IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lillian Minor, *et al*.,

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

Case No. SA-5:10-CV-1025-OG

PLAINTIFFS' OPPOSED MOTION AND MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

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I. INTRODUCTION

Plaintiffs,[1] by and through their counsel of record, respectfully move this Court for a preliminary injunction to prevent ongoing and irreparable harm resulting from Defendants' failure to provide them with a comprehensive assessment of their habilitative needs and the specialized services necessary to constitute a program of active treatment, as required by the Nursing Home Reform Amendments to the Medicaid Act ("NHRA"), 42 U.S.C. § 1396r(e) and their implementing regulations, 42 C.F.R. § 483.100, *et seq*. (the Pre-Admission Screening and Resident Review (PASRR) regulations).

The NHRA is part of a comprehensive remedial statute designed to address the widespread problem of warehousing people with IDD in the nation's nursing facilities and not providing needed treatment. Yet, the discovery to date belatedly produced by Defendants, Defendants' own internal review, and Plaintiffs' experts' evaluations, based in part on that discovery, have revealed that Texas is doing just that – warehousing people with IDD and not providing them with mandated specialized services. The significant, ongoing deficiencies in Defendants' PASRR program have caused Class Members to lose skills and to physically and mentally deteriorate. In some cases, this deterioration has become permanent and life-threatening.

[1] On May 20, 2016, the Court certified a class in this case defined as "[a]ll Medicaid-eligible persons over twenty-one years of age with intellectual or developmental disabilities or a related condition in Texas who currently or will in the future reside in nursing facilities, or who are being, will be, or should be screened for admission to nursing facilities pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.112, *et seq*." Order Granting Plaintiffs' Motion for Class Certification, May 20, 2016, ECF No. 287. There are at least 3,400 Class Members currently residing in nursing facilities throughout Texas. *See* Plaintiffs' Supplemental Memorandum of Fact and Law in Support of Second Amended Motion for Class Certification, ECF No. 249, at 6, n. 5.

As more fully described in the findings of Kathryn Dupree, the parties' former, jointly-selected Expert Reviewer and now the State's consultant ("Ms. Dupree"),[2] as well as in the Declarations and attached Reports of Plaintiffs' experts,[3] (altogether "expert reports"), Class Members have suffered, and continue to suffer, physical and psychological injury and loss of basic life skills, as a result of Defendants' failure to provide them with essential services required by federal law. Some have lost the ability to use their arms, legs, feet, and hands. Others have lost their ability to speak, walk, and eat, among other functional skills. Some have developed serious medical conditions, such as contractures, excessive weight loss, and chronic skin infections that, without specialized services, may become irreversible. And some are at risk of dying due to an increased risk of aspiration, choking, and pneumonia, among other life-threatening medical conditions.

After delaying discovery for months, thus forcing a motion to compel, in September of 2016, Defendants finally produced two of Ms. Dupree's Quality Service Review (QSR) reports — one from June of 2016 that covered all of 2015 and the other from July of 2016 that covered the first quarter of 2016. Among her findings, Ms. Dupree concluded that Defendants continued to fail to adequately assess Class Members' habilitative and other treatment needs and provide them

[2] Pursuant to the terms of the defunct Interim Agreement ("IA"), ECF No. 180, entered into by the parties but from which Texas has since withdrawn, the parties jointly selected Ms. Dupree to develop measures and protocols for assessing Defendants' compliance with the proposed Comprehensive Settlement Agreement that would replace the IA, as well as certain requirements of federal law. Ms. Dupree created a detailed process for implementing these compliance standards, including a sampling methodology, a protocol questionnaire, a scoring system, and a reporting format. After the IA was terminated on October 1, 2015, Ms. Dupree was employed by the Department of Aging and Disability Services (DADS) as the PASRR Quality Service Review Lead Reviewer. Plaintiffs reserve their right to object to Defendants' retention of Ms. Dupree.

[3] Barbara Pilarcik, R.N., Vickey Coleman, Ph.D., Randall Webster, Nancy Weston, and E. Sally Rogers, Ph.D.

with specialized services to meet these needs. In some cases, Defendants' compliance had *declined* over the past year.[4]

After learning of these recent QSR findings, Plaintiffs became concerned for the health and safety of the Class Members and moved promptly to analyze the current state of compliance. In October, they began to assemble a team of experts to assess the State's PASRR system and visit Local Intellectual and Developmental Disability Authorities (LIDDAs) and individuals with IDD in nursing facilities.

Plaintiffs' also began the process of obtaining the requisite authorization from Class Members and their legally authorized representatives (LARs) to obtain their nursing facility and LIDDA records. After obtaining all needed authorizations by late December, Plaintiffs promptly requested the nursing facility and LIDDA records. Additionally, Plaintiffs deposed five of the Texas' Health and Human Services Commission's (HHSC) employees responsible for the implementation of Texas' PASRR program, to enable Plaintiffs' experts to better understand Texas' PASRR system.

Because of the delays in obtaining the necessary responsive documents and data,[5] and in obtaining medical records from nursing facilities and LIDDAs, the expert reviews were not conducted until late January and February 2017.[6]

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[4] *See* PASRR QSR 2015 ANNUAL REPORT of COMPLIANCE (the "2015 PASRR Annual Report") and 2016 Quarter 1 PASRR QSR Compliance Status Report (the"Q1 2016 Report"), attached as Exs. A & B to the Declaration of Garth Corbett Regarding Exhibits in Support of Plaintiffs' Motion for Preliminary Injunction ("4th Corbett Decl."); *see also* Sec. II.B, *infra*.

[5] Plaintiffs also made numerous requests for information for data from the Texas Medicaid & Healthcare Partnership (TMHP) database, which contains Class Member PASRR evaluations and specialized services utilization data, among other things. On March 24, 2017, Defendants informed Plaintiffs they were finally sending the TMHP data.

[6] Since it was unclear when the expert reviews would be completed, and what they would find, Plaintiffs did not alter their proposed pre-trial schedule, submitted to Defendants in November,

Plaintiffs' experts have recently completed their reviews. These reviews have not only confirmed the QSR findings, but also find that Defendants' compliance with these requirements has further declined. *See* Sec. II.C, *infra.* As Plaintiffs' experts have concluded, Class Members are losing skills and physically and psychologically deteriorating. Texas' ongoing, and increasing, systemic failure to ensure that Class Members are adequately assessed and provided with the specialized services and active treatment that they need to prevent or decelerate regression violates the NHRA. In light of these very recent expert findings, Plaintiffs determined that this Motion for preliminary injunctive relief on these narrow issues is urgently needed.[7]

Accordingly, pursuant to Rule 65(a) of the Federal Rules of Civil Procedure, Plaintiffs bring this Motion to enjoin Defendants from continuing to fail to fulfill their obligations under the NHRA and other relevant provisions of the Medicaid Act, to provide Class Members with comprehensive assessments of their habilitative needs, all of the specialized services required to meet such needs, and a program of active treatment.

Under applicable law: (a) there is a likelihood that the Plaintiff Class will prevail on the merits; (b) the Plaintiff Class will suffer immediate irreparable injury if the injunction is not granted; (c) the threatened harm to the Plaintiff Class outweighs the threatened harm the injunction may cause Defendants; and (d) granting the preliminary injunction will not disserve the public interest.

2016. To do so at that time – or at any time before this month when the experts' findings were presented – would have been speculative and premature.

[7] Plaintiffs' Motion for Preliminary Injunction is narrowly tailored to seek immediate preliminary injunctive relief with respect to the provision of assessments, specialized services, and active treatment, as required by the NHRA, 42 U.S.C. § 1396r(e) and 42 C.F.R. § 483.100, *et seq*.. It does not address Plaintiffs' claims brought under Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131, *et seq*. or Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 and their implementing regulations.

This Motion is supported by the Memorandum of Law, *infra*, the Declarations of Plaintiffs' five experts and their attached expert reports; the Declaration of Garth Corbett Regarding Supplemental Exhibits in Support of Plaintiffs' Second Amended Motion for Class Certification ("3rd Corbett Decl."), Exs. A, B, & C, ECF No. 249-3; and the 4th Corbett Decl., and the exhibits attached thereto. Plaintiffs are not able to post bond or other security interest because their only income is public assistance.

II. STATEMENT OF FACTS

A. *Overview*

Defendants continue to operate, administer, and fund a deficient PASRR system that fails to comply with federal requirements for assessing and providing the approximately 3,400 Class Members residing in nursing facilities with all needed specialized services and active treatment. The State recently (and largely unsuccessfully) attempted to remedy deficiencies in this system with its redesign of its PASRR process.[8]

In May 2013 and June 2014, Defendants launched Phases I and II of their PASRR redesign. 3rd Corbett Decl., Ex. D ("Texas' PASRR Overview for Nursing Facilities"). This redesign, among other things, included an amendment to the State's contract with the LIDDAs, requiring them to assume all responsibilities for performing the Level II PASRR evaluations that are supposed to identify Class Members' habilitative needs in 15 discrete areas, as required by federal law, and to provide and/or arrange for the provision of certain specialized services, including

[8] This redesign was seemingly an effort to address federal law violations found by the Office of the Inspector General of the Department of Health and Human Services in the screening, assessment, and specialized services components of Texas' PASRR program for individuals with IDD, as well as the violations of the NHRA described in the Second Amended Complaint. ECF No. 173. *See* Docket No. 97-3 (Rep. of the Off. of Inspector Gen., Preadmission Screening and Resident Review for Younger Nursing Facility Residents with Mental Retardation, OEI-07-05-00230 (Jan. 2007)).

service coordination and alternate placement, employment assistance, supported employment, day habilitation, independent living skills (ILS), and behavioral support. *See* Attachment G to the 2016-17 LIDDA Contract, attached as Ex. C to 4th Corbett Decl. It also charged the LIDDAs with the responsibility to monitor the provision of all specialized services to Class Members in nursing facilities. *See id.* Additionally, in 2012, Texas amended its State Medicaid Plan to provide some additional specialized services to nursing facility residents with IDD, including ongoing physical therapy, speech therapy, occupational therapy, customized wheelchairs, and durable medical equipment. *See* 40 Tex. Admin. Code §§ 17.102(41)(A); 19.2701; State Plan Amendment, attached as Ex. D to 4th Corbett Decl.

Although this redesign improved the State's Level I screening and related policies and practices, the State has made virtually no progress with respect to ensuring that Class Members receive timely and professionally-adequate comprehensive assessments of their habilitative and nursing needs, as well as the provision of all needed specialized services and a program of active treatment. As discussed in detail below in Secs. II.B & C, Ms. Dupree has repeatedly found, and Plaintiffs' experts have confirmed, that the vast majority of Class Members do not receive comprehensive functional assessments of their habilitative needs or the specialized services to meet those needs. *See* Secs. II.B & C, *infra*. Defendants' systemic deficiencies have caused Class Members residing in nursing facilities to suffer deterioration and regression that in some cases has or could become irreversible and life-threatening.[9]

[9] Defendants may have planned additional reforms, but these reforms have not been implemented and will not suffice to correct Defendants' failures and the systemic deficiencies in Texas' PASRR program. Defendants have proposed a method for automating individualized specialized services requests from nursing facilities to DADS for approval. To date, that system still is not operational. *See* relevant excerpts of Texas HHSS Consolidated Budget Request, 2018-2019 Biennium, attached as Ex. E to 4th Corbett Decl.

B. *Findings of the Independent Expert Reviewer*

Ms. Dupree has consistently found that Defendants systemically fail to provide Class Members with adequate and appropriate assessments and specialized services that the individual needs.[10] *See* the "May 2015 Report" and The STATUS REPORT on IMPLEMENTATION of the QSR PASRR REVIEW PROCESS – September 25, 2015 ("September 2015 QSR Report"), 3rd Corbett Decl., Exs. B & C, ECF No. 249-3; 2015 PASRR Annual Report; and the Q1 2016 Report.[11]

The results of the 2015 PASRR Annual Report for the Outcomes and OMs relating to PASRR assessments and the provision of specialized services were remarkably similar to the initial May and September 2015 QSR Reports.[12] In the annual report, Ms. Dupree concluded that

[10] The IA directed the parties to negotiate a Comprehensive Settlement Agreement, including the development of Outcomes and Outcome Measures (OMs) to assess compliance with the provisions of the new Agreement. The measures developed to evaluate the Target Population of individuals in nursing facilities (Outcome 2), only focused on whether certain specialized services were *offered*, and not whether services were planned, delivered, monitored, and modified in a manner that met the federal standard for active treatment, as required by 42 CFR §§ 483.120(b) or 440(a)-(f). As a result, the QSR does not assess compliance with the NHRA's active treatment requirements.

Since Defendants subsequently repudiated the Comprehensive Settlement Agreement, Plaintiffs are not bound by their concessions in compromise with respect to the standards to measure Defendants compliance under the Agreement. Therefore, this Motion, and Plaintiffs' experts' reports, focus on whether Texas' PASRR program complies with the more rigorous federal requirements for active treatment, as mandated and interpreted by the federal Centers for Medicare and Medicaid Services (CMS).

[11] The Q1 2016 Annual Report is the most current QSR Report that Defendants produced in discovery. Defendants have a duty to promptly supplement their discovery responses with updated information. As of this date, Defendants have not produced any additional reports, suggesting either that the creation of the QSRs have stopped or that Defendants are delinquent in producing them.

[12] The earlier QSR 2015 reports found that only **15%** of Class Members received an appropriate Level II evaluation that assesses whether they can live in the community and identifies the specialized services that they need. *See* 2015 PASRR Level II Review (finding that Defendants do not timely and adequately identify individuals with IDD, which results in Defendants' failure to identify significant numbers of individuals with IDD). In September 2015, the QSR concluded that only **15%** of Class Members received all of specialized services identified in his/her individual

"neither N[ursing] F[acilitie]s, nor community S[ervice] P[lanning]T[eam]s complete the full range of the assessments that an individual needs including functional, independent living skill development, clinical, and employment related assessments," even though such assessments "are fundamental to planning services and developing measurable goals and objectives as part of an individual's service plan." 2015 PASRR Annual Report at 6. The 2015 Annual QSR Report concluded that only **35%** of Class Members residing in nursing facilities received specialized services with the frequency, intensity, and duration necessary to meet their appropriately identified needs, consistent with informed choice. *Id*. at 9. Ms. Dupree noted that there was "[c]onfusion as to the differences in rehabilitative versus habilitative services including when to stop billing Medicare and start requesting specialized services…NF staff consistently reported they do not know how to have … [specialized services] authorized." *Id*. at 6.

The Q1 2016 Report found that the State was again significantly deficient with respect to its overall compliance with PASRR assessment and specialized services requirements.[13] In these key areas, Ms. Dupree found that the State's compliance substantially *declined*. For example, the provision of PASRR Level II evaluations which identify all needed specialized services fell dramatically from **34%** in 2015 to **15%** in Q1 2016. *See* Q1 2016 Report, OM 3-3 at 29; *see also id*. at 11 (finding that in the first quarter of 2016, Defendants' performance declined with respect to whether "the PE recommends the [specialized services] needed and includes information about what the person needs to live in the community…The determination of [specialized services] needs

service plan. *See* September 2015 QSR Report at 11. Additionally, the QSR found that only **28%** of Class Members residing in nursing facilities had an ISP and a nursing facility plan of care that included all of the specialized services to meet their individual habilitative needs and that are delivered in in a consistent and coordinated manner. *See id*. at 12.

[13] For example, there was virtually no improvement in the State's overall compliance rate for Outcome 2. The State's overall compliance with this requirement was **35%** in the 2015 PASRR Annual Report and **36%** in the 2016 Q1 Report.

and community service needs are both only at 9% compared with 22% and 31% respectively in 2015…"). Ms. Dupree also concluded that assessments that are recommended during the PASRR process are "still not being completed." *Id*. at 9, OM 2-4 (completion of such assessments ranging between **6** and **33**%) and that "few, if any evaluators list all of S[pecialized] S[ervices] that the individual needs indicate should be assessed." *Id*. at 11.

