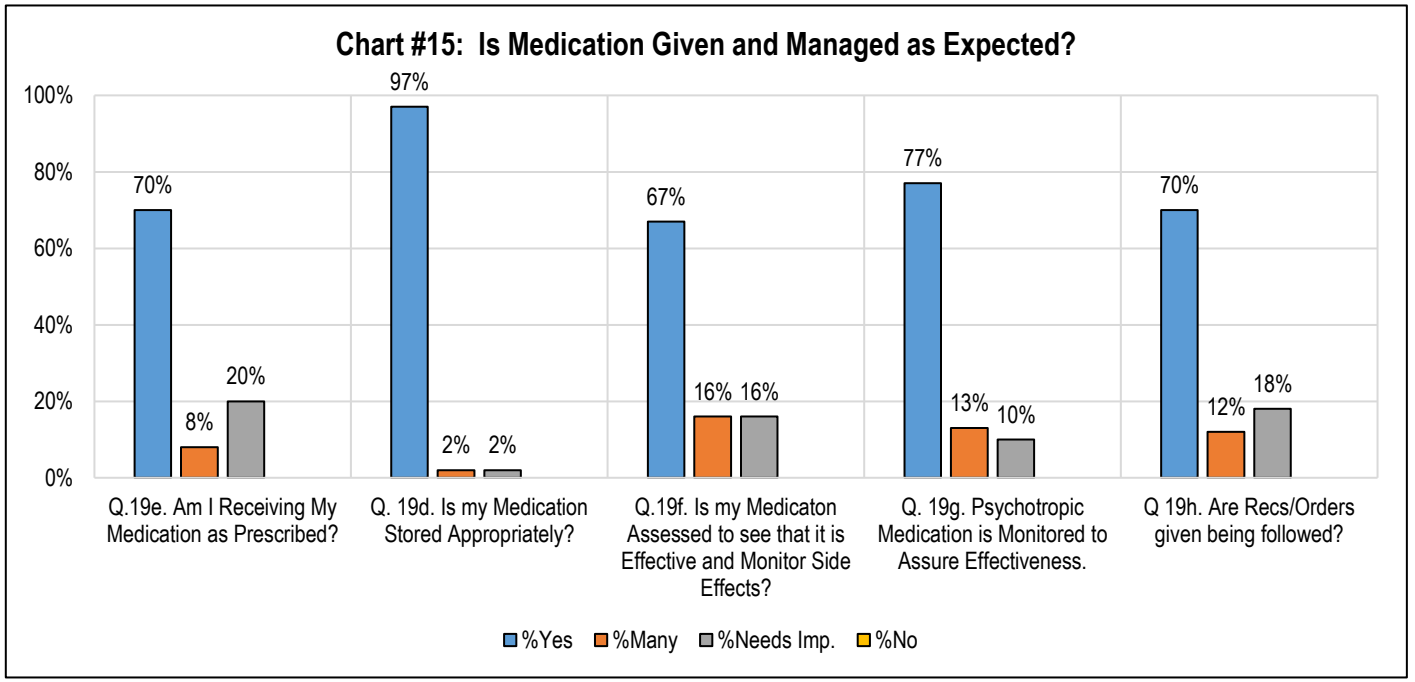
#1: Medication is given to the ***right person;***
#2: The individual receives the ***right medication***;
#3. The individual receives the ***right dose;***
#4. The individual receives medication through the ***right route;***
#5. The individual receives medication at the ***right time;***
#6. Administration ***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 the medications identified for the person in Therap/eChat, medications listed on the Medication Administration Record in both day and residential environments, the actual medication available in day and residential and the instructions on the medication container as compared to the order and instructions and delivery identified on the MAR. Specific questions which are scored and the 2017 findings follow.

Question #19e. Am I receiving my medication as prescribed?
Question #19d. Is my medication stored appropriately?
Question #19f. Is my medication assessed regularly to see that it is effective and monitor side effects? (E.g., laboratory studies, TD screens)
Question #19g. If I am taking psychotropic medication, does my PBSC work with my psychiatrist to assure that my medication is effective in managing my symptoms?

As the following chart illustrates, 30% of class members are not receiving medications as prescribed.

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



While 70% of class members were found to receive medications as intended, the 30% that did not cannot be ignored and should not be minimized. A single medication error could cause harm and damaging effects. Less than 100% compliance can be a significant and even life threatening danger. While some of the 30% noted may be entry or documentation errors or may include minor delays, there is still the chance that it could also be something more significant. An examination is warranted, especially for those areas which put class members in most jeopardy. In this case Questions 19e, 19f, 19g and 19h help provide some greater detail with respect to the nature of the findings.

18 people reviewed were not receiving their medication as prescribed (19e).
20 individuals were not having their medication assessed regularly to see that it is effective and that side effects were being monitored (19f)
7 people who take psychotropic medication did not have their PBSC working with his/her psychiatrist to assure that their medication is effective in managing the person's symptoms. (19g)
18 people did not have orders being followed. (19h)

The following information summarizes identified issues and findings in two ways. First, the identifying number of the Jackson Class Member (not their name) who was found to have experienced this issue; and second, the identification of the specific number of issues that class member experienced. For example, number 22 below is a specific class member who had (70) identified medication error issues. Number 35 is a different class member with (10) identified medication error issues. Some specific examples of findings related to medications follow in the pages below.

Chart #16: Number of Cass Members Affected and (# of Issues)		
Issue	Class Members Found to Have This Issue	# People (# of Issues)
Medication Errors	22 (70), 35 (10), 47 (12), 50,	4 JCM's with (92+) Med Errors
Missed Medication/not available	55 (5), 23 (5), 61 (multiple), 50 (2)	4 (13+)
Not following PCP Orders or specialist recommendations	55, 49, 22, 27, 6, 43, 34, 40,	8 (8)
MAR/Orders and Medication labels don't match	52 (3), 44, 4	3 (5)
Conflicting Instructions	22 (3), 6,	2 (4)
Documentation Errors	49 (2),	1 (2)
Expired Medication being given	35, 50,	2 (2)
Not given in the right route	49,	1 (1)
Lack of coordination between BSC and Psychiatrist	49,	1 (1)
Incorrect storage	35,	1 (1)
Drugs with same or similar content listed under different names.	28,	1 (1)
Medication not on MAR but given	40,	1 (1)

Person #22. Example of Findings for this one person.

During a 2 month period there were 5 incidents related to medication administration. GERs indicate multiple instances of medications not given as ordered: (e.g., Topranol, Reglan, Floragen).

- ✓ Reglan (Gastric ulcer to be given 3 x a day 30 minutes before meals).
- ✓ Floragen (for GI health to be given 2 x a day) not given because staff couldn't find the medication.
- ✓ 5:30, 8 and 9 p.m. meds both initialed on MAR as given at 6:40 p.m.; 4:30 Reglan and 9 p.m. Zyprexa are not to be given together.
- ✓ Reglan not given (different day than issue immediately above)
- ✓ Tropro XL (hypertension 2 x a day) not available for 8 p.m. dose.

- RORI filed based on observations of inaccurate med administration/documentation. Follow up review revealed 70 medication errors related to time of administration on MAR for March 2017, with no record of these med errors reported in Therap.

Person #35: Example of Findings for this one person.

Needs staff assistance to help re-position every two hours while in wheelchair, bed, recliner.... Two trips to ER in the last year, diagnosed with hiatal hernia, later a fractured hand.

#1. There have been 10 medication errors in 13 month period. (19e) **Ensuring all prescribed medication is available as required is a Repeat recommendation from 2010 CPR.**

#2. Medication box at the residence was unlocked and in an unlocked cabinet. (19d) **Ensuring medication (Specifically Ativan) is double-locked is a Repeat Recommendation from 2015 CPR.**

#3. Reviewer found a medication that expired but was being used (Erythromycin Benzoyl Peroxide) as staff were dating it when they opened it not using the date that the Pharmacy put on it when it was reconstituted. The House Manager threw out the expired product and there was a new product in the refrigerator.

G. Number of Health Related Issues Identified by Class Member and by Region

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.

In the 2017 Review 62 of the 65 individuals (95%) had individual health related issues needing review and/or attention.

Chart #17: Number of Health Related Issues Identified by Region
(Based on number of issues found in 2017, 2016 and 2015 Findings and Recommendations)

	Number of Health Care Issues Identified by Class Member[47]																								Total #						Average #		
Region	**0**			**1-2**			**3-4**			**5-6**			**7-9**			**10-15**			**16 - 20**			**20 +**			**Reviewed**			**Of Issues per region**			**Of Issues Per Person**		
Year	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**	**'17**	**'16**	**'15**
Metro	1	5	2	1	11	6	1	16	14	3	9	12	3	5	10	**8**	4	4	5	3	5	4	0	0	26	50	50	368	195	270	14.1	3.90	5.40
NE	2	2	3	1	4	3	0	2	1	1	3	5	1	0	1	1	0	0	4	0	0	0	0	0	10	11	13	101	30	42	10.1	2.73	3.23
NW	0	2	1	0	2	3	4	3	2	1	0	3	2	2	1	1	0	0	1	0	0	0	0	0	9	9	10	65	29	36	7.2	3.22	3.60
SE	0	1	1	2	3	4	0	4	3	2	1	1	1	0	0	4	1	1	0	0	1	1	0	0	10	10	11	116	33	52	11.6	3.30	4.73
SW	0	2	1	0	4	3	0	4	3	1	3	6	3	0	2	5	0	0	1	0	0	0	0	0	10	13	15	110	36	62	11.0	2.77	4.13
Statewide	**3**	**12**	**8**	**4**	**24**	**19**	**5**	**29**	**23**	**8**	**16**	**27**	**10**	**7**	**14**	**19**	**5**	**5**	**11**	**3**	**6**	**5**	**0**	**0**	65	93	99	**760**	**323**	**462**	**11.7**	**3.47**	**4.67**

[47] This does not identify every issue/finding. Some were not counted due to an issue being identified for one person that did not specially effect health.

As the chart above illustrates, overall, the number of health related issues needing to be addressed per person has increased after a two-year trend of decreases. This year, the average number of health care issues per person is 11.7, a marked increase from 3.47 per person in 2016.

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

Fifty-three (82%) class members were found to have more than 5 identified health related issues; five of those 53 had over 20 issues per person.

As mentioned earlier, the IQR asks more detailed questions in some areas which may have contributed to an increased number of issues. It is important to note, however, that while the number of issues may have grown the nature of the issues has remained very consistent over time. An examination of those health related issues is contained throughout this section. The other thing to note is that the number of issues reported for 2017 is, if anything, understated as the following examples illustrate. This is the same methodology that has been used in the past.

Chart #18: Sample of Issue Reporting

Issue	Region	Person	Detail	# of Issues Reported
Errors in Medical/Health Records				
eChat	Metro	#49	Noted to have 12 factual errors and missing 14 diagnoses.	2
Comprehensive Aspiration Risk Management Plan	Metro	#16	Contains seven distinct errors found in one (the most current) CARMP.	1
eChat	NE	#2	Noted to have 12 factual errors and was missing 10 diagnoses.	2
eChat	NE	#3	Missing 6 different diagnosis	1
eChat	SE	#17	6 different errors.	1
eChat	SE	#1	15 different diagnoses that are not in the eChat, and specifies 7 factual errors.	2
Health Care Plan(s)	SE	#1	Has seven different HCP's that contain multiple errors. (Each individual error not counted).	7
eChat	SW	#18	Missing 8 different diagnoses.	1
Comprehensive Aspiration Risk Management Plan	SW	#3	Contains five distinct errors found in one (the most current) CARMP.	1
Comprehensive Aspiration Risk Management Plan	SW	#4	Contains four distinct errors found in one (the most current) CARMP.	1
eChat	SW	#19	Missing 8 different diagnoses.	1
Medication Administration Errors				
	Metro	#55	Clonazepam was not administered for noon dosage (during DH) for 24 days. This is noted as one "issue" but could be noted as 24.	1
	SE	#22	70 Medication administration errors reported for March 2017. P T has been identified as "Most at Risk" for this issue, so this is being counted as 1 issue, though 70 errors were documented.	1
Nursing Support/Reports				

Issue	Region	Person	Detail	# of Issues Reported
	Metro	#55	Significant issues noted for Day Hab and Residential Quarterly Nursing Reports. As a result, 8 issues are being noted - 4 each for Res and Day. The combined number of specifics issues noted in the F&R is actually 47, because each quarterly report over a full year omitted multiple items, and almost all of them were late.	8
	SE	#1	Acuity level changed, however the nurse did not increase review frequency as required until many months after the change in need. This is only reported as one "issue", although it could be considered an issue for every review missed.	1
	NW	#20	There were 14 instances where bowel tracking reflected need for follow up, and the nurse did not. This is being noted as 1 "issue", though there were 14 missed oversight instances.	1

In an effort to examine the most urgent types of health related issues identified for individuals, this report starts with a review of those individuals identified with immediate and/or special needs.

H. Issues Identified for Those with Immediate and/or Special Needs[48]

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.

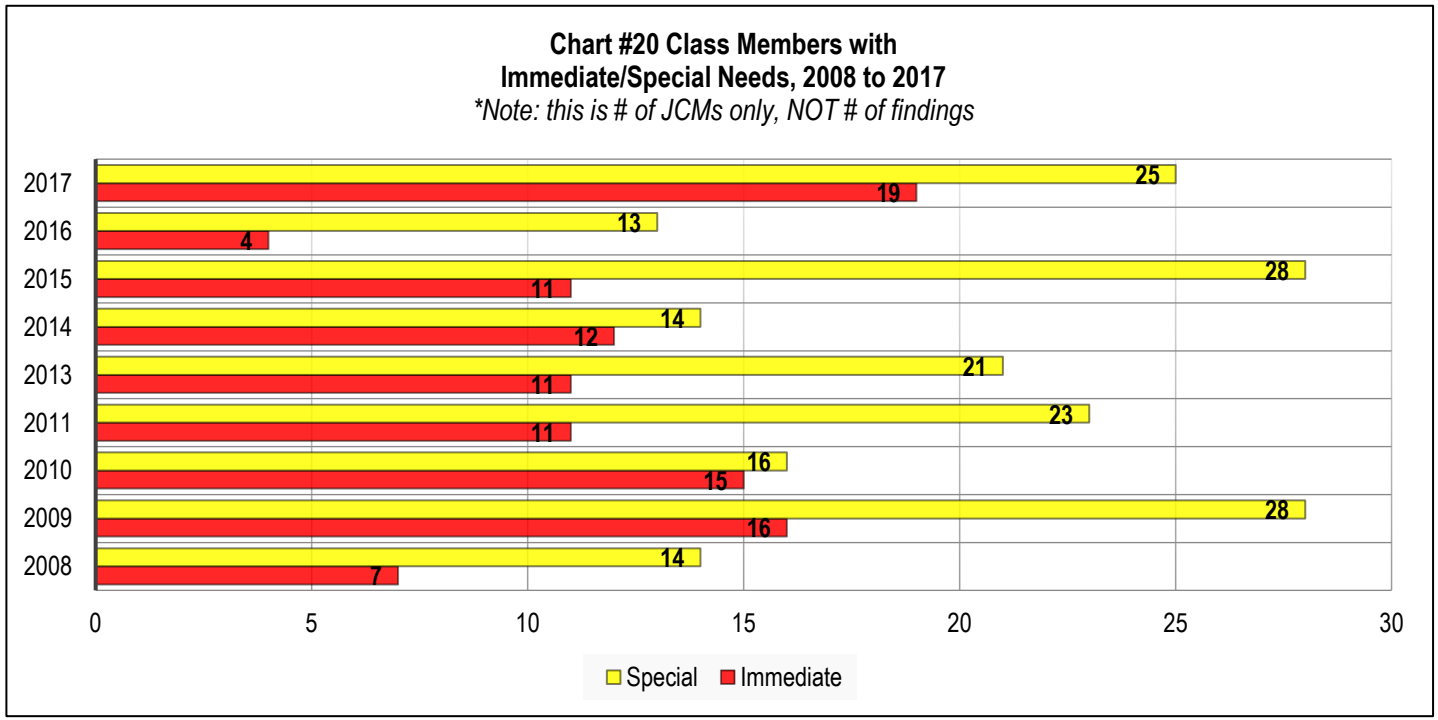
Typically, from 93 to 100 Jackson Class Members (JCM) are reviewed each year which is approximately one third of class members. Chart #19 shows the number of active JCM, the number of individuals included in the sample by year and of those reviewed, the number who were identified with Immediate and/or 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.

Chart #19: Unduplicated Count of JCMs with Immediate and/or Special Findings			
Year	**Active JCMs**	**Sample Size**	**# JCM (% of Sample)**
2017	262	65	40 (62%)
2016	269	93	18 (19%)

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

Chart #19: Unduplicated Count of JCMs with Immediate and/or Special Findings			
Year	**Active JCMs**	**Sample Size**	**# JCM (% of Sample)**
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%)

For information regarding the number of Immediate and/or Special Findings Identified by provider and case management agency see Appendix A. A comparison of the numbers of individuals identified with Immediate and/or Special Needs since 2008 follows.



As identified in the charts above, there has been an overall increase in the number of individuals identified with Immediate and Special Needs. An unduplicated total of 40 individuals (62% of the sample) were identified with Immediate and/or Special Needs in 2017.

- 25 individuals had no immediate or special needs identified.
- 19 individuals were identified to have Immediate Needs, 49 different Immediate Findings were identified for these 19 people.

- 25 individuals were identified with Special Attention Needs, 42 different findings were identified for those 25 people.

The following chart identifies the number of individuals, by region, who were identified with Immediate and/or Special Needs.

Chart #21: Individuals with Immediate/Special Needs by Region in 2017
(Note: this is NOT the same as number of findings, some individuals have more than one finding; also, some individuals had both Immediate & Special findings)

Type	Metro #1	SW	SE	NW	NE	Metro #2	Total
Immediate: JCM	1	3	1	0	5	9	19
# of Immediate Issues	1	3	3	0	13	29	49
Special: JCM	3	7	5	3	1	6	25
# of Special Issues	4	10	9	4	3	12	42
Unduplicated # of JCM	**3**	**8**	**6**	**3**	**6**	**14**	**40**
Total # of Issues	**5**	**13**	**12**	**4**	**16**	**41**	**91**
# in Sample	**9**	**10**	**10**	**9**	**10**	**17**	**65**

The following chart then summarizes the types of issues identified, by region, for those with Immediate and/or Special Needs.

Chart #22: Type of Health Care Coordination Issues Identified for People With Immediate and/or Special Needs by Region[49]

Issue: Lack of Adequate Health Care Coordination	Metro	NE	NW	SE	SW	Totals
Aspiration/CARMP Accuracy/Implementation Issues	15	6	0	3	2	26
Not following orders/recommendations	4	3	2	1	4	14
Medication Errors/Side Effects	8	2	1	0	0	11
Equipment Issues	4	1	0	5	0	10
Gaps in Services/Team Communication	4	1	0	1	4	10
Symptoms/Issues not being followed up	1	2	1	1	2	7
Falls/Fractures/Safety	3	1	0	1	2	7
Nursing Oversight/Inaccurate and conflicting information (HCP/MERPs…)	7	0	0	0	0	7
Totals	**46**	**16**	**4**	**12**	**14**	**92**

[49] This is regarding the number of different issues; as many findings highlighted more than one issue, this is more than the number of findings. For detail regarding issues Immediate and Special Issues including by provider and case management agency see the related information in the Appendix.

Lack of adequate Health Care Coordination and Nursing Oversight contribute to the issues identified below 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 follow by category (e.g., Aspiration/CARMP) and the number of identified issues that related to that category (e.g., 26 relating to Aspiration/CARMP issues).

Aspiration/CARMP Accuracy/Implementation Issues (26): Examples include:

Aspiration Risk Screening Assessment/recommendations missing or out of date: Person #2. *Most recent ARST is dated 10/31/2014, almost three years ago; individual's risk for aspiration has increased to high ("severe" noted in record) as a result of recent events/hospitalizations.*

Recommended prevention equipment not available/used: Person #4: *Suction toothbrushes available at the home but reviewer was told by staff that it was ok for them to use a regular toothbrush and suction as needed. Per CARMP, brushing must be completed using a suctioning toothbrush.*

Staff not trained on prevention/equipment use, for example: **Person #2.** *Aspiration risk level is high (severe is the language in the record). …Staff continued to feed individual even though (#2) "screamed and yelled the whole time" and "fought the whole way and closed … mouth when I tried to give … some food," tends to indicate that staff failed to recognize common signs of Aspiration. Staff documented that …eventually at 100% of … food and 16oz of water. (#2) was admitted to the hospital the next day 7/5/17, related to cough and congestion.*

CARMP inaccurate/incomplete information: Person #5. *GER dated 06/08/2017 Noted: "While showering [#5] might of aspirated. It was unnoticeable at the time. About an hour later … started coughing like a wet cough while sitting on the couch. Notified nursing with vital signs." CARMP does not include instructions while bathing or showering.*

CARMP not being followed, for example: **Person #6.** *Residential daily notes indicate three instances in which staff found and removed pieces of meat from … mouth. On 8/1 the note states staff noticed … chewing something after return from day hab and "removed a big piece of 1/2 meat and 1/2 fat" from …mouth, the 8/2 note states staff removed "6 big pieces of steak …had been chewing on since lunch from day hab", and the 8/18 note states home staff found "pieces of meat" in …mouth. …CARMP indicates that meats should be "minced (very small pieces 1/8 inch similar in size to sesame seeds)" and that following meals staff are to "sweep the oral cavity between the cheeks and gum for residue and pocketing." There was no evidence found of any internal incident report, GER, or report to DOH regarding either of these incidents for failure to properly follow dining instructions in … CARMP.*

CARMP expired and inaccurate: **Person #7.** *The eCHAT indicates that JS is at high risk for aspiration. The CARMP provided for the review expired on 10/11/17. According to the CM, this is the only CARMP JS has on file.*

Not following Orders/recommendations (14), Examples Include:

Recommended tests/health screens not completed:

- **Person #4.** *Neither the Fecal Occult Test (recommended 3/19/2017 by …physician) nor the PSA Level Check (recommended since …prostate was enlarged as noted in hospital discharge paperwork from 11/26/2016) were completed.*
- **Person #8:**
  - *March 2017, the PCP encouraged a return to eye doctor to better record cataracts and detached retinal issues, however there is no indication that this recommendation was followed.*

- *No nutritional evaluation since (19 months ago), diet is to be monitored due to diverticulosis.*
- *Not seen a dentist, due date was 5 months ago.*
- *Has not had an annual return visit to his ENT (2 months ago);*
- *Not been to a quarterly podiatry appointment since (17 months ago)*
- *Was to have a colonoscopy after his (4 months earlier) visit with his PCP.*
- *No blood and urine testing since (11 months earlier).*
- *There is a diagnosis of high cholesterol, but medication for this condition only started on 6/26/17. PCP was seen on March 1, 2017, but did not have labs drawn until mid-June, per staff interview.*

Appointments/Follow up not completed as recommended:

- **Person #1: Example of Findings** *Individual had an appointment with the CP Clinic in Albuquerque and was recommended for:*
  - *Brain MRI scan;*
  - *Neuro-ophthalmology assessment;*
  - *EEG, especially to assess background activity and rule out subclinical seizures;*
  - *Serum amino acids and urine organic acids;*
  - *Other routine studies, including TSH, T4, B6, folate, thiamine, pyroxidine level, CBC, Chem panel, ammonia.*
  - *Apart from the routine lab work, there is no evidence that the other recommendations were addressed.*
- **Person #2:** *The Urology follow up after appointment to review void records was never completed. This is of heightened importance due to (#2's) hospitalization for dilutional hyponatremia and syncope and recent decline in overall health.*

Health Care Plan (HCP) instructions not followed:

- **Person #3**
  - *The HCP indicates to give PRN medications (e.g., Milk of Magnesia) if 2 days without a BM and an enema if 4 days without a BM. Nursing records and bowel tracking records do not confirm consistent reporting and treatment as outlined in the HCP.*
  - *PRN approvals indicate MOM approved 6/21/17, BM tracking indicates that was the 4th day w/o BM…*
  - *PRN approvals indicate MOM approved 5/2/17 but BM chart indicates that was 5th day of no BM ….*

- **Person #2:** Bowel *tracking is not consistently kept. Although there is a HCP and MERP recommending that (#2) have bowel movements every day, there is no record to determine whether or not this is occurring. There is no record kept at the day program at all, and the residential provider's record has large gaps, sometimes as many as 15 days, between entries. Fluid intake and output tracking is likewise inconsistent. Void records ordered by urologist on 3/23/2017 were not completed, including not being completed each day and did not contain volume of output.*

Medication Administration Issues (11), Examples include:[50]

Medications not given as prescribed: Person #38:

- *The October MAR states "Levothyroxine/Synthroid 50mcg Take one tab by mouth 3x a week for low thyroid. Give on Mon, Wed, and Friday." Rx bottle in Med Box states "Take 1 tablet by mouth daily for thyroid."*
- *October MAR state "Trazadone 100 mgs take 1/2 tablet by mouth as needed." Rx bottle in Med Box states "Take 1/2 to 1 and 1/2 tablets by mouth at bedtime as needed for insomnia.*
- *It is unclear if the Trazadone is for anxiety or insomnia.*
- *There are conflicts between the two copies of the CARMP at Altered form of Medications Nurse (A)…copy states "Whole...Medications are placed in thickened water to soften", the Nurse (B) copy states "All medications are to be crushed and presented in honey thick liquid by spoon".*

Prescribed medication missing/not given as ordered: Person #55

MAR's and medications at both Day Hab and residence were reviewed. Clonazepam had been increased to 3 x a day from 2 x a day October 9, 2017. November 2017 IQR identified that #55 had missed up to 5 doses a week for 4 weeks of prescribed medication because residential staff through day hab staff was giving #55 medication at noon. The prescribed medication was not on the day hab MAR so none was given.

Medication not given as prescribed: Person #49. *Residential Staff are supposed to check blood pressure before administering Clonidine at 8AM and 8 PM daily. If it is under 100/60, the medication is to be held and the nurse notified. Records reviewed for 10/18 forward indicate that blood pressure was checked:*

- *10/18 x 1;*
- *10/20 x 2;*
- *10/21 x 1;*
- *10/27 x 2;*
- *10/28 x 2;*
- *11/2 x 1;*
- *11/3 x 1;*
- *11/4 x 1;*
- *11/7 x 1.*

Clonidine was signed out as given twice daily on all of those days.

Medication delivery unclear/being given in contradiction to orders: Person #55. *There have been 20 instances of ER, Urgent Care and IR visits during 12 month period related to G/J tube and tube site.*

- *Per MAR, some meds indicate to give by mouth but staff know to give all per G/J tube.*
- *Some meds indicate PEG and does not have a PEG.*
- *… vitamin D was not available and the house manager reported that …had just run out after the morning dose.*
- *…is receiving 60 ml water before and after med pass but the order was no longer on her MAR.*

[50] Additional examples provided on Pages 39, 40, and 42 of this report.

Because …has a G/J tube … could theoretically receive meds, flushes and formula through either port (gastrostomy or jejunostomy). …physician on …documented the following "… is not tolerating boluses through the G port - meds should continue to be given through the G port and water and feeding will go through J port". …MAR is not clear on what port medications, formula and flushes go through.

- *When house manager and Residential SC were asked which ports were used for meds and formula they both replied that meds go through the G port and formula (feeding) through the J port.*
- *When the residential staff was asked which ports she replied feedings through the G port and meds through the J port.*
- *When CMA at DH was asked which ports were used she stated both meds and formula went through the J port.*

Equipment Issues (10), Examples include:

New Wheelchair not provided: **Person #9:** *has needed a wheel chair (16 months ago), when … quit walking, one with a lap belt for …safety as noted by the PT…, but …has not gotten one, and still uses an uncomfortable transport chair with a gait belt wrapped around it for safety. No RORI filed.*

New Wheelchair not provided: **Person #10:** *w/c is not really … own and the PT has recommended a new one. …former w/c no longer was appropriate (since) adductor tendon release procedure (9 months ago). After that …got a … w/c that the PT is repairing with parts from his home as this w/c cannot be repaired under insurance. It is reported that …does not qualify for a new w/c from Medicaid (for another year).*

Equipment and Environmental Modifications Not Provided: **Person #11.** *…Team has been working on obtaining a hospital bed and environmental changes in the bathroom since at least (12 months). Staff was aware of the discussions and stated someone from out of state had been there to look at the bathroom a few months ago and had talked about a walk in shower … Staff did not know the status of the environmental modifications timeline.*

AFOs did not fit, regression in walking, not replaced: Person #12. *In August 2016 new AFO's were received. …began to regress in …walking (due to discomfort?). …team members believed the discomfort was due to …shoes. Consequently guardian acquired new shoes shortly after the AFOs. This didn't seem to correct the discomfort. When … new PT began (July 2017) he determined that it was …AFO's that were not fitting properly. As of the writing of this report (2018), …still does not have new AFOs.*

Gaps in Services/Team Communication (10) Examples Follow:

Confusion regarding DNR Order: **Person #4.** *ISP states there is a DNR. There is an Advanced Directive Refusal form signed and dated …by the guardian; however, according to the CM, Day and Residential staff; …does have a DNR at this time. (This is incorrect)*

Staff Turnover may impact safety: Person #13. *Some interviewed stated they feel individual is safer at home than at day hab because of the staff turnover which contributes to inconsistency of approach; Therapists report that due to consistent turnover, they are spending excessive amounts of time training; Individual staffing should enable flexibility in the daily routine to avoid extended hours a day at day hab, which is not in this specific individual's best interests.*

No PT Services: Person #3. *The CM site visit note … PT is resigning. CM interview of (12 months later) indicates that PT services are still not being provided. Reviewer observations confirm need for PT assessment and services to address wheelchair, positioning issues, maintenance of range of motion and function. There was no PT assessment at time of ISP meeting and no current PT services (13 months later).*

No OT and SLP Services: Person #7. *The OT has not provided an assessment as of …. The budget was approved for OT on (4 months earlier). Per residential staff, SLP has not provided services since shortly after the IDT planning meeting of (8 months earlier).*

No OT, SLP Services, needs wheelchair adjustment, hospital bed: Person #9.

- *… has not received OT and PT services (for at least 8 months) and is unable to walk, stand, transfer and is lacking in endurance and strength to perform even simple tasks.*
- *… has not received SLP services since (10 months) and remains NPO because an SLP has not been available to evaluate and develop a safe plan to re-introduce food and drink orally. (5 months earlier) swallow study indicated that ... could have pureed foods but with no SLP on team, no plan has been devised for this.*
- *… has needed a wheel chair since last (5 months earlier) when … quit walking, which would include a pillow for comfort and a lap belt for …safety as noted by the PT (10 months earlier), but … has not gotten one, and still uses an uncomfortable transport chair with a gait belt wrapped around it for safety.*
- *… needs …hospital bed to be at 45° angle while resting however there has not been a therapist available to provide the guidance needed so that all staff elevate his bed consistently. Staff indicate that they use best judgement.*
- *No RORIs have been filed*

Symptoms Not Recognized/Acted Upon (7), Examples Follow:

Person #1: *Individual has a diagnosis of Cerebrospinal fluid drainage device, shunt, valve, or other device. The shunt was placed …at age 9 or 11 days old, and was revised multiple times early in life. From what can be gathered, it appears the shunt has been inactive for many years and … is not considered to be actively suffering from fluid buildup. During (5 months earlier), there are several incident reports in the record of headache, and sometimes dizziness and nausea. For over a year now, …been experiencing bouts of increased lethargy and irritability. …had multiple falls and the right side of … body is not working well. There hasn't been a neurology consult, or the report of a recent MRI or CT scan of …head, so it is unsure when it was determined that fluid buildup was not a problem anymore. The TEASC and CP Clinic (reports) most of that is missing from the record. (surgery to replace shunt, which doctor indicated had been clogged for years with liquid build up around her brain was completed after review.)*

Tracking Gaps not identified/followed up on: Person #14. *Gaps in elimination record (only 45% of days recorded) indicate incomplete nursing review of elimination records. The elimination record indicates multiple instances of extended periods without a recorded BM. Missing days on the elimination record makes it impossible to accurately determine frequency of elimination. For the data that is recorded (12 month period) there are 6 instances of 3 consecutive recorded days w/o BM, 4 instances of 4 days, 2 instances of 5 days and one instance each of 7, 11,14 and 19 consecutive days listed on the elimination record without a recorded BM. No evidence was found of nursing follow up on the missing data from the elimination record or the appearance of extended periods without a BM.*

Skin breakdown noted, no evidence of follow up: Person #3. *The Nursing note of … indicates an area of shallow skin breakdown 1" x 1" over coccyx. No subsequent nursing notes provided indicate further nursing follow up on this skin breakdown. The Nursing note of (2 months earlier) notes skin breakdown on coccyx. No further notes documenting nursing follow up on skin breakdown until note of (1 month after first note) indicates PRN butt cream approved for skin breakdown. No direct nursing check or intervention regarding this skin breakdown documented until (one month after first note). The Nursing note of (4 months before second nursing note) indicates two pink areas on buttocks, states "will reassess tomorrow". No documentation found of reassessment.*

Falls/Fractures/Safety (7), Examples Follow

Person #15: *JCM has experienced repeated instances of falls (18 x in a 6 month period, 4 more falls in the following 3 month period, …also fell the week of this review). Guardian asked for wheelchair review on 11/22/16; FOC for PT Assessment was not completed until 6 months later.*

Person #16. fell out of …chair …and broke … jaw. Neglect was substantiated.

- There is evidence of falls - from van, from bed, and out of …chair.
- …fell when exiting the van … staff failed to follow the HCP for Falls…states should be taken to the ER for any falls… did not go to ER until the next day when the guardian told them to take to ER.

Nursing Oversight Issues: (7): Examples Follow:

HCPs and MERPs between Day/Residential Services conflict: Person #16. Some portions of HCPs and MERPs from the Residential and the Day Program are different from one another.

- Residential Aspiration MERP mentions the wrong individual in the directions.
- Reflux/GERD HCPs – Residential states, "avoid large meals and eating right before bed time"; "encourage … to remain sitting up for at least 30 minutes after meal", and Day states, "do not lie down for at least 3 hrs. after eating" CARMP states, "…must remain in an upright position for no less than 45 minutes following oral intake to decrease the risk of reflux"
- Bowel Functions/Constipation – Residential states, "…to participate in some sort of physical activity at least 20-30 minutes per day", Day states, "encourage daily exercise"
- Skin and Wound – Day instructs staff to, "encourage mobility or change positions every 2 hrs. to promote circulation to pressure areas"; Residential Healthcare Plan has no mention of repositioning.

Residential has both a HCP and MERP for aspiration, however, recent guidance states no HCP for aspiration should exist if there is a CARMP. …has a CARMP.