Finally, and perhaps most importantly, the Q1 2016 Report found that the State's compliance with the requirement that Class Members receive all needed specialized services went from bad to worse. Specifically, Defendants' provision of all needed specialized services with the frequency, intensity, and duration identified in their ISPs declined from **19%** at the end of 2015 to a mere **11%** in the first Quarter of 2016. *See id*., OM 2-5, Q1 2016 Report at 27. Similarly, Defendants' compliance with the requirement that ISPs and nursing facility plans of care include the specialized services that the individual needs and measures whether these specialized services are provided dropped from **27 %** in 2015 to only **21%** in the first quarter of 2016. *Id*., OM 2-8 at 28.

These recent QSR findings conclusively demonstrate Defendants' ongoing systemic failure to comply with requirements of the NHRA and other provisions of the Medicaid Act with respect to identification of habilitative needs, professionally-adequate assessments of those needs, and the provision of all specialized services sufficient to meet those habilitative needs.

C. *Findings of Plaintiffs' Experts*

1. Harm to Class Members from Texas' Failure to Provide Specialized Services and Active Treatment.

Plaintiffs' experts concluded that Defendants' failure to ensure that Class Members are provided with all needed specialized services in an amount, duration and intensity sufficient to

constitute a program of active treatment has resulted in harm to the Class Members and further risk of future harm. This harm includes the acquisition or exacerbation of serious, and sometimes irreversible and life-threatening, medical conditions such as: dysphagia, aspiration, and choking; problems with swallowing and other oral motor issues; extreme weight loss; contractures; limited or loss of mobility; inability to communicate effectively; respiratory problems; and skin integrity issues. *See* Declaration & Disclosure of Barbara Pilarcik ("Pilarcik Report") at 9-53; Declaration & Disclosure of Vickey V. Coleman, Ph.D. ("Coleman Report") at 4-32.

For example, D.M., a 58-year old man, has not received the specialized services and active treatment that he urgently needs, including specialized speech therapy and drinking precautions, positioning, and prompts each time he swallows food to address his severe swallowing problems, which causes him to be at risk of choking and aspiration resulting from dysphagia. Coleman Report at 7-10. D.M. also needs, but is not receiving, specialized occupational therapy to address the contractures that he has developed in his upper extremities and behavioral supports. *Id*. at 8-10. If D.M. does not receive needed specialized services and active treatment, he will continue to be at serious risk of harm, including a "high risk of aspiration, choking and possibly death." *Id*. at 10.

Similarly, C.C., a 49-year-old woman, is not receiving any needed specialized services, such as speech therapy to address a history of choking, dysphagia and mild aspiration. Although C.C. has communication limitations, no one working with her at the nursing facility is trained in sign language or an appropriate method to communicate effectively with her. Consequently, C.C. experiences an ongoing risk of physical harm, particularly if an emergency situation arises. Because of the lack of continuous, appropriate speech services for mealtime oversight, she is at risk of aspiration or other swallowing problems given her inability to safely chew her food. *Id*. at 11-13.

Many other Class Members also have lost skills that they previously possessed, such as communication skills, eating, or walking. *Id*. at 15, 18, 20-21, 23, 25, 32; Pilarcik Report at 9, 10, 12, 15, 17-18, 23, 28, 31, 34, 36, 44. For example E.S., a 45-year-old woman has lost self-care skills, social interactions, muscle strength and balance since her admission to the nursing facility. *Id*. at 13-15. She has not received any of the specialized services recommended in her 2016 PASRR evaluation. Even mandated service coordination has been lacking, and E.S.'s guardian has not heard from the service coordinator in over six months. *Id*. at 14.

B.C., a 73 year-old woman, also is not receiving any specialized services, in spite of a 2016 PASRR evaluation that recommended several therapies, and in spite of a documented increase in painful contractures. She requires total assistance from nursing facility staff. Due to the lack of needed specialized services, B.C. has deteriorated such that she is now greatly limited in her ability to leave the nursing facility and rarely leaves her bed. Coleman Report at 14-15.

Continuous active treatment also requires social integration. *Id*. at 5; Pilarcik Report at 9. Most of the Class Members reviewed by the experts have limited, if any, opportunities for community activities and integration. *Id*. at 11, 14-15, 17-18, 19-20, 22, 25, 27, 33, 46, 52; Coleman Report at 5-6, 7. N.T. is a 30-year old woman who, because the nursing facility failed to properly assess her needs and incorrectly believed she lacked any cognitive abilities or communication skills, had a single longstanding "goal" to listen to music in the dining room three times a week. Almost two years later, when professional staff finally recognized that NT could understand information, make decisions, and communicate, she started receiving some long overdue specialized services, but she still has not been provided an augmentative communication device. Pilarcik Report at 10-11. Because N.T. was not provided with all needed specialized services or active treatment, she has suffered significant harm, including the loss of her ability to maneuver her wheelchair, to eat some limited foods since she now

must be fed entirely through an NG tube, opportunities for self-determination, and to participate in community activities. *Id.* at 11-12.

This nursing facility is also "home" to several other young women and men with IDD who receive no specialized services, other than service coordination. Ms. Pilarcik observed that they were isolated in the facility and lacked specialized services and active treatment, including opportunities to receive community-based habilitative opportunities. *Id.* at 12. This situation is not unusual in Texas as the experts observed a pattern of other Class Members in nursing facilities suffering similar harm as a result of the lack of active treatment. *See id.* at 8-9, 12, 15, 18, 19, 23, 25, 28, 36, 52 (finding that about 60% of Class Members reviewed have rarely left the facility grounds and 65% would benefit from, but are not receiving, ILS; *see also* Coleman Report at 5-6 (finding that of the 10 Class Members reviewed, 7 (70%) had not left the nursing facility in many years, and none enjoyed community outings, although at least 6 had documentation in their records that they would benefit from day habilitation and/or ILS Training.).

2. Overview of Plaintiffs' Expert Reviews

Plaintiffs' experts conducted three types or levels of evaluations: (1) an overview of the statewide PASRR program, its redesign, and its compliance with federal and state PASRR requirements (the "System Review"); (2) an evaluation of the implementation of the PASRR program at the local level by the LIDDAs (the "Program Review"); and (3) an assessment of the impact of the PASRR program on individuals with IDD in nursing facilities (the "Client Review"). A social science research expert was retained to help design the Client Review.

a. *Client Review*

The Client Review was conducted by two well-qualified experts in the field of intellectual and developmental disabilities, Barbara Pilarcik, R.N., and Vickey Coleman, Ph.D. *See* Pilarcik

Report at 1-2 & App. 1; Coleman Report at 1-2 & App. 1. These experts reviewed a random sample of the individuals who were included in the 2015 Annual and the 2016 Quarterly QSR process. The procedures and methodology for drawing the sample of Class Members for the Client Review was designed and selected by E. Sally Rogers, Ph.D., a recognized social science research expert. *See* Declaration & Disclosure of E. Sally Rogers, Ph.D., and attached Sampling Report. That methodology was consistent with professionally-accepted practices in the field of social science research. *See id*. at 3-5. The Client Review sample was sufficient to allow the findings of the Client Review to be generalized to all individuals in the QSR sample, and to a lesser extent, to all individuals with IDD in nursing facilities. *See id*. at 4.

The Client Review experts assessed the impact of Texas' PASRR program on 27 randomly selected Class Members.[14] During February 2017, the experts visited each Class Member in his/her nursing facility; met with their family members, nursing facility professional and direct care staff, and LIDDA service coordinators; and reviewed two years of medical records from the nursing facility and LIDDA and other information. Pilarcik Report at 3 & App. 2; Coleman Report at 2-3 & App. 2.

b. *Program Review*

The Program Review was conducted by two IDD systems experts, Randall Webster and Nancy Weston, both of whom possess extensive experience in administering a statewide PASRR and IDD system. Both Mr. Webster and Ms. Weston are well-qualified to assess the service capacity of the LIDDAs they reviewed. Declaration and Disclosure of Randall Webster ("Webster Report"), Att. A; Declaration and Disclosure of Nancy Weston ("Weston Report"), Att. A. The Program Review considered the delivery of PASRR screening, evaluation, and specialized services provided by the LIDDAs, pursuant to their contracts with DADS and now HHSC. The purpose of

[14]Ms. Pilarcik reviewed 17 of the 27 Class Members and Dr. Coleman reviewed 10.

the Program Review was to assess the LIDDAs' capacity to implement the PASRR program and to provide and monitor the provision of specialized services, consistent with both federal and state requirements.

In conducting their Program Review, Mr. Webster and Ms. Weston reviewed numerous PASRR related regulations, rules, policies, procedures, manuals, data, compliance reports, and other relevant information. During January 2017, these two experts conducted onsite meetings with administrators and staff from 13 of the 39 LIDDAs.[15] Webster Report at 2-3; Weston Report at 3-4.

c. *Texas Data and Policies-System Review*

Ms. Weston also conducted a high-level System Review of Texas' policies, data, regulations, and PASRR system infrastructure. Ms. Weston reviewed Texas' PASRR rules, policies, procedures, manuals, and data; the depositions of four of DADS/HHSC staff responsible for the implementation of Texas' PASRR program; and federal PASRR regulations, policies, manuals, directives, and guidance concerning specialized services and active treatment for people with IDD in nursing facilities. *Id*. at 2-3 & Att. B.

3. Findings and Conclusions of Plaintiffs' Experts

a. *Failure to Provide Adequate PASSR Level II Evaluations and Comprehensive Functional Assessments to Identify Class Members' Habilitative Needs.*

Consistent with the 2015 and 2016 QSR findings, Plaintiffs' experts found that Defendants fail to ensure that Class Members receive adequate PASRR Level II (also known as "PE")

[15] The LIDDAs reviewed were those that served the Class Members in the Client Review. Ms. Weston met with administrators and staff from eight LIDDAs and Mr. Webster met with administrators and staff from seven LIDDAs.

evaluations and comprehensive functional assessments ("CFAs") of the their habilitative needs as required by the NHRA. CFAs are essential for treatment planning to identify each of the habilitative areas in which the individual needs specialized services. *See e.g*, Pilarcik Report at 4; Webster Report at 4, 7-8; Weston Report at 5, 16.[16]

1) Systemic Review Findings

Ms. Weston found systemic barriers to Texas' assessment process. For example, she determined that, contrary to federal requirements, Texas does not require that PASRR reviewers identify Class Members' needs in the 15 areas listed in the federal PASRR regulations, 42 C.F.R. § 483.136. Weston Report at 8.[17] Ms. Weston also concluded, as a result of reviewing Defendants' rules, policies, procedures, and deposition testimony from State employees responsible for implementing Texas' PASRR system, that Texas has failed to develop any policies, procedures, or rules requiring that a CFA to be conducted at any stage of the PASRR or treatment planning process, and that DADS has not developed or provided any CFA instrument for the LIDDAs to use to conduct a comprehensive assessment of all habilitative needs. *Id*.

2) Program Review Findings

Plaintiffs' Program Review experts also found deficiencies with respect to the Level II PASRR/PE evaluations. Both experts concluded that identification of Class Members'

[16] CFAs include an evaluation of an individual's "physical development and health, nutritional status, sensorimotor development, affective development, speech and language development, auditory functioning, cognitive development, social development, adaptive behaviors or ILS necessary for the individual to function in the community and as applicable, vocational skills. Furthermore, the comprehensive functional assessment needs to be conducted by an interdisciplinary team of professionals." Pilarcik Report at 4.

[17] Ms. Weston found that the only identification of needs completed on a consistent basis were those that involved certain nursing facility services like physical, occupational and speech therapies. Weston Report at 8-9. There were few, if any, other habilitative needs identified by PASRR reviewers that are met by specialized services provided by LIDAAs, like habilitation and vocational training, ILS, behavior supports, community integration, and transition assistance.

habilitative needs, when it occurs, is not based upon appropriate professional assessments or judgments that could serve as the basis of planning for, or delivering of, a needed service. Webster Report at 5-6; Weston Report at 15. The Program Review experts determined that because the Defendants have not developed or provided LIDDAs with a CFA instrument, LIDDAs were unable to conduct CFAs, and, therefore, lacked the foundation for service planning and delivery. Both experts concluded that unless LIDDAs performed CFAs, it was "very difficult, if not impossible" to determine what specialized services each Class Member needs, and in turn, to provide the services to them in the amount, frequency and duration that they require. Webster Report at 7-8; *see also* Weston Report at 10, 16.[18]

3) Client Review Findings

The Client Review experts determined that Class Members do not receive adequate Level II evaluations. For example, Dr. Coleman found that 60% of the Class Members she reviewed had no recommendations for specialized services other than service coordination,[19] and that none had any recommendations for specialized services provided by the LIDDAs, except for service coordination. Coleman Report at 5. Likewise, Ms. Pilarcik found that service coordination was the only specialized service that more than 60% of the Class Members she reviewed were receiving, and that service coordination was at best, intermittent, for two of them (AC, ES). Pilarcik Report at 8, 14-15, 16, 22, 24, 26-27, 30, 36, 40, 43, 45-46, 52.

[18] Mr. Webster noted that the failure to ensure that PE and CFAs are performed is "extremely problematic and inconsistent with professional standards because the relevant service planning hinges on a comprehensive assessment of all need areas to ensure that a service plan is developed which identifies all needed interventions and services in sufficient number and frequency and across all settings to meet the habilitative needs that are identified." Webster Report at 7; *see also* Weston Report at 16.

[19] Pursuant to new State policies, all individuals with IDD in nursing facilities are automatically assigned a service coordinator from the LIDDA.

The experts also found that Class Members do not receive CFAs to identify their habilitative needs. Remarkably, *none* of the Class Members reviewed by the experts received a CFA. *Id*. at 7-8; Coleman Report at 4. Absent these crucial assessments to identify habilitative needs, there is no way to determine the full range of specialized services that Class Members need. *Id*. at 4; Pilarcik Report at 4-5, 8.

b. *Failure to Provide All Necessary Specialized Services to Meet the Class Members' Habilitative Needs.*

Like Ms. Dupree, Plaintiffs' experts uniformly found that Texas fails to ensure that Class Members receive all needed specialized services. Habilitative specialized services are essential to help people with IDD in nursing facilities attain, maintain or improve their functioning and skills. *See e.g., id*. at 4-5.

1) System Review Findings

Ms. Weston concluded that the Texas lacks a sufficient infrastructure to ensure adequate planning, provision, and monitoring of specialized services. Weston Report at 9-10. Her conclusion is based on numerous deficiencies in Texas' PASRR system including: 1) the lack of a single, integrated service planning process for LIDDAs and nursing facilities, which results in the absence of coordination in service planning and delivery, as well as inconsistencies in service recommendations between nursing facilities and the LIDDAs; 2) Texas' policy of not seeking Medicaid funding for specialized services provided by the LIDDAs, except for possibly service coordination, which creates a disincentive for the State and its LIDDAs to utilize state only funded specialized services; 3) the lack of sufficient funding to ensure that adequate specialized services and active treatment are provided to Class Members to meet their habilitative needs; 4) an inadequate array of specialized services sufficient to meet the 15 habilitative domains required by

the NHRA's regulations; and 5) deficiencies in the delivery of specialized services which are not provided with sufficient duration, frequency, and intensity. *Id*.