Record missing information (missing one kidney): Person #9. Medical records are unclear as to when and how … came to have only one kidney. … was admitted to the hospital with various diagnoses, including acute kidney failure. …received dialysis for several days, but the documentation presented does not indicate the status of …kidney. At a PCP follow-up on …removal of … stitches (no indication as to why …had stiches) was scheduled as well as a nephrology referral was made. At the nephrology visit … it was recorded that left kidney absent was an incidental finding.

- The e-CHAT indicates that hypertrophy of kidney, right side was diagnosed ….
- UNM CT scan indicated that … (one) kidney is absent.
- In an effort to better understand contributing factors to this dramatic change in numbers a closer examination is warranted.

In an effort to better understand contributing factors to the dramatic change in Immediate and Special findings numbers in 2017, a closer examination is warranted, and is provided in the tables below.

Chart #23: Number of Individuals with Immediate/Special Issues by Year and Region
(Note: Number of findings are indicated (#), as some individuals have more than one Immediate/Special finding; there is Duplication if JCM has multiple Im, Sp)

Region	Metro		SW		SE		NW		NE		Statewide	
Year / Type	Immd	Spec	Immd	Spec	Immd	Spec	Immd	Spec	Immd	Spec	Immd	Spec
2017	10	9	3	7	1	5	0	3	5	1	19	25
2016	2	9	1	2	0	1	0	0	1	1	4	13
2015	10	17	0	3	1	2	0	3	0	3	11	28
2014	5	6	2	3	1	2	2	1	2	2	12	14
2013	4	12	2	3	1	1	2	3	2	2	11	21
2011	6	9	2	4	1	6	2	3	0	1	11	23
2010	7	10	3	0	0	2	5	1	0	3	15	16

Chart #24: 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 (10)	1	4		2	Adelante (11)	6	11		1.55
Agencies with 6 to 9 People in the Sample									
Tresco (7)	2	6	1	1.29	Tresco (7)	2	6	1	1.29
Agencies with 4 to 5 People in the Sample									
Dungarvin (5)		2		0.40	Dungarvin (5)		2		0.40
LLCP (3)	5	3		2.67	LLCP (4)	5	3		2.67
Agencies with 2 to 3 People in the Sample									
ARCA (3)	1	5		2	ARCA (1)	1			1
Benchmark (AWS) (3)	6	3		3	Benchmark (AWS) (3)	6	3		3
ENMRSH (3)		2		0.67	ENMRSH (3)		2		0.67
Mi Via (3)				0	Mi Via (3)				0
Ramah Care (3)		2		0.67	Ramah Care (2)		2		1
The New Beginnings (3)	11			3.67	The New Beginnings (1)	6			6
Tobosa (3)		4		0.75	Tobosa (3)		4		0.75
Aspire (2)	1	1		1	Aspire (2)	1	1		1
Bright Horizons (2)	2			1	Bright Horizons (1)				0
					CFC (2)	9			4.5
Community Options (2)	2	1		1.50	Community Options (2)	2	1		1.50

Chart #24: 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 1 person in the Sample									
Advantage Comm. (1)	1			1	Advantage Comm. (1)	1			1
At Home Advocacy (1)		1		1					
Better Together (1)				0	Better Together (1)				0
CARC (1)		1		1	CARC (1)		1		1
					Cornucopia (1)	2			2
					Empowerment (1)				0
Ensuenos (1)				0	Ensuenos (1)				0
ESEM (1)	4			4	ESEM (1)	4			4
					Expressions of Life (1)		3		0
					HDFS (1)				0
Leaders (1)	3			3	Leaders (1)	3			3
Lessons of Life (1)				0	Lessons of Life (1)				0
					Mandy's Farm (1)		1		1
					None (1)		1		1
Optihealth (1)	6			6					
					Phame (1)	2			2
PRS (1)		1		1	PRS (1)		1		1
R-Way (1)	2			2					
Santa Lucia (1)				0	Santa Lucia (1)				0
Tungland (1)				0	Tungland (1)				0

Chart #25: 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				
J&J (9)	3	8		1.22
Peak (9)	1	7		0.89
CM Agencies with 6 to 8 people in the Sample				
SCCM (8)	3	7	1	1.38
Unidas (7)	10	3		1.86
Visions (6)	9	3		2
CM Agencies with 4 to 5 people in the Sample				
A Step Above (5)	3	1		0.80
Carino (5)	13	1		2.8

Chart #25: 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 2 to 3 people in the Sample				
DDSD (SE & NE) (2)	4	1		2.5
Exel (3)		2		0.67
NMQCM (2)	2	5		3.5
Rio Puerco (2)		1		0.50
CM Agencies with 1 person in the Sample				
A New Vision (1)		1		1
Amigo (1)		2		2
NMBHI (1)				0
Unique Opportunities (1)	1			1

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/or issues. This section examines the most frequently identified health issues based on the Out of Home Placement Report.[51] The categories identified in the chart with some explanation include:

***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 diagnosis related to dehydration and/or UTIs.
Fractures: individuals hospitalized and diagnosed with broken bones.

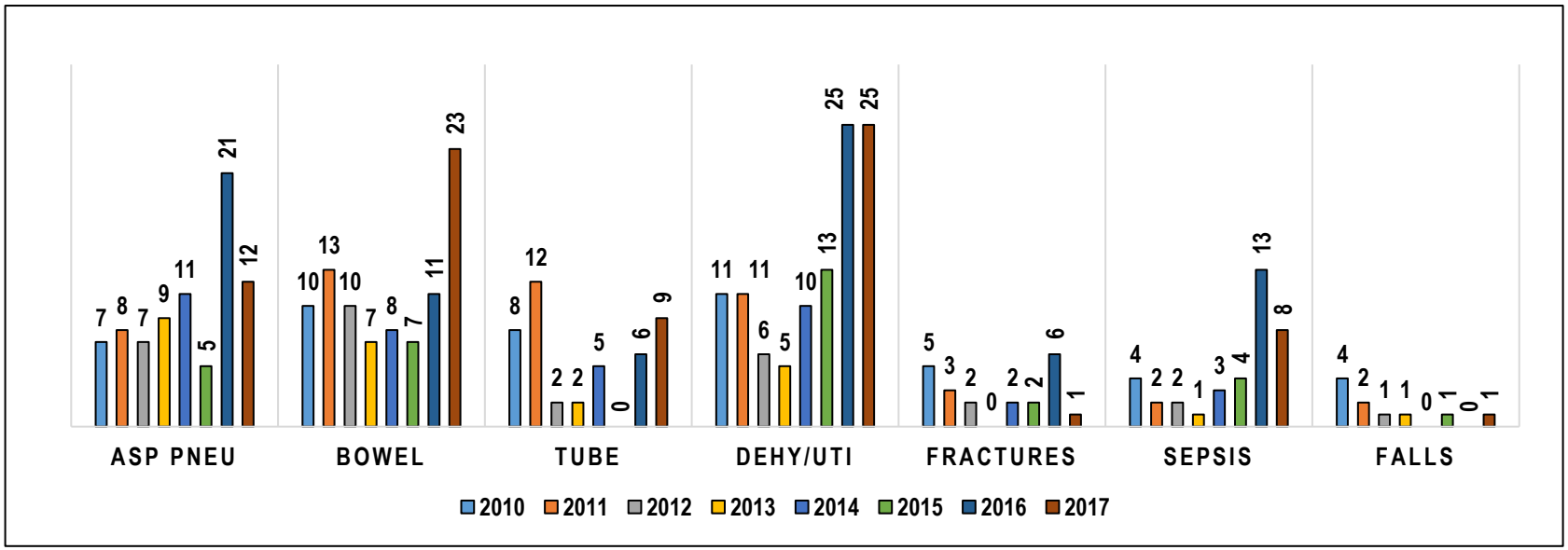
[51] The Out of Home Placement Report is provided by DOH/DDSD weekly and identifies, in part, class members by name who have been moved out of their home, where they were moved, why and some information regarding follow up. This information is current to December 29, 2017.

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.

For 2017, numbers listed below reflect those Out of Home Placement Reports received after last year's cutoff date (December 2, 2016) through December 29, 2017, slightly longer than a year. Dehydration and urinary tract infections once again accounted for the highest number of hospitalizations. Bowel-related issues were the second highest category, followed by aspiration pneumonia. (More information on pneumonia diagnoses resulting in hospitalizations is provided later.) Those hospitalized with diagnoses of bowel-related conditions is significantly increased over 2016. Also, while incidents of sepsis are down from last year's high, they are still double the highest rate seen in 2010-2015.

Chart #26: Hospitalizations by Identified Cause by Year

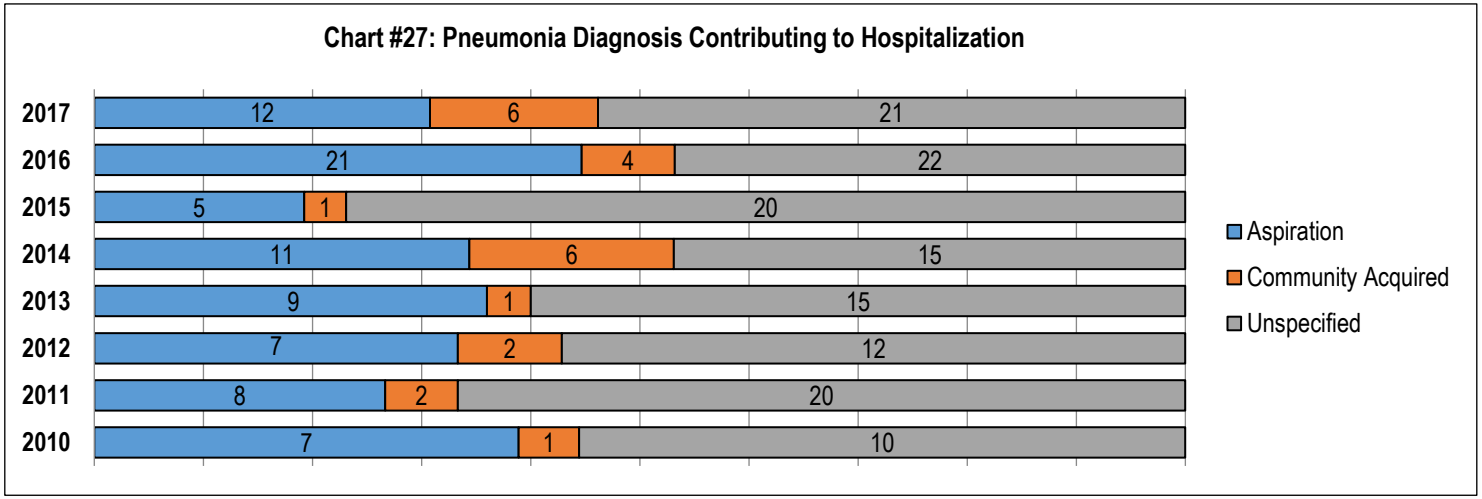


The following chart summarizes the number of pneumonia diagnoses associated with hospital stays by classification. As this chart illustrates, the diagnosis of unspecified pneumonia continues to be greater than the number of diagnoses in which the pneumonia is classified as aspiration or community-acquired. For many cases of unspecified pneumonia other information exists in the Out of Home Placement Report which indicates the pneumonia was related to aspiration (e.g., bed-side swallow study performed, tube placement, vomiting at the time of admission).

In the 2016 Community Practice Review, Systemic Recommendation #7 indicated: "A swift and close examination of Out of Home Placements and Hospital Readmissions needs to be conducted with an eye to identifying why such a dramatic spike has occurred (in pneumonias) and whether or not other identified issues can be avoided by

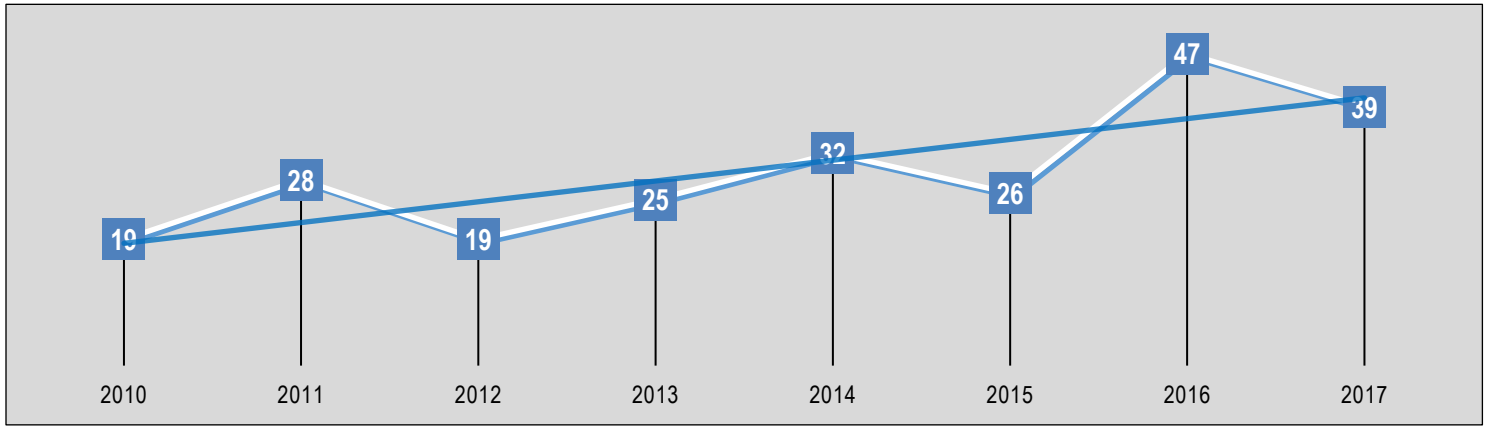
improving practice. This examination needs to become institutionalized and be conducted routinely. Based on these reviews, trends, findings and recommendations should be issued."

Since that time, DOH/DDSD has reported that an Assessment Protocol for reviewing pneumonia hospitalizations has been developed and is being refined as an action plan to collect and analyze data on all pneumonia hospitalizations among Jackson Class Members in 2016. Now, over a year later, no results from this tool or from any data which may have been collected has been provided. Based on the numbers which follow, regardless of what paper has been developed or data was gathered there has been no discernable impact minimizing non-specific pneumonia diagnosis. While the instances of diagnosed aspiration pneumonia reflects a decrease from 2016, no assumptions can be drawn without knowing more about the "unspecified" instances of pneumonia.



There are several problems stemming from non-specific pneumonia diagnoses. Without knowing whether a person has aspirated, changes to supports and services that are likely necessary to prevent a recurrence might not be considered. The team is hindered in effective discharge planning without understanding the type of pneumonia that led to the hospitalization, including, in many cases, whether the residential provider can safely support the individual during recuperation. Another consideration is infection control. For an individual diagnosed with bacterial pneumonia, there was some exposure to the infectious agent, but if the team is unaware that a bacterial infection occurred, they will not know to take steps to protect others from exposure to the pathogen. This is a limited list of examples of the problems that ensue from not understanding the source of a pneumonia infection. It is important that providers, nurses, case managers and teams have resources available to help them advocate for accurate pneumonia diagnoses, and improve the team's ability to accurately plan for supports and services needed to promote the individual's health and safety and protect others from preventable harm.

Chart #28: Total Pneumonia Diagnoses 2010 to 2017



The previous chart above illustrates the total number of hospitalizations related pneumonia of all types from 2010 through 2017. Although the total is down from the high of 2016, there was still significantly more pneumonia diagnoses in 2017 than the trend in previous years, and an upward trend line continues.[52] As evidenced by these numbers and as recommended last year, ***a rapid and detailed examination of these instances of pneumonia needs to be conducted*** with an eye to identifying the reason(s) for the upward trend. Based on this review of the trend, findings and recommendations should be issued.

Chart #29: Hospitalizations and Deaths Attributed to Aspiration Pneumonia 2010 to 2017

( ) = Number of times to hospital	2010	2011	2012	2013	2014	2015	2016	2017	Total
# of Persons who died who had a diagnosis of Aspiration Pneumonia	6	2	0	2	3	1	2	0[53]	16
# of Persons hospitalized with a diagnosis of Aspiration Pneumonia	7 (12x)	8 (8x)	7 (10x)	9 (10x)	11	5	17 (21x)	10 (12x)	73
Total	**13**	**10**	**7**	**11**	**14**	**4**	**19**	**10**	**79[54]**

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 and/or provision of treatment that is not effective. The risk of hospital readmission is heightened among persons with intellectual disability who have compromised

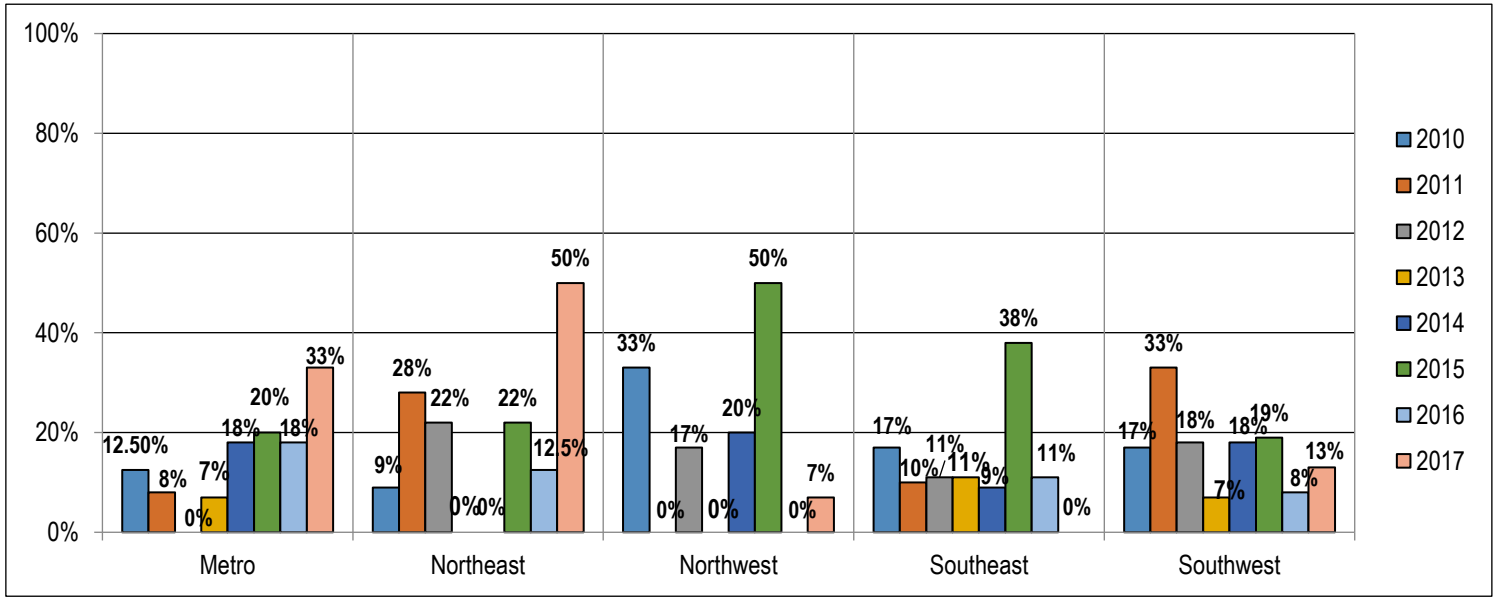
[52] The average yearly diagnoses of pneumonia for 2010 through 2015 was 24.83. When 2016 and 2017 are factored in, the average jumps to 29.75. For the last two years alone, the average is 44.5.
[53] Clinical cause of death and/or accurate diagnosis information was available at the time of this report 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.
[54] This is a duplicated count. The actual number of individual class members is 50.

communication skills, which designation applies to a large majority of Jackson Class Members, due to their inability to report symptoms. A total of 126[55] of the 738 (17%) Out of Home Placement records received since 2010 are readmissions. This is the third year re-hospitalizations were examined as part of this report. During the prior two years, the percentage of readmissions held steady at 15%. The overall percentage of the total increased 2% over the year due to a high number of readmissions for 2017. Twenty-nine percent (29%) of the 126 admissions for the year that just ended were readmissions. The total numbers by region break down as indicated in the following chart. Detail illustrating the rates of readmission to hospital by Region, by year, is also provided.

Chart #30: Five Year Readmission Rate by Region (2010 to 2016)

Region	Readmissions/Total Admissions	Five Year % of Total by Region
Metro	65/383	17%
Northeast	20/90	22%
Northwest	10/64	16%
Southeast	11/80	14%
Southwest	20/121	16.5%
TOTAL	**126/738**	

Chart #31: Percentage of Hospital Readmissions per Year by Region



Out of Home Records currently available indicate that there are a variety of reasons why an individual might return to the hospital so soon after discharge.

[55] 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.

- Occasionally, readmissions are due to lack of timely follow up on discharge orders. For example, one person was hospitalized a second time in December 2017 for treatment of pneumonia after his antibiotic prescription was not filled upon discharge a week earlier.
- Some individuals are discharged from the hospital and readmitted within a short time with the same diagnosis. Each person's circumstances are different, but most often, the reason for this is that the individual was not adequately recovered when discharged. In one instance documented for 2017, an individual experienced four separate hospitalizations during the same two-month period, all with pneumonia listed as a diagnosis.
- Still other readmissions appear to be related to problems with recovery from surgery. For example, one individual was hospitalized for seven days in mid-2017, during which time he had scheduled surgery on his aortic valve. He was discharged, but admitted a day later with anemia. Two weeks after his second discharge, he was hospitalized for a third time, on this last occasion with a number of complaints, including a bowel obstruction.

Between 2015 and 2016 (the first two years these data were analyzed), there was a downward trend in readmissions. That trend reversed last year, owing to especially high rates of readmission in Metro and Northeast Regions. In the Metro Region, 24 of 73 (33%) admissions were within 30 days of a prior discharge. In the Northeast Region, 9 of 18 (50%) admissions were with 30 days of a prior discharge. While there is no clear evidence-based trend, there are a few instances where there are comments documented in the notes accompanying the OOH report indicating that the primary care provider requested that the class member be transported to a different hospital for the subsequent admission, due, apparently, to concerns about the capacity of the first facility to provide adequate care.

Supporters, and indeed, DOH and DDSD, are faced with competing challenges in meeting class members' needs when an acute illness arises. On one hand, we are charged with the support of a group of individuals with complex medical challenges, frequently further complicated by barriers in communication. On the other, the community resources available to provide adequate care are faced with their own pressures relating to lack of significant experience in treating individuals with I/DD and significant constraints on most medical resources.

While it is very important to understand the reason for the increasing trend here, it will likely also be helpful to develop a systematic process or methodology for 'discharge advocacy.' In particular, 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, as identified in the above section addressing non-specific pneumonia diagnoses. 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 even delayed discharge 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 a big component of that, as we see from the 2017 numbers, is preventing unnecessary readmissions.

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.

Currently there is 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.

Out of seven hundred and thirty eight (738) Out of Home Placement Reports which have been filed since 2010, there were reports of 38 class members being referred for hospice. Several of these class members have been referred for hospice services more than one time.[56] 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, twenty-nine have died. Nine 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 the course of a Review.

The decision to turn the treatment focus from diagnosis, treatment and/or 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 considering treatment decisions for Jackson Class Members, this topic is greatly complicated by compromised communication skills common among this population. 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 follows 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 a third of 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.

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.

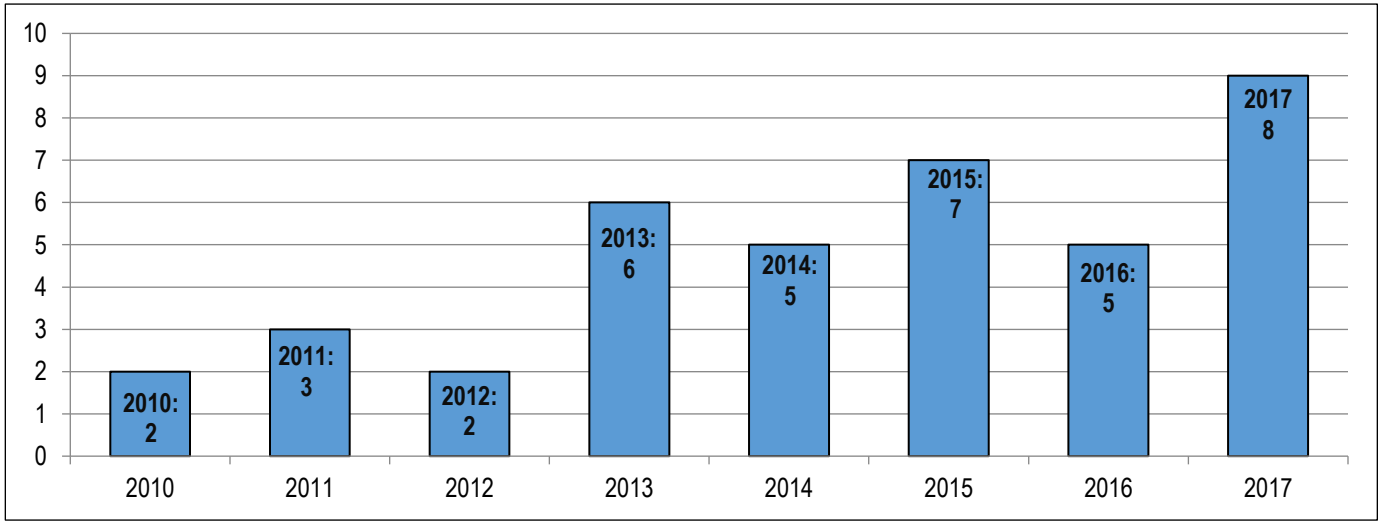
- It would be helpful to have consistent and routine tracking and reporting of information on the use of hospice including:
    - Who goes into Hospice (Out of Home Placement Report provides some of that information now);
    - When the person goes into Hospice/Palliative Care (OOH Placement Report sometimes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

[56] 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.

- 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 #32: Statewide Hospice Referral from Hospitals by Year



L. Class Member Deaths

In 2017, as of December 29, twelve class members have died. 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. 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 #33: Demographic Information for People Who Died 2014 – 2017

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

Demographic	2014	2015	2016	2017
Men	4	8	9	10
Women	2	4	4	2
Age Range/Av. Age	48 to 73[57] 58 years 6 months	37-67[58] 57 years 6 months	43-83[59] 64 years 8 months	37-77[60] 59 years, 9 months
# Receiving Hospice	3	7	6	3
Hospice Diagnosis	1. Mass in R.Lung/Pneu 2. Pneumonia 3. Stomach Cancer	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?
Average # of days in Hospice	6 days 1/14 days; 1/1 day; 1/3 days	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 [61]

[57] 2014: 2 individuals were 48 years old; 1 was 56, 1 was 61, 1 was 66 and 1 was 73.
[58] 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.
[59] 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.
[60] 2017: 1 individual was 37; two 51; two 57; one 59; one 62; two 64; one 66; one 72; one 77
[61] *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	2014	2015	2016	2017
Guardians	2 Sister; 1 Mother; 1 Brother; 1 Sister-in-Law; 1 Arc;	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
Regions	2: Metro 2: SW 1: NE 1:SE	6: Metro 1: NE 1: SE 4: SW	5: Metro 4: NE 2: NW 2: SE	7: Metro 2: NE 1: NW 2: SE
Providers	1 Alanzia then Adelante 1 EnSuenos 1 Safe Harbor 1 Transitional Lifestyles 1 Tresco 1 Nursing Home	3: Adelante 2: ARCA 1: Dungarvin 1: ENMRSH 1: Family Options 4: Tresco	1: Advantage Communication 3: ARCA 1: AWS 1: CARC 1: ESEM 1: Expressions of Life 1: HDFS 2: Mi Via 1: Ramah Care 1: Tungland	1: A Better Way 1: Adelante 1: Advantage Communications 2: Arca 1: AWS 1: Bright Horizons 1: CDD 2: Dungarvin 2: Mi Via 1: Tresco
Case Management	1 PEAK 1 SCCM 1 Unidas 1 Unique CM 1 Visions 1 Nursing Home	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

Those involved in the process of dying have a variety of physical, spiritual, emotional and 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 to be 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 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 where 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.

VI. INDIVIDUAL SERVICE PLAN (ISP)[62]

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 …

Identifying what level of ***assistance Team members provided to the individual*** so he/she could be involved to the extent desired/possible.
Verifying that the ***individual's thoughts and ideas*** about his/her plan 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 is ***accurate and adequate*** to meet 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***, 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 *has steadily increased* during the past four years.

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; and
In 2017, 65 people had 607 findings; **the average number of findings per person was 9.34**.

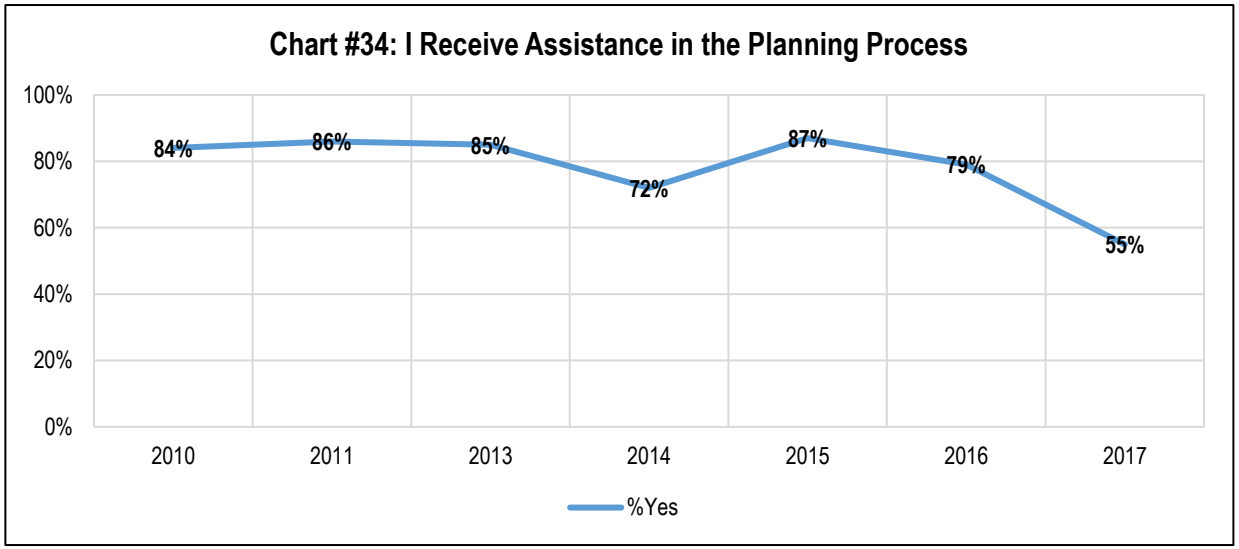
B. Was the Person Provided with Assistance to Participate in the Planning Process?

The 2018 DD Waiver Standards[63] and New Mexico Administrative code (§ 7.26.5), as did previous versions, 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 and to review current assessment information, prepare for the meeting, create a plan with the person to facilitate or co-facilitate the

[62] 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.
[63] Which went into effect March 1, 2018.

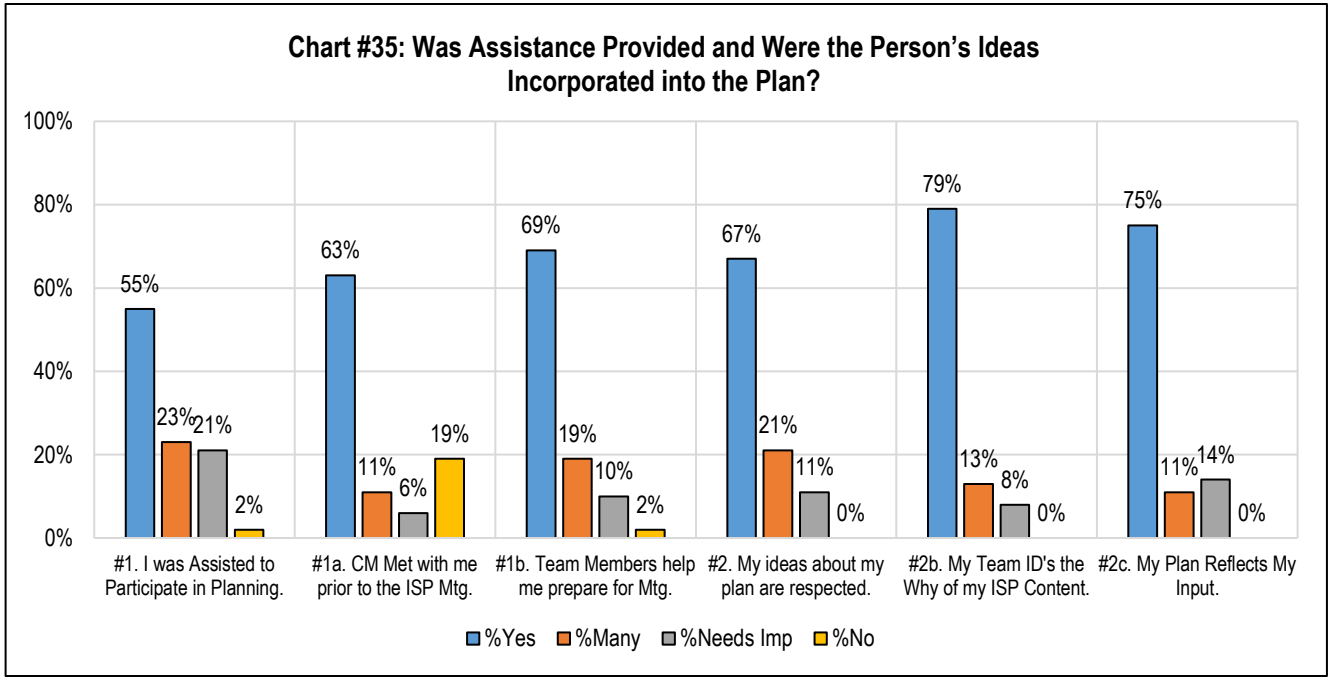
meeting if desired, discuss the budget, review current forms and provide supports for greater informed participation in the ISP development by the person. The intended outcome is to ensure that the individual's thoughts and ideas are known and drive the development and ultimate content of the plan. Since 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 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%.



The low score in 2017 may be explained, in part, because the questions in the 2017 IQR are more specific about what "assistance and support" is expected in an effort to assist the person to be meaningfully involved in his/her Plan development. For example, CPR Question #86 reads: "Was the person provided the assistance and support needed to participate meaningfully in the planning process?" The comparable 2017 IQR Question is: Question #1. There is evidence that team members assist me in the planning process? However, there are additional questions in 2017 that identify what assistance/support is expected. For example:

Question #1a. Is there documentation that the case manager met with me prior to my meeting and asked me about how I want to spend my days and my future?
Question #1b. Do team members help me prepare for my meeting by providing the assistance I need to participate meaningfully in the planning process?
Question #2. My thoughts and ideas about my plan are respected.
Question #2a. If I can speak, do I tell you that I feel as if my team listens to me?
Question #2b. If I do not speak for myself, did my team members tell you why my vision statements, outcomes and action steps were chosen?
Question #2c. If I have provided input, does the plan reflect my input?



C. Many Team Members Know Me Well, Fewer Believe I can Learn and Gain Skills

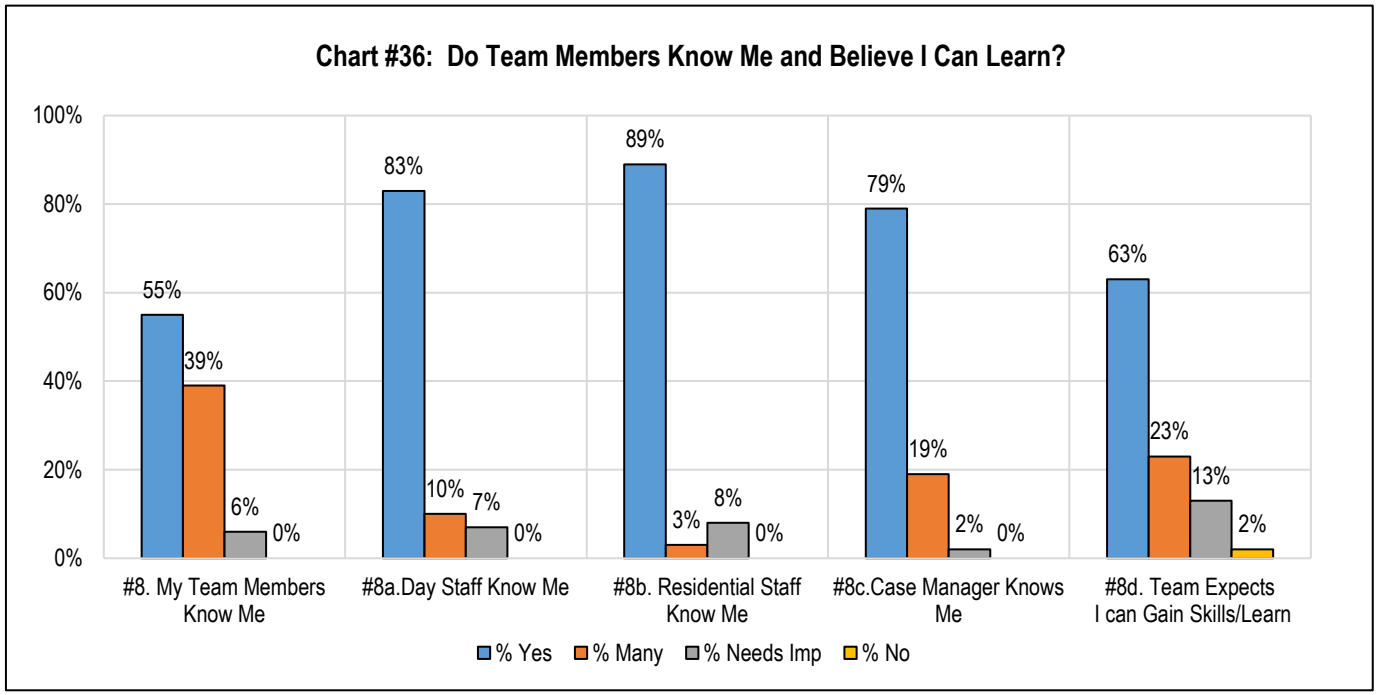
Related Evaluative Component Required for Disengagement:
Safety Objective S5.3a. Case managers must demonstrate that they know the current strengths, needs, preferences, and medical conditions of each JCM they serve and the JCM's ISP must address these factors.

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 #8. My Team Members Know Me
Question #8a. Do those who provide direct support during day/work know me well?
Question #8b. Do those who provide direct support at home know me well?

Question #8c. Does my case manager know me well?
Question #8d. Do my team members have expectations that I can gain skills and learn?



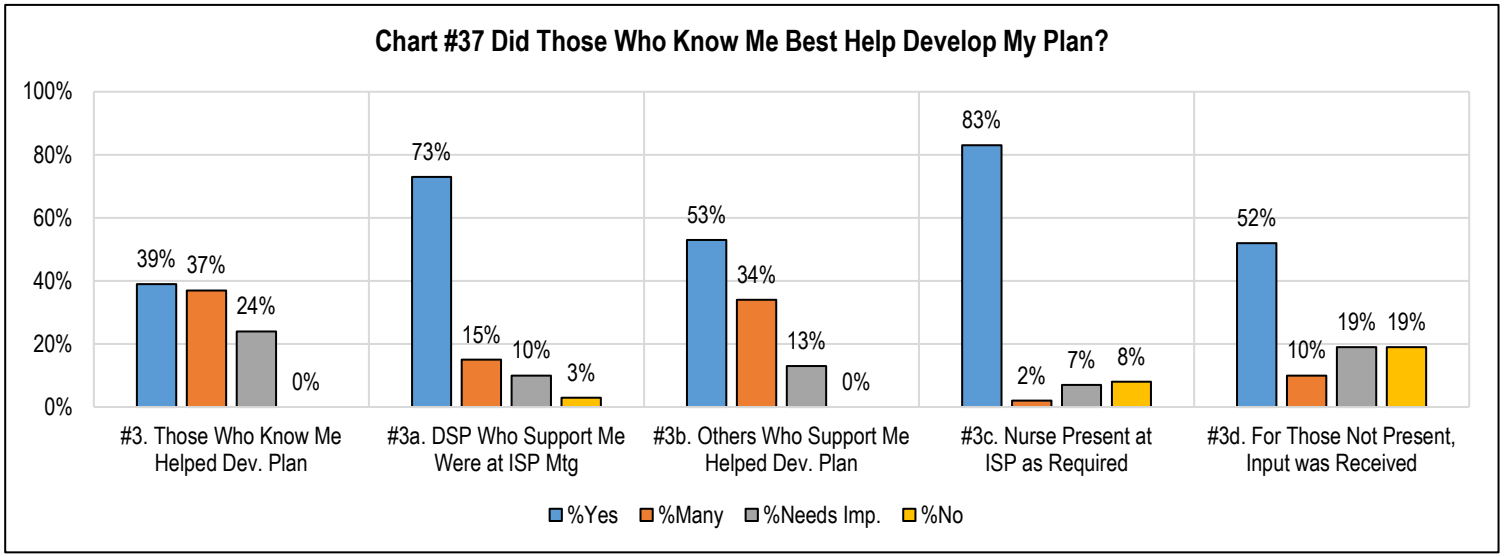
D. Many of those Who Know Me Best Had Input Into My Plan

Another challenge is the engagement of Direct Support Professionals, who know the person best, in developing the plan. One piece 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 to influence the content of the ISP. 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 #3: Those who support me and know me best help me to develop my plan. [64]
Question #3a: Were Direct Support Professionals who support me present at my planning meeting?
Question #3b. Were others who support me present at the planning meetings?
Question #3c. As needed or required, is a nurse/healthcare coordinator present at the ISP and at the IDT Meetings?

[64] CPR Question #62.

Question #3d. For anyone not present, is there evidence that input has been obtained prior to the meeting? [65]



From 2010 to 2016, on average, 51% of those who know the person best helped develop the person's plan. 2017 shows a decrease in the percentage of those who know the person best at 39%. During 2010 to 2016, on average, for 42% of those not present there was evidence of their participation in the development of the ISP outside of the meeting. 2017 shows a welcome increase in this same area to 52%, however, more wide-spread plan development engagement of those who know the person best needs to continue to improve.

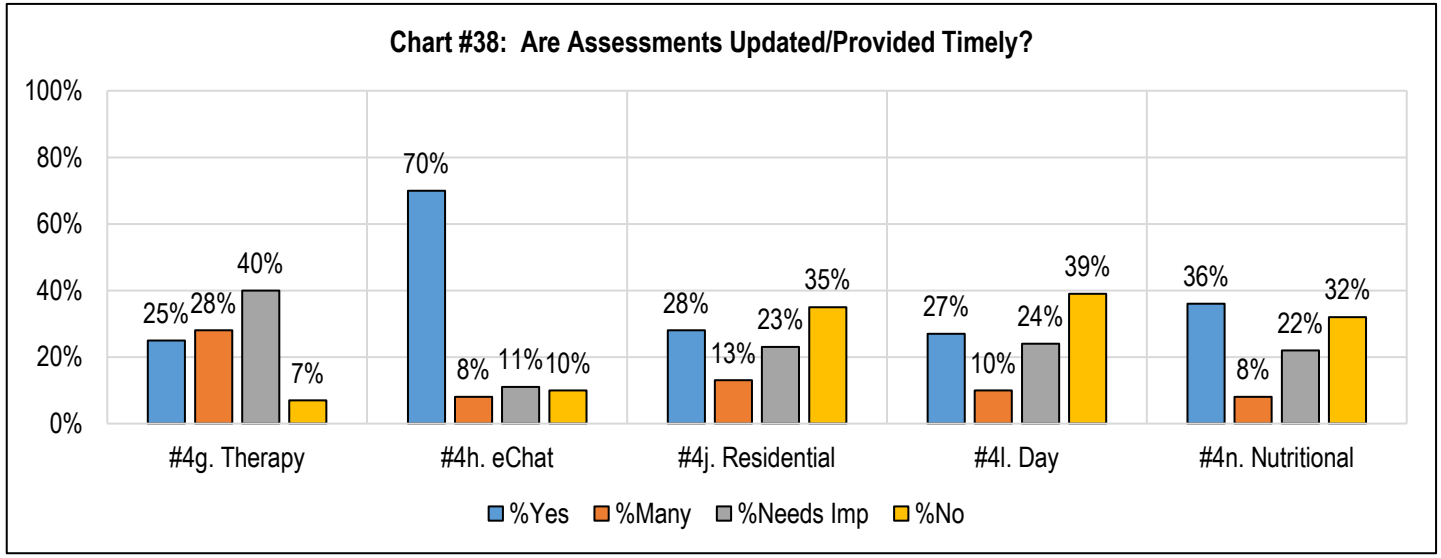
E. Developing the ISP Based on Timely and Adequate Assessments.

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. 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.[66] Ongoing ***assessments*** are to be completed at least 14 days in advance of the annual ISP[67] 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.

[65] CPR Question #63.
[66] 2018 NM DD Waiver Standards, Chapter 6. Individual Service Plan, 6.3. Page 62,
[67] Initial assessments can be completed at any time during the ISP year.

Questions that are asked which specifically relate to timeliness of assessments include:

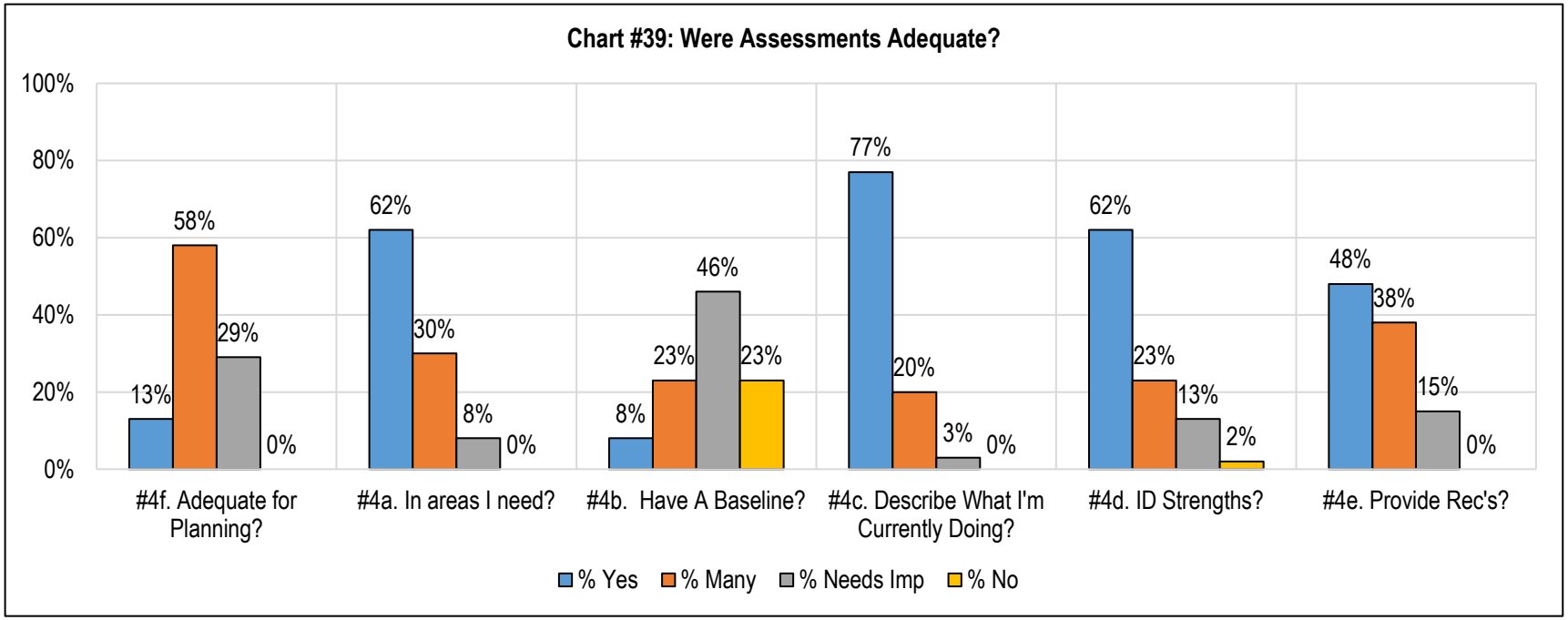
Question 4g. Therapy assessments were provided timely?
Question 4h. eChat was updated timely? (eChat is the electronic health assessment/record)
Question 4j. Residential assessments were provided timely?
Question 4l. Assessments for supports offered during the day were provide timely?
Question 4n. Nutritional assessments were provided timely?



While most assessments were not provided timely, some assessments were ultimately provided as identified in the Health Section above.

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 the criteria sought is identified in several of the questions contained in the following chart, specifically:

Question 4a. Do I have an assessment ***in all areas that I need***?
Question 4b: Does the assessment describe ***where I 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 –maintenance.)
Question 4c: Does the assessment describe ***how I am currently doing*** in each area?
Question 4d. Does the assessment describe ***my strengths*** in each area?
Question 4e. Does the assessment ***give recommendations*** to my team on ***what new skills I might learn*** and how to help me learn them consistent with my preferences? (Experts conducting assessments need to give specific recommendations which directly relate to the identified goals and objectives.)

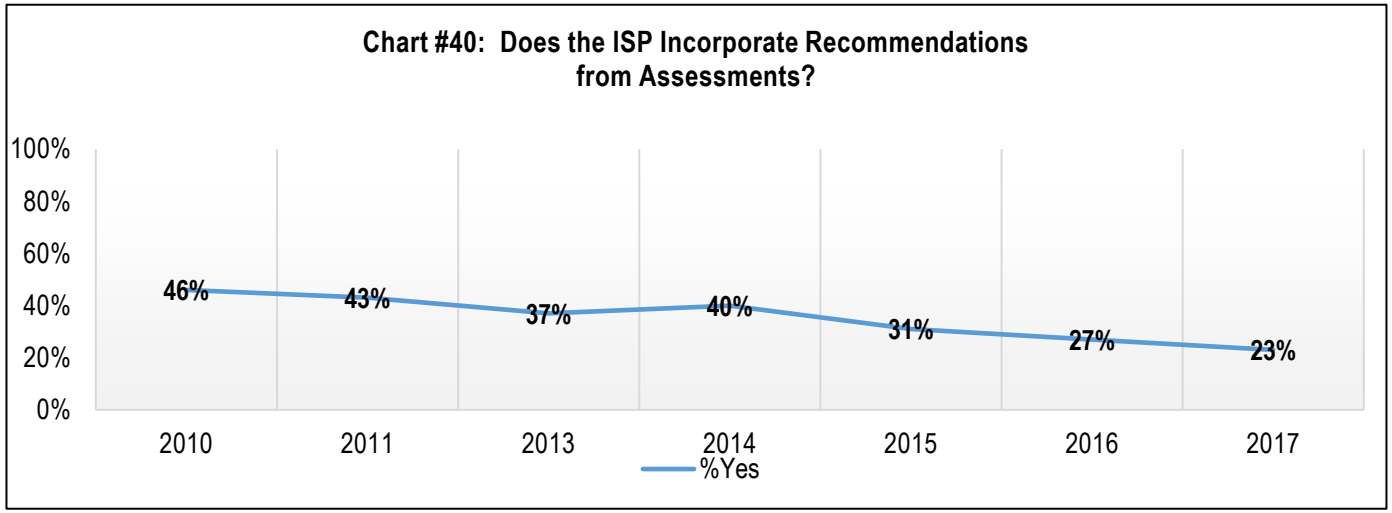


The information often found to be missing from assessments is a measurable baseline. In order to know the effectiveness of an intervention, it is critical to know where the individual started, or their 'baseline'. For example, if the Outcome is to walk 100 ft. a day one needs to know how far the individual 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. 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 to access their specific background of 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 13% 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

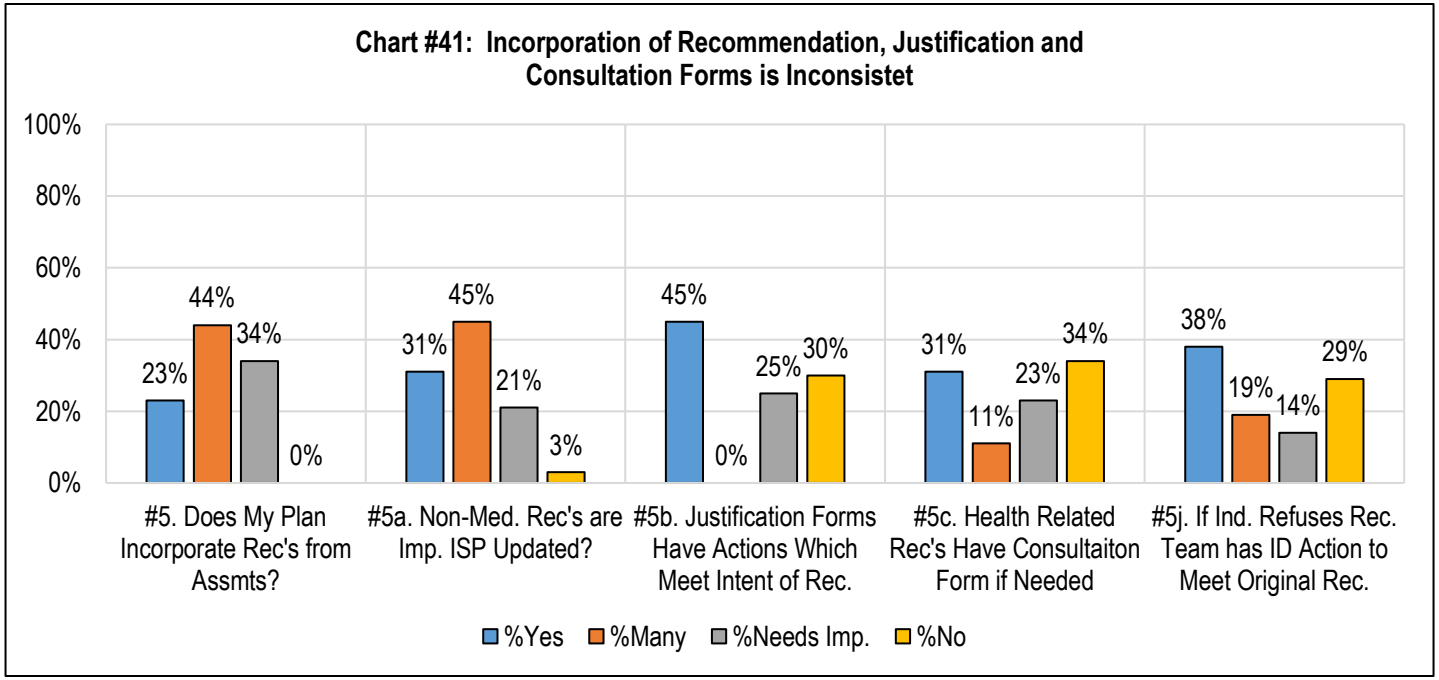
Question #5. My plan incorporates the recommendations from assessments, or explains why recommendations are not included.[68] [69]



With only 13% of class members found to have assessments adequate for ISP planning, the examination of the use of assessments to guide formation of ISP recommendations has a very inadequate foundation. Informed recommendations cannot reasonably be expected as an outcome of limited or faulty assessments. Nevertheless, questions used to probe the use of recommendations made as a result of assessments as well as protections put in place consistent with the intent of recommendations include:

Question #5a. For non-medical recommendations, has the team implemented the recommendation and made necessary changes to the ISP?
Question #5b. Do Justification Forms(s) (Non-Health related or others) contain the identification of additional safeguards that have/will be put into place that will help meet the objectives of the original recommendation?
Question #5c. 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?
Question #5j. If the individual refuses to participate and follow a recommendation, has the team identified what safeguards have/will be put into place that will help meet the objectives of the original recommendation?

[68] CPR Question #57. Did the Team consider what assessments the person needs and would be relevant to the team's planning efforts?
[69] CPR Question #60. Were the recommendations from assessments used in planning?

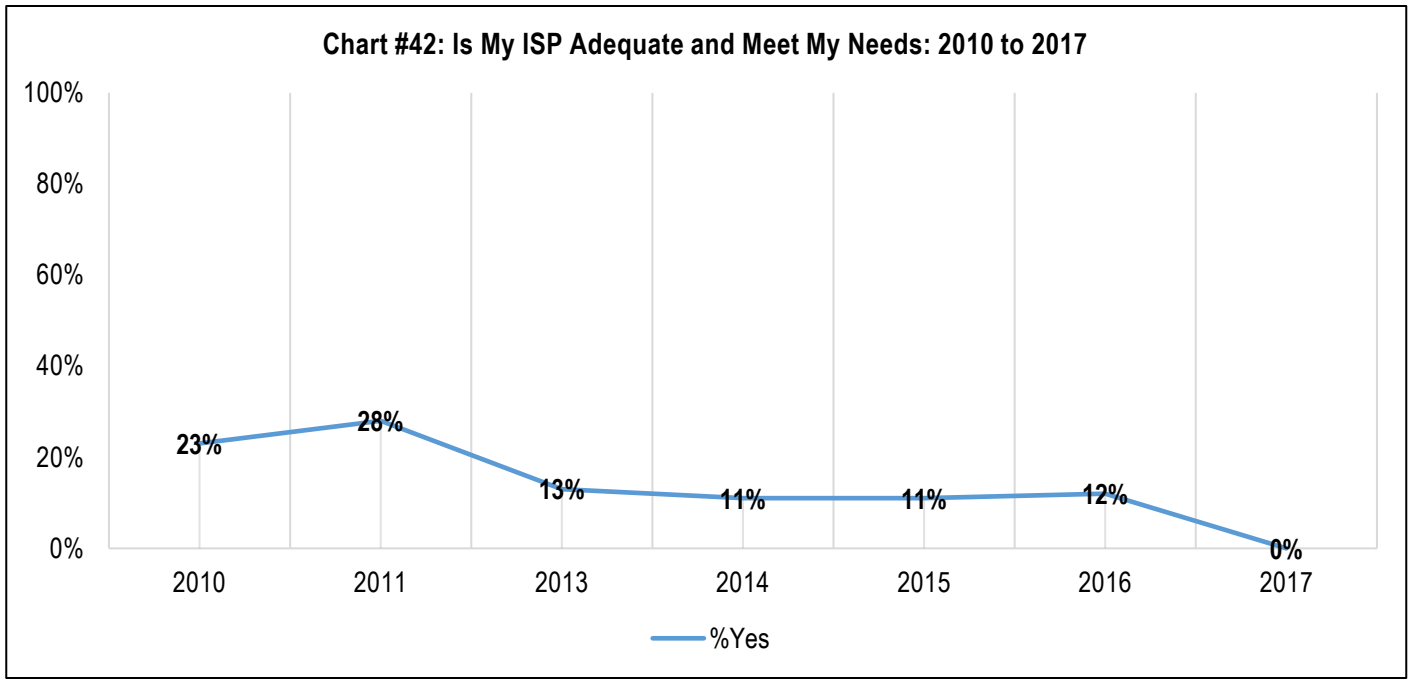


G. Is the ISP Adequate and Meet the Person's Needs?

There are 18 scored questions that relate to the adequacy of the ISP. A sample of those questions is displayed in the chart below. All of the questions are summarized in Appendix F. First, a recent historical perspective on the adequacy of the ISP is summarized in the first chart. What follows is a closer examination of samples of what is looked for when determining adequacy.

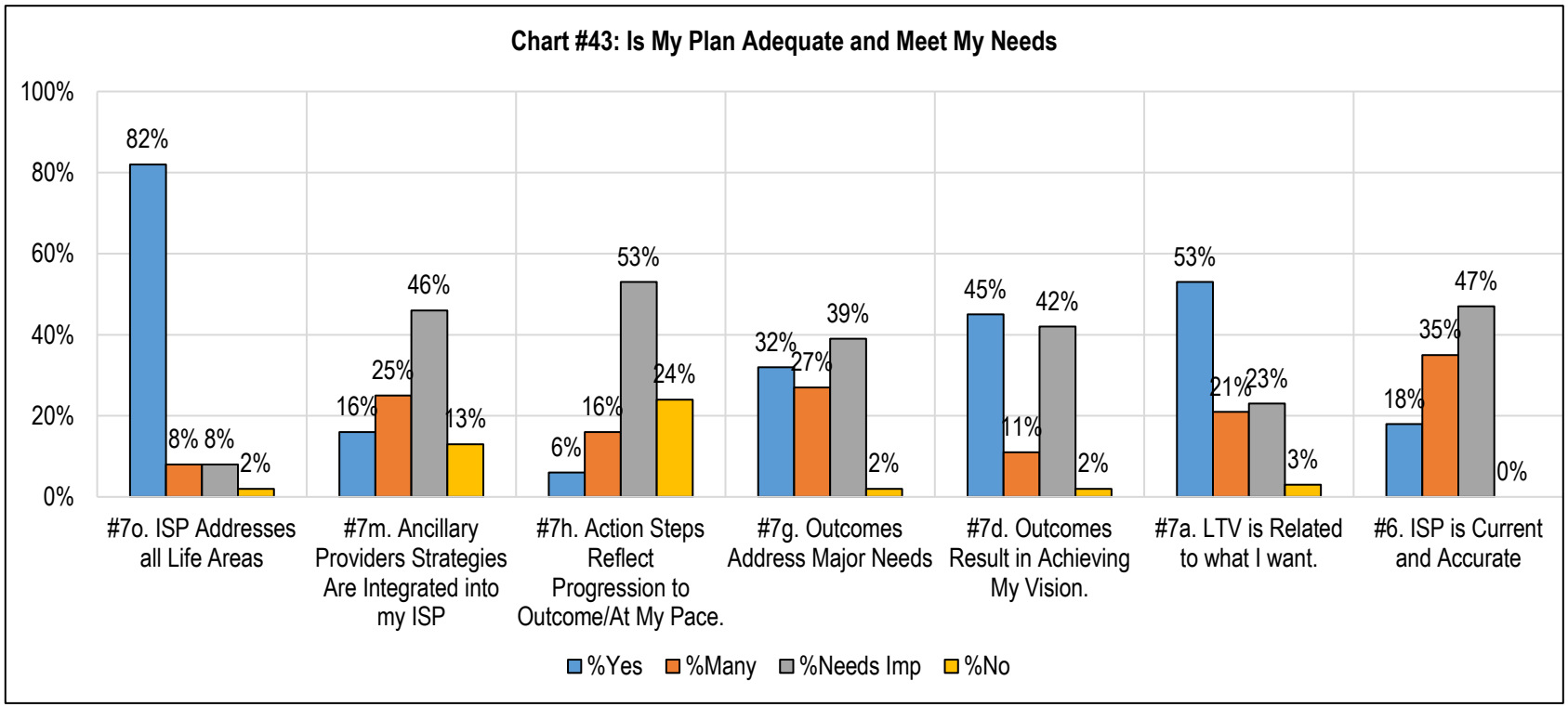
Question #7. My ISP is adequate and meets my needs.[70]

[70] CPR Question #78 and 146. Overall, is the ISP adequate to meet the person's needs?



The following questions explore areas of the ISP which influence the findings of adequacy.

Question #6. My ISP contains current and accurate information.
Question#7a. Is the Long Term Vision related directly to what I want to achieve in the next three or more years?
Question #7d. Will the outcomes, if achieved, ultimately result in achieving my vision?
Question #7f. Will the outcomes, if achieved, enable me to grow and learn next year?
Question #7g. Do the Outcomes address my major needs?
Question #7h. Are my action steps organized to reflect a progression toward the outcome, at a pace which is appropriate to me?
Question #7m. Have strategies of ancillary providers been integrated into my Outcomes, Action Plans and Teaching and Support Strategies?
Question #7o. Does the ISP address live, work/learn, fun/relationships and health/other that complements the person's desires and capabilities?

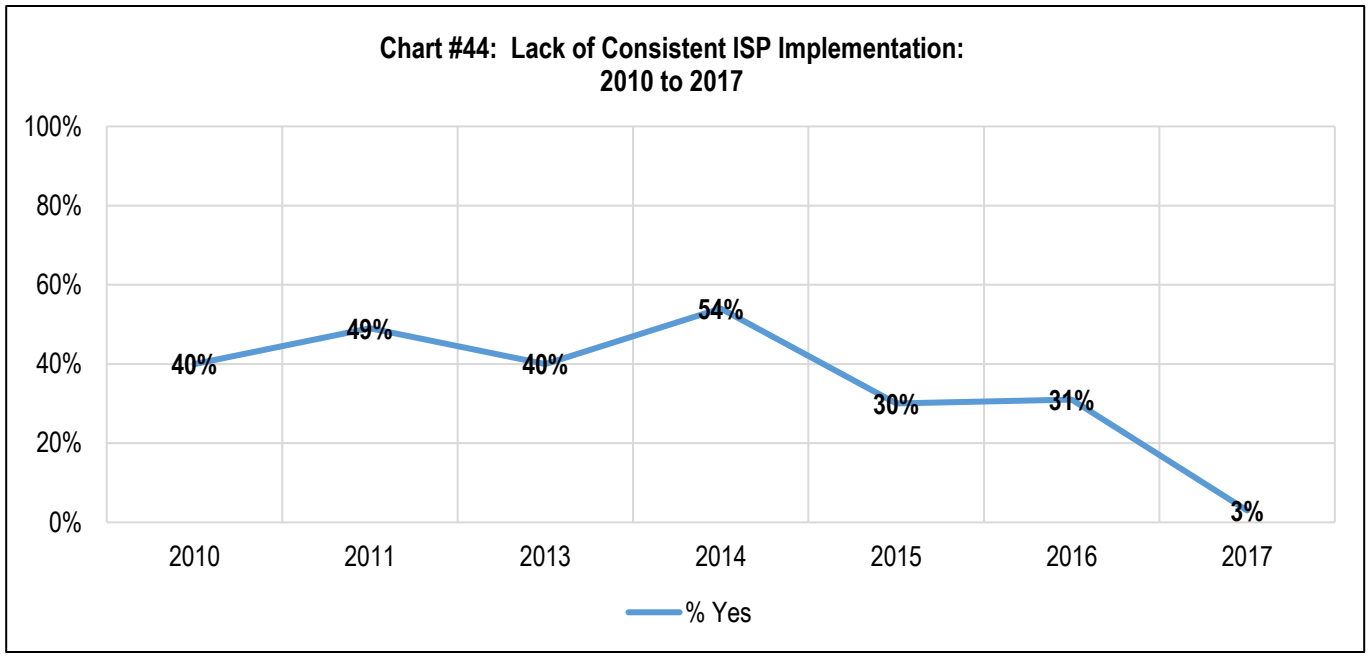


H. Is the ISP Consistently Implemented?

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%.

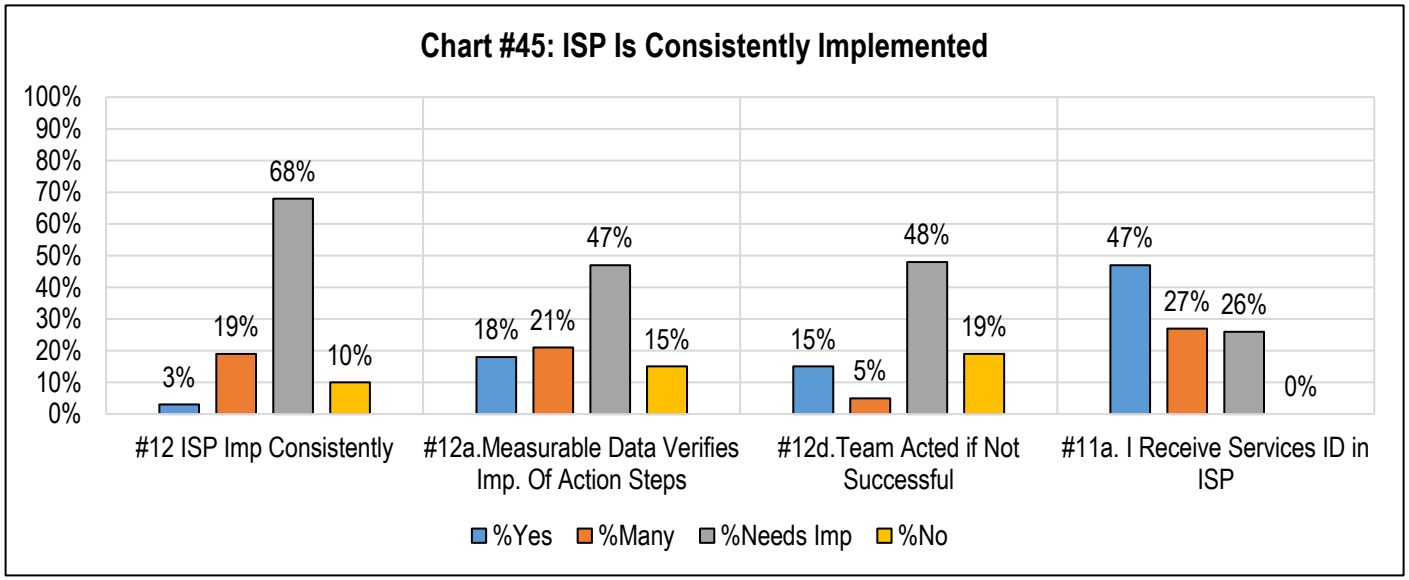
Question #12: My ISP is implemented consistently.