2) Program Review Findings

The experts found that an extremely low number of Class Members received LIDDA-provided specialized services, except for service coordination. Mr. Webster and Ms. Weston determined that almost no Class Member received behavioral supports. Weston Report at 17-18; Webster Report at 9. And for those limited instances where behavioral support services were provided, they were not part of a structured behavior plan. *Id*. Similarly, they found that less than 10% of individuals with IDD in nursing facilities receive supported employment or day habilitation services. *Id*.; Weston Report at 17-18. Very few Class Members in nursing facilities receive ILS Training, which are specialized services to assist people with IDD to live as independently as possible. *Id*. at 18; Webster Report at 10. When Class Members received these services, they were not provided based upon a CFA or as part of service plan with treatment goals, but rather as informal method of socialization. Weston Report at 18.

The experts also found numerous programmatic deficiencies that contributed to the lack of specialized services. For example, they found that nursing facilities often resisted or simply failed to provide needed specialized services. *Id*. at 17; Webster Report at 8. This was due, in part, to the state-mandated individualized authorization process which requires professionals at every nursing facility to request approval from DADS to provide nursing facility specialized services, and which then expects nursing facilities to pay for the services upfront. *Id.* This process improperly removes treatment decisions concerning specialized service from professionals on service planning teams, and causes delays and rejections of services requests. Weston Report at 10, 13. They also learned that this authorization (and then re-authorization) process often has a

negative impact on decisions about whether a Class Member needs specialized services. *Id*.; Webster Report at 8. And recent policy changes now prohibit LIDDA service coordinators from tracking or following up on specialized services requests, thereby exacerbating the lack of coordination between nursing facilities and LIDDAs, and further delaying the provision of needed specialized services.[20] Weston Report at 17.

3) Client Review Findings

Like the QSR, and Plaintiffs' other experts, Dr. Coleman and Ms. Pilarcik concluded that Defendants consistently fail to ensure that Class Members receive the specialized services that they need to avoid, or decelerate, physical and psychological deterioration. Despite their urgent need for specialized services, Class Members rarely receive LIDDA specialized services, except for service coordination.

For example, M.M., a 74-year old man, is not receiving any specialized services except for service coordination. Pilarcik Report at 16-18. Since his admission in February 2012, M.M. has lost the ability to walk, is increasingly dependent on a wheelchair and isolated from his best friend and former roommate. Among other things M.M. needs specialized physical therapy to regain his ability to walk, and urgently needs specialized speech therapy to prevent aspiration or pneumonia—both of which are life-threatening. *Id*. Similarly, R.B., a 56-year old man, has not received needed specialized services, and is at serious risk of harm because staff are not consistently implementing his aspiration protocol. R.B. also is at risk of losing his ability to perform other activities, and needs behavioral supports and ILS to prevent further deterioration. *Id*. at 19-20.

[20] Although LIDDA service coordinators are responsible for monitoring the delivery of all services to Class Members, they have no access to the information about whether Class Members have received the necessary specialized services from their nursing facilities. Weston Report at 17.

The Client Review experts also found that nursing facility staff had little or no training on how to support individuals with IDD. Coleman Report at 9, 13, 17, 20, 25, 26, 28, 32; Pilarcik Report at 9. Additionally, they found that the LIDDA staff responsible for providing service coordination and other specialized services lacked a detailed understanding and training on what types of specialized services were available or how to ensure that such services could be consistently delivered throughout the day and across all settings. *Id.* at 8-9.

c. *Failure to Provide Continuous Active Treatment*

Plaintiffs' Experts all concluded that Defendants do not provide Class Members with a continuous and consistent program of active treatment, as defined by CMS.

1) System Review Findings

Based on her review of the deposition testimony and the State's own regulations and policies, Ms. Weston concluded that Texas' PASRR system is not designed and implemented in a manner that ensures that Class Members receive specialized services in the amount, duration, and frequency to constitute active treatment. Weston Report at 12-15. Specifically, Ms. Weston determined that Texas does not create an expectation that LIDDAs or nursing facilities provide Class Members with active treatment, as evidenced by the fact that there are no regulations, policies or any training materials that even mention the term "active treatment." *Id*. at 13.[21] Ms. Weston also learned that the administrators and staff directly responsible for the implementation of the PASRR system and the oversight of the provision of specialized services have no understanding of the concept of "active treatment." *Id*. at 12.

[21] The only mention of active treatment in any of the State's documents was in a legislative appropriate request submitted in 2015. *Id*.

Ms. Weston also concluded that Defendants have not created an infrastructure that ensures Class Members receive the assessments and specialized services that constitute a program of active treatment. *Id*. at 13. Ms. Weston found that there are no policies that ensure that Class Members' active treatment needs are assessed, planned, coordinated or provided by LIDDAs or nursing facilities. *Id*. Moreover, there are no requirements that nursing facility and LIDDA staff are trained on the requirements of active treatment. *Id*. Finally, Ms. Weston found that Texas has no structure in place to monitor and oversee its PASRR system in a manner that ensures that Class Members receive specialized services and active treatment. *Id*. at 14.

2) Program Review Findings

The Program Reviewers also concluded that Defendants do not provide Class Members with active treatment. Among other things, the experts found: (1) Defendants fail to ensure that LIDDA and nursing facility staff are aware of the PASRR active treatment requirement; and (2) that the LIDDAs do not monitor the provision of active treatment. *Id*. at 19; Webster Report at 10-12. The experts determined that although LIDDAs provide service coordination, it is not delivered as part of, and does not facilitate, the provision of active treatment. *Id*. at 10-11; Weston Report at 19-20.

3) Client Review Findings

Likewise, the Client Reviewers concluded that *none* of the individuals who need specialized services are receiving active treatment. As a result, almost all of these individuals, and by implication, almost all of the individuals in the QSR and all Class Members in nursing facilities, are suffering harm from "a total absence of active treatment." Coleman Report at 6; Pilarcik Report at 8-9.

D. *Texas' PASRR System Administrators Lack an Understanding of PASRR Specialized Services and Active Treatment Requirements, and Fail to Adequately Monitor and Take Corrective Actions to Ensure That Class Members Receive Assessments, Specialized Services, and Active Treatment to Meet Their Needs.*

State administrative staff responsible for implementing the PASRR system, including supervisory administrators of Texas' PASRR system and related IDD programs, revealed that they lack a consistent and comprehensive understanding of the PASRR system, specialized services, and active treatment. *See* Deposition of Stacey Lindsey ("Lindsey Dep."), 46:2-14, 47:4-16, attached as Ex. F to 4th Corbett Decl.(Manager of LPDS unit for the Local Authority section of HHSC's IDD services uncertain of the concept of "active treatment" and unaware of which specialized services are provided by nursing facilities and which are provided by LIDDAs); Deposition of Merinda Blevins ("Blevins Dep."), 46:9-20, attached as Ex. G to 4th Corbett Decl. (LPDS unit staff have heard the term "active treatment" but do not know what it means). State PASRR administrators are also unclear on the meaning of a "comprehensive functional assessment." Deposition of Geri Willems ("Willems Dep."), 97:19-20, attached as Ex. H to 4th Corbett Decl. ("Functional assessment. I am not sure what that's in relation to.").

The State's own PASRR administrators and staff testified that they are only familiar with a small part of the PASRR system and have little understanding of, or coordination with, most other components of the program. *See e.g.*, Willems Dep., 57:11-58:20 (PASRR unit manager unfamiliar with LIDDA training or utilization of specialized services, the Service Planning Team (SPT), or ISP); *see also* Deposition of Cathy Belliveau ("Belliveau Dep."), 22:7-19, 78:11-24, 126:18-21, 144:25-145:2 attached as Ex. I to 4th Corbett Decl. (PASRR Specialist collects data on IDT meetings but unaware of any collection of specialized services information; reviews request

and authorizations for specialized services but does not know of monitoring of delivery of specialized services or any barriers to active treatment; and unfamiliar with a SPT).

Some of Texas' PASRR administrators and staff are not even aware of the outcomes of the QSR, including the need for corrective actions in cases where the QSR reviews indicated noncompliance. For example, the LPDS unit manager who has responsibility for developing procedures, supports and training the 39 LIDDAs that are monitoring the provision of specialized services is generally unaware of the QSR findings that the Texas PASRR system fails to identify habilitative needs and provide specialized services to meet those needs for the large majority of people with IDD in nursing facilities and could not recall any action her unit took in response to Ms. Dupree's QSR findings. Lindsey Dep., 114:3-123:12; *see also* Blevins Dep., 126: 7-15, 18-24, 127:1-7 (testified that she does not know the purpose of the QSR and is uncertain whether she would want to know the results of the QSR).

Likewise, the manager of Texas' PASRR Unit within the HHSC is only minimally aware of the QSR data and findings. Willems Dep., 96:2-15 (PASRR Unit manager does not routinely review all quarterly and final PASRR QSR Compliance Reports); *see also* 60:11-25 (PASRR Unit manager unaware whether Texas collects data concerning the provision of specialized services or active treatment). Similarly, the PASRR program specialist responsible for quality monitoring and training is unfamiliar with the QSR Q1 2016 Report**.** Belliveau Dep., 138:12-14.

Finally, State administrators who develop budgets and request funding for the PASRR program have consistently and erroneously projected the cost of specialized services and other elements of the PASRR redesigned program. For example, Defendants have stated that they expect to spend several million dollars to provide specialized services in the next several years. But these funds have been woefully insufficient to date, as documented in the expert reports, and

appear to be insufficient to meet the future needs of the Class Members. *See* "Report on Cost of PASRR February 2017," attached as Ex. J to 4th Corbett Decl.; *see also* Weston Report at 10.

III. THE STANDARD FOR GRANTING A PRELIMINARY INJUNCTION

For a preliminary injunction to issue, the Court must find: (1) a substantial likelihood that Plaintiffs will prevail on the merits; (2) a substantial threat that irreparable harm will result if the injunction is not granted; (3) that the threatened injury outweighs the threatened harm to Defendants; and (4) that the granting of the preliminary injunction will not disserve the public interest. *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 837 F.3d 477, 488 (5th Cir. 2016); *Paulsson Geophysical Servs., Inc. v. Sigmar*, 529 F.3d 303, 309 (5th Cir. 2008); *De Leon v. Perry*, 975 F. Supp. 2d 632, 649 (W.D. Tex. 2014), *aff'd*, 791 F.3d 619 (5th Cir. 2015). Generally, the unavailability of a remedy at law, such as damages, constitutes irreparable harm. *Janvey v. Alguire*, 647 F.3d 585, 600 (5th Cir. 2011); *Allied Home Mortg. Corp. v. Donovan*, 830 F. Supp. 2d 223, 227–28 (S.D. Tex. 2011); *Knowles v. Horn*, No. CIV. A. 3:08-CV-1492, 2010 WL 517591, at *7 (N.D. Tex. Feb. 10, 2010). The decision whether or not to issue a preliminary injunction lies within the sound discretion of the trial court. *Daniels Health Scis., L.L.C. v. Vascular Health Scis., L.L.C.*, 710 F.3d 579, 582 (5th Cir. 2013).

Here, preliminary injunctive relief is necessary to prevent further, irreparable physical and psychological harm to the Plaintiff Class caused by Defendants' failure to assess their basic habilitative needs and to provide them with the specialized services with the frequency, intensity, and duration sufficient to constitute continuous active treatment. As more fully set forth in Secs. IV-V, *infra*, Plaintiffs have met all of the factors necessary for this Court to issue the requested preliminary injunction.

IV. THERE IS A SUBSTANTIAL LIKELIHOOD THAT PLAINTIFFS WILL PREVAIL ON THE MERITS.

A. *The Requirements of the Nursing Home Reform Amendments and the PASRR Provisions of the Medicaid Act*

1. Overview of the PASRR Provisions of the NHRA

In enacting the NHRA, Congress sought to enforce the long-standing Medicaid proscription against the costly and inhumane practice of institutionalizing individuals who did not require such confinement. *Rolland v. Romney*, 318 F.3d 42, 45-46 (1st Cir. 2003). It did so by mandating a professional review process designed to stem the inappropriate placement of individuals with IDD into institutions that are unable to provide them with active treatment. *Id*. at 46; *see also Idaho Health Care Ass'n v. Sullivan*, 716 F. Supp. 464, 472 (D. Idaho 1989) (rejecting constitutional challenge to the NHRA, court found that Congress properly acted to benefit "many individuals who are unable to look out for themselves in that they were being inappropriately placed in nursing homes where they were not receiving active treatment for their individual needs").

The NHRA mandates the PASRR process for all persons with IDD referred or admitted to nursing facilities. 42 U.S.C. § 1396r(e). An individual cannot be admitted to a Medicaid nursing facility unless the appropriate state agency[22] determines whether: (1) a person with IDD requires the level of services provided by a nursing facility; *and* (2) the person requires active treatment.[23] 42 U.S.C. § 1396r(b)(3)(F)(ii). In addition, by April 1, 1990, and thereafter, states are required to review

[22] Under the NHRA, 42 U.S.C. § 1396r(e)(7)(B)(iv), and State law, 40 Tex. Admin. Code Rule § 17.101 *et seq.*, the state agency responsible for conducting evaluations and for implementing the PASSR program is HHSC, although prior to September 1, 2016 it was DADS.

[23] In a 1990 amendment to the Medicaid statute, Congress substituted the term "specialized services" for "active treatment" but made it clear the two terms are synonymous in the context of PASRR requirements.

all current facility residents who have IDD to determine whether they continue to require the level of services provided by a nursing facility *or* require the level of services of an intermediate care facility described under 42 U.S.C. § 1396d(d). 42 U.S.C. § 1396r(e)(7)(B)(ii)(I); 42 C.F.R. § 483.114(b).[24] The review must also determine "whether or not the resident requires specialized services for [IDD]." 42 U.S.C. § 1396r(e)(7)(B)(ii)(II). Failure to perform the preadmission screenings or periodic reviews results in denial of federal reimbursement. 42 U.S.C. § 1396r(e)(7)(D).

Congress commanded the Secretary of Health and Human Services to promulgate regulations to implement several provisions of the statute. Thus, unlike certain federal laws where the administrative agency, on its own initiative, issues interpretative rules, here Congress expressly delegated to the administering agency the responsibility to develop specific requirements with respect to the PASRR process and the funding conditions for serving individuals with IDD in nursing facilities. *Rolland*, 318 F. 3d at 48; *Rayford v. Bowen*, 715 F. Supp. 1347, 1352-53 (W.D. La. 1989).

The regulations describe in detail the process and criteria for conducting PASRR screens and evaluations. These evaluations must be based upon detailed criteria set forth in the regulations, must review and fully consider available data,[25] must issue findings that correspond to the individual's "current functional status," and must disseminate a comprehensive report that describes all specialized services needed by the individual. 42 C.F.R. § 483.126.

[24] In a 1996 amendment to the NHRA, the requirement to conduct annual reviews was deleted. Instead, reviews are mandated only when there is a substantial change in the resident's condition. 42 U.S.C. § 1396r(e)(7)(B). There have been no corresponding modifications to the regulatory requirements for annual reviews. 42 C.F.R. § 483.114.

[25] This is especially important with respect to the PASRR determination of whether the individual should be placed in "another appropriate setting." 42 C.F.R. § 483.128(f).

2. HHSC's Responsibilities for PASRR

HHSC licenses nursing facilities in Texas. Because these facilities participate in the federal Medicaid program, HHSC is required to review and certify these facilities pursuant to the federal requirements for nursing facilities under 42 C.F.R. §§ 483.1-483.75, as well as the PASRR regulations, 42 C.F.R. § 483.100 *et seq*. As part of its responsibility for surveying, inspecting and certifying nursing facilities, HHSC is required to identify and correct any lack of compliance by nursing facilities with the PASRR regulations. *Id*. And as the state developmental disability authority, it is also responsible for operating the PASRR program and ensuring compliance with all PASRR requirements.

3. PASRR Requirements Concerning the Identification of Individuals with IDD, Diversion from Nursing Facility Admission, and Assessment of their Habilitative Needs.