An often cited reason 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 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 250 questions of the individual, guardian, 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 #12a. Is measurable data kept which verifies the consistent implementation of each of my action steps?
Question #12d. If I am not successful in achieving my action steps, has my team tried to determine why, and change their approach if needed?
Question #11a. Do I receive all of the services listed in my ISP? (e.g., therapy, transportation, day, residential)

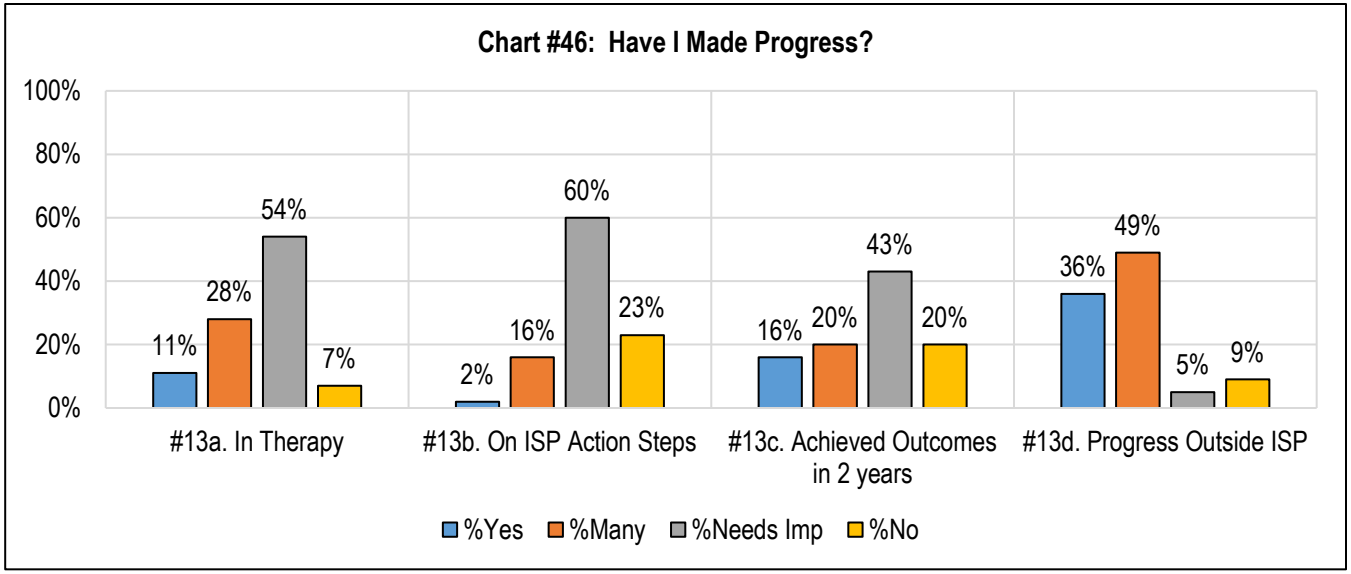


I. Have I Made Progress?

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[71]) to determine the need for additional training, effectiveness and readiness for fading. 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. [72]

[71] 2018 NM DD Waiver Standards, Chapter 6. ISP 6.6.3. Page 66.
[72] 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. Have I Regressed?

Health Objective H3.2 Direct Service Personnel/Supervisors are able to identify subtle signs of change/acute symptoms.

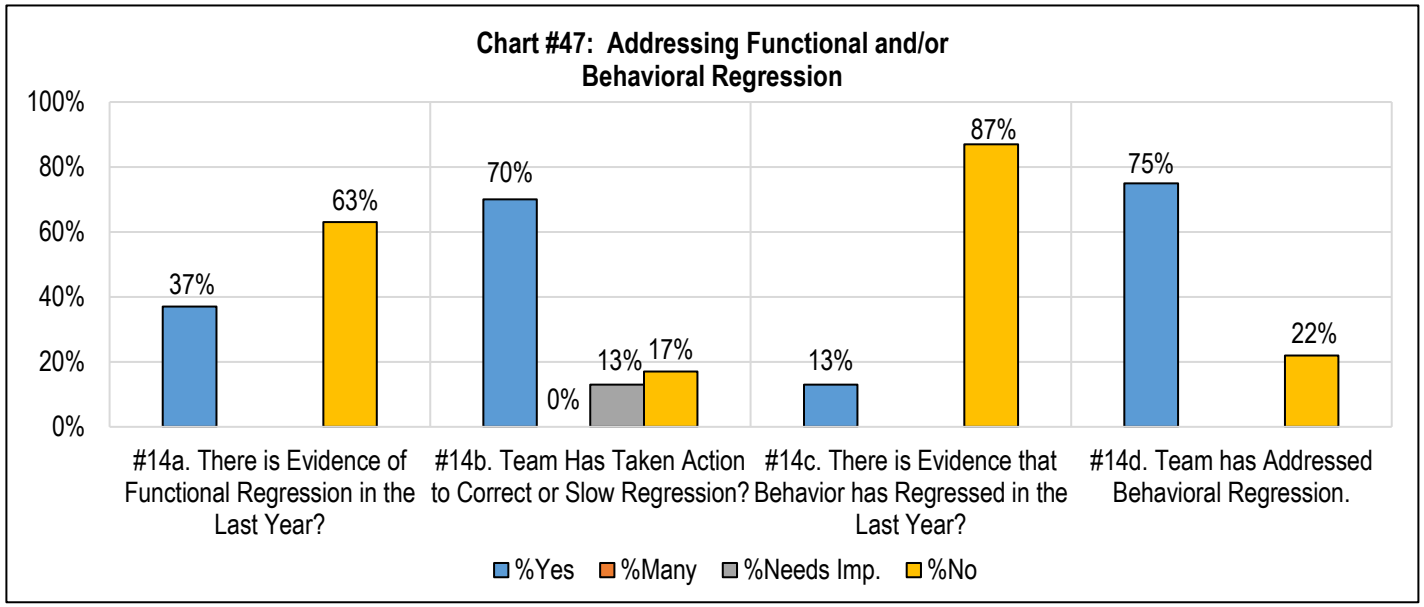
The average age of the Jackson Class is 58, or middle age. Yet, age alone isn't the single indicator of overall wellbeing. Many Class Members have multiple diagnosis and medical conditions which may limit their physical movement and overall health. Nevertheless, regression for all of us should serve as an alert and warrants close examination to determine the cause. Some regression may be due to lack of adequate services while some might be a natural progression of an identified disease or temporary illness. Frequently the issue is: does the team know about the regression and have they acted to correct or slow the regression.

Question #14: If I am having problems, my team has addressed them.
Question #14a. Is there evidence or documentation that I have regressed in my ability to function in the last year?
Question #14b. If so, has my team taken action to correct or slow this regression?[73]
Question #14c. Is there evidence or documentation that my behavior has regressed in the last year?[74]
Question #14d. If so, has my team addressed this?[75]

[73] CPR Question #121. Is the Team adequately addressing regression?
[74] CPR Question #120. Is there evidence or documentation of behavioral or functional regression in the last year?
[75] CPR Question #121.

In terms of numbers of class members affected:

23 individuals were identified as having regressed in their ability to function in the past year. 39 did not experience regression. (Q.14a).
16 individuals had teams that had taken action to correct or slow this regression. Again, 39 did not experience regression. (Q.14b)
3 other individuals had action taken that 'needed improvement'.
4 individuals had no identified action taken by their teams.
8 individuals had evidence of behavioral regression in the last year. 54 individuals did not experience behavioral regression. (Q.14c)
6 of these 8 individuals had teams who addressed their regression. (Q.14d)
2 individuals' teams had no identified action taken by their teams.



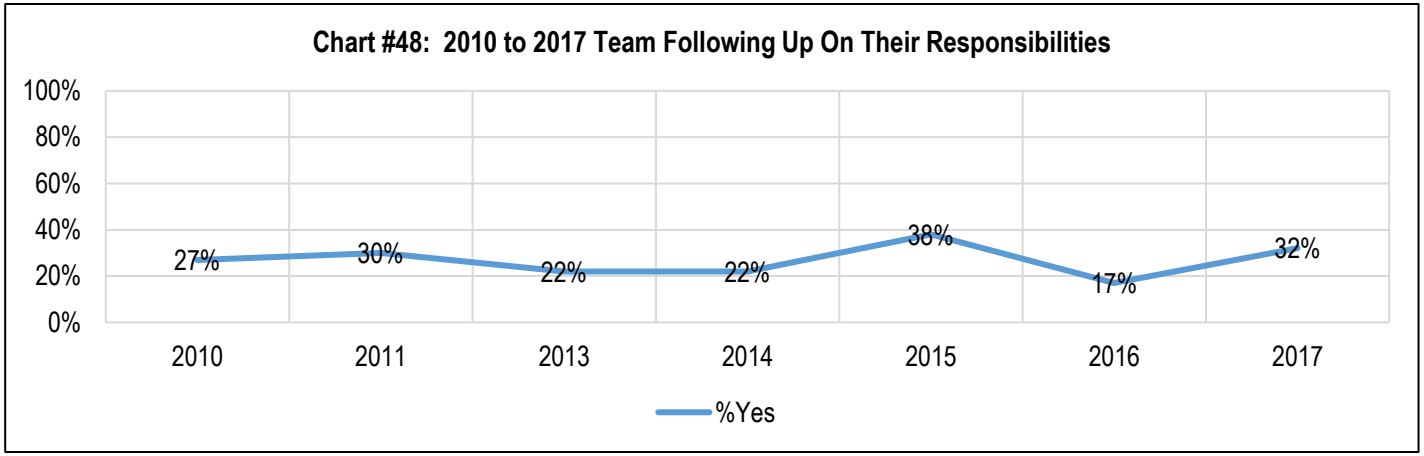
It is noteworthy and to be celebrated that the majority of class members experiencing functional and/or behavioral regression (70% and 75% respectively) have had their teams take action to slow or reduce the regression. However, for those with functional and/or behavioral regression that has not been addressed this is not acceptable.

K. Are Team Members Consistently Following Up on Their ISP Responsibilities

There is a long and consistent pattern of residential and day team members not following up on their programmatic responsibilities implement the Individual Support Plan.

Question #10.[76] My team members are following up on their responsibilities to assist me.

[76] CPR Question #114.



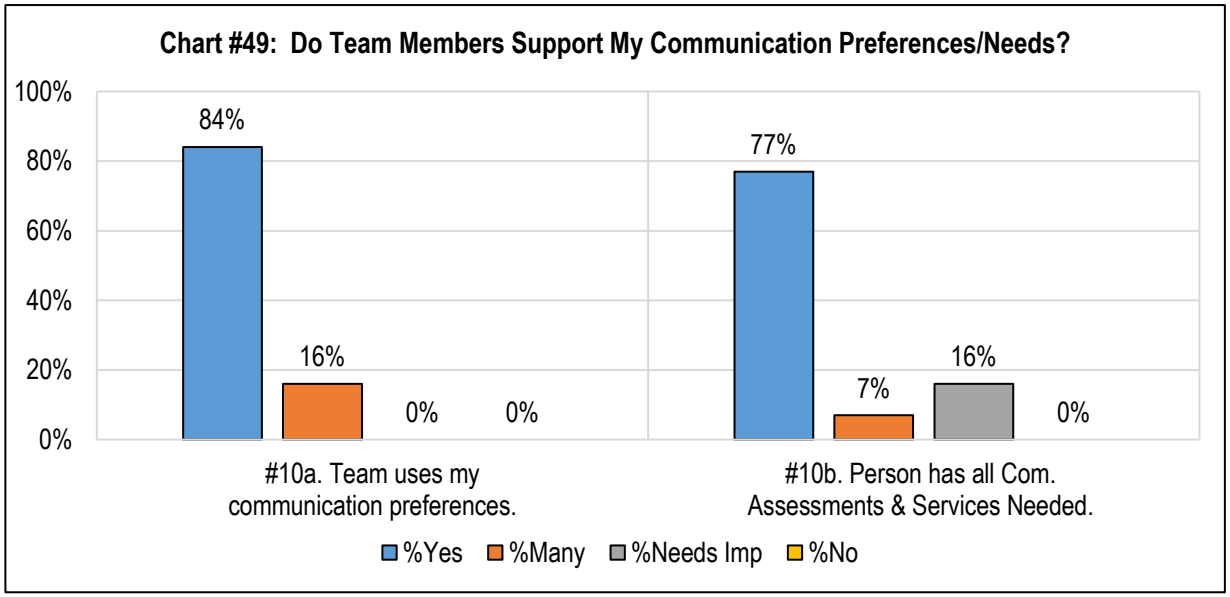
L. Do Team Members Use the JCMs' Communication Preferences1/

The ability to communicate and be understood is an essential life skill which impacts on our wellbeing emotionally, economically and socially. Some people with intellectual or developmental disabilities (IDD) have communication difficulties. 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.

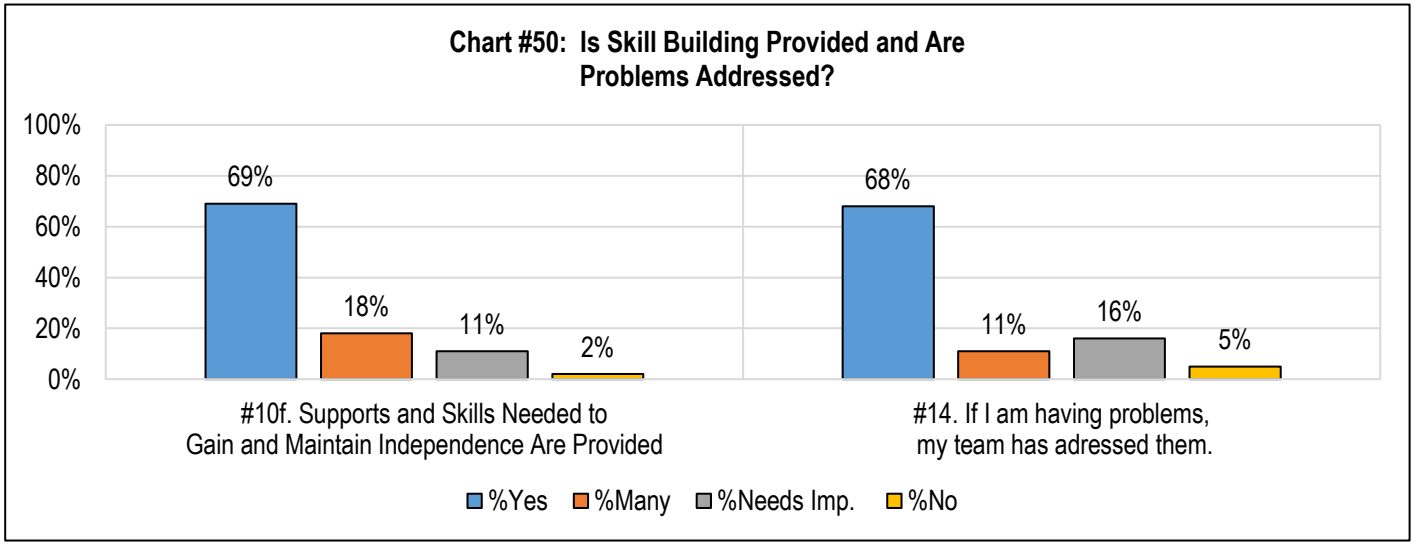
In order to understand the best way to communicate with an individual, communication assessments are essential. New Mexico has speech and language pathologists (SLPs) in many areas of the state so acquiring assessments and needed equipment and services is frequently possible.

One area of good practice is that 52 (84%) of those reviewed had team members who communicated with the individual using his/her communication preferences.

Question #10a. Do my team members communicate with me using my communication preferences?
Question #10b. I have received all communication assessments and services needed?



M. Do JCMs Receive Support and Skills Needed to Gain Independence?

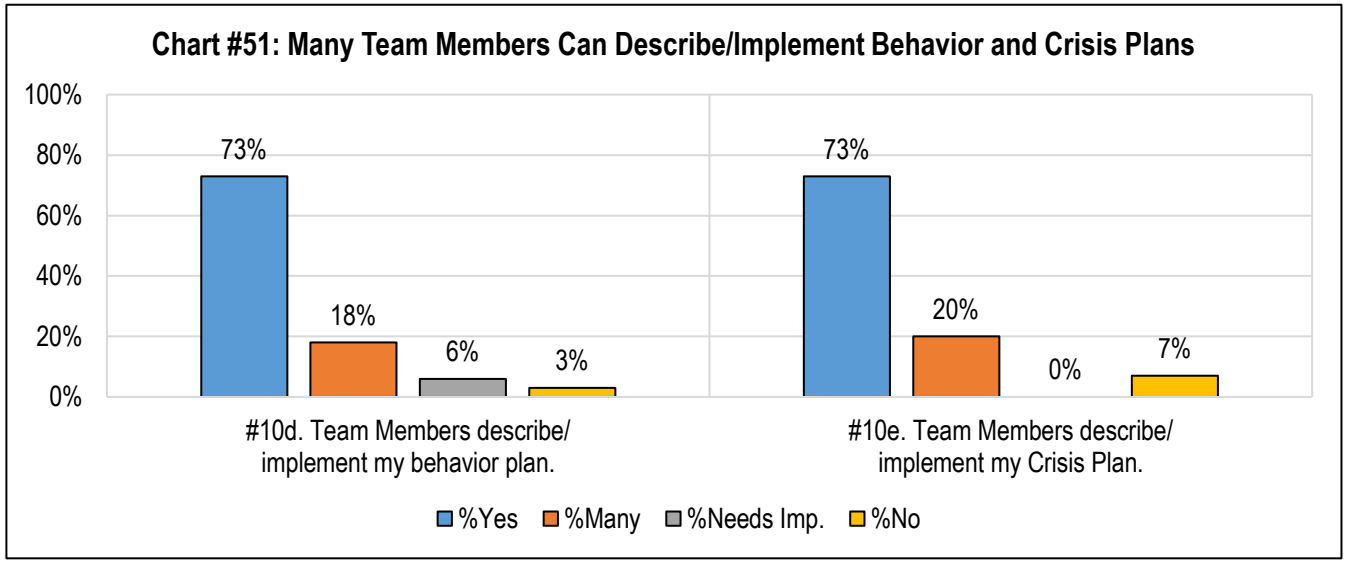


As stated earlier, services and supports to class members are intended to increase the person's skills leading towards greater independence. For individuals with degenerative conditions, maintenance of existing skills may be the goal. Services are intended to, in part, enable people to have the skills necessary to engage in community life, have access to the community, control their personal resources, seek employment and work in competitive settings.[77] One relevant question which specifically speaks to skill building is Question #10f. Am I provided with the support and skills needed to gain and maintain as much independence as possible? Another for people who are experiencing barriers is IQR Question #14. If I am having problems, my team has addressed them.

N. Can Team Members Describe/Implement Behavior and Crisis Plans?

As the chart which follows shows, many class members have staff supporting them who can describe their behavior and crisis plans. There is also evidence present for 73% of class members reviewed that these plans are being implemented. It is hoped that this number will increase as it is critical that behavior and crisis plans are consistently implemented in order to protect class members, and in some cases, others from harm.

Question #10d. Can my team members describe and/or is there evidence that they have implemented my behavior plan?
Question #10e. Can my team members describe and/or demonstrate how to implement my crisis plans?



O. Is Functional and Behavioral Regression Addressed?

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.

[77] 2018 DD Waiver Standards, Statement from Advocates, page 4.

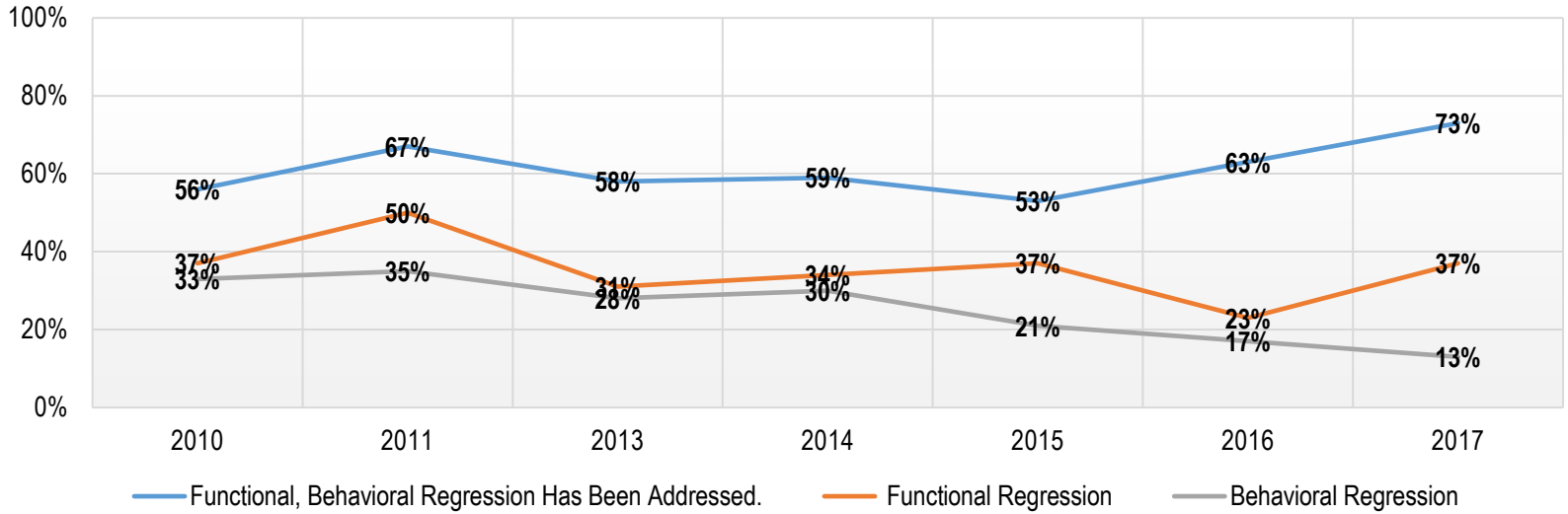
Health Objective H3.3 When informed of signs of change in health status (including chronic and acute pain) agency nurses take immediate action.

When addressing functional regression, the IQR investigates whether or not an individual has lost an acquired function. For example, if an individual use 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? If I am hitting out at staff or hitting myself when I never did before or the frequency of these behaviors has spiked, is it because of pain? As stated earlier, most class members do not communicate by using sequenced verbal words or sentences. Our bodies communicate information whether we can speak or not, consequently, being acutely aware of changes in things like functional and behavioral abilities is essential for care givers working with severely disabled individuals. The overall IQR Question which addresses this issue is:

Question #14: If I am having problems, my team has addressed them.[78]

When put into historical context, you can see that when individuals are experiencing functional and/or behavioral regression, in 2017 73% of the time the regression is being addressed. While improvement continues to be needed, the trend is in the right direction.

Chart #52: Addressing Functional, Behavioral Regression

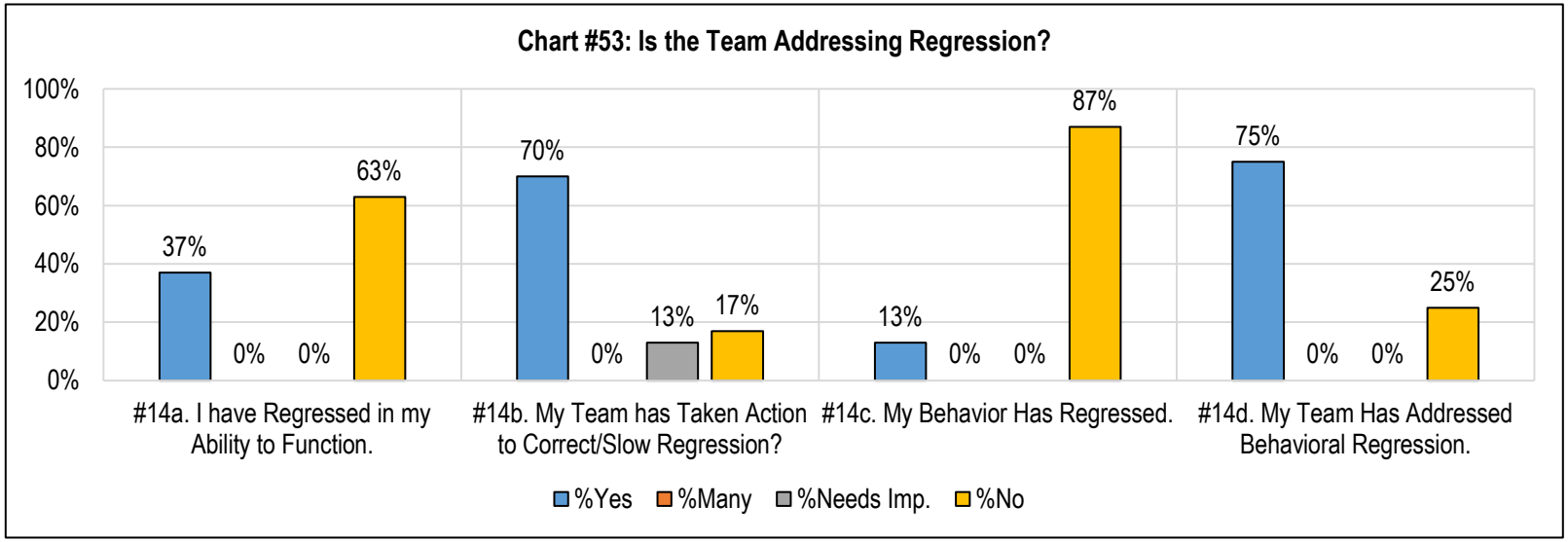


The following questions help illustrate the difference between functional and behavioral regression.

[78] CPR Question #121. … is the IDT adequately addressing the regression (functional and/or behavioral). In 2017 70% of the teams were addressing functional regression, 75% of the teams were addressing behavioral regression.

Question #14a. Is there evidence or documentation that I have regressed in my ability to function in the last year?
Question #14b. If so, has my team taken action to correct or slow this regression?
Question #14c. Is there evidence or documentation that my behavior has regressed in the last year?
Question #14d. If so, has my team addressed this?[79]

As the following chart illustrates, some teams are moving forward to address the needs of individuals who are losing functional abilities as well as those who are experiencing behavioral regression.



[79] CPR Question #121.

VII. CASE MANAGEMENT

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.[80] The accomplishment of these essential elements depend 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 managers 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, like providers, the findings throughout this entire report needs to be considered.

B. Case Managers: Continuing Areas of Good Practice.

Question #8c: Does my case manager know me well?[81]

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.*** Historically, case managers have scored well on this question. Since 2008 the score for this question has been consistently at or above 88%. This year the score dipped to 79%. When answering this question, reviewers look to see if the Case Manager thoroughly describes 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 s/he possesses; willingness to try things; willingness to participate in activities; etc.

During the 2016 Community Practice Review, 79 of the 90 (88%) class members reviewed and scored had case managers who knew them well. As shown in the chart below, 11 of 15 Case Management Agencies[82] (73%) scored 100% on this question in the 2017 Review.

[80] NM 2018 DD Waiver Standards, Chapter 8 Case Management.
[81] Question #26 in the CPR.
[82] This includes DDSD which provides Case Management Services to individuals in the NE and SE regions.

Question #16a: Does my case manager visit me at least twice a month, and in varying locations where I receive services and supports?[83]

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 in line with the ISP/SLP's instructions? Is the person properly seated in their wheelchair, is the person receiving prescribed medication as intended, 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

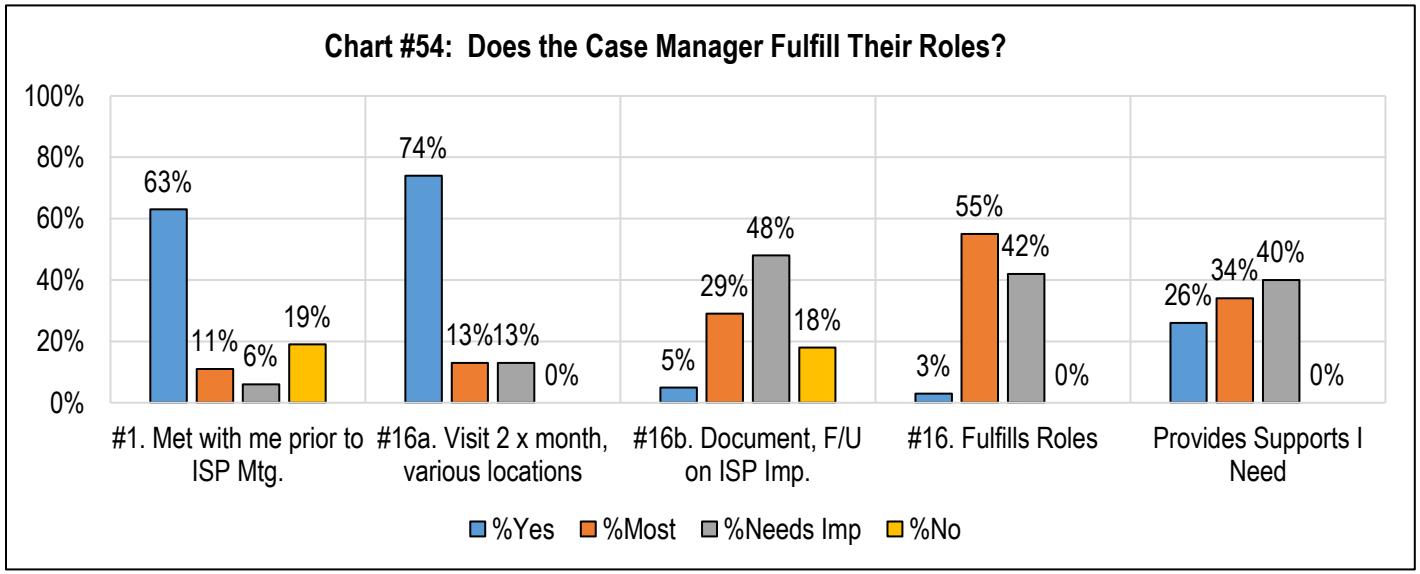
Relevant Evaluative Component Required for Disengagement:
Safety Objective S5.3b. Case Managers must ensure that each JCM's ISP is properly implemented.
Safety Objective S5.3c. Case Managers must identify significant risks, needed supports, and unmet needs for each JCM; must convene the IDT promptly 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.

Questions specifically related to case management include:

Question #1a.: Is there documentation that the case manager met with me prior to my (ISP) meeting and asked me about how I want to spend my days and my future?
Question #16: My case manager fulfills his/her roles as advocate, team leader and monitor of services and supports.
Question #16a: Does my case manager visit me at least twice a month, and in varying locations where I receive my services and support?
Question #16b: Does my case manager document and follow-up on my progress on outcomes and action steps? [84]
Question #16c: Does my case manager provide me with the supports and services I need? [85]

[83] Question #29 in the CPR
[84] Question #32 and #83 in the CPR.
[85] Question #33 in the CPR.

The following chart provides a quick picture of the overall answers to questions related to case managers fulfilling their roles.



Other questions provide additional information regarding the engagement of the case manager.

Question #1a.: Is there documentation that the case manager met with me prior to my (ISP) meeting and asked me about how I want to spend my days and my future?

The CM is required to meet with the person receiving services and their guardian prior to the ISP meeting and 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[86]. As the chart above illustrates, 39 (63%) class members met with their case managers in advance of their annual ISP meeting, 23 (37%) did not.

It is critical to know whether or not the person is making progress towards desired outcomes which is a requirement of Case Managers as part of their twice monthly visits. As noted earlier in this report, one of the major challenges related to the ISP is that 97% of the ISP's reviewed were not being implemented as intended. While one of their primary responsibilities is monitoring to ensure that the ISP is initially implemented as agreed, the case manager also carries responsibility to routinely verify that the ISP continues to be implemented as intended and if not, to take action by notifying the provider.

[86] 2018 DD Waiver Standards, 6.4. Preparation for the ISP Meeting, page 62.

The site visit form that the case manager fills out 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 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. The other challenge 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.

Question #16c. Does my case manager provide me with the supports and services I need?

Relevant Evaluative Component Required for Disengagement:
Health Objective H1.7d. Defendants, through appropriate personnel, e.g., provider agencies and case managers, must ensure that a healthcare professional's recommendations are implemented within the prescribed timeframe. (See Health Section).

The key to understanding the impact of these low scores is understanding how critically important the role of monitoring really 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 and fix. 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 there is no satisfactory resolution 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 systems 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.

Question #16: My case manager fulfills his/her roles as advocate, team leader and monitor of services and supports.

97% of those reviewed did not have case managers who fulfilled their roles as advocate, team leader and monitor of services and supports. 74% of those reviewed did not have case managers who provided them with the supports and services they needed. As stated earlier, providers carry first line responsibility for providing needed supports and services in a way that meets the person's needs, protects them from harm, keeps them safe, and is responsive to the individuals' preferences, needs and clinical requirements. When supports and services needed by the individual are not provided it is everyone's responsibility to know and to act timely. Acting, for case managers is frequently notifying those who can resolve the identified issue and continuing to report on the issue until it is resolved. One mechanism the Developmental Disabilities Supports Division has made available to case managers who are having difficulty resolving an issue(s) is the Regional Office Request for Assistance[87] form and process. For IQR purposes, if the Case Manager has demonstrated through documentation that he knows there is an issue and, in

[87] See 2018 DD Waiver Standards multiple citations including Chapter 19. Provider Reporting, 19.6. Page 236, Chapter 9. Case Management pages 76, 81, 82.

turn, acts timely to notify those who can help resolve the issue (e.g., the provider, the Regional Office), the case manager is held harmless in terms of scoring on that particular issue, e.g., staff not following the individual's Comprehensive Risk Management Plan or the person not having Physical Therapy for months. However, if supports and services are not provided consistent with the person's Plan(s) and there is no evidence that the case manager knew from his/her visits/monitoring and/or didn't act timely to notify and resolve the issue that will impact negatively on the scores related to the case manager fulfilling his/her roles and responsibilities.

For ease of reference, the IQR Questions are listed again here.

Question #1a. Is there documentation that the case manager met with me prior to my meeting and asked me about how I want to spend my days and my future?
Question #8c. Does my case manager know me well?
Question #16. My CM fulfills his/her roles as advocate, team leader and monitor of services and supports.
Question #16a. Does my CM visit me at least twice a month, and in varying locations where I receive services and supports?
Question #16b. Does my CM document and follow-up on my progress on outcomes and action steps?
Question #16c. Does my CM provide me with the supports and services I need?