The PASRR review is designed to determine first whether an individual is appropriate for admission to, and retention in, a nursing facility because he needs the level of nursing services that can only be provided in a nursing facility. 42 U.S.C. §§ 1396r(b)(3)(F)(ii), 1396r(e)(7)(A)&(B). A basic condition for federal reimbursement of nursing facilities is that the State determine, pursuant to a thorough assessment according to PASRR standards, that available community alternatives cannot meet the person's needs, and that the individual must be placed in a nursing facility. 42 C.F.R. § 483.132. Congress intended the number of nursing facility residents with IDD to decline dramatically as a result of the PASRR screening.

The PASRR provisions of the NHRA require that individuals being considered for admission to a nursing facility are carefully screened to determine if the person has or is suspected of having an IDD diagnosis (Level I screen). 42 C.F.R. § 483.128(a). Anyone seeking admission to a nursing facility whose Level I screen indicates that they may have an IDD must then be

assessed and evaluated through a process which is referred to as a Level II evaluation or, in Texas, a PE review. The purpose of the PE is to confirm whether individuals have an IDD, whether they satisfy the nursing facility level of care criteria, whether their needs can be met in the community through the provision of appropriate services and supports, and whether they could benefit from the provision of specialized services designed to maximize their functioning or to prevent regression. 42 C.F.R. §§ 483.128(a), 132.

The PE must analyze the individual's strengths and needs in 15 habilitative areas to determine whether the individual would benefit from specialized services and to identify the specific services that will meet the assessed need. 42 C.F.R. § 483.136 sets forth the minimum data required for the PE, including medical problems and the impact of these problems on the individual's independent functioning. If the PE determines that an individual needs specialized services, it must then determine if the nursing facility can provide all needed specialized services and active treatment. If the review concludes the facility cannot, the individual cannot be admitted to that nursing facility. 42 C.F.R. § 483.126.

If the individual is admitted to the nursing facility, the individual must receive a comprehensive functional assessment of all habilitative areas, as a basis for planning and delivering specialized services. These assessments must be done by qualified professionals and then used by an interdisciplinary team to determine the exact type, amount, intensity, and duration of specialized services. The team must develop a detailed service plan that includes goals, timetables, providers, and the amount, intensity, and durations of specialized services. A qualified IDD professional must coordinate and monitor these services, modify the plan as needed, review and update it annually, and ensure that all identified services are actually provided. 42 C.F.R. §§ 483.120 and 483.440(a)-(f).

4. PASRR Requirements Concerning the Provision of Specialized Services That Constitute Continuous Active Treatment.

Specialized services, as defined by 42 C.F.R. § 483.120(a)(2) for individuals with IDD mean " . . . the services specified by the state which, combined with services provided by the nursing facility or other service providers, results in treatment which meets the requirements of Active Treatment (483.440(a)(1))." Active treatment means the aggressive, consistent implementation of a program of specialized and generic training, treatment, health and related services that are aimed at allowing the individual to function as independently and with as much self-determination as possible, and the services designed to prevent or decelerate regression and loss of abilities. 42 C.F.R. § 483.440(a). In the PASRR regulations, specialized services are defined with specific reference to the federal Intermediate Care Facilities (ICFs) IDD active treatment regulations, reflecting that: (1) the State alone is responsible for the provision of specialized services; (2) the nursing facility is responsible only for traditional nursing services; and (3) the State is ultimately and fully responsible for ensuring that all of these services, taken together, constitute a program of active treatment, as defined by 42 C.F.R. § 483.440(a)-(f). If the individual requires specialized services, the State must provide those services with the frequency, intensity, and duration that, taken together with needed nursing services, meet the federal standard for active treatment. 42 C.F.R. § 483.440(a)-(f).

The PASRR regulations further require that the State (not the nursing facility or any other entity) "must provide or arrange for the provision of specialized services in accordance with this subpart to all nursing facility residents with IDD whose needs are such that continuous supervision, treatment and training by a qualified IDD professional is necessary as identified in the screening." 42 C.F.R. § 483.120(b). The regulations issued by the Secretary describing the State's basic obligations under NHRA to conduct the PASRR process, 42 C.F.R. § 483.106, make clear that the

State's developmental disability authority cannot delegate its ultimate responsibility to comply with the statute to another entity. *Id.* at § 483.106(e). Congress also intended to ensure that if the resident requires specialized services, the State actually provides them. *See id.*; 42 U.S.C. §§ 1396r(e)(7)(C)(i)(IV) & (ii)(III).

As recognized by the First Circuit in *Rolland*, 318 F. 3d at 57 (*affirming Rolland v. Cellucci*, 198 F. Supp. 2d 25 (D. Mass. 2002)):

> The Secretary . . . created two definitions of specialized services. For those with mental illness, "specialized services" are defined as services "specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care" developed by an interdisciplinary team, prescribing specific therapies and activities, and directed toward diagnosing and reducing behavioral symptoms and improving functioning. 42 C.F.R. § 483.120(a)(1). For individuals with mental retardation, such as the appellees here, however, the Secretary crafted a definition of specialized services that incorporated the active treatment standard traditionally applied in ICF/MRs.
>
> And then as held by this Court,
>
> "the plain language of Section [42 C.F.R. §] 483.440 . . . states that the required continuous active treatment program 'included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart" – *i.e.*, Part 483, Subpart I, which encompasses subsections (b) through (f). 42 C.F.R. §483.440 (a)(1); *Rolland v. Patrick*, 483 F. Supp. 2d 107, 114 (D. Mass. 2007) (noting that Section 483.440(a) incorporates "all active treatment standards 'described in this subpart'").'"

Steward v. Abbott, 189 F. Supp. 3d 620, 639 (W.D. Tex. 2016). And as held by the First Circuit and this Court, the federal mandate to provide active treatment for individuals with IDD in Medicaid-funded facilities means the same thing for individuals in nursing facilities as it does for individuals in ICFs. *Id.* This interpretation of the PASRR requirements was confirmed by the district court in *Rolland*, on remand from the First Circuit. *See Rolland*, 483 F. Supp. 2d at 113-

114.[26] The *Rolland* Court then incorporated subsections of 42 C.F.R § 483.440 (a) through (f) into its Order Approving Revised Active Treatment Standards (*Rolland* Order), Civil Action No. 98-30208-KPN, Docket No. 456 (August 2, 2007), including the "Revised Active Treatment Standard" attached to its Order. ECF No. 456-2, attached as Ex. K to 4th Corbett Decl.

This Court's holding on specialized services and active treatment—which echoes that of other courts— is a definitive statement of the federal law applicable to the NHRA and PASRR claims, issued after Defendants had urged this Court to hold otherwise. *See Defendants' Motion to Dismiss Plaintiffs' Second Amended Complaint*, ECF No. 244, at 66-67. This holding is the law of this case for purposes of this request for injunctive relief and for all other purposes going forward. [27]

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[26] The District Court specifically said that "the First Circuit was not rejecting Plaintiffs' argument but, rather, Defendants' argument that an active treatment standard was not only beyond their obligations, but unattainable. *See id*. In essence, the First Circuit determined that, although Defendants were not required to comply with every regulation applicable to ICF/MRs, they were required to implement the 'active treatment' aspects of the regulations, as that term concerned individuals with IDD in nursing facilities. *See id*. at 56–57. With that in mind, the First Circuit explained, the Secretary of Health and Human Services had crafted a definition of specialized services for nursing home residents 'that incorporated the active treatment standard traditionally applied in ICF/MRs.'" *Id.* at 113.

[27] As noted by the United States Supreme Court, "when a court decides upon a rule of law, that decision should continue to govern the same issues in subsequent stages of the same case." *Christianson v. Colt Indus. Operating Corp.*, 486 U.S. 800, 816 (1988) (quotations omitted). The Fifth Circuit has repeatedly applied the law of the case doctrine to issues decided in motions to dismiss. *United States v. Goudeau*, 512 F. App'x 390, 393 (5th Cir. 2013) (collecting cases applying law of the case to motions to dismiss an appeal). The standard for any challenge to this holding (or law of the case), in the Fifth Circuit, is that "controlling authority has since made a contrary decision of the law applicable to such issues . . . [or] the decision was clearly erroneous and would work [sic] manifest injustice." *Free v. Abbott Labs., Inc.*, 164 F.3d 270, 272 (5th Cir. 1999). Neither of these two prongs applies here: this Court's holding that all of the federal standards for active treatment apply to the NHRA claims here continues to be uncontroverted by the Fifth Circuit (and supported by at least one Court of Appeal and the plain language of the statute) and the standard does not produce any injustice here, manifest or otherwise. To the contrary, as is shown *infra*, requiring Defendants to provide active treatment to people with IDD in nursing facilities is the only way to implement Congress' purpose in enacting the NHRA, the Secretary's mandate in promulgating the PASRR regulations, this Court's application of the

B. *Texas' Failure to Adequately Implement NHRA Requirements.*

As more fully described in Sec. II, *supra*, Texas' PASRR program fails to properly evaluate and assess individuals who seek admission to nursing facilities, fails to provide a comprehensive functional assessment to identify all habilitative needs of those who are admitted, fails to provide the full array of specialized services to meet all habilitative needs, and fails to provide active treatment to individuals with IDD in nursing facilities. For each of these reasons, Texas' PASRR program fails to meet the obligations under federal law.

1. Defendants' Failure to Adequately Conduct PASRR Evaluations and Adequately Assess Habilitative Needs.

Defendants are responsible for ensuring that Class Members receive a PASRR evaluation to determine whether nursing facility placement is appropriate, whether the nursing facility to can meet the individual's needs, and whether the individual needs specialized services. 42 C.F.R. §§ 483.106(e); 483.132. Defendants are also responsible for ensuring that Class Members are comprehensively assessed for specialized services, and those who require specialized services are promptly provided these services at the appropriate level, intensity and duration to constitute a program of active treatment. 42 C.F.R. §§ 483.120(a); 483.440(a)-(f). Despite these obligations, as Ms. Dupree and Plaintiffs' experts have concluded, Defendants fail to conduct comprehensive and professionally adequate PASRR evaluations and virtually *never* provide Class Members with CFAs. *See* Q1 2016 Report at 9, 29; Weston Report at 8-9, 15-16 ; Webster Report at 7-8; Pilarcik Report at 7-8; Coleman Report at 4-5; *see also* Secs. II.B & C, *supra*. Defendants' failure to ensure that Class Members receive adequate and accurate PASRR evaluations and comprehensive functional assessments violates the NHRA.

NHRA and PASRR requirements, and the compelling need of individuals with IDD for active treatment.

2. Defendants' Failure to Provide Class Members Residing in Nursing Facilities with All Needed Specialized Services.

Defendants are also responsible for ensuring that Class Members in nursing facilities are provided with all needed specialized services. 42 C.F.R. § 483.120(a). Nevertheless, as Ms. Dupree has repeatedly found and Plaintiffs' experts have confirmed, Defendants do not operate a PASRR system that ensures that Class Members receive all needed specialized services. The Client Reviewers found that Class Members frequently do not receive needed specialized services from nursing facilities and virtually none receive specialized services from the LIDDAs except for service coordination. Coleman Report at 5; Pilarcik Report at 8. Defendants also do not provide an adequate array of specialized services with sufficient duration, frequency, and intensity. Weston Report at 10-11. Consequently, Class members languish in nursing facilities, losing skills and physically and psychologically deteriorating. *See* Secs. II.B & C, *supra*. Defendants' failure to ensure that Class Members receive all needed specialized services violates the NHRA.

3. Defendants' Failure to Provide Active Treatment.

Defendants have made almost no effort to provide Class Members with federally mandated active treatment. *See* Secs. II.C & D, *supra*. Texas has no infrastructure in place to provide active treatment. Weston Report at 12-14. Neither nursing facility staff nor LIDDA staff responsible for ensuring that Class Members receive specialized services are aware of the active treatment requirement. *Id.* at 19; Webster Report at 11. Even Defendants' own PASRR administrators concede that they are unfamiliar with the concept of active treatment in nursing facilities. Lindsey Dep., 46:2-14, 47:4-16, Blevins Dep., 46:9-20. *None* of the Class Members reviewed by the Client Reviewers received active treatment. *See* Sec. II. C, *supra*. Defendants' failure to provide Class Members with continuous active treatment violates federal law.

V. THE COURT SHOULD ISSUE A PRELIMINARY INJUNCTION REQUIRING TEXAS TO TAKE SPECIFIC ACTIONS TO REMEDY DEFICIENCIES IN ITS PASRR PROGRAM.

A. *There is a Substantial Risk that Plaintiffs Will Suffer Irreparable Harm.*

The irreparable injury resulting from Defendants' ongoing refusal and failure to provide Class Members with the professionally appropriate assessments of their habilitative needs, specialized services to meet those needs, and active treatment is severe and ongoing. *See* Weston Report at 8-9, 14-16; Webster Report at 11. Many Class Members have been deprived of specialized services and active treatment for years and have suffered regression, deterioration, and a longstanding denial of active treatment. Still others are at imminent risk of harm, as their urgent needs go unaddressed. And still others – including a significant portion of those reviewed by both the QSR process and Plaintiffs' experts – need, but are not receiving, specialized services that allow them to gain skills, become more independent, function outside of an institution, or simply participate in some community activities. Violation of federal law enacted to protect the health, safety, and welfare of vulnerable individuals is itself a form of harm. *See* Coleman Report at 6-7; Pilarcik Report at 7-9; *see also* Sec. II.C, *supra*.

The deprivation of prompt specialized services mandated by the Medicaid Act constitutes irreparable harm. *See Knowles*, 2010 WL 517591, at *7 (plaintiff demonstrated irreparable injury where he was at substantial risk of death and had no adequate remedy at law if his Medicaid-funded community-based services were withdrawn); *Camacho v. Tex. Workforce Comm'n*, 326 F. Supp. 2d 794, 802 (W.D. Tex. 2004) (irreparable harm shown where state sought to enact rules restricting Medicaid eligibility, which, if allowed to take effect, would cause plaintiffs to lose medical benefits and leave them with no way to pay for medical care, care for their children and work, and cause financial loss), *aff'd*, 408 F.3d 229 (5th Cir. 2005); *Oak Park Health Care Ctr.*,

LLC v. Johnson, No. 09-CV-217, 2009 WL 331563, at *3 (W.D. La. Feb. 10, 2009) (finding irreparable harm to nursing home residents and their families where cessation of provider contract would result in residents having to suddenly move to a new facility).

Here, Plaintiffs have clearly shown that, absent immediate preliminary injunctive relief, they are being and will be irreparably harmed as a result of their deterioration, their inadequately and untreated physical conditions, the lack of specialized services to meet their habilitative needs, and the total absence of active treatment. Because they have no adequate remedy at law, equitable relief, in the form of a preliminary injunction, is necessary. *See* Sec. II, *supra*.

B. *The Harm to Plaintiffs Outweighs Any Harm to Defendants.*

The substantial injuries to the Plaintiff Class sharply outweigh any injury to Defendants. As described above, the severe harm to the Plaintiff Class if no injunction issues will result in further physical deterioration, functional regression, and perhaps death. Defendants' failure to provide Class Members with the necessary evaluations and professional assessments of their habilitative and medical needs, with the specialized services to meet these needs, and with the federally-mandated program of active treatment has caused them to incur a profound loss of their functional skills, extreme physical and medical deterioration, and endless lost opportunities to become more independent, more engaged in useful activities, and more able to function on their own. For example, some like D.M., C.C., R.B., and M.M. are at risk of aspiration and aspiration pneumonia, or choking due to not receiving specialized speech therapy consistent with a program of active treatment to address their dysphagia. *See* Sec. II.C, *supra*. Others, such as B.C., A.C., S.W., and M.M., have deteriorated, losing skills and developing painful contractures. *See id*. Still others, like, J.H., E.S., and P.A. are isolated and have lost social skills and opportunities to become more independent. *Id.* Defendants, by contrast, will suffer little or no harm, particularly because

an injunction would only require Defendants to do what they are already legally required to do, but with the specificity and oversight to ensure that they do it.