Chart #55: Scores by Case Management Agency

Agency	# in Sample	#1a Yes	#8c Yes	#16 Yes	#16a Yes	#16b Yes	#16c Yes
A New Vision	1	0	1 (100%)	0	1 (100%)	0	1 (100%)
A Step Above	5	1 (20%)	5 (100%)	0	3 (60%)	0	1 (20%)
Amigo	1	1 (100%)	1 (100%)	0	1 (100%)	0	0
Carino	5	4 (80%)	3 (60%)	1 (20%)	3 (60%)	2 (40%)	2 (40%)
DDSD (NERO & SERO)	2	1 (50%)	2 (100%)	0	0	0	1 (50%)
Excel	3	3 (100%)	2 (67%)	0	3 (100%)	0	0
J&J	9	4 (44%)	8 (89%)	0	7 (78%)	0	2 (22%)
NMBHI	1	1 (100%)	1 (100%)	0	0	0	0
NMQCM	2	1 (50%)	2 (100%)	0	2 (100%)	0	0
Peak	9	5 (56%)	8 (89%)	0	6 (67%)	0	6 (67%)
Rio Puerco	2	2 (100%)	2 (100%)	1 (50%)	2 (100%)	1 (50%)	1 (50%)
SCCM	8	5 (63%)	8 (100%)	0	6 (75%)	0	0
Unidas	7	6 (86%)	4 (57%)	0	6 (86%)	0	1 (14%)
Unique Opportunities	1	1 (100%)	0	0	1 (100%)	0	0
Visions	6	4 (67%)	4 (67%)	0	4 (67%)	0	1 (17%)

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

Agency	# in Sample	#1a Yes	#8c Yes	#16 Yes	#16a Yes	#16b Yes	#16c Yes	# of 100%	# 75% to 99%	# 51% to 74%	# 50% or below
Agencies with 8 or more individuals in the sample											
J&J	9	4 (44%)	8 (89%)	0	7 (78%)	0	2 (22%)	0	2	0	4
Peak	9	5 (56%)	8 (89%)	0	6 (67%)	0	6 (67%)	0	1	2	3
SCCM	8	5 (63%)	8 (100%)	0	6 (75%)	0	0	1	1	1	3
Agencies with 6-7 or more individuals in the sample											
Unidas	7	6 (86%)	4 (57%)	0	6 (86%)	0	1 (14%)	0	2	1	3
Visions	6	4 (67%)	4 (67%)	0	4 (67%)	0	1 (17%)	0	0	3	3
Agencies with 3-5 individuals in the sample											
A Step Above	5	1 (20%)	5 (100%)	0	3 (60%)	0	1 (20%)	1	0	1	4
Carino	5	4 (80%)	3 (60%)	1 (20%)	3 (60%)	2 (40%)	2 (40%)	0	1	2	3
Excel	3	3 (100%)	2 (67%)	0	3 (100%)	0	0	2	0	1	3
Agencies with 1-2 individuals in the sample											
DDSD (NERO & SERO)	2	1 (50%)	2 (100%)	0	0	0	1 (50%)	1	0	0	5
NMQCM	2	1 (50%)	2 (100%)	0	2 (100%)	0	0	2	0	0	4
Rio Puerco	2	2 (100%)	2 (100%)	1 (50%)	2 (100%)	1 (50%)	1 (50%)	3	0	0	3
A New Vision	1	0	1 (100%)	0	1 (100%)	0	1 (100%)	3	0	0	5
Amigo	1	1 (100%)	1 (100%)	0	1 (100%)	0	0	3	0	0	3
NMBHI	1	1 (100%)	1 (100%)	0	0	0	0	2	0	0	4
Unique Opportunities	1	1 (100%)	0	0	1 (100%)	0	0	2	0	0	4

VIII. RESIDENTIAL AND DAY SERVICES

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)[88].

As the following chart shows, 199, or 78%, of the 256 active Jackson Class Members[89] are receiving ***Supported Living*** supports. Supported Living is designed to address assessed needs and lead to the accomplishment of individually identified outcomes.[90]

There are 38 JCMs (15%) 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 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.[91]

Likewise, 177 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.[92]

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

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[88] 2018 NM DD Waiver Standards, Chapter 10. See 10.3. Living Care Arrangements (LCA), page 96.
[89] Number of active Jackson Class Members as of December 31, 2017.
[90] 2018 NM DD Waiver Standards, Chapter 10. See 10.3.9. Living Supports – Supported Living, Page 102.
[91] 2018 NM DD Waiver Standards, Chapter 10. Living Care Arrangements (LCA), Living Supports Family Living, See 10.3.8.2.1., Page 100.
[92] 2018 NM DD Waiver Standards, Chapter 11. See 11.3.2. Community Life Engagement, page 116, 117

Chart #57: Type of Residential and Day Services Received by JCMs

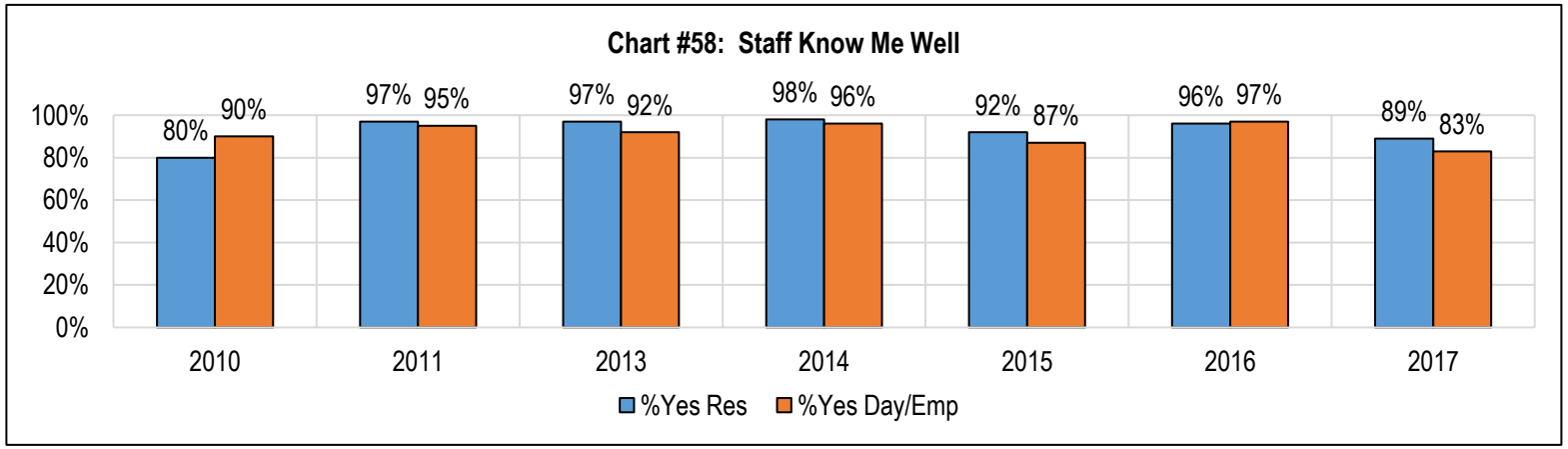
Residential Service Type	# Receiving
Supported Living	199
Family Living	38
Mi Via	12
Independent Living	4
ICF/IDD	3

Day Service Type	# Receiving
Adult Habilitation (AH)	177
Adult Hab/Supported Employment (SE)	31
Adult Hab/Community Access (AC)	14
Community Access	12
Community Access/Supported Employment	2
Supported Employment	5
Mi Via	12
None	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% for both 2011 and 2013. 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.

Question #8a: Do those who provide direct support during day/work know me well? [93]
Question #8b: Do those who provide direct support at home know me well? [94]



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

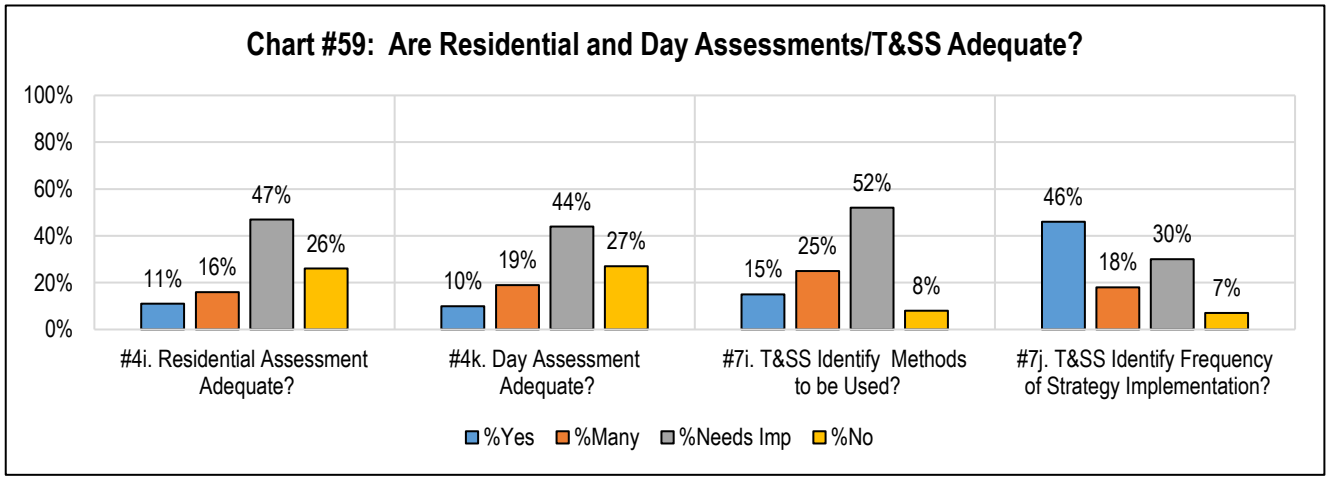
[93] CPR Question #35
[94] CPR Question #44

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, possible desired Outcomes 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.[95]

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[96])*** to support Action Plans developed as part of the ISP. Teaching and Support Strategies 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 TSS. All T&SS and WDSI should support the person in achieving his/her Vision.[97]

Question #4i. Residential Assessments were adequate?
Question #4k. Assessments completed for supports offered during the day were adequate?
Question #7i. Do teaching and support strategies (T&SS) and/or therapy plans designed to be implemented by Direct Support Professionals clearly specify the methods to be used so that anyone reading them can implement the strategies?
Question #7j. Do T&SS specify how often and under what circumstances the strategies are to be implemented?

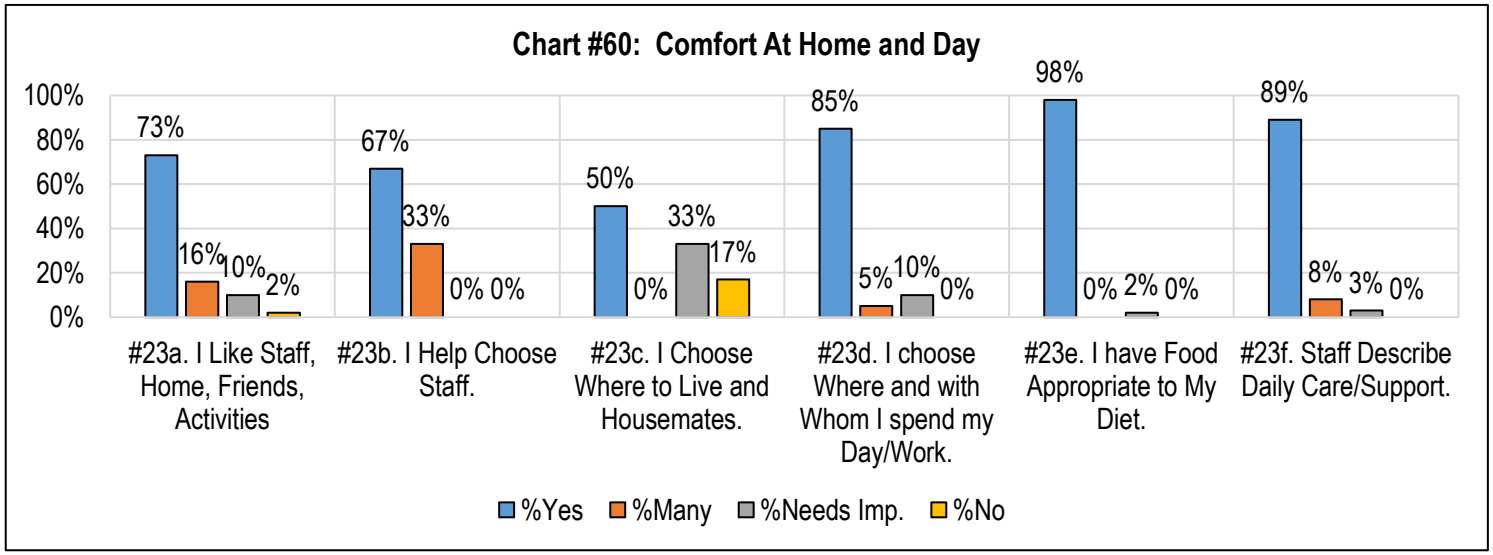


E. Do JCMs Feel Comfortable Where They Live and Work?

[95] 2018 NM DD Waiver Standards, Chapter 6. Individual Service Plan, 6.3. Page 62,
[96] 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.
[97] 2018 NM DD Waiver Standards, Chapter 6. Individual Service Plan, 6.6.3.2, Page 66

The IQR probes for information regarding the individual's level of choice and comfort as it relates to home and day services.

Question #23a. Have I told you that I like my staff, my home, my friends and my activities? If I don't speak, have I given you other forms of communication to help you determine my feelings?
Question #23b. Did I help choose the staff who help me?
Question #23c. Did I choose to live here and to live with the other people in my home?[98]
Question #23d. Did I choose where and with whom I work and spend my day?[99]
Question #23e. Do I have sufficient, safe, healthy and nutritious food that is appropriate to my recommended diet, if applicable?[100]
Question #23f. Can my staff describe how to provide daily care/supports to me?[101]



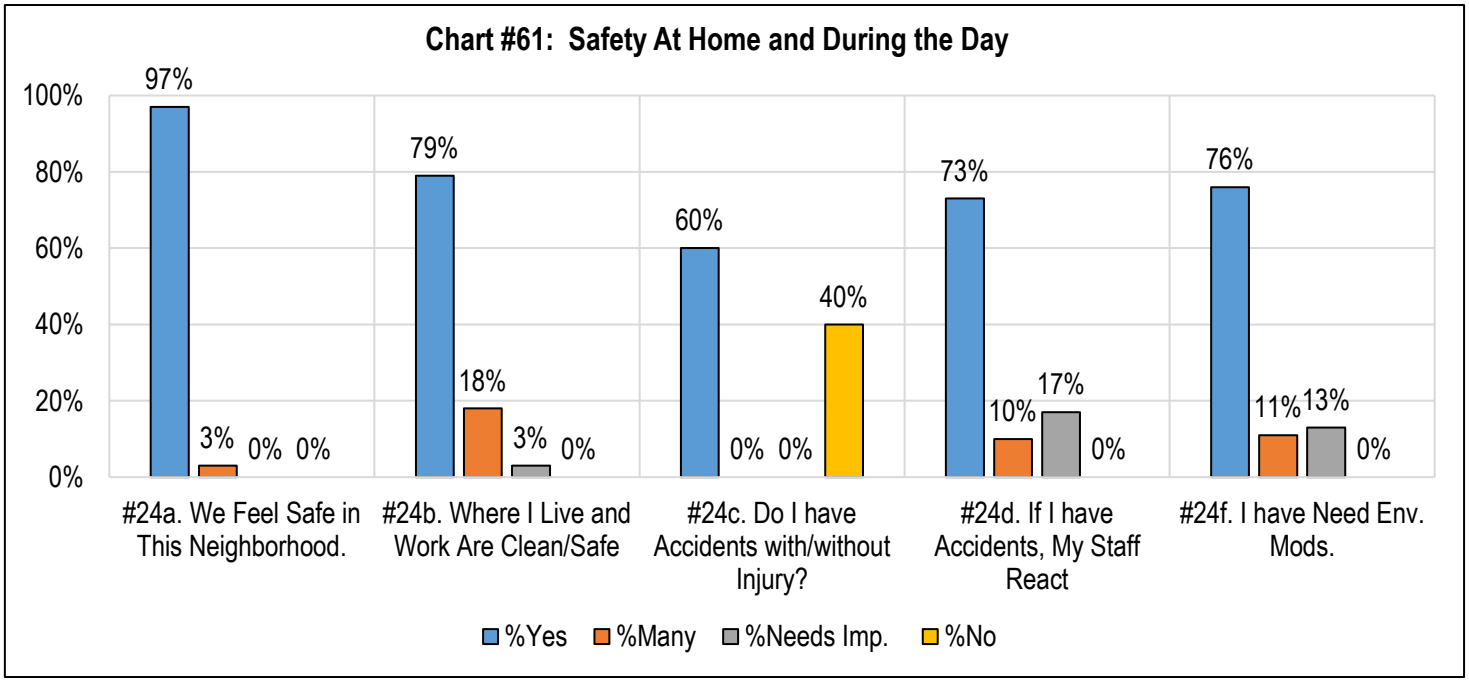
F. Are Residential and Day Sites Safe?

Safety of both the home and neighborhood is evaluated.

Question #24a. Do my staff and I feel safe in this neighborhood?
Question #24b. Are the places where I live and work clean, free of safety hazards and conducive to the work/activities I engage in?[102]
Question #24c. Do I have accidents, with or without injury?

[98] CPR Question #89.
[99] CPR Question #90.
[100] CPR Question #108.
[101] CPR Question #39.
[102] CPR Question #43 and #47

Question #24d. If I have accidents, does my staff react appropriately and timely?
Question #24f. Have needed environmental modifications been made to ensure access, privacy and safety?



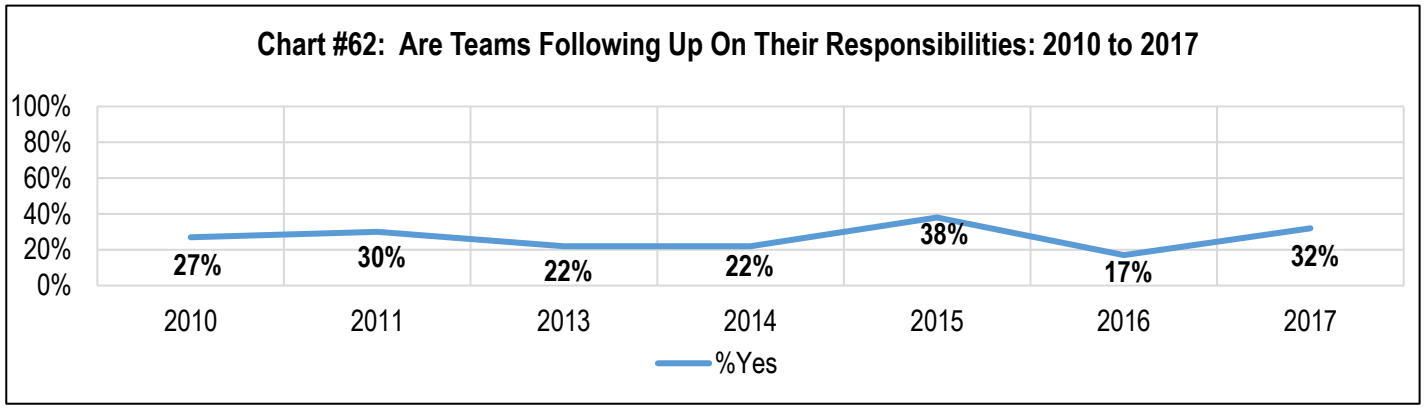
G. Are Team Members Consistently Following Up on Their Responsibilities?

One area of good practice is that 52 (84%) of those reviewed had team members who communicated with the individual using his/her communication preferences, e.g., language, device (IQR #10a).

However, 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, etc.

Question #10.[103] My team members are following up on their responsibilities to assist me.

[103] CPR Question #114.

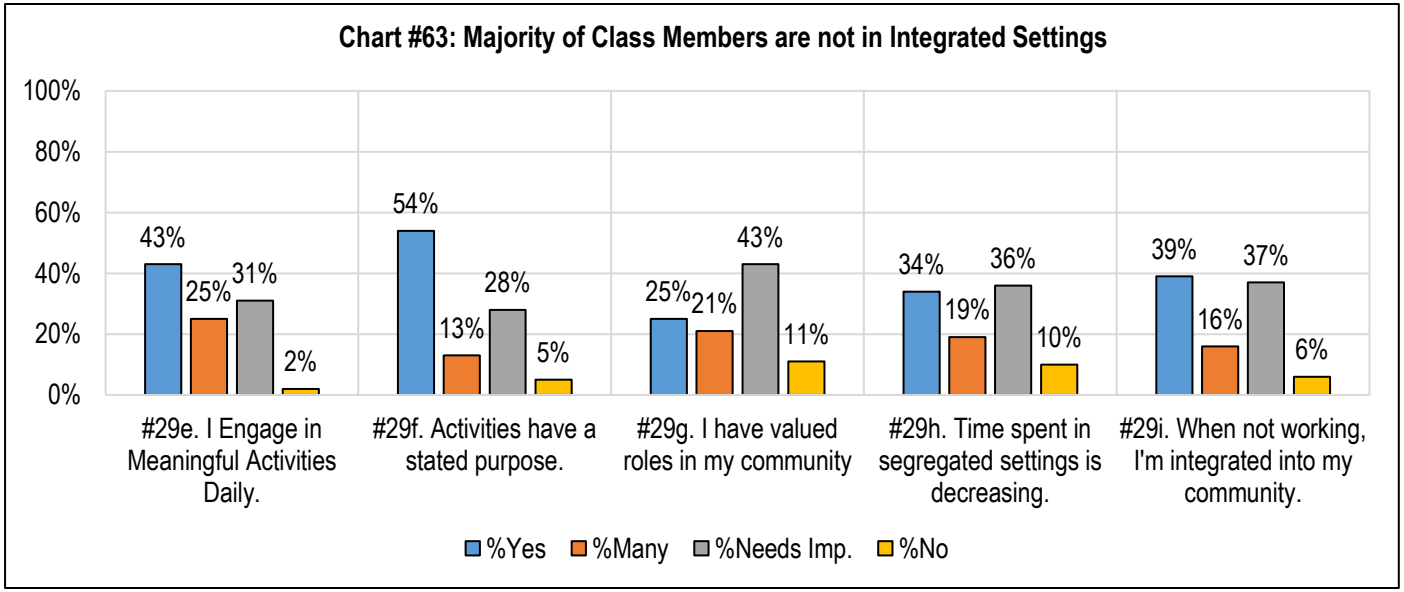


H. Are JCMs Integrated and Experiencing Meaningful Community Engagement?

All people, regardless of disability, deserve the opportunity for a full life in their community where they can live, learn, work and play alongside each other 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.[104] 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. Looking at class members experiences in the community include questions such as:

Question #29e. Do I engage in activities that have meaning to me every day?
Question #29f. Do the activities I engage in have a stated purpose? Is that purpose actively pursued with experiences that are intentional and planned?
Question #29g. Do I have valued roles in my community?
Question #29h. Is my IDT taking steps to decrease the amount of time I am spending in congregated, segregated settings?
Question #29i. When I am not working, am I routinely integrated into my community at a level that fits my preferences?

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

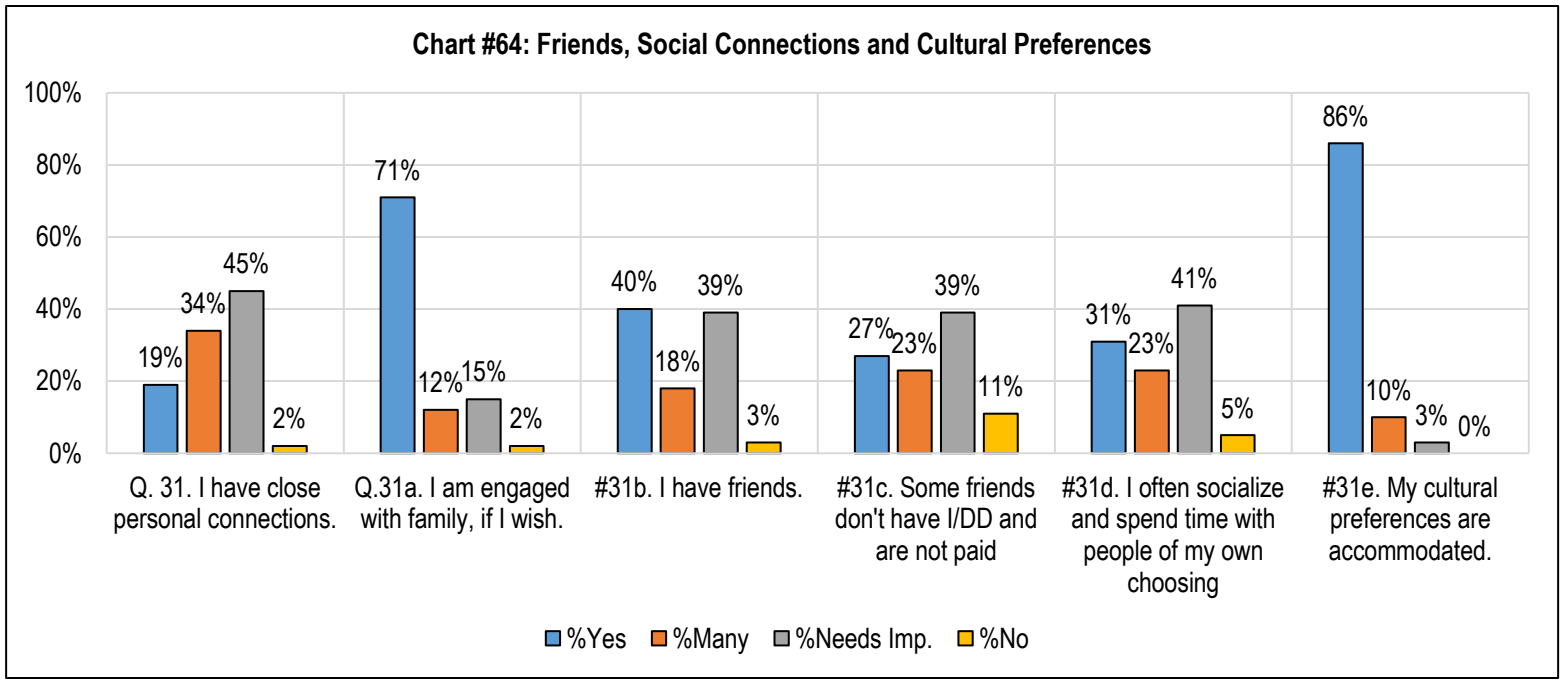


I. Do JCMs Enjoy Social Connections?

Some of the IQR Questions which probe friendships and social connections for people with I/DD include:

Question #31: I have close personal connections.
Question #31a. Am I supported to remain engaged with my family, to the extent I desire?
Question #31b. Do I have friends?
Question #31c. Are some of my friends and acquaintances people who do not have I/DD an who are not paid to be in my life?
Question #31d. Do I get to socialize and spend leisure time with those of my own choice often?[105]
Question #31e. Are my cultural preferences accommodated?[106]

[105] CPR Question #91
[106] CPR Question #102



J. Are JCMs Networked Into Their Community?

Some of the questions asked related to this area include:

Question #33a. Does my staff enable me to make meaningful contact with people in my community?
Question #33b. Does my team work to help me expand my networks an my relationships in accordance with my preferences and needs?
Question #33c. Am I a "regular" in identified places?
Question #33d. Am I being taught skills so I can successfully assume valued roles in my community?
Question #33f. Do I have adequate access to and use of community/generic services and natural supports?

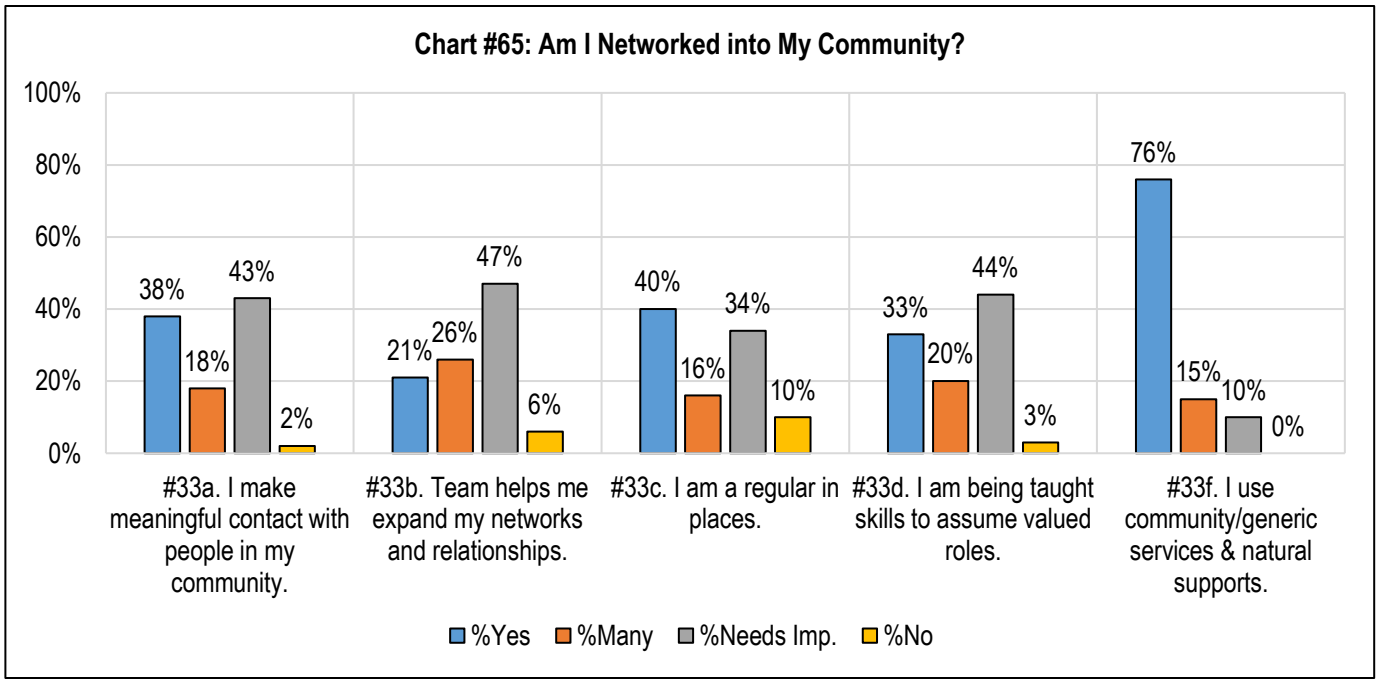


Chart #65: Am I Networked into My Community?
100%
80%
60%
40%
20%
0%
38%
18%
43%
2%
21%
26%
47%
6%
40%
16%
34%
10%
33%
20%
44%
3%
76%
15%
10%
0%
#33a. I make meaningful contact with people in my community.
#33b. Team helps me expand my networks and relationships.
#33c. I am a regular in places.
#33d. I am being taught skills to assume valued roles.
#33f. I use community/generic services & natural supports.
%Yes
%Many
%Needs Imp.
%No

IX. 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 a decision about employment while others may have a rich and varied employment history and can make an informed choice based on that history.[107]

A. Components of Informed Choice: Assessment

The expectation is that the IDT 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.[108] 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.[109]

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:

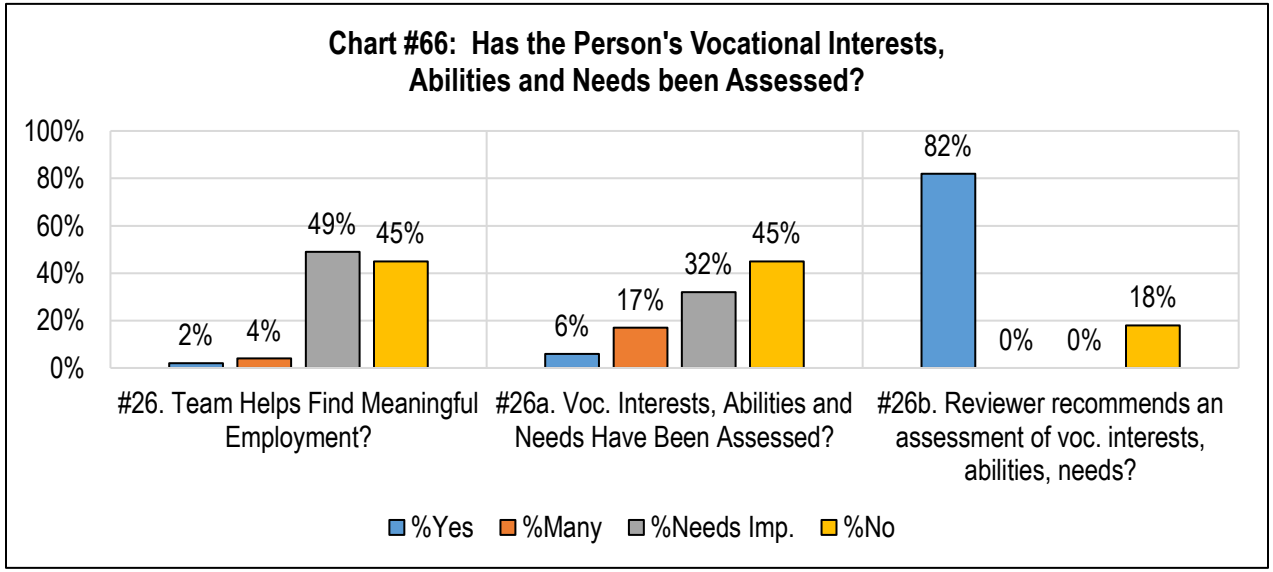
a. A person-centered assessment should contain, at a minimum: information about the person's background and status;
b. the person's strengths and interests;
c. conditions for success to integrate into the community, including conditions for job success (for those who are working or wish to work); and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

[107] 2018 NM DD Waiver, Chapter 11. 11.2, Page 115
[108] 2018 NM DD Waiver Standards, Chapter 11, 11.2 Employment First, Page 115.
[109] www.ilo.org/public/english//region/asro/bangkok/ability/.../voc_assessment.pdf

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 counter-intuitive 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 #26. My team helps me to find meaningful employment.
Question #26a. Has my team assisted me to assess my vocational interests, abilities and needs?[110]
Question #26b. Does the reviewer recommend an assessment of this person's vocational interests, abilities and needs?



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.[111]

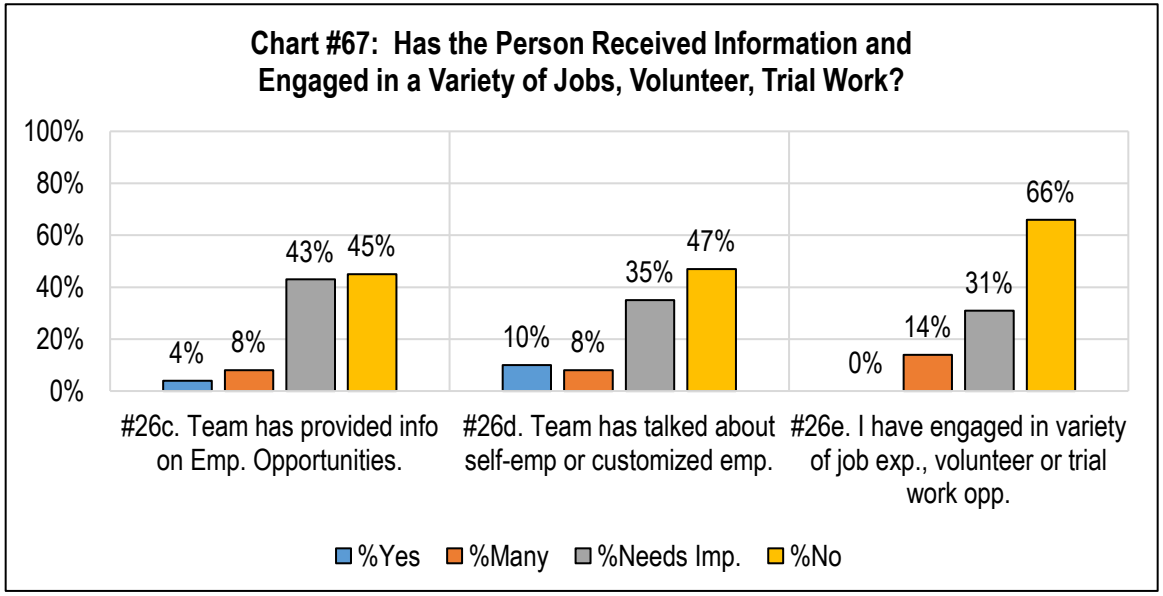
[110] CPR Question #126.
[111] 2018 NM DD Waiver Standards, Chapter 11. Community Inclusion, Page 116.