Furthermore, any claim that Defendants may make with regard to hardship due to fiscal constraints cannot, as a matter of law, serve as a valid excuse for not fulfilling their obligations under Medicaid and the NHRA. *Ala. Nursing Home Ass'n v. Harris*, 617 F. 2d 388, 396 (5th Cir. 1980) ("A state is not obligated to participate in the Medicaid program. However, once it has voluntarily elected to participate in the program, the state must comply with federal statutes. Inadequate state appropriations do not excuse noncompliance) (citations omitted); *Camacho*, 326 F. Supp. 2d at 802, (In finding that the hardships to plaintiffs outweighed any harm to defendant, court held that as a matter of law, " '[A] state's budget problems cannot serve as an excuse for altering federal eligibility requirements of federal funding; if they could, the federal requirements would become superfluous' ") *quoting Planned Parenthood Cent. Tex. v. Sanchez*, 280 F. Supp. 2d 590, 606 (W.D. Tex. 2003)*; Camacho v. Tex. Workforce Comm'n*, 408 F.3d 229 (5th Cir. 2005) ("States electing to participate in the [Medicaid] program must comply with requirements imposed by the Act and regulations of the Secretary of Health and Human Resources"); *Lopez v. Heckler*, 713 F.2d 1432 (9th Cir. 1983); *Kansas Hosp. Ass'n v. Whiteman*, 835 F. Supp. 1548, 1552-53 (D. Kan. 1993).

Moreover, under the conditions of participation in the Medicaid program, Defendants simply cannot assert that resource constraints preclude their compliance with the mandates of Title XIX, the obligations of the NHRA, or the commitments set forth in the Texas Medicaid State Plan.[28] When the Class Members' loss of basic life skills is balanced against the modest, if any,

[28] Moreover, Defendants' failure to comply with federal law potentially has serious, negative resource implications for the State. Under federal law, Texas should not receive federal

fiscal cost to Defendants, and the potential loss of a huge amount of federal reimbursement, the balance of harm clearly tilts in favor of an injunction.

C. *An Injunction Will Serve the Public Interest.*

Granting preliminary relief that requires Defendants to provide Class Members with professionally appropriate assessments, specialized services, and the active treatment, as required by the NHRA, will serve the public interest.

Courts have consistently held that the public interest is served where injunctions are issued to stop government officials and entities from violations of the law, particularly in regards to constitutional and statutory laws pertaining to civil rights, welfare and medical benefits and other rights, including Medicaid. *Camacho*, 326 F. Supp. 2d at 802, *quoting Finlan v. City of Dallas*, 888 F. Supp. 779, 791 (N.D. Tex. 1995) (*quoting Nobby Lobby, Inc. v. City of Dallas*, 767 F. Supp. 801 (N.D. Tex. 1991), *aff'd*, 970 F.2d 82 (5th Cir. 1992)) ("[T]he public interest always is served when public officials act within the bounds of the law and respect the rights of the citizens they serve."); *Kansas Hosp. Ass'n*, 835 F. Supp. at 1552-53 (finding where the "effect of a temporary restraining order would be to enforce the federal law and regulations governing the Medicaid program," it is in the public interest).

In enacting the NHRA, Congress explicitly recognized the public interest in ensuring that individuals with IDD in nursing facilities receive the necessary specialized habilitative services to prevent regression and to meet the federal standard for active treatment. H.R. Rep. No. 391(1), 100th Cong., 1st Sess. 459 (1987), reprinted in 1987 Code Cong. & Admin. News 2312-1 to 2313-279 (Congress found that "substantial numbers of mentally retarded and mentally ill residents are

reimbursement for nursing facility care that does not comply with federal standards on specialized services and active treatment. 42 U.S.C. § 1396r(e)(7)(D) and 42 CFR §§ 483.122 and 483.124.

inappropriately placed, at Medicaid expense, in [nursing facilities]. These residents often do not receive the active treatment or services that they need.").

Courts have also recognized the importance and validity of the NHRA and the PASRR process. *See Tex. Health Care Ass'n v. Sullivan*, No. A-89-CA-45, 1992 WL 206271, at * 8-9 (W.D. Tex. Apr. 1, 1992) ("The PASARR legislation is plainly a direct and reasonable way to attempt to eliminate the warehousing of mentally ill and mentally retarded patients in nursing homes."); *see also Rayford*, 715 F. Supp. at 1356 ("There can be no doubt that Congress could decide that mentally ill and retarded patients were inappropriately placed in nursing homes. It would be hard to imagine a more rational means of putting a stop to this than to prevent such individuals from entering nursing homes unless a determination is made that it would be appropriate."); *Tex. Health Care Ass'n v. Bowen*, 710 F. Supp. 1109, 1110 (W.D. Tex. 1989) (In enacting the 1987 OBRA, "it appears uncontested that the revisions were intended to end inappropriate placement of mentally ill and mentally retarded individuals in nursing homes not equipped to deal with such individuals' special needs").

Here, Class Members have a clear federal statutory right to professionally-appropriate assessments, the full range of specialized services, and, most importantly, active treatment. *See* Sec. IV, *supra*. They have been denied these rights for many years and have consequently lost skills and developed serious medical conditions, some of which are life threatening. If no immediate relief is afforded, these already dangerous conditions will be exacerbated and they will further regress. *See* Secs. II & IV, *supra*. Remedying such violations is clearly in the public interest.

D. *Specific Actions to Remedy Defendants' Violations of Federal Law.*

In order to remedy Defendants' failure to provide Class Members with professionally adequate assessments, needed specialized services, and a full program of active treatment, as required by the NHRA and its implementing PASRR regulations, Plaintiffs respectfully request that the Court issue an Order containing the following remedial provisions:

> 1. Require the State to conduct PE reviews by a qualified IDD professional who makes a professional judgment, based upon all available information, whether the individual has a need for habilitative services in each of the fifteen areas listed in 42 CFR § 483.136;
>
> 2. Require the State to do a Comprehensive Functional Assessment of each individual with IDD who is admitted to a nursing facility with 15 days of admission;
>
> 3. Require the State to provide specialized services to individuals with IDD in nursing facilities in the amount, duration and scope necessary to address all identified habilitative need areas;
>
> 4. Require the State to ensure that individuals with IDD in nursing facilities receive a program of active treatment that is planned, delivered, and supervised by qualified IDD professionals, consistent with the requirements of 42 CFR § 483.440(a)-(f);
>
> 5. Require the State to provide service coordination that monitors specialized services provided by the nursing facility or the LIDDA and ensures that these services are delivered in a consistent, coordinated, and continuous manner that constitutes a program of active treatment, as required by 42 CFR § 483.440(a)-(f);
>
> 6. Require the State to ensure that nursing facilities fully comply with all PASRR requirements, and provide nursing facility and specialized services in a consistent, continuous, coordinated manner that constitutes a program of active treatment, as required by 42 CFR § 483.440(a)-(f); and
>
> 7. Require the State to provide training to all entities and staff responsible for implementing its PASRR program and the above remedial provisions.

E. *Plaintiffs Should Not Be Required to Post a Bond.*

Plaintiffs should not be required to post a security bond if a preliminary injunction is issued. Although Fed. R. Civ. P. 65 (c) permits courts to order the posting of a bond, they are not required to do so. *Kaepa, Inc. v. Achilles Corp.*, 76 F.3d 624 (5th Cir. 1996). Courts regularly decline to

require a plaintiff to post bond where the harm to the plaintiff significantly outweighs the harm to defendant and the plaintiff is indigent. *Temple Univ. v. White*, 941 F.2d 201, 220 (3d Cir. 1991) (waiver of bond requirement in case brought to enforce Medicaid rights); *Orantes-Hernandez v. Smith*, 541 F. Supp. 351, 385 (C.D. Cal. 1982) (indigent plaintiffs not required to post security when a TRO was issued against defendants).

Here, the Class Members are indigent. *See* Second Amend. Compl.,¶ 36. Thus, they should not be required to post a security.

VI. CONCLUSION

For the reasons set forth above, Plaintiffs respectfully request that this Court preliminarily enjoin Defendants, their officers, agents, servants, employees, and attorneys, and any and all persons in active concert or participation with them, from denying Class Members professionally appropriate assessments of their habilitative needs, all specialized services needed to meet those needs, and active treatment, as required by federal law, and require them to take the specific actions identified in Sec. V.B, *supra*.

Dated: April 3, 2017.

Respectfully submitted,

/s/ *Garth A. Corbett*

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CERTIFICATE OF CONFERENCE

I Garth Corbett, hereby certify that Plaintiffs' Counsel has conferred with counsel for Defendants on the relief requested in Plaintiffs' Motion for Preliminary Injunction and accompanying Memorandum of Points and Authorities in Support of Motion, and certify that Defendants are opposed to the relief sought herein.

CERTIFICATE OF SERVICE

I hereby certify that on April 3, 2017, a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's CM/ECF System.

/s/ *Garth A. Corbett*
GARTH A. CORBETT

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lillian Minor, *et al.*,

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

Case No. SA-5:10-CV-1025-OG

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

DECLARATION AND EXPERT DISCLOSURE OF BARBARA T. PILARCIK IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B), that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case.

1. My report, which is attached, contains a complete statement of all of my opinions as well as an explanation of the basis and reasons for those opinions.

2. My report describes the facts, data and other information I considered in forming my opinions.

3. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

4. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.

5. Within the last four (4) years, I have not testified as an expert, either in a deposition or at trial.

6. I have been retained by the Plaintiffs and the United States as a joint expert in the *Steward v. Smith* litigation. My compensation in this litigation is $150.00 per hour for my review, preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated:

Barbara T. Pilarcik

Barbara T. Pilarcik

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

PRE-ADMISSION SCREENING AND RESIDENT REVIEW SPECIALIZED SERVICES AND ACTIVE TREATMENT REPORT OF BARBARA PILARCIK

1. PURPOSE

I was asked by the plaintiffs to conduct a review of a sample of individuals with intellectual and/or developmental disabilities (I/DD) who are residing in nursing facilities in Texas. The purpose of this review was to obtain information that would allow me to determine whether or not these individuals are receiving a comprehensive functional assessment of their habilitative strengths, needs and preferences; whether they are receiving all of the specialized services they require to address those needs; whether they are receiving a program of active treatment that provides for (a) the acquisition of behaviors necessary to function with as much self-determination and independence as possible and (b) the prevention or deceleration of regression of current optimal functional status; and whether they are currently experiencing any harm as a result of a lack of services or active treatment.

2. QUALIFICATIONS

I have over 36 years of experience in the field of I/DD and another 17 years as a registered nurse. I have been a licensed registered nurse since 1963. My years of experience have included working in general, psychiatric and obstetrics hospitals; in school and camp nursing; and for the Commonwealth of Massachusetts, Department of Mental Health. Most recently, I was employed for 32 years by The Association for Community Living (Association), a private, non-profit agency serving people with developmental disabilities throughout western Massachusetts. I served as the Executive Director of The Association for 8 years; I retired in 2016. The Association was founded in 1952 by five mothers who were determined that their children would not need to leave their families and community in order to receive care specific to their needs, and that other children would also benefit from their efforts. From the beginnings of clinical nursery schools in the basement of churches, The Association today provides services throughout the four counties of Western Massachusetts, a population base of just under one million people. The Association has over 20 group homes that each serve between two and five individuals, with the exception of two eight-person homes that were previously Intermediate Care Facilities for persons with I/DD (ICF/IDD). The 20 residential programs provide staffing and services 24 hours a day, seven days a week. The services are habilitative and based upon each person's individual needs to achieve as much independence and self-determination as possible. In addition to the over 100 people served in the group home model, the Association also serves over 200 people in a Shared Living, or Host Home model. Individuals live with host families of their choosing, or with their biological family and also receive services based upon their needs and preferences. The Association has a large and active family services system, serving over 1000 families, and provides social and recreational activities, including a creative arts program, transition services, pre-school programs and family support groups. The Association is also the regional Autism Center, serving over 1500 individuals and their families.

The Association opened the first ICF/IDD in the state over 30 years ago. This federally funded program provides active treatment to individuals with IDD who also have complex medical needs. Today the Association serves individuals with complex medical needs in specialized homes. The Association has 31 people in five homes, all of whom have medical complexities, including tracheostomies, feeding tubes, implantable devices, customized wheel chairs, continuous oxygen, diabetes, serious seizures disorders and rare conditions such as mitochondrial disorders. One of the homes has been designated to serve individuals who require mechanical ventilation to breathe. During the time the Association was licensed by the Department of Public Health under the ICF/IDD regulations, the Association met all licensing and regulatory requirements for active treatment. The Association, now known as Pathlight, is currently licensed by the Department of Developmental Disabilities.

I have many years of practical experience in planning, developing, evaluating and delivering a range of services to individuals with I/DD, including those with complex medical needs. In addition to being the Executive Director of the Association, I have also been an expert consultant to help monitor settlement agreements in Virginia and the District of Columbia. I was an expert witness and testified in federal court in the *Rolland* case in Massachusetts, a lawsuit that affirmed the rights of individuals with I/DD in nursing homes to receive active treatment. I was a reviewer for the Quality Service Reviews in Texas from January 2015 until October 2015. I have evaluated services for individuals with I/DD for over 15 years. The *Evans* case in Washington DC successfully concluded this past year and resulted in significant improvement in the lives of those individuals.

I have presented at local, state, national and international conferences on various topics including transition planning, supporting people during hospitalization, quality systems, safe practices, and shared living services. I have worked with organizations throughout the United States and as far away as China and Azerbaijan. I worked collaboratively with other leaders in the field to respond to an article in the *Journal of the American Academy of Pediatrics* to emphasize the importance of family-based services for children with I/DD and serious medical conditions. I wrote a grant which was funded by the Massachusetts Developmental Disabilities Council to publish a manual titled *Supporting Individuals with Mental Retardation During Hospitalization.* The manual has been distributed throughout the United States and Canada and is part of the Quality Mall, an online resource of best practices. I served on the Massachusetts Department of Developmental Services strategic planning committee on health care. This committee implemented new policies and processes to support the health care needs of individuals served by the Department. The materials we developed have been used by other states. I have been the President of a several local and state organizations in the human services field, and am currently a member of the Public Policy Committee of the Arc of Massachusetts, and a Board member of The Providers' Council of Massachusetts and the Corporation for Independent Living (CIL). CIL is a non-profit housing agency that has developed hundreds of homes for individuals with disabilities in Connecticut and Massachusetts. I also served for ten years on the Ethics Committee of the Baystate Medical Center Visiting Nurse Association.

My experience encompasses direct service, nursing care, advocacy, policy development, program design, evaluation, management and systems change in the field of developmental disabilities. For my curriculum vitae, please see Attachment 1.

3. METHODOLOGY AND MATERIALS REVIEWED

I designed a protocol for and conducted an on-the-ground review of a sample of individuals who were initially part of the 2015 and first quarter 2016 Quality Services Review (QSR) conducted under the Interim Settlement Agreement between the State of Texas, the Department of Justice (DOJ), and the *Steward* plaintiffs. I reviewed 17 individuals who were randomly selected from that larger group of individuals. The random sample of individuals was provided to me by plaintiffs. As part of the review I met with each individual in their place of residence, with the nursing facility staff who knew the individual best, the service coordinator assigned to that individual, and whenever possible, the guardian, Legally Authorized Representative (LAR), or a family member. All individuals agreed to be interviewed and I visited all in person. I also toured the facility and saw their room and any other locations within the facility where they spent time such as the dining room or an activities room. Two years of clinical and case management records were sent to me by Disability Rights Texas through a secure, encrypted portal and I reviewed those records. I also reviewed the most recent records on site at each nursing facility.

I reviewed the active treatment protocol that was used in and approved by the federal court in *Rolland.* I modified that protocol to fit Texas nursing facilities and used it as a guide in conducting my review and shared the protocol with and provided training to the other reviewer, Dr. Vickey Coleman. We used it to ensure that we were asking consistent questions specifically relevant to federal and state standards, including active treatment, to obtain the same type of information.

After reviewing the records, collecting information during the on-the-ground review process and any follow-up telephone calls to guardians or service coordinators, and reviewing professional standards used to evaluate the adequacy of service planning and delivery, I analyzed this information and drafted a report for each individual (see Individual Findings and Conclusions, below). In each report I made a determination as to whether or not the Texas PASRR system as currently constructed and implemented is meeting the needs of each person. I then aggregated the information from all 17 individuals and made broader findings concerning the four key questions for this review: whether individuals with I/DD in nursing facilities receive a comprehensive functional assessment, receive all needed specialized services, receive active treatment, and experience any harm. After I made my findings, I cross-checked them with the relevant QSR data about each individual and analyzed any variations.

In addition to the nursing facility and Local Authority records that I read for each individual whom I reviewed, I also considered the Revised Active Treatment Standard, *Rolland v. Patrick*, Case 3:98-cv-30208-KPN, Document 456-2 Filed 08/02/2007; PASRR Requirements and Enhanced Community Coordination, DADS FYs 2016 and 2017 Contract, Attachment G; DADS Local Intellectual and Developmental Disability Authority PASRR Reporting Manual, Revised October 2015; DADS Instructions for Mental Retardation Authority Processing of OBRA PASRR Referrals, Part 483-Requirements for States and Long Term Care Facilities and the CMS Memo to State Survey Agency Directors of September 28, 2007 regarding PASRR and the Nursing Home Survey Process. I also reviewed the 2015 and 2016 QSR reports as filed by Kathryn DuPree, Lead QSR Reviewer. For a full list of all materials that I reviewed, please see Attachment 2. I compared these professional standards with what I found in my review process and determined whether or not the PASRR system as implemented in Texas is meeting those standards.

4. PROFESSIONAL STANDARDS FOR INDIVIDUALS WITH I/DD

A professionally accepted program for individuals with I/DD begins with a thorough, accurate and comprehensive functional assessment which takes into consideration the individual's age and the implications for active treatment at that stage in life; identification of the presenting problems and disabilities and where possible, their causes; identification the individual's specific developmental strengths and developmental and behavioral needs; and identification of the individual's needs for services without regard to the actual availability of those services. The comprehensive functional assessment includes an evaluation of an individual's physical development and health, nutritional status, sensorimotor development, affective development, speech and language development, auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the individual to function in the community and as applicable, vocational skills. Furthermore, the comprehensive functional assessment needs to be conducted by an interdisciplinary team of professionals.

The assessment, properly performed, will result in an identification of each habilitative need area and a description of a program of specialized services that will meet the identified needs of the individual and build upon their strengths. These services are incorporated into an individual support plan (ISP), prepared by an interdisciplinary team, that outlines the specific needs that are being addressed and how those needs will be met. An adequate individual support plan must include individualized goals, objectives, services to be provided (described in terms of the frequency, intensity, and duration of each service) and the professionals responsible for providing each service. For example, a person who expresses a desire to learn to walk again will have a physical therapy assessment that identifies the specific skills that need to be attained such as lower extremity strength and improvement of balance and the methods that will be used to meet those needs, including measurable indicia of performance, projected attainment date, frequency of service and person(s) responsible for implementing the plan to regain walking skills. It will also include any adaptive devices or equipment that will assist the person in meeting that goal such as a rolling walker. These various specialized services and goals are developed into a single coherent plan that clearly sets forth the individualized goals and the collaborative effort of the various staff in the individual's life. Implementation of the plan also includes a description of the staff training necessary to achieve competency in assisting the individual in their goal attainment. The plan is then shared with all relevant members of the team and the individual and/or their guardian or family member and reviewed at regular intervals. The plan is changed in response to changing needs of the individual or attainment of goal(s) before the next regular meeting.

Goals for individuals with I/DD are based upon the concept of habilitation, unless they are recovering from an acute episode, in which case rehabilitation is indicated as it would be for other people in the same situation. Habilitation refers to a process aimed at helping individuals with a disability to attain, keep or improve skills and functioning for daily living. It can include such services as physical, occupational and speech therapy and various services such as behavioral supports, independent living skills, and social integration. Rehabilitation refers to regaining skills, abilities or knowledge that has been lost or compromised as a result of acquiring a disability or due to a change in one's disability or circumstances. For example, an older woman with I/DD who falls and breaks her hip requires both: the rehabilitation services of physical therapy to strengthen her legs and regain balance; and on-going habilitative physical therapy to ensure that she can continue to work on her muscle

strength and balance beyond the time for normal healing for an otherwise non-disabled woman. The habilitative therapy should also continue in all areas of her care and all the staff who care for her need to be trained in assisting her to follow her therapy program.

Habilitative services are particularly important for people with I/DD due to the fact that they often have concurrent health conditions such as weak muscle strength in persons with Down Syndrome or cardiac problems in persons with Williams Syndrome. Many of the causes of I/DD also have other systemic involvement that compromises general overall health. The cognitive impairment in persons with I/DD often means that they do not understand the importance of various healthy life style behaviors. While many of us in the general population understand the negative aspects of a diet of highly processed, high fat and high sugar food, it is often difficult for those with cognitive impairment to understand the long-term gain over the short-term denial. Ongoing support from trained professionals in I/DD can provide training that helps the person understand how to be healthy. In addition, many persons with I/DD do not use speech to communicate; often caregivers who are not trained in understanding non-verbal communication and behaviors mistakenly fail to understand that the individual with I/DD is using the only thing they have to communicate a need -- negative behavior. For instance, one of the individuals that I reviewed, NT, did not speak and the nursing facility staff and the others mistakenly believed she was not competent to engage in discussions around her services. Nearly two years passed before staff – and a persistent service coordinator –discovered her non-speech communication and her ability to express her opinions regarding her services. Texas compartmentalizes specialized services into nursing facility and LIDDA specialized services, and this appears to have the effect of focusing more attention on the former, and less on the latter. But the LIDDA specialized services, like Independent Living Skills, Day Habilitation, Employment, and Behavior Supports are precisely those that allow the individual to gain new skills, increase their independence, and engage in the community. These services also are vital to providing individuals the training and support they need to avoid future risks. Thus, they often are the pathway – if not the foundation – to professionally appropriate habilitation and active treatment for many individuals.

Active treatment has been part of the standard for services for people with I/DD since the 1980s. The standard (at 42 CFR 483.440 and 42 CFR 483.120(a)(2)) states that each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment must be carried over to all elements of the individual's life and settings where they live and receive services. For example, an OT goal that helps the individual to learn to use a fork to eat their food must be implemented every time the person eats food requiring a fork. To do otherwise confuses the individual regarding the task they are learning and impedes the attainment of this socially acceptable behavior.

My experience in providing services to individuals with I/DD over the past 36 years has proven that habilitative services help individuals attain skills and prevent or slow regression of skills. I have developed programs specifically for people transitioning from nursing facilities. These individuals have many complex medical needs and have been in an institution for most of their lives, often entering when they were children. There were no other options and the families often stayed involved with them. For example, we served one man who had a tracheostomy, a g-tube, and a pacemaker, was very

tight with muscle spasms and had repeated respiratory infections. He had lived with his family until the care needs became too great and then was placed into a facility. At one point, during a hospitalization for pneumonia, he was given last rites. With a comprehensive plan of care that included nursing support, physical therapy, a nutritionist, a massage therapist and highly trained and skilled direct support staff, we were able to keep him out of the hospital for the next 25 years. It was the daily, consistent, and skilled care of our staff and their ability to recognize and quickly respond to any change in status that allowed him to live an active life, including a dream trip to Disneyworld – tracheostomy, oxygen, feeding tube pump and all.

In sum, the PASRR system is meant to identify those individuals who have been admitted to a nursing facility who have I/DD, to ensure that they receive a comprehensive assessment of their disabilities and needs, to develop a single integrated plan of services so they can acquire the behaviors which will help them to function with as much self-determination and independence as possible, and to prevent or slow the regression of current optimal functional status.

5. UNIQUE CHALLENGES SERVING INDIVIDUALS WITH I/DD

While individuals with I/DD are much like everyone else in that they encompass a range of wonderful qualities such as perseverance, optimism, dedication, honesty, transparency and devotion, they also present challenges that are not generally found within the regular population and which are a result of the fact that they have a developmental and/or intellectual disability. By definition, the underlying neurological system is comprised. This affects many aspects of the functioning of the rest of body systems, at least to some degree. Cognitive impairment may also affect general overall health, particularly if caregivers are unaware of the impact that lack of understanding and communication has on the person's ability to accurately respond to health needs.

There has been considerable attention in the past several years to the concept of "The Fatal Four." It has been recognized, often through mortality reviews conducted by states, that there are four conditions that are commonly seen among individuals with I/DD, which, if left unrecognized and untreated, can lead to death. The four conditions are constipation, aspiration, dehydration, and seizures. The first three are preventable and the fourth, seizures, can often be controlled and managed with proper treatment. The Fatal Four are often difficult to identify or diagnose in a person with I/DD. As a result, they often go untreated and are linked to a significant number of preventable deaths. The combination of the lack of awareness by the individuals of what is happening to them, and their challenges in communicating with caregivers means that caregivers are the primary safeguards to prevent and recognize the conditions before they become serious.

Some of the reasons these rather mundane conditions can be fatal in a person with I/DD are their living arrangements, their medications, their difficulty in expressing what is happening, and the unusual way symptoms are presented. For example, a person living in a facility that does not provide easy access to water may only receive water at meal time, which puts them at risk for both constipation and dehydration. Immobility also increases the risk of constipation and aspiration. Both constipation and dehydration can exacerbate seizures, which, in turn, can lead to aspiration. Constipation can lead to a bowel obstruction, which can be fatal if not treated quickly. In addition, seizure medications often cause constipation. Dysphagia refers to difficulty in swallowing. Dysphagia is a condition that must be identified and managed to prevent aspiration of food into the lungs. Poor muscle tone, often present in individuals with I/DD, makes eating food difficult and swallowing disorders can lead to aspiration.

Aspiration of food (choking) often results in aspiration pneumonia, which can lead to sepsis and acute respiratory failure. Seizure activity is affected by infections, and the blood levels of anticonvulsant drugs is affected by dehydration.

It is important to recognize that these "Fatal Four" are largely preventable. It begins with an accurate assessment of the person's abilities in each of these areas, including their medications and side effects, the individual's capacity to understand and communicate, and the best methods for facilitating compliance with treatment programs. The information gained from these assessments is then incorporated into a treatment plan prepared by an interdisciplinary team of professionals that includes feeding protocols, bowel regimen or seizure guidelines. The treatment plan then must be carefully implemented by trained staff, with scrupulous attention to the protocols, accurate documentation and data collection, evaluation of the treatment regimen, and adjustment as required by professional analysis of the data. For persons with I/DD, well trained, professionally-supported direct care staff, sufficient in number and without high turnover rates, are the key to substantially reducing the incidence of the "Fatal Four" and allowing persons with I/DD to experience a healthy life within the limitations of their challenging medical conditions.

Finally, contractures are a permanent shortening of muscles, usually on a limb. Contractures can be so severe that the limb may be hyperflexed, as occurs when the hand folds up against the inner aspect of the lower arm. Most contractures can be prevented. Not moving the limb, called static positioning, causes the muscles to shorten over time and for the elastic tissue to be replaced with non-stretchy, fibrous tissue. Contractures of the hands or fingers severely impact the person's ability to perform self-care and toileting needs, becoming dependent on others on a daily basis. Contractures of the lower limbs can lead to immobility which reduces independence and also contributes to other medical conditions such as osteoporosis. Identification of potential contractures is usually done by either an occupational therapist or a physical therapist. Depending on the underlying condition, a physical therapist develops an active program of treatment which can significantly lessen the likelihood of contracture development or further progression of the contracture. These treatment protocols need to be carried out throughout the individual's day and be scrupulously followed in order to continually provide stretching and neuromuscular feedback on proper body positioning, and to build up strength and balance.

6. AGGREGATE FINDINGS

A. Comprehensive Functional Assessment

None of the individuals reviewed had received a comprehensive functional assessment. The comprehensive functional assessment must take into consideration the person's age, identify the presenting problems and disabilities and then identify their strengths, developmental and behavioral needs and services necessary to meet those needs. While most of the individuals received both the PASRR Level I screening and the PASRR Evaluation and various nursing facility assessments, these assessments were not performed at the same point in time by an interdisciplinary team of professionals. They were often done weeks or months apart, and not part of a single, coherent assessment and program plan. Therapies, such as occupational therapy (OT) or physical therapy (PT) were done separately from the initial assessments and not integrated into a single plan of services. Areas of assessment that were often lacking were social development and adaptive behaviors or independent living skills necessary for the client to be able to function in the community. The result of this lack of a

comprehensive functional assessment has resulted in a program plan for services, as captured in the Individual Service Plan (ISP), that tends to focus on minor skill development goals such as "watch television whenever he wants" (MM). It does not provide specific goals to increase self-determination and independence, as occurred with NT when staff did not realize her abilities to comprehend and denied a communication device which she is now getting -over two years after her original comprehensive functional assessment.

In the field of developmental disabilities, as is true for health care in general, all effective services begin with a thorough understanding of the needs and strengths of the person receiving care. To shortchange this process by conducting it in a fragmented manner results in a service plan that has low expectations, lack of clear direction, and lost opportunities for maintenance or growth of skills in independent living, self-determination and loss of optimal functional status.

B. Specialized Services

None of the individuals reviewed who are eligible for specialized services under DADS' policies were receiving all of the specialized services recommended or needed. All individuals were receiving service coordination although two individuals were receiving it inconsistently (AC, ES) and one (AOl) had 4 or 5 different service coordinators in the last few years. There was also a lack of communication between service coordination and the nursing facilities (AM, ES, JH, YG), and a lack of understanding or reluctance to use the PASRR services provided by the nursing facilities (GM, MM, SSc, AOl). Several nursing facility staff stated that the PASRR system is difficult to use and they prefer to use restricted insurance systems to fund, on a time-limited basis, necessary therapies. This approach has resulted in therapies, in particular OT, PT, and ST, being provided later than necessary, on an intermittent and time-limited basis, and often in response to a precipitating event, rather than on an ongoing basis to achieve identified habilitative goals. In addition, since the nursing facility staff do not understand the PASRR system, they rarely consider other specialized services such as Independent Living Skills Training (ILS), Day Habilitation or Behavioral Health Services. As a result some people have just begun to receive ILS services after years of confinement in a nursing facility, while many individuals are still not being considered for these services. Others who would benefit from Behavioral Support Services have not received them and have suffered harm as a result (ES, SS). Other than service coordination, the most frequently used specialized service is the customized manual wheelchair (CMWC). But NT, who previously used a motorized wheelchair, has a CMWC, rather than a motorized one, and no longer has the ability to independently maneuver about her environment.

Specialized services are fundamental to ensuring that the individual receives a continuous, aggressive active treatment program. The provision of intermittent, specialized services (AOl, AM), the long delay in receiving services (DP, NT), and the absence of recommended or necessary services (AOv, EC, AC, JH, MM, PA, RB, SSc, and YG) has resulted in a lack of active treatment for these individuals.