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.[112]

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

Question #26c. Has my team provided me with information about the range of employment opportunities and how to access those options?
Question #26d. Has my team talked with me about becoming self-employed, or developing a customized employment opportunity?
Question #26e. Has my team assured that I have been able to engage in a variety of job exploration opportunities, volunteer work, and trial work opportunities?

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.[113]



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.

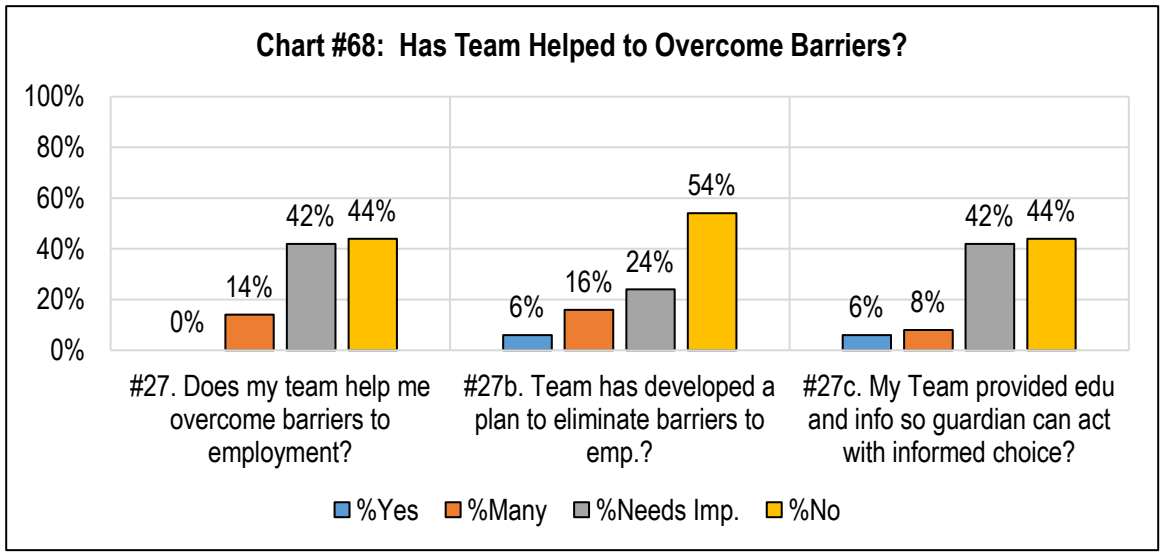
[112] Ibid.
[113] NM 2018 DD Waiver Standards, Chapter 11. Community Inclusion, Page 116.

C. Components of Informed Choice: **Employment Barriers**

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.[114]

In New Mexico, the 2017 IQR also probed for information regarding why people are not working and what supports they have received to overcome identified employment barriers.

Question #27. My team helps me overcome barriers to employment.
Question #27b. If there are barriers to employment has my team developed a plan to eliminate those barriers?
Question #27c. If my guardian does not agree with employment, has my team provided education and information that make it possible for my guardian to act with informed choice?

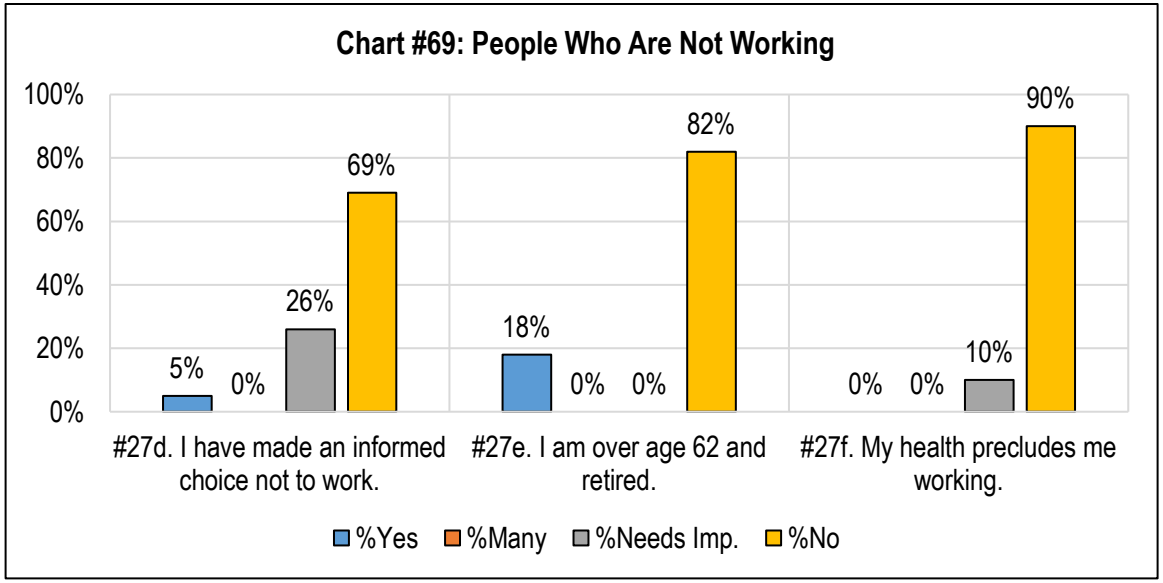


[114] Supported Employment: Participant Training Manual, Elizabeth M. Boggs Center on Developmental Disabilities, Robert Wood Johnson Medical School, Department of Pediatrics, University of Medicine & Dentistry of New Jersey.

D. JCMs in 2017 Identified as Not Working

After exploring assessments, experiences with a variety of work or volunteer opportunities and employment barriers are explored.

Question #27d. I have made an informed choice and chosen not to work
Question #27e. I am not working because I am over the age of 62 and consider myself retired.
Question #27f. I am not working at the moment because my health precludes it, my team and I will decide when I can reconsider work, but not less than annually.



E. JCMs who are working

Note: The agreed upon criteria for counting class members as "working at criteria" is: working at least 10 hours per week, making at least minimum wage and receiving a paycheck from a business.

New Mexico reports that 33% of people with I/DD in NM Waiver are working in competitive employment.[115] New Mexico data shows that 2 (.08%) of JCM are working at criteria.

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

For the 2017 IQR Review sample, no class members reviewed were working at the agreed criteria of 10 hours a week, at minimum wage or better in an integrated setting. Minimum wage varies across the state of New Mexico from a high in Santa Fe ($11.10 per hour, going to $11.40) to lower amounts elsewhere in the state such as $8.75 in Albuquerque. Integrated setting, for this report, means that the individual receives a pay check from a business, not an I/DD provider agency.

For all class members, based on DDSD's Wages and Hours Report of October 13, 2017 and February 2, 2018, the following 16 people are close to meeting this criteria (wages vary). Ten of these individuals (63%) are in the Metro Region, 3 (19%) are in the SE Region, 2 (13%) are in the SW Region, and 1 (6%) in the NE Region.

Chart #70 JCMs Hours/Income
Yellow = Does not meet agreed criteria

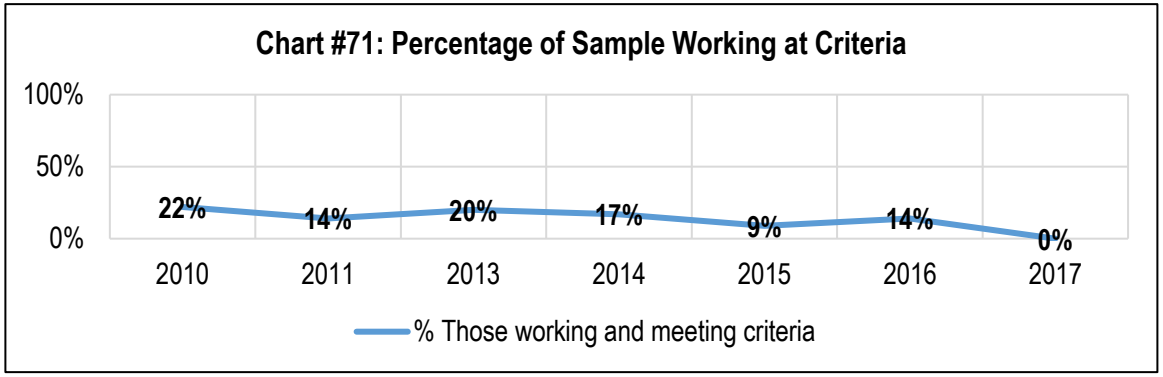
#	Person	Hours/Week	Hourly Rate	Paycheck Source
1	#23	11.38	$7.50 (ABQ $8.75)	Business
2	#24	15	$12.78	Business
3	#25	10	$13.21	Business
Below Criteria (50% of Hours per Week or closer, Other Criteria Met)				
4	#26	8.5	$9.00	Business
5	#27	6	$8.50	Business
Below Criteria (Less than 50% of Hours per Week, One Other Criteria Met)				
6	#28	5	$8.71	Business
7	#29	4.5	$8.50	Business
8	#30	4	$9.01	Business
9	#31	4	$8.48	Business
10	#32	3	$7.50	Business
11	#33	3	$7.50	Business
12	#34	3	$9.00	Business
13	#40[116]	2	$8.88	Business
14	#39[117]	1	$8.80	Business
15	#36[118]	1.5	$8.58	Business
16	#37	.75	$8.75	Business

F. JCMs in the 2017 Sample Who Are Working and Meet Criteria

Some of the IQR Questions related to employment and people working include:

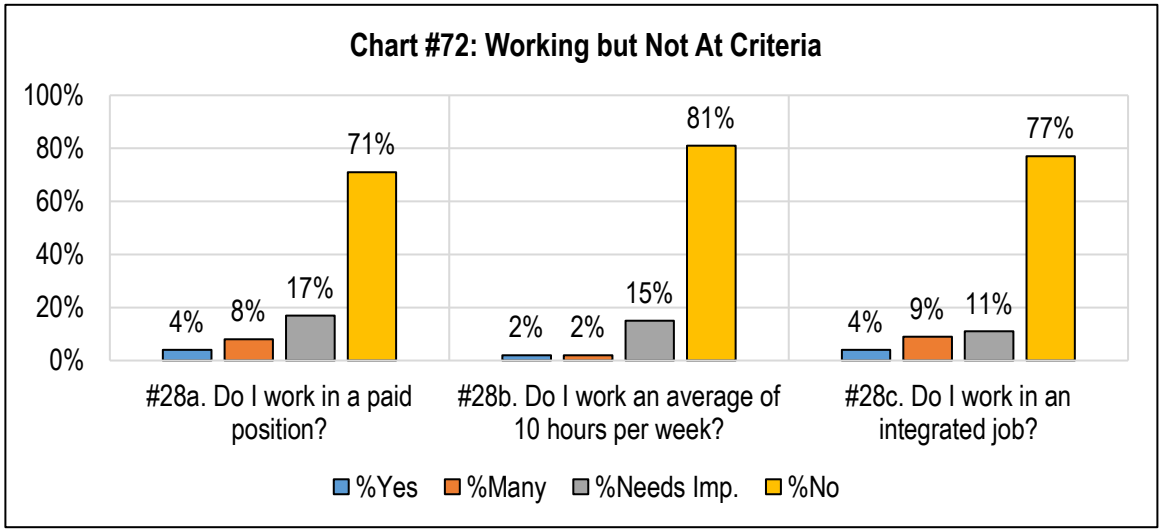
[116] #40 was not on the 10.13.17 Report but was on the 2.21.18 Report.
[117] #39 was not on the 10.13.17 Report but was on the 2.21.18 Report
[118] #36 was on the 10.13.17 Wages and Hours Report but not on the 2.21.18 Report.

Question #28: I have a job?[119]



G. JCMs in 2017 Who Are Working, Do Not Meet Criteria

Question #28a. Do I work in a paid position?
Question #28b. Do I work an average of 10 hours per week?[120]
Question #28c. I am working in a community, integrated job?

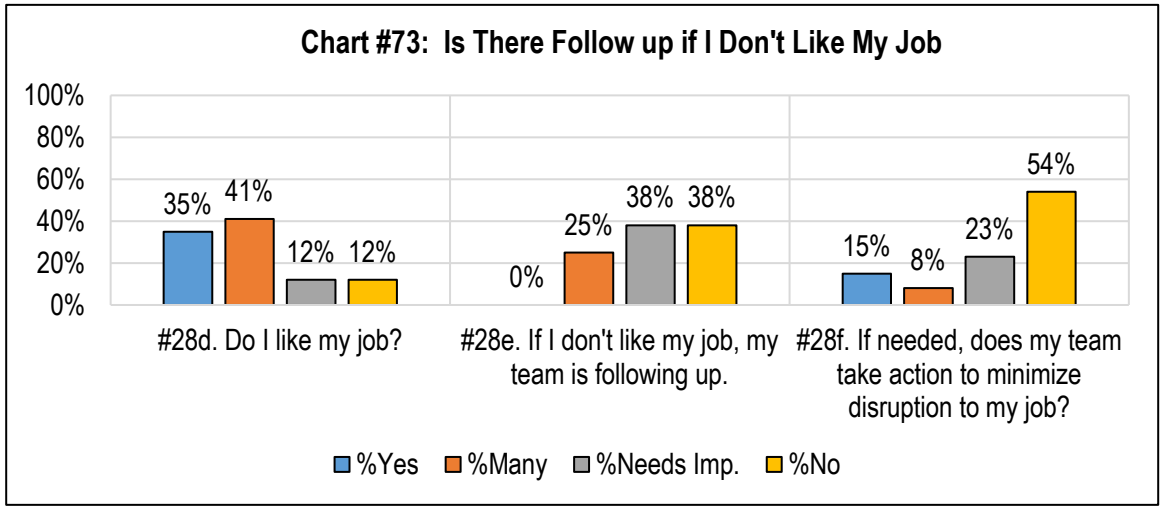


[119] That meets the criteria listed here. CPR Question #130.
[120] CPR Question #130a.

H. JCMs who are working: Do they like their Jobs?

For class members who do have a job, questions are asked about the jobs they have and their level of satisfaction with the current job. Some of those questions are highlighted below.

Question #28d. Do I like my job?
Question #28e. If I don't like my job, is my IDT following up?
Question #28f. When there has been a change in my life that impacts my employment status, did the team meet within 10 days and take action to minimize the disruption to my employment?



X. THERAPY AND EQUIPMENT

A. Introduction to Professional and Clinical Services

New Mexico DD Waiver Therapy Services are required to be consistent with the Participatory Approach Philosophy and the Collaborative-Consultative service delivery model. This service emphasizes supporting increased participation, independence and community inclusion in combination with health and safety. Therapy services are required to support achievement of the person's visions and Desired Outcomes in the ISP and prioritized areas of need identified through therapeutic assessment.

Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nutritional Counseling Services (NCS), Positive Behavior Support (PBS) and Behavioral Support Consultation (BSC) are skilled therapies/supports recommended by a person's IDT members along with a clinical assessment that demonstrates the need for therapy/support services.

Physical Therapy (PT) is a skilled licensed therapy service involving the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, conditions or injuries.[121]

Speech-Language Pathology (SLP) is a skilled licensed therapy service that involves the non-medical application of principles, methods and procedures for the diagnosis, counseling, and instruction related to the development of and disorders of communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction and sensorimotor competencies. Speech-Language Pathology services are also used when an individual requires the use of an augmentative and/or alternative communication system and/or strategies.[122]

Occupational Therapy (OT) is a skilled licensed therapy service involving the use of everyday life activities (occupations) for evaluation, treatment, and management of functional limitations. Occupational Therapy addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being and quality of life.[123]

Nutritional Counseling Services (NCS) allows for the collaboration, consultation, evaluation, assessment, planning, development, implementation, teaching, and monitoring of a nutritional plan that supports the individual with nutritional needs to attain or maintain the highest possible level of health.[124]

Positive Behavior Support (PBS) emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life—understanding that a natural reduction in other challenging behaviors will follow. The BSC identifies skills and capacities that contribute to a person's ability to experience success and satisfaction in a range of settings. Support includes all efforts to teach, strengthen, and expand positive behaviors. An important, but secondary consideration is to understand, anticipate, and prevent problem behaviors that have general and specific outcomes or functions for the person.[125]

[121] 2018 NM DD Waiver Standards, Chapter 12. Professional and Clinical Services, 12.4.4.2, Page 142
[122] 2018 NM DD Waiver Standards, Chapter 12. Professional and Clinical Services, 12.4.6.2., Page 145.
[123] 2018 NM DD Waiver Standards, Chapter 12. Professional and Clinical Services, 12.4.5.2, Page 143.
[124] 2018 NM DD Waiver Standards, Chapter 12. Professional and Clinical Services, 12.5., Page 155.
[125] 2018 NM DD Waiver Standards, Chapter 12.Professional and Clinical Services, 12.2.1., Page 131.

Behavioral Support Consultation (BSC) services are intended to enhance the DD Waiver participant's quality of life by providing positive behavioral supports as the individual works on functional and relational skills. BSC services identify distracting, disruptive and/or destructive behavior that impacts quality of life and provides specific prevention and intervention strategies to manage and lessen the risks these behaviors present.[126]

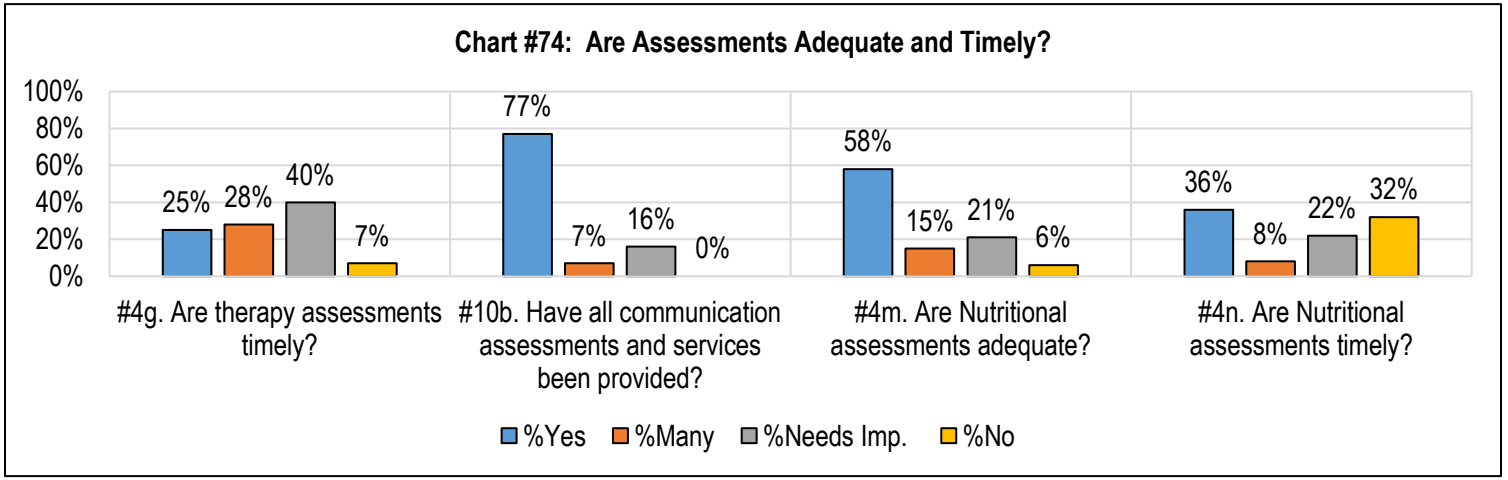
Professional and clinical services may include: assessment, development of related support plans, training of paid and unpaid caregivers to carry out the plan, and monitoring activities. The services are delivered in the person's home or in the community as described in the ISP.[127]

B. Are Assessments Adequate and Timely?

Best practice has shown that assessments form the foundation of any good plan by identifying the person's strengths, abilities and needs. The Health Section of this report also addresses assessments in the broader context. Assessments addressed in the Health Section include health, nursing, residential and day services. It is important here to point out that when considering the adequacy of all assessments, which is addressed in IQR Question #4: 'My team obtained adequate and timely assessments in areas most likely to lead to my greater independence', that none were found adequate. The most frequently missing components to an adequate ISP in therapy assessments is specific baseline data, identifying strengths and giving recommendations.

IQR Questions related to professional and clinical service assessments include:

Question #4g. Are therapy assessments provided timely?
Question #10b. I have received all communication assessments and services needed.
Question #4m. Nutritional assessments were adequate?
Question #4n. Nutritional assessments were provided timely?

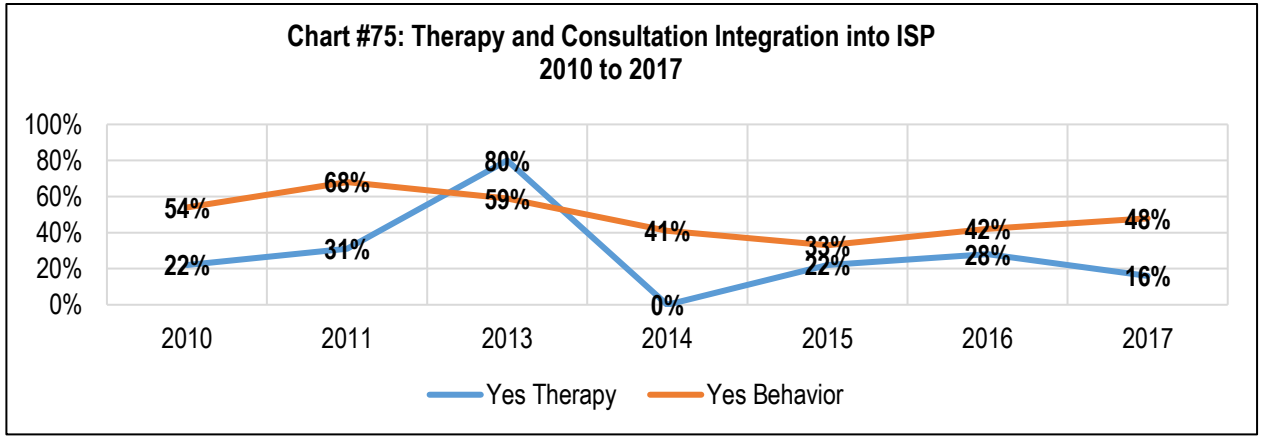


[126] Ibid
[127] 2018 NM DD Waiver Standards, Chapter 12. Professional and Clinical Services, Page 130.

C. Have Strategies of Therapists and Consultants Been Integrated Into the ISP?

The specific IQR questions related to this include:

Question #7m: Have strategies of ancillary providers been integrated into my Outcomes, Action Plans and Teaching and Support Strategies? [128]
Question #11d. Are behavior support services integrated into the ISP?[129]



D. Do People Have the Equipment and Technology They Need?

Having needed equipment which is positioned so the person can breathe and eat properly, communicate if verbal abilities are limited, have more control over their environment and gain as much independence as possible is critical.

> ***Equipment*** is defined as any item needed to enable a person to be successful in his/her environment. Examples of equipment include: durable medical equipment such as wheelchairs of any type, walkers, shower chairs, shower trolleys, hospital beds, eating and drinking equipment; also personal items such as glasses, dentures, hearing aids.
>
> ***Adaptive equipment*** is also included e.g.; communication systems, switches, electronic devices (anything with an on/off switch) and/or simple non-electric items such as picture devices communication systems including communications rings.

Equipment identified as being needed must be available and used by the person in all relevant environments; it should work as intended; and continue to be appropriate to the person. If the person refuses to use the equipment identified, there should be evidence that the appropriate specialist has been consulted and alternative devices/interventions assessed, sought and tried. Devices designed specifically for use to support work tasks only, need not be used at home and vice versa.

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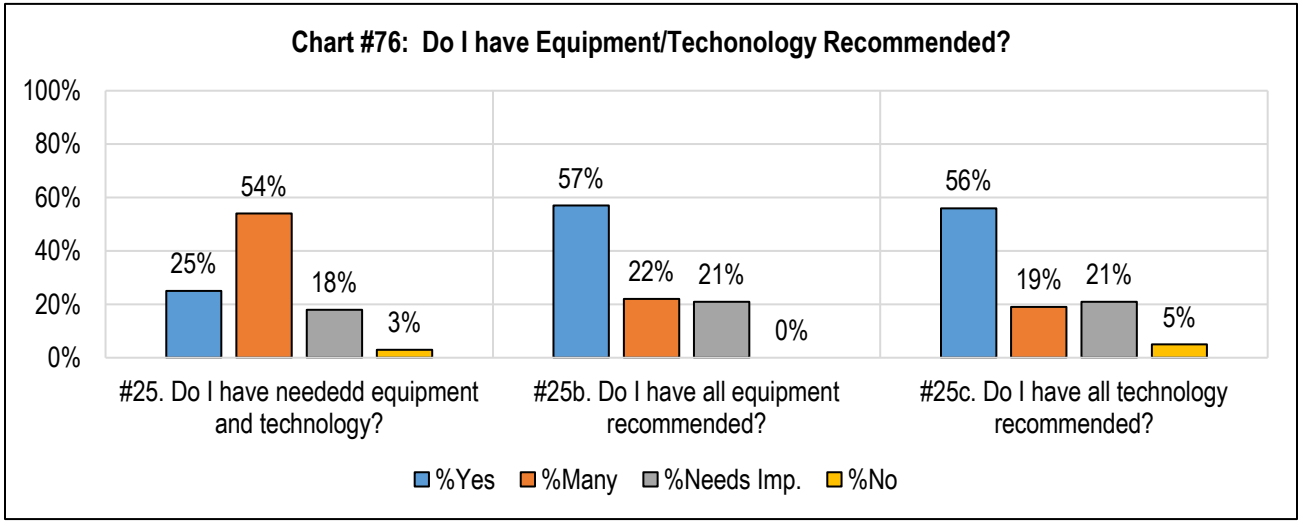
[128] CPR Question #72: Overall, are the recommendations and /or objectives/strategies of ancillary providers integrated into the outcomes, action plans and Teaching Support Strategies of the ISP.
[129] CPR Question #137. Are behavior support services integrated into the ISP?

Relevant IQR Questions include:

Question #25: I have the equipment and technology I need to be safe and comfortable.
Question #25b. Do I have all of the equipment that has been recommended by therapists or medical professionals?
Question #25c. Do I have all of the technology that has been recommended by therapists or medical professionals?

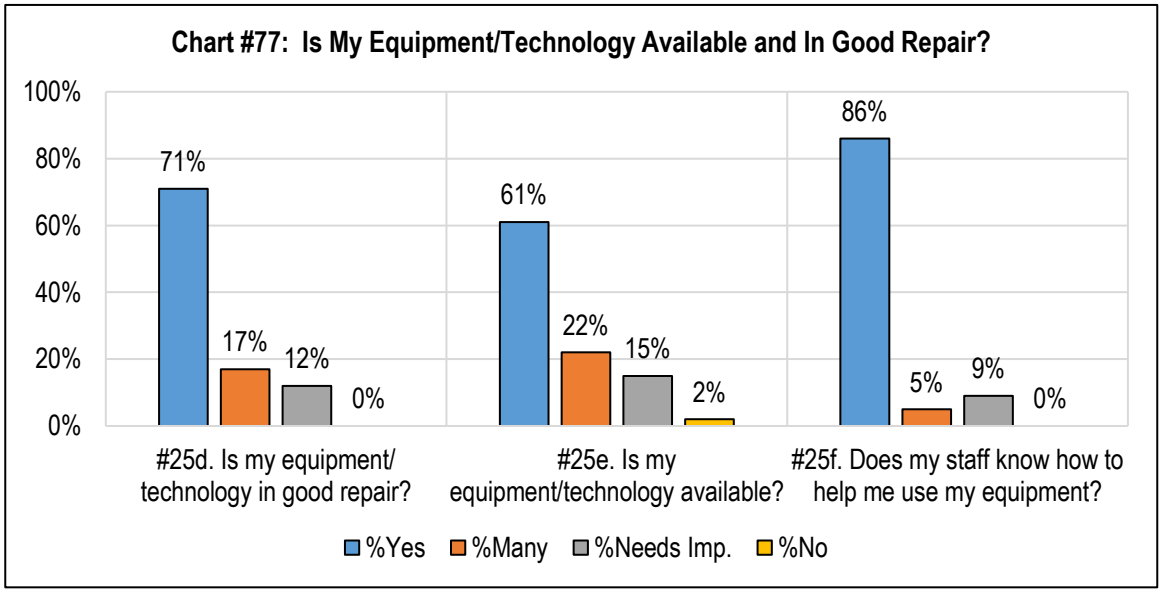


It is important to note that the way the DOH/DDSD identifies gaps in services (e.g., PT, OT, SLP, BSC, dentists, physicians, etc.) is through the receipt of the Regional Office Request for Intervention/Assistance (RORI/RORA). Individuals, guardians, case managers, residential and day providers, and therapists are all encouraged to file RORI/RORA requests as needed. Based on RORI/RORA information, a report is issued regarding gaps in therapies, barriers to acquiring durable medical equipment timely (e.g., wheelchairs, shower chairs, splints, etc.). Unfortunately, team members are reluctant to file. In large part, things get done and needs are met based on relationships. Currently, RORI/RORA filings have the stigma of being a way of telling on or singling out another team member, which can result in the person filing the RORI/RORA being ostracized and/or thrown off the team. As a result, there is under-reporting of these issues at the DOH/DDSD level.

E. Is the Equipment/Technology in Good Repair and Used?

In addition to having equipment, it needs to work, be accessible to and used by the person for whom it was recommended. That includes staff knowing how to use the equipment so they can support the person to learn to use the equipment/technology consistently throughout their day. As the following graph shows, in light of the turnover in staff, the therapists have done a good job in training staff so they know how to use the equipment. Questions relevant to repair and use include:

Question #25d. Is my equipment and technology in good repair?
Question #25e. Is my equipment/technology available in all appropriate environments?
Question #25f. Does my staff know how to help me use my equipment appropriately?

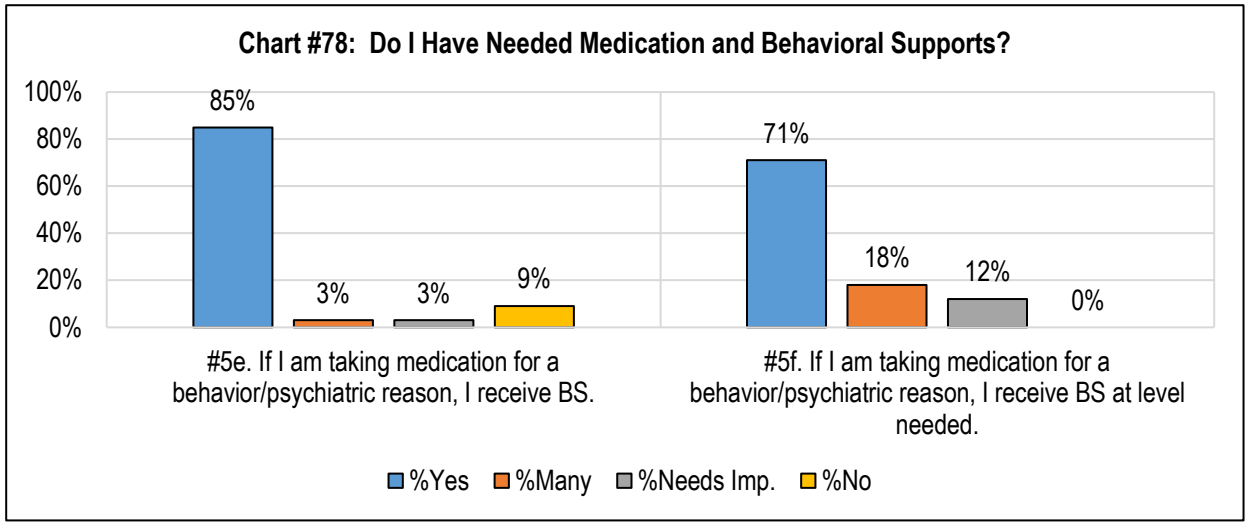


F. Are People Receiving Needed Behavior Support Services?

The BSC has the essential responsibility for identifying key aspects of positive behavior and positive behavior support. The BSC leads the continuous discovery of antecedent conditions: the who, what, where and when of all behavior; the why regarding motivation and behavioral function; and generates prevention and intervention strategies. The BSC is to support the person's successful achievement of Vision-driven Desired Outcomes.

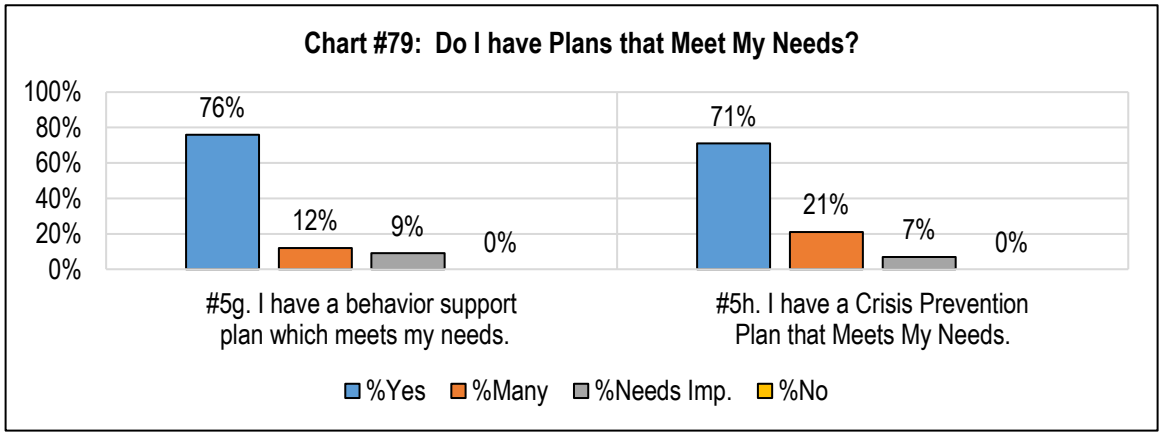
Relevant questions include:

Question #5e. For individuals who receive medication for behavior/psychiatric issues, does the person receive behavioral support services?
Question #5f. For individuals who receive medication for behavior/psychiatric issues, are they receiving behavioral support services at the level needed?