C. Active Treatment

None of the individuals reviewed who are eligible for specialized services under DADS' policies received a program of active treatment. Active treatment builds upon a comprehensive functional assessment, conducted by an interdisciplinary team of professionals to produce a single, integrated program of services. The assessments provide clear goals and assign responsibility for the provision of specialized services across the spectrum of the individual's life on a day-by-day basis. Active treatment

requires that all those who work with the individual are trained in the person's plan and have the competencies necessary to fulfill the goals and objectives of the plan. The plan is implemented throughout the day, every day, of the individual's life. While some services, such as Independent Living Skills, might take place a few times a week in the community all staff who work with that individual need to be aware of the goals worked on in that program, so that they can be reinforced whenever the opportunity arises. Staff can follow up with conversations about the event, help plan for the next outing, or help the individual to make decisions about what else they would like to achieve.

OT skills also take place outside the therapy room and involve direct support staff who are assisting the person to dress or toilet in the evening. ST develops a protocol around safe feeding for the individual with dysphagia, and then trains staff in the procedure, but it is the consistent implementation of that protocol, at every single meal, that ensures that the individual will not develop an aspiration pneumonia.

Habilitation is central to active treatment. Specialized services are designed to be habilitative, in order to ensure that there is the acquisition of behaviors necessary for the client to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functioning. Residing in a nursing facility does not mean that the person has no life left to enjoy and cannot continue to grow and achieve new skills, maintain their level of functioning and be able to have the same rights as other citizens. The pursuit of happiness does not end at the entrance of the nursing facility.

D. Harm

All but one of the individuals reviewed have suffered harm as a result of the lack of needed specialized services and active treatment. That one individual (GH) has been in a persistent vegetative state for over a decade. The harm has occurred due to a delay in provision of services, the absence of recommended or necessary specialized service, the intermittent nature of specialized services provided through the Medicare, the lack of staff training in I/DD, the poor communication between the service coordination system and the nursing facilities, the lack of use of the PASRR specialized services by the nursing facilities, and the high turnover of staff both at the nursing facilities and in service coordination. Harm has been severe in that one individual has deteriorated significantly in the last two years (ES). Most others have shown some level of deterioration, due, in significant part, to the lack of specialized services (see Individual Findings, Section 7, below). These services have been available through the PASRR system but have not been utilized to benefit this group of individuals. They have paid the price for the lack of competency of the system.

7. INDIVIDUAL FINDINGS

Individual: NT
Copperas Cove LTC Partners
Copperas Cove, TX Review date: February 6, 2017

NT is an engaging 30-year-old woman who has resided in a nursing facility in Copperas Cove since October 27, 2014. She has languished in this facility due in no small part to the facility's failure to recognize her non-verbal communication skills. Previously she lived with her caregiver in a family home where she received 55.5 hours of home health agency services a week. She had a motorized wheel

chair, which she was able to independently maneuver. She went on community outings, such as shopping trips with her sister, and graduated from high school. She was placed in the nursing facility for a temporary 30-day stay, following the death of her caregiver. No one picked her up after 30 days, leading to her official admission to the facility. NT has quadriplegia, cerebral palsy, present at birth, as well as a seizure disorder which is controlled. She receives all nutrition through a gastric tube. Although she now is not allowed to have any food or liquids by mouth, her sister reports that previously she was able to eat some soft foods and particularly liked chocolate.

On the day I met NT, she was attractively dressed in a bright purple track suit, reclining in her customized manual wheel chair. She was neat, clean and her hair was attractively styled. She smiled broadly and although non-verbal, was able to respond to questions and comments with a thumbs-up sign, vocalizations and facial expressions. The service coordinator described how she will "play possum" and pretend to be sleeping in order to end a conversation – and NT demonstrated just how she did that with a broad smile. She likes to be active and likes music. She is dependent on nursing staff to meet all of her care needs. Throughout my visit she remained engaged in our conversation, and responded to direct questions.

NT did not have a comprehensive functional assessment by professionals with experience with persons with intellectual and developmental disabilities (I/DD). NT had a PASRR Level I done on 10/22/2014 that affirmed that she has a Developmental Disability (cerebral palsy). Convalescent care is marked; the remaining parts of the PASRR evaluation are blank. She had a PASRR Evaluation done on 10/28/2014 which states that a 30-day stay is anticipated. Other than Service Coordination, no Specialized Services were recommended. She had a Diagnostic Review Form completed on 10/28/14 which only shows Axis III-infantile cerebral palsy. Her first Individual Service Plan (ISP), dated 4/09/2015, states that NT could not make any decisions for herself, could not communicate in any manner, and needed no Specialized Services. The ISP noted that she wants to participate in music and social activities.

Within two months of the initial ISP, the service coordinator began wondering if NT had cognitive abilities and could communicate her thoughts and preferences. She started exploring communication opportunities because she, like NT's direct care staff, realized NT actually was communicating by raising her arm, blinking her eyes and pointing to pictures in books. On 6/18/2015, NT's service planning team (SPT) agreed she could benefit from a speech evaluation to determine if there were an appropriate assistive technology device to help her communicate. Five months later, on 11/6/2015, the nursing facility's speech therapist conducted an evaluation, but concluded that NT lacked the necessary motor skills to utilize such a communication device. Thus, professional staff continued to assume NT could not consider alternatives or express preferences about almost anything. At NT's next annual ISP meeting on 03/31/2016, no Specialized Services were recommended. But that changed after the nursing facility finally recognized – 19 months after her admission – that NT had significant cognitive abilities and could communicate with supports.

NT was evaluated for PT and OT on 5/27/2016, and subsequently, started getting some needed therapies through PASRR. The therapy department eventually initiated the paperwork to obtain an augmentative communication device for NT. One has been ordered, but still was not available when I visited several months later. When it arrives, it will attach to her wheelchair.

NT has received some, but not all, necessary specialized services. Between June and December of 2016, PASRR services recommended for NT included Specialized Occupational Therapy (OT); durable medical equipment (an evaluation of the wheelchair upper limb orthotic system to facilitate communication board use); Specialized Physical Therapy (PT) and Speech Therapy (ST) assessments; day habilitation; a customized manual wheelchair; and Specialized PT.

In December 2016, after the nursing facility finally recognized that NT wanted to and could participate in a range of specialized services, including those provided by the LIDDA outside of the facility, she started attending a day program two days a week from 9 am to 3 pm, which allowed her to leave the facility on a regular basis for the first time in over two years. Staff reported that she loved it. But this single, positive experience was short-lived: within a month or so, the program closed its doors, leaving her with no other options.

Contrary to the statement in the 2015 ISP, NT would have benefited at that time from Specialized Services in the areas of PT, OT, ST, Day Habilitation Services, and Independent Living Skills Training (ILST). These needs carry over into the present time. OT services could provide her with the skills to be more independent in activities of daily living such as bathing, using her wheelchair, personal hygiene, and tooth brushing. PT would help strengthen her muscles and increase her abilities to assist with transfers. ST could assist her in communicating with others, thereby decreasing social isolation. She would benefit from ILST as she likes to be active, go shopping and participate in other community activities as she did prior to admission to the nursing facility. The facility does not provide a young woman such as NT with opportunities to engage in age-relevant activities, or to engage with peers outside the facility. She participates in the activities within the facility but is not able to go on outings due to her mobility and medical needs. Notably, NT's team has recommended a swallow study, which the nursing facility has failed to conduct. According to the record, the study was denied "because Medicaid won't cover while in nursing facility." The veracity of this statement should be investigated and if covered, the swallow study should be performed. A Swallow Study would help determine if she could resume eating some foods by mouth as she did prior to her admission to the nursing facility. The taste of food is one the most fundamental of human pleasures.

The current director of nursing agreed that NT was intelligent, could read and understand information, and would benefit from moving to the community. For almost the entire duration of NT's stay in this nursing facility, her ISP and other records indicated she would benefit from returning to the community. Those records indicated that various obstacles, like a lack of a guardian, prevented this from happening. Two years later, the facility recognized that she did not need a guardian, and that she could make her own decisions, and, therefore, that she could leave as soon as an appropriate living arrangement could be identified. Presently, NT is scheduled to transfer to a community host home setting in March 2017.

NT is not receiving, and has never received over the past two years, a continuous active treatment program due to the delayed and intermittent nature of the Specialized Services of OT, PT, ST, and day habilitation services, and the lack of any ILST services. She did not receive a comprehensive functional assessment performed by an interdisciplinary team of professionals. The assessments she did receive did not take into consideration her young age, and primarily consists of diagnoses. It does not elaborate on her strengths, including her interests and abilities while living in the community. The assessments are done by the nursing facility staff and are comprised of health or medical related

concerns. Her ISPs continue to list one objective/outcome: "N wants to participate in music activities and socials in the dining room three times a week." It does not provide for training in personal skills for greater independence such as personal hygiene, dental hygiene, grooming, dressing and communication. She has been without an augmentative communication device, despite her ability to use one. She did not have the recommended Swallow Study, which may reveal that she could resume eating some foods by mouth. Her wheelchair is a customized manual wheelchair, not a powered wheelchair as she previously was able to maneuver, providing greater independence. Except for a brief period at the end of 2016, she has spent all of her time within the confines of the nursing facility. Her personal preferences of shopping, music and other activities have not been met. The nursing facility staff stated she would benefit from more community activities, day habilitation services, and living in the community.

Staff do not receive any training specific to serving individuals with IDD. They are certified nursing assistants, but do not receive training in understanding the specific concerns of persons with IDD, including the benefits of active treatment and habilitative services.

NT has suffered harm over her two years and three months at the nursing facility due to the lack of Specialized Services and active treatment. She lost skills she previously had including the ability to eat some foods and maneuver her own wheelchair. There was a lack of recognition of her non-verbal communication skills, depriving her of opportunities for self-determination. For most of the last two years, she never had the chance to work on body positioning; she never had the chance to self-propel in a motorized wheelchair; she never had the chance to make decisions or choices; she never had the chance to go into the community; and she never had the chance to get needed Specialized Services to learn new skills and prevent the loss of abilities she previously had. While NT will finally escape this situation if she leaves the nursing facility, as projected, she has been forced to endure more than two years of persistent lack of needed services, lack of active treatment, and ongoing harm.

Unfortunately, NT is not alone in this regard, and in this facility. During my visit to the nursing facility, I saw several other young individuals with IDD; the staff stated that they were not receiving any Specialized Services and would benefit from them. Although my review focused on NT, I observed six additional persons with I/DD in the common areas, many of whom were in their 30s, and most of whom I was told had been at this facility for decades. All six were kept and ate in a separate room that seemed to be reserved for individuals with I/DD or a related condition. Nursing facility staff reported that most did not receive any Specialized Services other than service coordination. Two individuals had briefly attended the same day habilitation program as NT until it abruptly closed. These are the only two individuals who received any form of Specialized Services.

Individual: ES
Spring Branch Transitional Care Center
Houston, TX Review Date: February 13, 2017

ES is a 45-year-old woman who resides at Spring Branch Transitional Care Center. She has been at Spring Branch at least since 5/05/2014, based on the records, though nursing facility staff said she has lived here for a number of years. She moved here from another long-term care facility. According to ES, at one point she lived with her father who lives in Wyoming. She also told me she has two daughters who have been placed in foster care. She did not know where they are now, but she readily provided their names – the names she gave them at birth – and their current ages. She was articulate and measured in her responses to my questions. Her voice was quiet and, with the exception of the forthright information regarding her daughters, her answers were minimal in content. Overall, her general affect seemed blunted, and she presented with very low energy.

ES's room was on a locked unit on the third floor of the facility. When I met her, she was lying in bed, dressed in a t-shirt and pajama bottoms. She was not wearing her helmet, but it was located within her reach. Her wheelchair was also in the room. Her semi-private room was messy with a dried red liquid spilled on her over-the-bed tray table; there were linens on the floor. ES, who can read and write, said that she liked puzzles, coloring and some of the activities at the nursing facility. She had participated in the ice cream social earlier that day.

ES did not have a comprehensive functional assessment conducted by a team of interdisciplinary professionals who are experienced in working with individuals with I/DD. She had a PASRR Level 1 conducted on 5/05/2014, which indicated intellectual disability and mental illness. She had a PASRR Evaluation done on 11/07/2016 which affirms I/DD and MI. It recommends Specialized Services of Occupational Therapy (OT), Physical Therapy (PT), Speech Therapy (ST), Alternate Placement Services, Service Coordination, Independent Living Skills Training (ILST), Behavioral Support, Employment Assistance, Supported Employment, and Day Habilitation Services. As described in more detail below, she is not receiving any of these services on a regular basis. She also is not receiving adequate assessment services in the area of physical development and health. She rarely sees a neurologist despite having an active seizure disorder, and the psychiatrist who sees her does so on a pro bono basis. She is prescribed medication for her psychiatric diagnoses which include unspecified mood (affective) disorder, unspecified psychosis not due to a substance or known physiological condition, bipolar disorder, unspecified major depressive disorder, single episode, unspecified, and anxiety disorder, unspecified. She has been hospitalized for her seizure disorder as recently as January 2017 and on 12/22/2016 when it was found she had very high levels of one of her anti-epileptic drugs.

Her Individual Service Plan (ISP), dated 5/25/2016, includes a statement that she has a "ventricular nerve stimulator" which is inaccurate and misleading. She has a vagus nerve stimulator, implanted in her left chest wall and her left vagus nerve, to assist in controlling her seizures. A ventricular nerve stimulator is used for controlling the heart and is implanted in the right chest wall, accessing the right vagus nerve. While the devices are similar, their intended action is very different and they treat different conditions. The ISP sections "preferences" and "strengths" are inadequate, as they simply state "I like to be independent" and "I like to have contact with my guardian."

As noted above, ES is not receiving any of the multiple Specialized Services recommended in her PASRR Evaluation of 11/07/2016. Even service coordination has been lacking. It has not been consistent and does not appear to include other relevant members of her team, such as the guardian and the nursing facility staff. The nursing facility staff and the guardian both state there is a lack of communication among important team members. The guardian said that she has not heard from the service coordinator in over six months. The nursing facility staff report that the Local Authority is very unresponsive to their inquiries for assistance and does not solicit their input in ES's ISP. The service coordinator does not regularly attend care planning meetings, although she has been more present within the last couple months.

Although the nursing facility staff said she had received OT and PT at different times, the records available show she only had OT once, from 5/22/2014 through 7/20/2014. Since then, according to the records, she has not received any PT or OT services even though she has experienced multiple falls, many of them resulting in head lacerations requiring surgical repair. A fall on 12/23/2016 required staples to the back of her head. She also had a surgical repair to a head laceration in June and July of 2016; a CT scan of her head on 5/31/2016; and a laceration to her head on 12/15/2016. She was ordered PT, OT, and ST evaluations on 4/20/16, and was ordered a PT and OT evaluation on 5/12/2016 after a hospitalization, but there is no record that they occurred. In addition, she has a diagnosis of muscle wasting and atrophy, which would also indicate a need for PT. She was also ordered to have a speech therapy evaluation on 5/16/2016 related to her diagnosis of oropharyngeal dysphagia. However, there is no record that she received the evaluation. In addition, there is no indication that she is receiving any of the other recommended services: Independent Living Skills Training (ILST), Behavioral Support, Employment Assistance, Supported Employment, or Day Habilitation. Based on the nursing facility record, she never received any of these services.