G. Do Those Needing BSC have the Plans Needed?

Question #5g. I have a behavior support plan which was developed out of the behavior assessment and which meets my need?[130]
Question #5h. Do I have a specific Crisis Prevention Plan for dangerous behavior that meets my needs?[131]

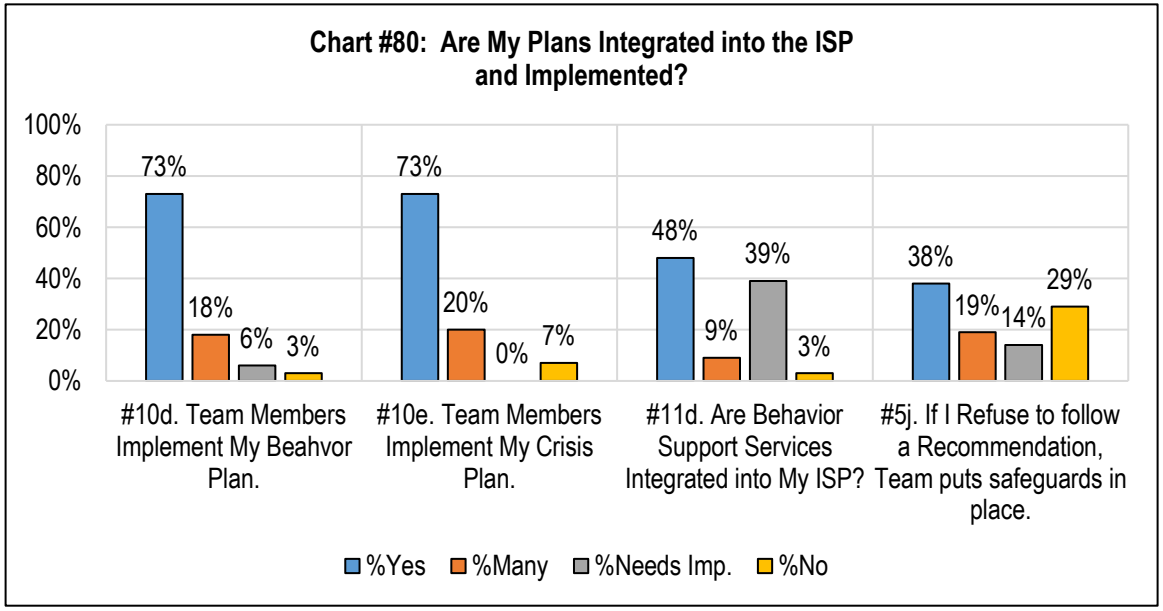


H. Are Plans Integrated into the ISP and Are they Being Implemented?

[130] CPR Question #134.
[131] CPR Question #73a.

Once Behavior Support Consultants develop a Positive Behavioral Support and/or Crisis Plan, it is critical that staff be trained on their contents and implement them consistent with the BSC's recommendations. In addition, if an individual is refusing to follow recommendations, BSCs can play a positive role in identifying ways to enable alternatives and/or, over time, enable the person to willingly follow the recommendations (e.g., if individuals refuse to go to a doctor's office, wear glasses, braces, etc.) Relevant IQR questions include:

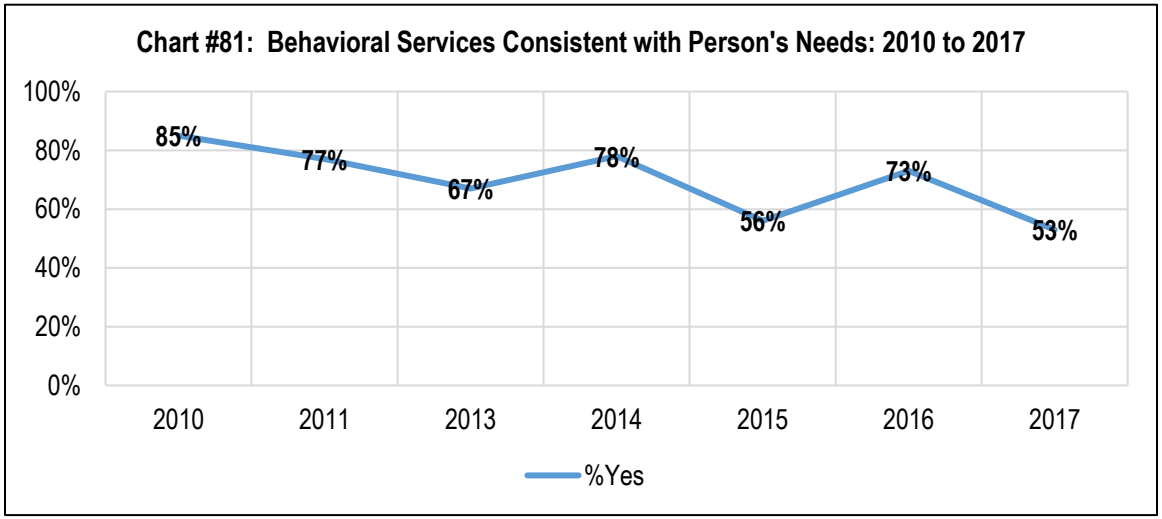
Question #10d. Can my team member describe and/or is there evidence that they have implemented my behavior plan?
Question #10e. Can my team members describe and/or demonstrate how to implement my crisis plans?
Question #11d. Are behavior support services integrated into the ISP?
Question #5j. If the individual refuses to participate and follow a recommendation, has the team identified what safeguards have/will be put into place will help meet the objectives of the original recommendations.



I. Are Behavioral Services Provided Consistent with the Person's Needs?

Question #5i. Does this person receive behavioral services consistent with his/her needs?[132]

As the following chart demonstrates, over time, the number of class members receiving behavioral supports consistent with their needs is trending downward. Reasons include lack of integrating behavioral support strategies in the ISP, lack of consistent implementation of Positive Behavioral Support Plans by staff which may be related to turnover and consistent training, as well as teams not inviting Behavioral Support Consultants to assist when the person refuses to follow recommendations. Further exploration would certainly assist in identifying the details of this decline.



[132] CPR Question #136

XI. RIGHTS AND PROTECTIONS

The 2018 NM DD Waiver Standards, Appendix C, 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."*

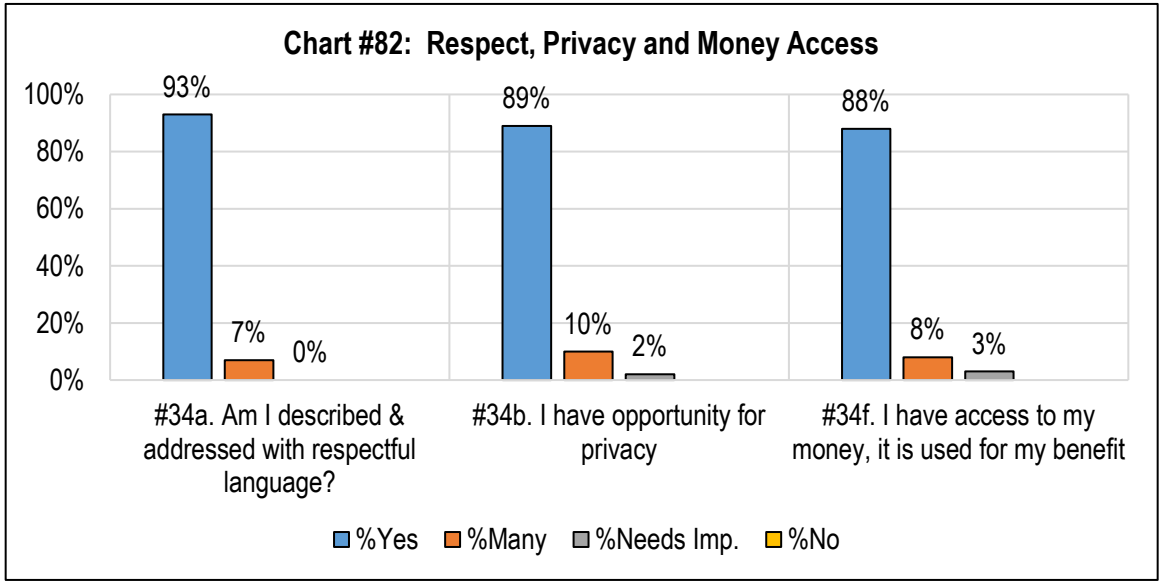
A. Class Members Are Addressed with Respectful Language and Have Opportunity for Privacy

Some of My Rights Include:

- ✓ Choosing to be alone and my privacy is respected.
- ✓ Having privacy and confidentiality.
- ✓ Controlling my money.

IQR Questions which touch on these rights include:

Question #34a. Am I described and addressed using respectful language?
Question #34b. Do I have time, space and opportunity for privacy?[133]
Question #34f. Do I have access to my money when I need it and is my money used for my benefit?



B. Restrictions, Restraints and Reviews

Some of My Rights Include:

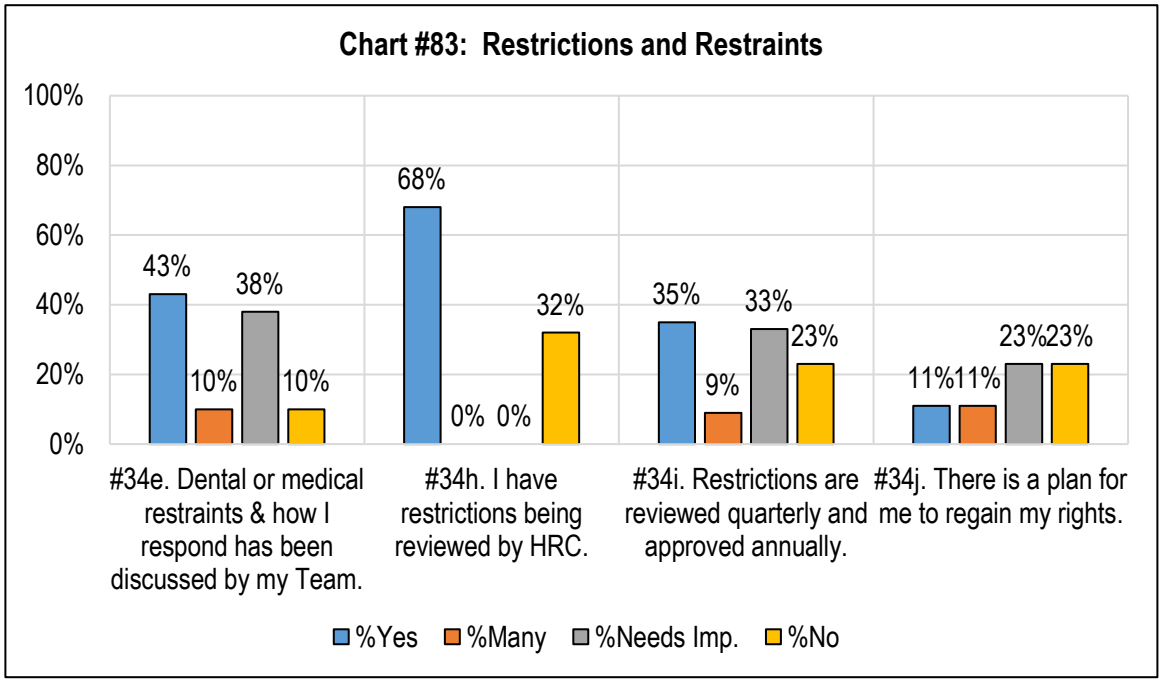
- ✓ Participate in any discussion about restricting my rights.
- ✓ Being free from coercion, restraint, seclusion and retaliation.

Modification to my rights:

- ✓ Less intrusive supports must be attempted prior to a modification or restriction.
- ✓ Requires regular review to measure and assess effectiveness of restriction/modification.

Question #34e. Have my team and I discussed, if applicable, any restraints that are utilized for medical or dental treatment, how I respond to them and if they are safe?
Question #34h. Do I have restrictions that should be reviewed by a human rights committee?
Question #34i. Have restrictions been reviewed (quarterly) and approved (annually) by the human rights committee.
Question #34j. There is a plan to enable me to regain my rights and reduce or eliminate these restrictions.

[133] CPR Question #53



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

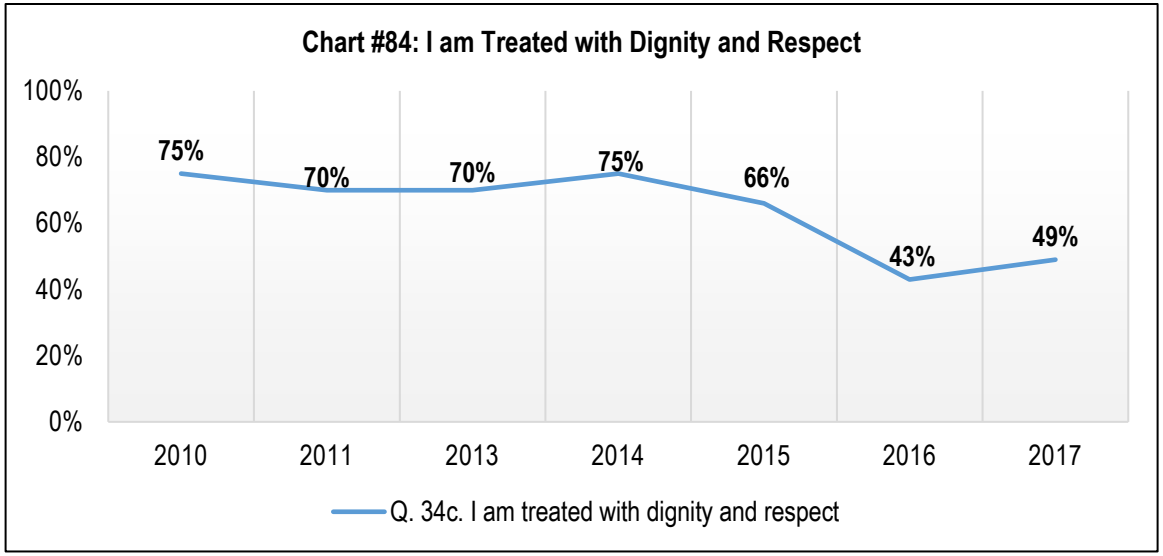
Question #34c. Am I treated with dignity and respect?[134]

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.

[134] CPR Question #103.



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.[135]

Some of My Rights Include:

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

The IQR probes for information related to the following questions:

Question #35a. Do my team and my guardian know how to report incidents of abuse, neglect, and exploitation internally and externally?
Question #35b. Have all incidents of suspected abuse, neglect and exploitation been reported and investigated?
Question #35c. Did my team meet and take appropriate action?

[135] 2018 NM DD Waiver Standards, Chapter 18. Incident Management System, Page 229

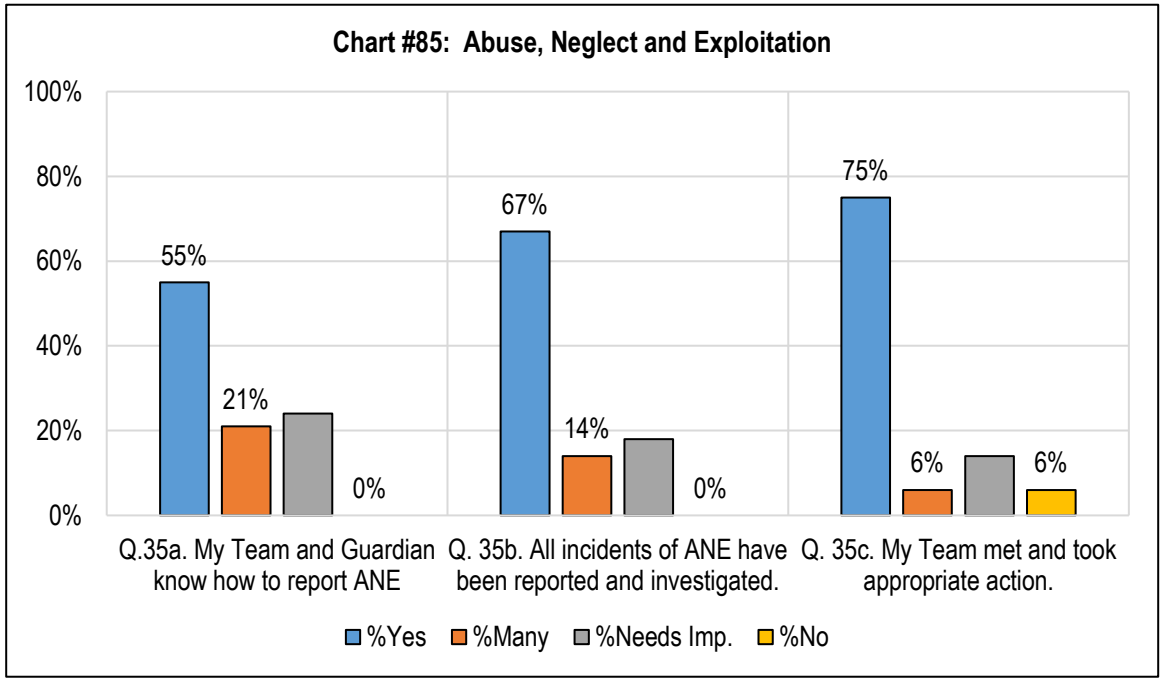


Chart #85: Abuse, Neglect and Exploitation
100%
80%
60%
40%
20%
0%
55%
21%
0%
67%
14%
0%
75%
6%
6%
Q.35a. My Team and Guardian know how to report ANE
Q. 35b. All incidents of ANE have been reported and investigated.
Q. 35c. My Team met and took appropriate action.
%Yes
%Many
%Needs Imp.
%No

XII. GOOD NEWS: OVERALL CONSISTENT AND IMPROVING AREAS

During the 2017 Individual Quality Review, much as has been the norm during the past seven Community Practice Reviews, many regions show consistently high scores in specific areas. These areas address if the person has the opportunity to make ***informed choices*** and if the individual ***finds their guardian, case manager, day and residential support staff to be helpful*** and gets along with them. 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, overall. 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 83% of the day staff and 89% of the residential staff do know the individuals reviewed (Q#8a and Q#8b). Statewide, 89% of direct care staff were able to describe how to provide daily care/supports (Q#23f.) Additionally, 84% of Teams overall were found to communicate with individuals using their communication preferences (Q#10a). As part of that communication between the team/staff and the individual, 86% of people responded promptly to the individuals when they made choices (Q#30c).

Another important area to note that has been an ongoing positive for the Jackson Class is the safeguards provided by many Guardians. For those for whom it was applicable, 82% of guardians were found to advocate for the individuals at the level needed (Q#15b). 85% of guardians respond to contacts from the individual and team members in a timely manner (Q#15c). Also, for 89% of the individuals reviewed statewide, the guardians reported satisfaction with the services provided by the Case Managers.

The safety and comfort of the class members is something that was examined in depth by the IQR. The individuals and staff for 97% of the state felt safe in their residential neighborhoods (Q#24a). Within the homes, 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#25f). Overall, 98% of the sample statewide were found to have appropriate, sufficient, safe, healthy and nutritious food (Q#23e).

Ensuring the rights of the Jackson class was also an area of focus during the 2017 IQR. How individuals are spoken of and to was reviewed, as well as honoring their preferences, choices and privacy. For 86% of the individuals, statewide, individual cultural preferences were accommodated (Q#31e). For 93% of the sample, it was found that the class members were described and addressed using respectful language (Q#34a), and 89% were found to have time, space and opportunity for individual privacy (Q#34b). In an instance when a member of an individual's team were to suspect a violation of their rights, 81% of teams were able to make a complaint.

B. Metro Region

Direct Care Staff: 85% of the residential staff knew the individuals reviewed (Q#8b). In the Metro region, 92% of direct care staff were able to describe how to provide daily care/supports (Q#23f). Additionally, 85% of Teams overall were found to communicate with individuals using their communication preferences (Q#10a).

Guardianship and Case Management: 85% of guardians were found to advocate for the individuals at the level needed (Q#15b). 88% of guardians respond to contacts from the individual and team members in a timely manner (Q#15c). For 94% of the individuals reviewed in the region, the guardians reported that they found the Case Manager helpful. (Q#15d). 81% of Case Managers were reported to visit the individuals they supported at least twice a month, and in varying locations (Q#16a).

Services and Plan: In the Metro region, 92% of individuals have ISPs that address live, work/learn, fun/relationships and health/other that complements their desires and capabilities (Q#7o). 88% of individuals were found to have all communication assessments and services needed (Q#10b).

Safety and Comfort: The individuals and staff for 96% of the region felt safe in their residential neighborhoods (Q#24a). For individuals who required any assistive technology or devices, 84% of staff were found to know how to appropriately and safely help with the use of their equipment (Q#25f). 100% of the individuals in the Metro region were found to have appropriate, sufficient, safe, healthy and nutritious food (Q#23e).

Individuality, Rights and Social Connections: For 83% of the individuals in the Metro region, cultural preferences were accommodated (Q#31e). 80% of the sample were supported to be engaged with their family, at the extent they desired (Q#31a.) 96% of the Metro class members were described and addressed using respectful language (Q#34a), and 85% were found to have time, space and opportunity for individual privacy (Q#34b). In an instance when a member of an individual's team were to suspect a violation of their rights, 87% of teams were able to make a complaint (Q#34d).

C. Northeast Region

Direct Care Staff: 88% of Teams in the Northeast region were found to communicate with individuals using their communication preferences (Q#10a). As part of that communication between the team/staff and the individual, 100% of people responded promptly to the individuals when they made choices (Q#30c).

Guardianship and Case Management: 100% of guardians in the region were found to advocate for the individuals at the level needed (Q#15b) and the same 100% of guardians respond to contacts from the individual and team members in a timely manner (Q#15c). Also, for 100% of the individuals reviewed, the guardians reported satisfaction with the services provided by the Case Managers (Q#15e) and noted that the Case Manager was helpful (Q#15d).

Services and Plan: In the Northeast region, 88% of individuals have ISPs that address live, work/learn, fun/relationships and health/other that complements their desires and capabilities (Q#7o).

Safety and Comfort: The individuals and staff for 100% of the region felt safe in their residential neighborhoods (Q#24a). Within the homes, 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#25f). Overall, 86% of the individuals in the region were found to have appropriate, sufficient, safe, healthy and nutritious food (Q#23e).

Individuality, Rights and Social Connections: For 100% of the individuals in the Northeast region, cultural preferences were accommodated (Q#31e) and 100% of the sample were supported to be engaged with their family, at the extent they desired (Q#31a). 100% of the individuals reviewed were found to have adequate access to and use of community/generic services and natural supports (Q#33f). 100% of the Northeast sample class members were described and addressed using respectful language (Q#34a), and 86% were found to have time, space and opportunity for individual privacy (Q#34b). In an instance when a member of an individual's team were to suspect a violation of their rights, 88% of teams were able to make a complaint (Q#34d).

D. Northwest Region

Direct Care Staff: 100% of the day and residential staff knew the individuals reviewed (Q#8a and Q#8b). 100% of direct care staff were also able to describe how to provide daily care/supports (Q#23f). Additionally, 100% of Teams in the region were found to communicate with individuals using their communication preferences (Q#10a), and 100% of individuals had people who responded promptly when they made choices (Q#30c).

Guardianship and Case Management: 88% of Case Managers were reported to visit the individuals they supported at least twice a month, and in varying locations (Q#16a), and 88% knew the individual well (Q#8c).

Safety and Comfort: The individuals and staff for 100% of the region felt safe in their residential neighborhoods (Q#24a). Overall, 100% of the individuals in the region were found to have appropriate, sufficient, safe, healthy and nutritious food (Q#23e).

Individuality, Rights and Social Connections: For 88% of the individuals in the Northwest region, cultural preferences were accommodated (Q#31e). 100% of the individuals reviewed were found to have adequate access to and use of community/generic services and natural supports (Q#33f). 100% of the Northwest sample class members were described and addressed using respectful language (Q#34a), and 100% were found to have time, space and opportunity for individual privacy (Q#34b). In an instance when a member of an individual's team were to suspect a violation of their rights, 88% of teams were able to make a complaint (Q#34d).

E. Southeast Region

Direct Care Staff: 100% of the day and 90% residential staff knew the individuals reviewed (Q#8a and Q#8b). In the Southeast region, 80% of direct care staff were able to describe how to provide daily care/supports (Q#23f). Additionally, 100% of Teams overall were found to communicate with individuals using their communication preferences (Q#10a) and 100% of individuals had people who responded promptly when they made choices (Q#30c).

Guardianship and Case Management: 89% of guardians were found to advocate for the individuals at the level needed (Q#15b). 89% of guardians respond to contacts from the individual and team members in a timely manner (Q#15c). For 100% of the individuals reviewed in the region, the guardians reported that they found the Case Manager helpful. (Q#15d) and 100% were satisfied with the services and supports provided to the individual (Q#15e). 90% of Case Managers in the Southeast Region knew the person well.

Safety and Comfort: The individuals and staff for 90% of the region felt safe in their residential neighborhoods (Q#24a). For 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#25f). 100% of the individuals in the Southeast region were found to have appropriate, sufficient, safe, healthy and nutritious food (Q#23e).

Individuality, Rights and Social Connections: For 100% of the individuals in the Southeast region, cultural preferences were accommodated (Q#31e). 90% of the region's class members were described and addressed using respectful language (Q#34a), and 90% were found to have time, space and opportunity for individual privacy (Q#34b). 80% of individuals reviewed were found to have adequate access to and use of community/generic services and natural supports (Q#33f). In an instance when a member of an individual's team were to suspect a violation of their rights, 80% of teams were able to make a complaint (Q#34d).

F. Southwest Region

Direct Care Staff: 89% of the day staff knew the individuals reviewed (Q#8b). In the Southwest region, 89% of direct care staff were able to describe how to provide daily care/supports (Q#23f). Additionally, 89% of Teams overall were found to communicate with individuals using their communication preferences (Q#10a).

Guardianship and Case Management: 89% of guardians were found to advocate for the individuals at the level needed (Q#15b) and 89% of guardians respond to contacts from the individual and team members in a timely manner (Q#15c). For 100% of the individuals reviewed in the region, the guardians reported that they found the Case Manager helpful. (Q#15d) and 100% of Guardians were satisfied with the services and supports provided.

Services and Plan: In the Southwest region, 100% of individuals have ISPs that address live, work/learn, fun/relationships and health/other that complements their desires and capabilities (Q#7o). 100% of individuals were found to have all communication assessments and services needed (Q#10b).

Safety and Comfort: The individuals and staff for 88% of the region felt safe in their residential neighborhoods (Q#24a). 100% of the individuals in the Southwest region were found to have appropriate, sufficient, safe, healthy and nutritious food (Q#23e).

Individuality, Rights and Social Connections: 80% of the Southwest region class members were described and addressed using respectful language (Q#34a).

Appendix A: 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 B: 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		
J&J	2	1	1	1	5			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)
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 C: Number of Repeat Findings/Recommendations by Agency – 2011-2017

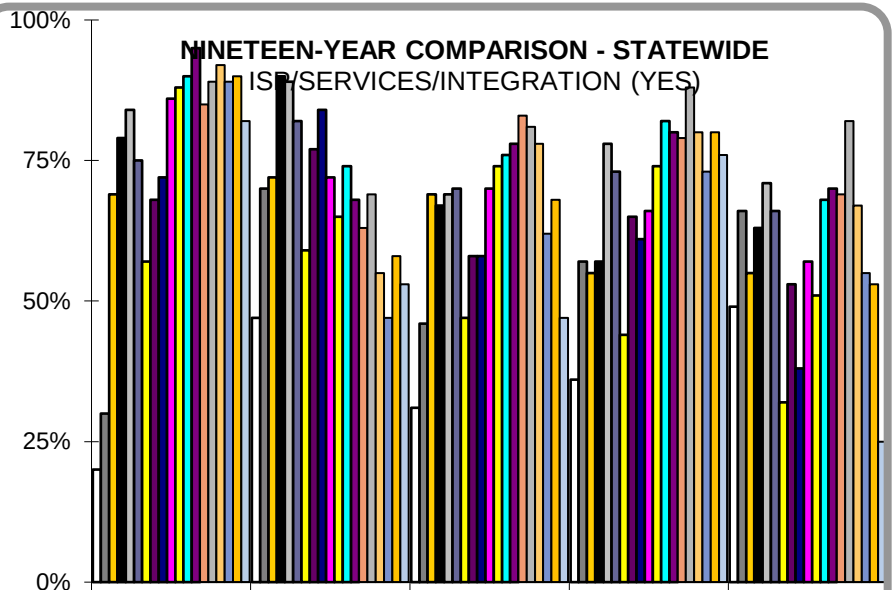
Note: If the number of Repeat Findings/Recommendations goes up or down it cannot automatically be seen as "improvement" or "decline" for that agency as there are instances of multiple reviews and changes in agencies by JCMs. However, this does provide information that can be used by the Regions to determine '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**

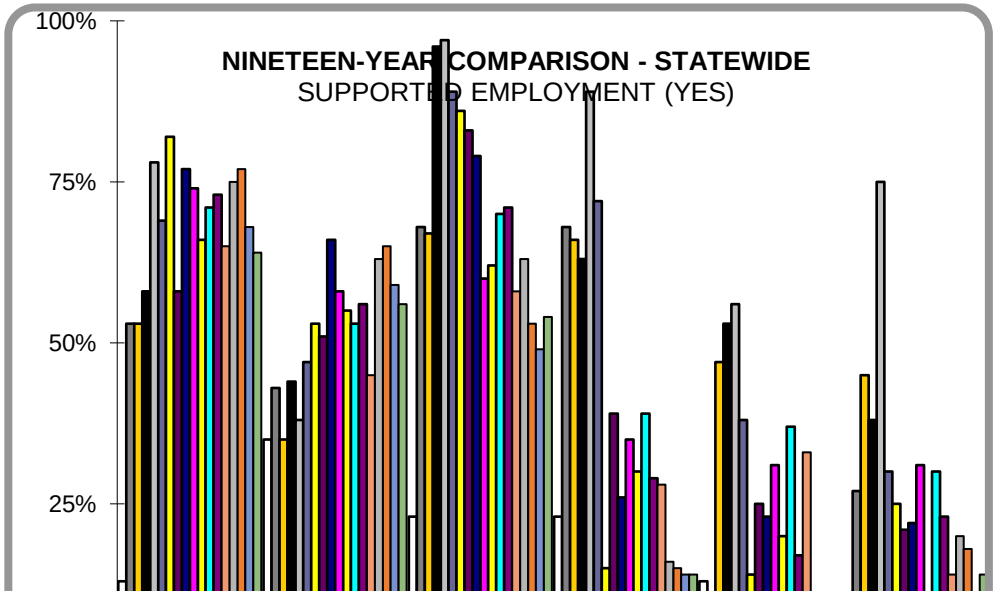
RESIDENTIAL # Repeats by CPR	2017	2016	2015	2014	2013	2011
(# in 2017 Sample)	N/A =Agency not reviewed that year					
A Better Way	N/A	3	0	N/A	N/A	1
Ability First	N/A	N/A	5	N/A	N/A	N/A
Achievements	N/A	N/A	N/A	N/A	N/A	8
Active Solutions	N/A	N/A	1	3	N/A	N/A
Adelante (10)	41	36	20	28	12	9
Advantage Communications (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

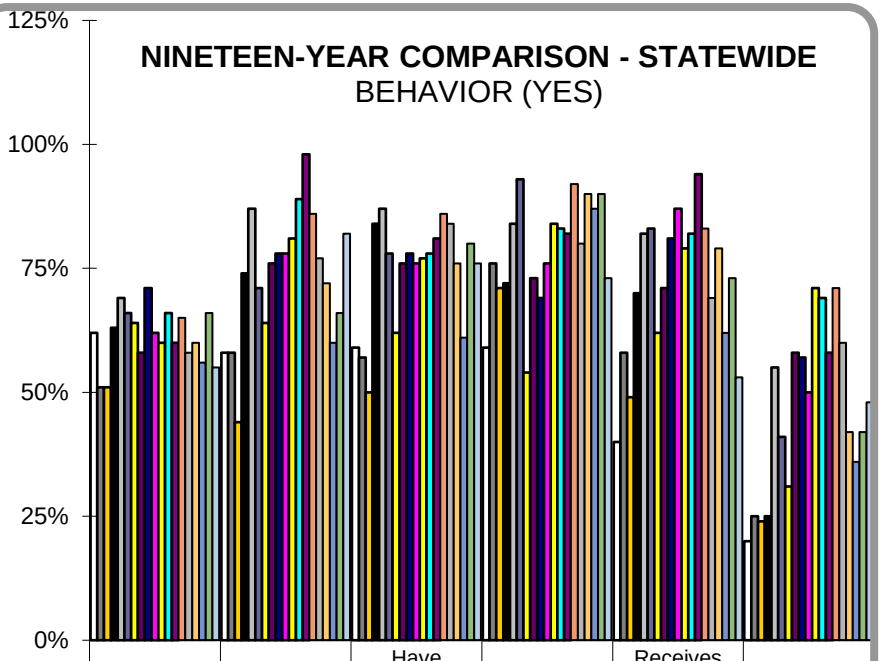
Appendix D: Historic Disengagement Charts, Statewide



	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%

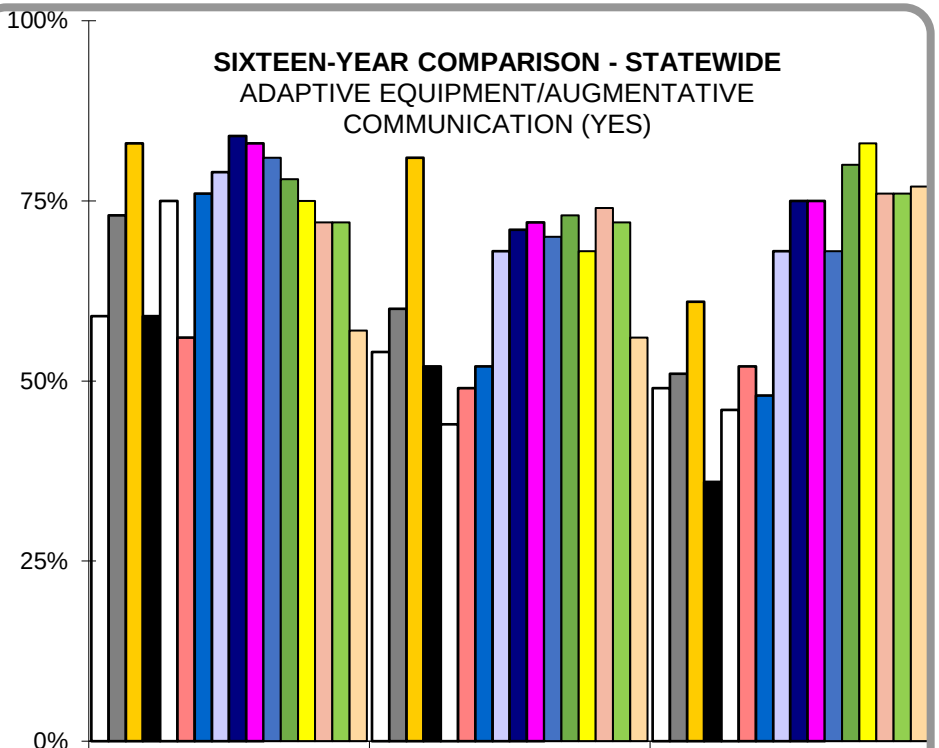


	Need Vocational Assessment	Need Supported Employment	Receive Employment Assessment	Assess Conforms to DOH/DDD Regs	Have Career Development Plan	Receive Employment Services
1997	13%	35%	23%	23%	13%	9%
1998	53%	43%	68%	68%	0%	27%
1999	53%	35%	67%	66%	47%	45%
2000	58%	44%	96%	63%	53%	38%
2001	78%	38%	97%	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%



NINETEEN-YEAR COMPARISON - STATEWIDE
BEHAVIOR (YES)

	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%



SIXTEEN-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%

Appendix E: CPR & IQR Data Tables

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
Case Management Services						
26. Does the case manager "know" the person?	94% Yes (102) 6% Partial (7)	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)	17IQR#8c 79% Yes (49) 19% Many (12) 2% Need Imp (1)
27. Does the case manager understand his/her role/job?	55% Yes (60) 45% Partial (49)	51% Yes (52) 49% Partial (50)	48% Yes (47) 52% Partial (50)	56% Yes (54) 44% Partial (42)	56% Yes (50) 44% Partial (40)	17IQR#16 3% Yes (2) 55% Many (34) 42% Need Imp (26)
28. Did the case manager receive training on the topics needed to assist him/her in meeting the needs of this person?	85% Yes (93) 15% Partial (16)	80% Yes (82) 20% Partial (20)	79% Yes (77) 21% Partial (20)	86% Yes (83) 14% Partial (13)	82% Yes (74) 18% Partial (16)	
29. Is the case manager available to the person?	87% Yes (95) 13% Partial (14)	86% Yes (88) 14% Partial (14)	80% Yes (78) 20% Partial (19)	82% Yes (79) 18% Partial (17)	78% Yes (70) 22% Partial (20)	17IQR#16a 74% Yes (45) 13% Many (8) 13% Need Imp (8) (1 N/A)
30. Was the case manager able to describe the person's health related needs?	73% Yes (80) 27% Partial (29)	72% Yes (73) 28% Partial (29)	63% Yes (61) 37% Partial (36)	66% Yes (63) 34% Partial (33)	78% Yes (70) 22% Partial (20)	
31. Does the case manager have an appropriate expectation of growth for this person?	69% Yes (75) 29% Partial (32) 2% No (2)	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)	
32. Does the case management record contain documentation that the case manager is monitoring and tracking the delivery of services as outlined in the ISP?	41% Yes (45) 58% Partial (63) 1% No (1)	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)	17IQR#16b 5% Yes (3) 29% Man (18) 485 Need Imp (30) 18% No (11)
33. Does the case manager provide case management services at the level needed by this person?	41% Yes (45) 57% Partial (62) 2% No (2)	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)	17IQR#16c 26% Yes (16) 34% Many (21) 40% Need Imp (25)

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
34. Does the case manager receive the type and level of support needed to do his/her job?	92% Yes (100) 8% Partial (9)	91% Yes (93) 9% Partial (9)	87% Yes (84) 13% Partial (13)	88% Yes (84) 13% Partial (12)	86% Yes (77) 14% Partial (13)	
Day/Employment Services						
35. Does the day/employment direct services "know" the person?	95% Yes (104) 5% Partial (5)	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)	17IQR#8a 83% Yes (50) 10% Many (6) 7% Need Imp (4) (2 N/A)
36. Does the direct service staff have adequate input into the person's ISP?	73% Yes (80) 25% Partial (27) 2% No (2)	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)	
37. Did the direct service staff receive training on implementing this person's ISP?	83% Yes (91) 17% Partial (18)	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)	
38. Was the direct service staff able to describe this person's health related needs?	60% Yes (65) 40% Partial (44)	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)	
39. Was the direct service staff able to describe his/her responsibilities in providing daily care/supports to the person?	82% Yes (89) 18% Partial (20)	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)	
39.a. Was the direct service staff able to provide specific information regarding the person's daily activities, including the exact times of the day?	95% Yes (104) 5% Partial (5)	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)	
39.b. Can the direct service staff describe his/her responsibilities in implementing the person's ISP goals/objectives/outcomes/action plans?	83% Yes (91) 17% Partial (18)	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)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
40. Did the direct service staff have training in the ISP process?	79% Yes (86) 18% Partial (20) 3% No (3)	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)	
41. Did the direct service staff have training on the provider's complaint process and on abuse, neglect and exploitation?	88% Yes (96) 12% Partial (13)	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)	
41.a. Have training on the provider's complaint process?	93% Yes (101) 6% Partial (6) 2% No (2)	91% Yes (93) 7% Partial (7) 2% No (2)	88% Yes (84) 8% Partial (8) 3% No (3) (2 not scored)	87% Yes (82) 9% Partial (8) 4% No (4) (2 not scored)	86% Yes (75) 9% Partial (8) 5% No (4) (3 not scored)	
41.b. Have training on how and to whom to report abuse, neglect and exploitation?	94% Yes (103) 6% Partial (6)	91% Yes (93) 7% Partial (7) 2% No (2)	91% Yes (86) 9% Partial (9) (2 not scored)	85% Yes (80) 13% Partial (12) 2% No (2) (2 not scored)	86% Yes (75) 13% Partial (11) 1% No (1) (3 not scored)	
42. Does the direct service staff have an appropriate expectation of growth for this person?	65% Yes (71) 32% Partial (35) 3% No (3)	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)	
43. Is the day/employment environment generally clean, free of safety hazards and conducive to the work/activity intended?	97% Yes (105) 3% Partial (3) (1 CND)	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)	
Residential Services						
44. Does the residential direct services staff "know" the person?	97% Yes (106) 3% Partial (3)	97% Yes (99) 3% Partial (3)	98% Yes (95) 2% Partial (2)	92% Yes (88) 8% Partial (8)	96% Yes (86) 4% Partial (4)	
45. Does the direct service staff have adequate input into the person's ISP?	72% Yes (78) 27% Partial (29) 2% No (2)	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)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
46. Did the direct service staff receive training on the implementing this person's ISP?	84% Yes (92) 16% Partial (17)	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)	
47. Is the residence safe for individuals (void of hazards)?	96% Yes (105) 3% No (3) (1 not scored)	91% Yes (93) 9% No (9)	93% Yes (90) 7% No (7)	99% Yes (95) 1% No (1)	89% Yes (80) 11% No (10)	
48. Was the residential direct service staff able to describe this person's health-related needs?	72% Yes (78) 28% Partial (31)	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)	
49. Was the residential direct service staff able to describe his/her responsibilities in providing daily care/supports to the person?	79% Yes (86) 21% Partial (23)	77% Yes (79) 23% Partial (23)	81% Yes (79) 19% Partial (18)	84% Yes (81) 16% Partial (15)	88% Yes (79) 12% Partial (11)	
49.a. Was the staff able to provide specific information regarding the person's daily activities?	91% Yes (99) 9% Partial (10)	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)	
49.b. Can the direct service staff describe his/her responsibilities in implementing the person's ISP goals & objectives?	81% Yes (88) 19% Partial (21)	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)	
50. Did the residential direct service staff have training in the ISP process?	76% Yes (83) 23% Partial (25) 1% No (1)	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)	
51. Did the residential direct service staff have training on the provider's complaint process and on abuse, neglect and exploitation?	88% Yes (96) 12% Partial (13)	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)	
51.a. Have training on the provider's complaint process?	93% Yes (101) 5% Partial (5) 3% No (3)	89% Yes (91) 9% Partial (9) 2% No (2)	91% Yes (87) 8% Partial (8) 1% No (1) (1 not scored)	89% Yes (85) 6% Partial (6) 5% No (5)	92% Yes (83) 6% Partial (5) 2% No (2)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
51.b. Have training on how and to whom to report abuse, neglect and exploitation?	91% Yes (99) 7% Partial (8) 2% No (2)	94% Yes (96) 5% Partial (5) 1% No (1)	92% Yes (89) 8% Partial (8)	88% Yes (84) 9% Partial (9) 3% No (3)	87% Yes (78) 12% Partial (11) 1% No (1)	
52. Does the residential direct service staff have an appropriate expectation of growth for this person?	72% Yes (78) 26% Partial (28) 3% No (3)	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)	
53. Does the person's residential environment offer a minimal level of quality of life?	95% Yes (104) 4% Partial (4) (1 not scored)	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)	
Health						
54. Overall, were the team members interviewed able to describe the person's health-related needs?	39% Yes (43) 61% Partial (66)	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)	17IQR#21b 66% Yes (41) 24% Many (15) 8% Need Imp (5) 2% No (1)
55. Is there evidence that the IDT discussed the person's health-related issues?	64% Yes (70) 36% Partial (39)	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)	17IQR#21 18% Yes (11) 66% Many (41) 16% Need Imp (10)
56. In the opinion of the reviewer, are the person' health supports/needs being adequately addressed?	36% Yes (39) 63% Partial (69) 1% No (1)	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)	17IQR#19 23% Yes (14) 48% Many (30) 29% Need Imp (18)
Assessments						
57. Did the team consider what assessments the person needs and would be relevant to the team's planning efforts?	58% Yes (63) 42% Partial (46)	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)	
58. Did the team arrange for and obtain the needed, relevant assessments?	41% Yes (45) 58% Partial (63) 1% No (1)	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)	17IQR#18 10% Yes (6) 56% Many (35) 34% Need Imp (21)

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
59. Are the assessments adequate for planning?	48% Yes (52) 52% Partial (57)	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)	17IQR#4f 13% Yes (8) 58% Many (36) 29% Need Imp (18)
60. Were the recommendations from assessments used in planning?	43% Yes (47) 56% Partial (61) 1% No (1)	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)	17IQR#5 23% Yes (14) 44% Many (27) 34% Need Imp (21)
Adequacy of Planning and Adequacy of Services						
61. Is there a document called an Individual Service Plan (ISP) that was developed within the last year?	100% Yes (109)	100% Yes (102)	100% Yes (97)	100% Yes (95) (1 not scored)	100% Yes (90)	17IQR#9 87% Yes (53) 8% Many (5) 5% Need Imp (3) (1 N/A)
62. Was the ISP developed by an appropriately constituted IDT?	50% Yes (54) 50% Partial (55)	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)	17IQR#3 39% Yes (24) 37% Many (23) 24% Need Imp (15)
63. For any team members not physically present at the IDT meeting, is there evidence of their participation in the development of the ISP?	45% Yes (38) 44% Partial (37) 11% No (9) (25 N/A)	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)	17IQR#3d 52% Yes (25) 10% Many (5) 19% Need Imp (9) 19% No (9) (14 N/A)
64. Overall, is the long-term vision adequate?	55% Yes (60) 41% Partial (45) 4% No (4)	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)	17IQR#7b 53% Yes (33) 15% Many (9) 31% Needs Imp (19) 2% No (1)
65*. Overall, does the Narrative and/or Progress Towards Reaching the Long-Term Vision Section of the ISP give adequate guidance to achieving the person's long-term vision?	70% Yes (76) 28% Partial (30) 3% No (3)	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)	17IQR#7c 45% Yes (28) 21% Many (13) 29% Need Imp (18) 5% No (3)

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
66*. Overall, is Vision Section of the ISP used as the basis for outcome development?	82% Yes (89) 17% Partial (18) 2% No (2)	75% Yes (77) 24% Partial (24) 1% No (1)	72% Yes (70) 25% Partial (24) 3% No (3)	66% Yes (63) 34% Partial (32) (1 not scored)	76% Yes (68) 24% Partial (22)	
67*. Overall, do the outcomes in the ISP include criteria by which the team can determine when the outcome (s) have been achieved?	66% Yes (72) 28% Partial (31) 6% No (6)	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)	17IQR#7e 31% Yes (19) 8% Many (5) 47% Need Imp (29) 15% No (9)
68*. Overall, are the ISP outcomes related to achieving the person's long-term vision?	73% Yes (80) 24% Partial (26) 3% No (3)	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)	17IQR#7d 45% Yes (28) 11% Many (7) 42% Needs Imp (26) 2% No (1)
69*. Overall, do the ISP outcomes address the person's major needs?	61% Yes (67) 36% Partial (39) 3% No (3)	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)	17IQR#7g 32% Yes (20) 27% Many (17) 39% Need Imp (24) 2% No (1)
70*. Overall, are the Action Plans specific and relevant to assisting the person in achieving his/her outcomes?	49% Yes (53) 42% Partial (46) 9% No (10)	43% Yes (44) 54% Partial (55) 3% No (3)	39% Yes (38) 55% Partial (53) 6% No (6)	53% Yes (50) 44% Partial (42) 3% No (3) (1 not scored)	31% Yes (28) 61% Partial (55) 8% No (7)	
71*. Overall, are the Teaching and Support strategies sufficient to ensure consistent implementation of the services provided?	43% Yes (47) 52% Partial (57) 5% No (5)	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)	17IQR#7i 15% Yes (9) 25% Many (15) 52% Need Imp (32) 8% No (5) (1 N/A)
72*. Overall, are the recommendations and/or objectives/strategies of ancillary providers integrated into the outcomes, action plans, and Teaching and Support Strategies of the ISP?	48% Yes (52) 44% Partial (47) 8% No (9) (1 N/A)	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)	17IQR#7m 16% Yes (10) 25% Many (15) 46% Need Imp (28) 13% No (8) (1 N/A)

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
73*. If needed, does the ISP contain a specific Crisis Prevention Plan that meets the person's needs?	76% Yes (80) 24% Partial (25) (4 N/A)	77% Yes (74) 22% Partial (21) 1% No (1) (6 N/A)	80% Yes (74) 19% Partial (18) 1% No (1) (4 N/A)	76% Yes (71) 22% Partial (20) 2% No (2) (2 N/A) (1 not scored)	66% Yes (57) 33% Partial (29) 1% No (1) (3 N/A)	
73a. If needed, does the ISP contain a specific Crisis Prevention Plan for dangerous behavior that meets the person's needs?	87% Yes (33) 11% Partial (4) 3% No (1) (71 N/A)	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)	17IQR#5h 71% Yes (10) 21% Many (3) 7% Need Imp (1) (48 N/A)
73b. If needed, does the ISP contain a specific Medical Emergency Response Plan (MERP)?	68% Yes (73) 30% Partial (32) 2% No (2) (3 N/A)	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)	17IQR#20c 47% Yes (29) 24% Many (15) 27% Need Imp (17) 2% No (1)
74*. Does the ISP contain information regarding primary health (medical) care?	90% Yes (98) 10% Partial (11)	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)	
74a*. Does the ISP face sheet contain contact information for the PCP?	92% Yes (100) 6% Partial (7) 2% No (2)	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)	
74b*. Is the Healthcare Coordinator's name and contact information listed in the ISP?	95% Yes (104) 3% Partial (3) 2% No (2)	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)	
75. Does the ISP reflect how the person will get to work/day activities, shopping, social activities?	87% Yes (47) 6% Partial (3) 7% No (4) (55 N/A)	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)	
76. Does the ISP reflect how the person will obtain prescribed medications?	90% Yes (98) 7% Partial (8) 3% No (3)	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)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
77. Does the ISP contain a list of adaptive equipment needed and who will provide it?	42% Yes (43) 48% Partial (49) 10% No (10) (7 N/A)	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)	17IQR#25a 38% Yes (23) 26% Many (16) 30% Need Imp (18) 7% No (4) (1 N/A)
78. Overall, is the ISP adequate to meet the person's needs?	28% Yes (30) 72% Partial (79)	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)	17IQR#7 0% Yes 27% Many (17) 73% Need Imp (45)
79. If #78 is rated "2", is the ISP being implemented?	73% Yes (22) 27% Partial (8) (79 N/A)	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)	17IQR#12 3% Yes (2) 19% Many (12) 68% Need Imp (42) 10% No (6)
80a. If there no ISP or if #78 is rated "0" or "1" or "n/a", is the ISP being implemented?	39% Yes (31) 58% Partial (46) 3% No (2) (30 N/A)	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)	
80b. If there is no ISP, or if #78 is rated "0" or "1", are current services adequate to meet the person's needs?	28% Yes (22) 72% Partial (57) (30 N/A)	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)	17IQR#11 3% Yes (2) 53% Many (33) 44% Need Imp (27)
81. Overall, were the direct service staff trained on the implementation of the ISP?	72% Yes (78) 28% Partial (31)	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)	
82. Overall, were the direct service staff able to describe their responsibilities in providing daily care/support to the person?	69% Yes (75) 31% Partial (34)	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)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
83. Overall, do the progress notes or other documentation in the case management record reflect the status of the goals and services of the key life areas stated in the ISP?	39% Yes (42) 60% Partial (65) 2% No (2)	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)	
Expectations for Growth						
84. Based on all of the evidence, in the opinion of the reviewer, has the person achieved progress in the past year?	64% Yes (70) 35% Partial (38) 1% No (1)	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)	17IQR#13 0% Yes 37% Many (23) 61% Need Imp (38) 2% No (1)
85. Overall, does the IDT have an appropriate expectation of growth for this person?	46% Yes (50) 54% Partial (59)	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)	17IQR#8d 63% Yes (39) 23% Many (14) 13% Need Imp (8) 2% No (1)
Quality of Life						
86. Was the person provided the assistance and support needed to participate meaningfully in the planning process?	86% Yes (94) 14% Partial (15)	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)	17IQR#1b 69% Yes (42) 19% Many (12) 10% Need Imp (6) 2% No (1) (1 CND)
87. Is the person offered a range of opportunities for participation in each of the life areas?	73% Yes (75) 27% Partial (28) (6 CND)	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)	
88. Does the person have the opportunity to make informed choices?	81% Yes (44) 19% Partial (10) (55 CND)	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)	17IQR#30 47% Yes (29) 44% Many (27) 10% Need Imp (6)

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
89. About where and with whom to live?	86% Yes (38) 11% Partial (5) 2% No (1) (65 CND)	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)	17IQR#23c 50% Yes (3) 33% Need Imp (2) 17% No (1) (56 CND)
90. About where and with whom to work/spend his/her day?	89% Yes (40) 11% Partial (5) (64 CND)	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)	17IQR#23d 85% Yes (17) 5% Many (1) 10% Need Imp (2) (42 CND)
91. About where and with whom to socialize/spend leisure time?	89% Yes (39) 11% Partial (5) (65 CND)	90% Yes (36) 10% No (4) (62 CND)	86% Yes (32) 14% Partial (5) (60 CND)	86% Yes(30) 9% Partial (3) 6% No (2) (60 CND) (1 not scored)	80% Yes (12) 20% Partial (3) (75 CND)	
92. Does the evidence support that providers do not prevent the person from pursuing relationships and are respecting the rights of this person?	96% Yes (98) 4% Partial (4) (7 CND)	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)	17IQR#31f 92% Yes (34) 8% Need Imp (3) (22 N/A, 3 CND)
93. Overall, were the direct service staff interviewed trained on the provider's complaint process and on abuse, neglect and exploitation?	78% Yes (85) 22% Partial (24)	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)	17IQR#35a 55% Yes (34) 21% Many (13) 24% Need Imp (15)
94. Does this person and/or guardian have adequate access to the available complaint processes/procedures?	96% Yes (102) 3% Partial (3) 1% No (1) (3 CND)	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)	
95. Does this person know his/her guardian?	98% Yes (46) 2% No (1) (62 CND)	100% Yes (46) (1 N/A, 55 CND)	100% Yes (29) (1 NA, 67 CND)	96% Yes (26) 4% No (1) (2 N/A, 66 CND) (1 not scored)	100% Yes (25) (1 N/A, 64 CND)	
96. Does this person believe the guardian is helpful?	100% Yes (16) (93 CND)	93% Yes (13) 7% No (1) (1 N/A, 87 CND)	100% Yes (8) (1 N/A, 88 CND)	100% Yes (8) (2 N/A, 85 CND) (1 not scored)	100% Yes (3) (1 N/A, 86 CND)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
97. What is the level of participation of the legal guardian in this person's life and service planning?	42% Active (46) 44% Moderate (48) 13% Limited (14) 1% None (1)	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)	17IQR#15a 40% Active (25) 31% Moderate (19) 21% Limited (13) 8% None (5)
98. In the Reviewer's opinion, does the person need a friend advocate?	7% Yes (8) 93% No (101)	3% Yes (3) 97% No (99)	10% Yes (10) 90% No (87)	8% Yes (8) 92% No (87) (1 not scored)	7% Yes (6) 93% No (84)	
99. Does the person have a friend advocate?	13% Yes (1) 88% No (7) (101 N/A)	0% Yes 100% No (3) (99 N/A)	0% Yes 100% No (10) (87 N/A)	0% Yes 100% No (8) (87 CND) (1 not scored)	33% Yes (2) 67% No (4) (84 N/A)	
100. If the person is retired, does he/she have adequate opportunities to engage in activities of interest during the day?	77% Yes (23) 23% Partial (7) (79 N/A)	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)	17IQR#29b 53% Yes (8) 27% Many (4) 13% Need Imp (2) 7% No (1) (47 N/A)
101. Does the person have daily choices/appropriate autonomy over his/her life?	78% Yes (85) 21% Partial (23) 1% No (1)	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)	17IQR#30 47% Yes (29) 44% Many (27) 10% Need Imp (6)
102. Have the person's cultural preferences been accommodated?	94% Yes (100) 5% Partial (5) 1% No (1) (3 CND)	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)	17IQR#31e 86% Yes (51) 10% Many (6) 3% Need Imp (2) (1 N/A, 2 CND)
103. Is the person treated with dignity and respect?	70% Yes (76) 30% Partial (33)	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)	17IQR#34c 48% Yes (30) 21% Many (13) 31% Need Imp (19)
Satisfaction						
104. Overall, is the person satisfied with the current services?	89% Yes (31) 11% Partial (4)	85% Yes (23) 15% Partial (4)	86% Yes (25) 14% Partial (4)	96% Yes (24) 4% Partial (1)	86% Yes (12) 14% Partial (2)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
	(74 CND)	(75 CND)	(68 CND)	(70 CND) (1 not scored)	(76 CND)	
105. Does the person get along with the case manager?	100% Yes (21) (88 CND)	100% Yes (13) (89 CND)	100% Yes (7) (90 CND)	100% Yes (15) (80 CND) (1 not scored)	88% Yes (7) 13% Partial (1) (82 CND)	
106. Does the person find the case manager helpful?	100% Yes (11) (98 CND)	100% Yes (10) (92 CND)	100% Yes (5) (92 CND)	100% Yes (8) (87 CND) (1 not scored)	86% Yes (6) 14% Partial (1) (83 CND)	
107. Does the legal guardian find the case manager helpful?	93% Yes (90) 5% Partial (5) 2% No (2) (12 CND)	93% Yes (81) 6% Partial (5) 1% No (1) (1 NA, 14 CND)	89% Yes (73) 7% Partial (6) 4% No (3) (15 CND)	97% Yes (83) 1% Partial (1) 2% No (2) (1 N/A, 8 CND) (1 not scored)	95% Yes (73) 5% Partial (4) (1 N/A, 12 CND)	
108. Does the person have adequate food and drink available?	99% Yes (101) 1% Partial (1) (7 CND)	100% Yes (99) (3 CND)	100% Yes (96) (1 CND)	99% Yes (91) 1% Partial (1) (3 CND) (1 not scored)	100% Yes (90)	17IQR#23e 98% Yes (59) 2% Need Imp (1) (2 CND)
109. Does the person have adequate transportation to meet his/her needs?	96% Yes (105) 4% Partial (4)	93% Yes (95) 7% Partial (7)	93% Yes (90) 6% Partial (6) 1% No (1)	95% Yes (90) 4% Partial (4) 1% No (1) (1 not scored)	91% Yes (82) 8% Partial (7) 1% No (1)	
110. Does the person have sufficient personal money?	91% Yes (98) 9% Partial (10) (1 CND)	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)	17IQR#34f 88% Yes (53) 8% Many (5) 3% Need Imp (2) (2 CND)
111. Does the person get along with their day program /employment staff?	100% Yes (61) (48 CND)	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)	
112. Does the person get along with the residential provider staff?	99% Yes (75) 1% Partial (1) (33 CND)	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)	
Team Process						

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
114. Are the individual members of the IDT following up on their responsibilities?	30% Yes (33) 67% Partial (73) 3% No (3)	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)	17IQR#10 32% Yes (20) 53% Many (33) 15% Need Imp (9)
115. If there is evidence of team conflict, has the team made efforts to build consensus?	75% Yes (30) 25% Partial (10) (69 N/A)	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)	17IQR#17c 57% Yes (8) 43% No (6) (48 N/A)
116. Do records or facts exist to indicate that the team convened meetings as needed due to changed circumstances and/or needs?	78% Yes (81) 22% No (23) (4 N/A, 1 CND)	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)	17IQR#17d 73% Yes (36) 10% Many (5) 12% Need Imp (6) 4% No (2) (13 N/A)
117. Is there adequate communication among team members between meetings to ensure the person's program can be/is being implemented?	75% Yes (82) 24% Partial (26) 1% No (1)	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)	
118. Do you recommended Team Process Training for this IDT?	5% Yes (5) 95% No (104)	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)	
119. Is there evidence or documentation of physical regression in the last year?	50% Yes (54) 50% No (54) (1 CND)	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)	17IQR#14a 37% Yes (23) 63% No (39)
120. Is there evidence or documentation of behavioral or functional regression in the last year?	35% Yes (38) 65% No (71)	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)	17IQR14c 13% Yes (8) 87% No (54)
121. If #119 or 120 is Yes, is the IDT adequately addressing the regression?	67% Yes (41) 30% Partial (18) 3% No (2) (48 N/A)	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)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
122. Has the person changed residential/day services in the last year? If Yes, was the change:	24% Yes (26) 76% No (83)	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)	17IQR#10 32% Yes (20) 53% Many (33) 15% Need Imp (9)
122a. Planned by the IDT?	81% Yes (21) 12% Partial (3) 8% No (2) (83 N/A)	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)	
122b. Appropriate to meet needs?	88% Yes (23) 12% Partial (3) (83 N/A)	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)	
123. Has the IDT process been adequate for assessing, planning, implementing and monitoring of services for this person?	35% Yes (38) 65% Partial (71)	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)	17IQR#7n 3% Yes (2) 34% Many (21) 58% Need Imp (36) 5% No (3)
Supported Employment Services						
124. Has the IDT, or the reviewer recommended a supported employment assessment for the person?	65% Yes (71) 35% No (38)	75% Yes (76) 25% No (26)	77% Yes (74) 23% No (22) (1 not scored)	68% Yes (65) 32% No (30) (1 not scored)	64% Yes (56) 36% No (32) (2 not scored)	17IQR#26b 82% Yes (51) 18% No (11)
124A. Has the Team recommended a supported employment assessment for the person?	Added in 2015			26% Yes (25) 74% No (70) (1 not scored)	28% Yes (25) 72% No (63) (2 not scored)	
124B. Is the reviewer recommending a supported employment assessment for the person?	Added in 2015			65% Yes (62) 35% No (33) (1 not scored)	63% Yes (55) 38% No (33) (2 not scored)	
125. In the opinion of the IDT or the reviewer, does the person need supported employment?	45% Yes (49) 55% No (60)	63% Yes (64) 37% No (38)	65% Yes (62) 35% No (34) (1 not scored)	59% Yes (56) 41% No (39) (1 not scored)	56% Yes (49) 44% No (39) (2 not scored)	
125A. Does the Team recommend supported employment for the person?	Added in 2015			20% Yes (19) 80% No (76) (1 not scored)	25% Yes (22) 75% No (66) (2 not scored)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
125B. Is the Reviewer recommending supported employment for the person?	Added in 2015			60% Yes (57) 40% No (38) (1 not scored)	56% Yes (49) 44% No (39) (2 not scored)	
126. Did the person receive a supported employment assessment?	58% Yes (41) 28% No (30) (38 N/A)	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)	17IQR#26a 6% Yes (3) 17% Many (9) 32% Need Imp (17) 45% No (24) (9 N/A)
127. Does the supported employment assessment conform to the DOH regulations?	29% Yes (20) 23% Partial (16) 48% No (33) (40 N/A)	16% Yes (12) 45% Partial (34) 39% No (29) (27 N/A)	15% Yes (11) 25% Partial (18) 60% No (44) (23 N/A) (1 not scored)	14% Yes (9) 23% Partial (15) 63% No (40) (31 N/A) (1 not scored)	14% Yes (8) 31% Partial (18) 55% No (32) (30 N/A) (2 not scored)	
128. Does the person have a career development plan (based on assessments) that meets the person's needs?	29% Yes (16) 36% Partial (20) 35% No (19) (54 N/A)	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)	
129. Is the person engaged in supported employment?	36% Yes (18) 64% No (32) (59 N/A)	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)	
129A. Is the person working?	Added in 2015			30% Yes (17) 70% No (40) (38 N/A) (1 not scored)	28% Yes (14) 72% No (36) (38 N/A) (2 not scored)	
130. Is the supported work provided in accordance with the following?	14% Yes (7) 28% Partial (14) 58% No (29) (59 N/A)	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)	6% Yes (3) 17% Many (9) 32% Need Imp (17) 45% No (24) (9 N/A)
130a. At least a 10-hour work week?	20% Yes (10) 80% No (40) (59 N/A)	23% Yes (15) 77% No (49) (38 N/A)	17% Yes (11) 83% No (53) (32 N/A)	9% Yes (5) 91% No (52) (38 N/A)	16% Yes (8) 84% No (42) (38 N/A)	

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
			(1 not scored)	(1 not scored)	(2 not scored)	
130b. Person earns at least ½ of minimum wage?	36% Yes (18) 64% No (32) (59 N/A)	31% Yes (20) 69% No (44) (38 N/A)	24% Yes (15) 75% No (48) (32 N/A) (2 not scored)	26% Yes (15) 74% No (42) (38 N/A) (1 not scored)	26% Yes (13) 74% No (37) (38 N/A) (2 not scored)	
130c. Work setting is at least 50% non-handicapped co-workers?	36% Yes (18) 64% No (32) (59 N/A)	31% Yes (20) 69% No (44) (38 N/A)	28% Yes (18) 72% No (46) (32 N/A) (1 not scored)	27% Yes (15) 73% No (41) (39 N/A) (1 not scored)	24% Yes (12) 76% No (38) (38 N/A) (2 not scored)	
130d. There is a reasonable expectation that the job will continue?	34% Yes (17) 66% No (33) (59 N/A)	33% Yes (21) 67% No (43) (38 N/A)	28% Yes (18) 72% No (46) (32 N/A) (1 not scored)	30% Yes (17) 70% No (40) (38 N/A) (1 not scored)	26% Yes (13) 74% No (37) (38 N/A) (2 not scored)	
Behavior						
131. Is the person considered by the IDT to need behavior services now?	68% Yes (72) 32% No (34) (3 N/A)	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)	17IQR#5d 55% Yes (34) 45% No (28)
132. In the opinion of the reviewer, does the person need behavior services?	65% Yes (69) 35% No (37) (3 N/A)	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)	17IQR#11e 58% Yes (36) 42% No (26)
133. Have adequate behavioral assessments been completed?	80% Yes (59) 16% Partial (12) 4% No (3) (35 N/A)	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)	17IQR#7n 3% Yes (2) 34% Many (21) 58% Need Imp (36) 5% No (3)
134. Does the person have behavior support plans developed out of the behavior assessments that meet the person's needs?	89% Yes (64) 8% Partial (6) 3% No (2) (37 N/A)	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)	17IQR#5g 76% Yes (26) 12% Many (4) 9% Need Imp (3) 3% No (1) (28 N/A)

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
135. Have the staff been trained on the behavior support plan?	92% Yes (66) 7% Partial (5) 1% No (1) (37 N/A)	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)	17IQR#10d 73% Yes (24) 18% Many (6) 6% Need Imp (2) 3% No (1) (29 N/A)
136. Does the person receive behavioral services consistent with his/her needs?	77% Yes (57) 19% Partial (14) 4% No (3) (35 N/A)	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)	17IQR#5i 53% Yes (20) 29% Many (11) 13% Need Imp (5) 5% No (2) (24 N/A)
137. Are behavior support services integrated into the ISP?	68% Yes (49) 28% Partial (20) 4% No (3) (37 N/A)	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)	17IQR#11d 48% Yes (16) 9% Many (3) 39% Need Imp (13) 3% No (1) (29 N/A)
Adaptive Equipment/Augmentative Communication						
138. Has the person received all adaptive equipment needed?	81% Yes (81) 19% Partial (19) (9 N/A)	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)	17IQR#25b 57% Yes (33) 22% Many (13) 21% Need Imp (12) (3 N/A, 1 CND)
139. Has the person received all assistive technology needed?	70% Yes (59) 29% Partial (24) 1% No (1) (25 N/A)	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)	17IQR#25c 56% Yes (24) 19% Many (8) 21% Need Imp (9) 5% No (2) (18 N/A, 1 CND)
140. Has the person received all communication assessments and services?	68% Yes (65) 32% Partial (31) (13 N/A)	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)	17IQR#10b 77% Yes (44) 7% Many (4) 16% Need Imp (9) (5 N/A)

Question	2011 (sample=109)	2013 (sample=102)	2014 (sample=97)	2015 (sample=96)	2016 (sample=90)	2017 (sample=62)
Individual Service Planning						
141. Does the person have an ISP that addresses living, learning/working and social/leisure that correlates with the person's desire and capabilities, in accordance with DOH regulations?	85% Yes (93) 15% Partial (16)	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)	17IQR#7o 82% Yes (51) 8% Many (5) 8% Need Imp (5) 2% No (1)
142*. Does the person have an ISP that contains a Vision section that is based on a long-term view?	63% Yes (69) 32% Partial (35) 5% No (5)	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)	17IQR#7a 53% Yes (33) 21% Many (13) 23% Need Imp (14) 3% No (2)
143. Does the person receive services and supports recommended in the ISP?	83% Yes (90) 17% Partial (19)	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)	17IQR#11a 47% Yes (29) 27% Many (17) 26% Need Imp (16)
144. Does the person have adequate access to and use of generic services and natural supports?	79% Yes (86) 21% Partial (23)	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)	17IQR#33f 76% Yes (47) 15% Many (9) 10% Need Imp (6)
145. Is the person adequately integrated into the community?	69% Yes (75) 29% Partial (32) 2% No (2)	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)	17IQR#29g 25% Yes (15) 21% Many (13) 43% Need Imp (26) 11% No (7) (1 N/A)
Summary						
146. Overall, is the ISP adequate to meet the person's needs?	28% Yes (30) 72% Partial (79)	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)	17IQR#7 0% Yes 27% Many (17) 73% Need Imp (45)
147. Is the program of the level of intensity adequate to meet this person's needs?	28% Yes (30) 72% Partial (79)	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)	17IQR#36 0% Yes 44% Many (27) 56% Need Imp (35)