I concur with the recommendations in ES's PASRR Evaluation. She requires assistance with all of her self-care needs and would benefit from OT and PT to increase her independence and improve her functioning. Her guardian also suggested that with OT services, she could probably perform more activities of daily living. She does not have any medical diagnoses or physical impairment that would limit her ability to perform her own self-care. ES also would benefit from Behavioral Support services. She has had several episodes of aggression toward other residents, often resulting in her transfer to a locked unit. In addition, several references in the record, confirmed in my interviews with the nursing facility staff, suggest at least some of her falls may be intentional as attention seeking behavior. A comprehensive behavioral assessment would assist her in developing a plan to reduce these dangerous behaviors and enable her to have better health and social interactions. She would benefit from ILST as she does not have a peer group at the nursing facility and would thrive on interactions in the community. ILST would provide her with some 1:1 attention and enable her to learn to function more independently. She can read and write and would benefit from the stimulation of more normalized activities such as going to the library or enjoying a movie. She would also benefit from day habilitation services and, similarly, Supported Employment services to enhance her skills. Given her relatively young age, 45, she would benefit from the structure and challenge of working in a supported environment. Nursing facility staff and her current guardian agree she would benefit from opportunities to converse with people her own age and be productive.

ES is not receiving active treatment. She did not have a functional assessment, she is not receiving the recommended specialized services except for inconsistent and often, non-responsive,

service coordination. She is not receiving services that would assist her in learning new skills, and her guardian believes that she is losing the skills she has. ES is not supported to have greater independence through the acquisition of increased skills for self-care, ambulation, behavior control, social interaction or self-determination. She spends most of her time lying in bed despite the fact that she has several strengths such as the ability to read and write.

Staff of the nursing facility do not receive any additional training in providing services to individuals with I/DD.

ES has suffered harm due to her lack of both Specialized Services and active treatment, as well as necessary medical services. She has a serious seizure disorder, which is not controlled even though she is on several anticonvulsant medications and has an implanted device, the vagus nerve stimulator. The guardian pointed out she was hospitalized for seizures three weeks prior to my visit. She has also been hospitalized for seizures on 8/20/2016 and received an injection of Ativan for seizures on 10/20/2016. She has had many laboratory tests that have shown that her anticonvulsant drug levels are beyond normal range, usually too high, but on occasion, too low. This is true of both Valproic acid and Keppra. Uncontrolled, repeated seizures result in irreversible injury to the brain, compromising functional ability and premature death. Side effects of Keppra include infection, drowsiness, headache, nervousness, aggressive behaviors, hostility, fatigue and irritability. Side effects of Valproic Acid include drowsiness, nausea, vomiting, diarrhea, flu-like symptoms, and depression. High doses increase the likelihood of side effects and low doses increase the likelihood of seizures. A review of the record from 4/22/2016 through 12/30/2016 shows that 5 of the 9 levels done of Valproic Acid were not within the normal range. For the same period, 4 of the 5 levels done of Keppra were not within the normal range. Despite the seizure activity and the blood level problem, she sees a neurologist rarely. There is an order for a neurology consult from the primary care physician dated 1/09/2017 and the guardian thought she saw one last month, but there are no records of a neurology consultation. The multiple falls, whether intentional or due to her level of medications or lack of strength, are causing her harm. Several of her falls have resulted in head lacerations requiring surgical repair. While she has been treated for these events, she has not received a comprehensive consultation for traumatic head injury. The nursing facility staff question whether she may have a more serious, undetected brain injury due to the repeated head injuries.

Despite the fact that her record often refers to the intentional nature of these falls, she is not receiving any behavioral services which would help to address this dangerous behavior. She has also had several outbursts of physical aggression toward other residents, resulting in her transfer to a locked unit. She is seeing a psychiatrist, but the nursing staff states that he is doing is as a pro-bono service since she is denied psychiatric services from her insurance. This can result in visits which may not be as frequent as necessary and a potential lack of continuity regarding ongoing psychiatric oversight. As stated above, she has several psychiatric diagnoses.

ES has also suffered harm in that she has lost skills in self-care, social interactions and muscle strength and balance. Numerous recommendations for services that would help her to gain more independence, self-determination and the opportunity for a meaningful life have been ignored. As a result, her world has shrunk to a semi-private room on a locked unit.

Individual: MM
Regency Manor Nursing Facility
Temple, TX Review Date: February 7, 2017

MM is a 74-year-old gentleman who has resided at Regency Manor Nursing Facility since 2/14/2012. He moved here from a nursing facility in Hearne, Texas, and prior to that, he lived at home with another individual in Rosebud, Texas. According to MM's guardian, a complaint was substantiated against that person, prompting MM's removal from the home. According to the record, he attempted to leave Regency Manor on several occasions, leading to his transfer to the secure unit on 9/17/2014. At the time of my visit, he was still living on the secure unit at the nursing facility.

When I met MM, he was in the facility's dining room, dressed neatly in jeans and a t-shirt. He answered my questions briefly but clearly. He stated he liked popcorn and watching television. He is described as a "loner" who prefers to stay in his room to watch television, although he will come to the dining room at times and sit with his former roommate. He generally does not participate in activities in the nursing facility. In addition to an intellectual and developmental disability, he has mental health diagnoses of schizophrenia and depression, and sometimes displays behaviors such as attempting to remove his clothing, crying and having outbursts.

His guardian said he has noticed a visible decline in MM's abilities over the last couple of years. Reportedly, MM is able to walk, but prefers to use a wheelchair which he self-propels. He was walking more frequently up until about six months ago when he experienced a fall. His service coordinator and guardian report that due to his fear of falling, he now uses the wheelchair on a regular basis. He is able to provide his own care, but requires assistance and supervision; he needs encouragement to get out of bed and dress himself. He loves popcorn, and is very motivated to obtain it.

MM did not receive a comprehensive functional assessment by an interdisciplinary team of professionals experienced in providing services to individuals with I/DD. He had a diagnostic review on 5/01/2014 which shows mental retardation, severity unspecified, and little else. The records provided include an incomplete PASRR Evaluation (multiple pages are missing), and a PASRR Level 1 Screening, dated 1/6/2015, that indicates he has an intellectual disability and a mental illness. He did have a PASRR Specialized Services (PSS) Form which showed that PSS services were reviewed on 12/16/2015, 3/15/2016, 6/13/2016, 9/13/2016, and 12/13/2016. Other than service coordination, no Specialized Services are recommended. He has an Individual Service Plan (ISP), dated 12/13/2016, in which the only goals are to watch television whenever he wants and to have popcorn whenever he wants, with supervision. According to the SPT Meeting Summary, progress is being made on these "goals" because staff are honoring his requests. These are not goals that will increase his independence or maintain his current level of functioning. Previously, MM had a goal, now discontinued, to work on walking and balance. MM's guardian and his service coordinator remain concerned that MM will become dependent on using his wheelchair even though he is capable of walking. Meeting notes from 12/13/16, included in the ISP, state that at times MM will get out of bed and walk to the dining room independently, and that staff are to make sure MM is up and out of bed several times throughout the day. When I discussed this with the service coordinator, she noted that not all staff members encourage MM to walk.

MM is not receiving Specialized Services other than service coordination. Despite his problems with ambulation and unsteadiness, he has not received Specialized Services in the areas of physical

therapy (PT) or occupational therapy (OT). According to SPT Meeting Notes, he had a physical therapy (PT) and occupational therapy (OT) evaluation around September 2016, and was recommended for restorative services. He then received PT three times a week for thirty days. It was discontinued on 11/15/16. He also received time-limited PT, delivered by nursing facility staff, for a brief period earlier that year. The Service Coordinator's Progress notes indicate that at that time, Specialized Services forms were submitted requesting habilitative PT through PASRR. During my visit, the Service Coordinator said that the nursing facility faxed the paperwork and did not receive a response, and further reported that this is a consistent issue.

MM would have benefitted from PT and OT from the outset, beginning at the time of his admission in 2012 and continuing through the current date. He is losing functional ability; it will be harder and harder to slow the rate of his decline. MM is now spending much of his time in bed, watching television, unless a concerted effort is made to have him get up and do other activities.

He has not had evaluations for speech therapy (ST) despite a diagnosis of dysphagia. The guardian requested a swallow study on 9/17/2015, due to MM's dislike of honey-thickened liquids, coupled with the incongruity of requiring him to drink such liquids yet allowing him to eat popcorn. The nursing facility has not followed up on the request for a swallow study; the ISP states he has "no issues with chewing or swallowing" even though both the ISP and the Nursing Facility Plan of Care point out he has dysphagia and requires supervision when eating because he tends to eat too fast and has had choking episodes in the past. This is a potentially dangerous situation, particularly because aspiration is one of the leading causes of mortality in individuals with I/DD. There is no information in the records reviewed which explain why nursing facility staff said he has no issues with chewing or swallowing. He should receive a speech therapy (ST) evaluation to determine the status of his dysphagia.

In addition, there is no psychological assessment despite his mental health diagnoses and documented behaviors. Although he is receiving psychiatric/behavioral services at least monthly from Vericare, he does not have a behavior support plan. He is on psychotropic medications and has diagnoses of depression and schizophrenia. His desire to stay in bed and lack of motivation may be a result of his depression. A behavior specialist should provide an assessment to determine if a behavior support plan would be beneficial to address his depression, behaviors, and his ongoing adjustment to his placement in a nursing facility. Over the past two years he has become less willing to participate in many activities at the nursing facility. An Independent Living Skills provider, trained in working with individuals with I/DD, could provide the one-on-one attention he needs to resume his previous level of social interactions and encourage him to explore areas of interest and enjoyment. It would also give him an opportunity for a different activity in his very circumscribed life.

MM's guardian attends all service planning meetings, but stated that there is little connection between the nursing facility's plan of care and the LIDDA's ISP. MM's service coordinator noted that she rarely is notified about or participates in the nursing facility's care planning meetings. The significant turnover of leadership and staff at the nursing facility means that few people really know or understand MM, especially on the secure unit where he spends his entire day.

According to the service coordinator, the challenges of serving MM, as well as the eight other individuals with I/DD in this nursing facility, are considerable, given the difficulty scheduling and coordinating service planning meetings, the lack of consistent staff interventions or support services, inadequate transportation to community services, and staff turnover. Even when the SPT recommends

specialized services, the nursing facility is reluctant to request them, apparently because they feel it is a hassle to request authorization from the state agency (DADS). The service coordinator is no longer allowed to follow up with DADS about such requests, making it difficult to determine why specialized services are rejected.

MM is not receiving active treatment through a program of continuous, aggressive, consistent implementation of services which are based on his strengths and preferences and which would enable him to function with as much self-determination and independence as possible. Moreover, he has suffered regression of his previous level of functioning over the past two years. Other than service coordination, he is not now nor has he ever received Specialized Services. The nursing facility has not followed through on the guardian's request for a swallow study and the service coordinator's offer of a customized manual wheel chair. MM's only two goals in his ISP are to allow him to watch television in bed and to have as much popcorn as he wants. Both of these goals direct staff behavior and do not enable him to acquire any new skills or prevent regression of his current skills. The guardian would like him out of bed as much as possible. While MM refuses some services and activities, he does not receive behavioral supports which would provide a structured framework for staff to encourage greater independence and activity. Lack of PT and OT is likely to cause a further decline in ambulation and self-care skills, and lack of ST leaves the question of his dysphagia unresolved with the potential for aspiration pneumonia.

Staff do not receive any additional training in working with individuals with I/DD.

MM has suffered harm as a result of not receiving needed Specialized Services and a lack of active treatment. As his guardian stated, MM has declined in the last two years. When he was admitted to the facility, he was ambulatory and would walk about the building. He is no longer ambulatory, and prefers to spend most of his time in bed or in his room watching television. He has not received a behavior assessment or ILST, which might allow him to resume his previous level of social interactions. His fear of falling will impact his loss of ambulation and transfer skills, making his decline more inevitable. As noted above, his ambulation and self-care skills are likely to further decline due to the lack of PT and OT, and MM is at risk of choking or aspiration pneumonia due to the lack of an ST evaluation.

Individual: RB
Marbridge Villa
Manchaca, TX Review Date: February 9, 2017

RB is a 56-year-old gentleman who has resided at Marbridge Villa since May 23, 2012. Previously he lived at home with his mother, who has since passed away. His sister is his guardian; he also has a close relationship with an aunt who calls regularly. RB loves to laugh and sing and generally has a pleasant demeanor. He enjoys movies such as "9 to 5" and "The Sound of Music." He is verbal, although not talkative and can be difficult to understand. He requires assistance in his activities of daily living (ADLs). He likes to walk about the nursing facility, and is usually carrying VHS tapes, papers and markers. His behavior sometimes is described as compulsive, and occasionally causes some consternation when he goes through other people's possessions in search of similar items.

RB was hospitalized for over a month from March 27, 2016 to May 7, 2016. The admitting diagnosis was aspiration pneumonia. While he was hospitalized, doctors attempted, without success, to repair his hiatal hernia. He became ill with generalized sepsis, and suffered respiratory failure, necessitating intubation and j-tube placement. He was also hospitalized for aspiration pneumonia in April 2015. When I met RB, he was in his room with his VHS tapes, papers and markers. He made eye contact and minimally responded to my questions and comments. He indicated he wanted to conclude the conversation by saying, "Bye, Barbara."

RB did not have a comprehensive functional assessment conducted by an interdisciplinary team of professionals who are experienced in working with individuals with I/DD. As indicated in the 2/19/2015 Individual Service Plan, he had a PASRR Evaluation which was positive for I/DD. There was not a PASRR Evaluation nor a PASRR Level 1 form in the records made available to me. He had multiple nursing facility assessments done by social workers and nursing staff, but none by any disability professional or an interdisciplinary team. These nursing facility assessments are focused on medical/nursing needs and do not identify RB's specific developmental strengths and needs. He has an Individual Service Plan (ISP), the most recent of which is dated 6/10/2015.

The service coordinator and the social worker report that they conduct their planning meetings jointly and participate in the other's plan of care. Attendance at meetings generally consists of a variety of relevant staff, the service coordinator and the individual, although RB participates only minimally in his planning. His sister/guardian is consulted regarding his service planning. The ISP has two goals/outcomes: (1) the service coordinator will advocate for RB to have soda while also respecting his dietary needs; and (2) the service coordinator will communicate with the social worker to ensure RB has access to phone whenever he wishes to speak to his family. These goals are not related to increasing his self-determination and independence, but rather, are goals for staff to achieve in ensuring that some of his health needs and human rights are met. The service coordinator reports that the nursing facility is responsive to requests and will follow up as warranted.

RB is not receiving all the Specialized Services that would meet his needs. Staff at the nursing facility indicate that he would benefit from Independent Living Skills (ILST) because he would enjoy the 1:1 attention it affords, and it would provide opportunities for him to increase his social interaction and community involvement. He has been recommended for this service, but to date, no provider has been identified. He would also benefit from Behavioral Support services due to his compulsions around VHS

tapes, paper and markers. These behaviors have placed him at risk for aggression from other residents as he sometimes intrudes into their rooms and private spaces, looking for such items.

In addition, RB would benefit from continued Speech Therapy (ST). In 2015, RB also had ST for four weeks following a brief hospitalization for aspiration pneumonia. At that time, the speech therapist stated that he had not met his goals for safely eating and was at a high risk for aspiration. As described above, about a year ago he had a very serious episode of aspiration pneumonia which resulted in a 5-week hospital stay. He also had a j-tube placed for all nutritional support, and was not able to eat anything by mouth. Aspiration is one of the leading contributors to death for individuals with I/DD and it is critical that his aspiration protocol be followed consistently. Upon discharge in May of 2016, he received nursing facility rehabilitation services, including Occupational Therapy (OT), Physical Therapy (PT) and ST, but only for three months. These therapies were effective as he progressed from minimal abilities to a return to his previous level of functioning. He also progressed to eating soft foods, and he no longer has a j-tube. However, the speech therapy discharge summary, dated 8/12/2016, indicates that he remains a high risk for aspiration. In addition, the discharge summary concluded that despite extensive training, staff "continues to demonstrate inconsistent support" on safety precautions. Nevertheless, RB is not receiving any of these therapies on an ongoing basis for habilitation, even though he could benefit from Specialized Services.

RB is not receiving active treatment as he has not received a comprehensive functional assessment that resulted in an individual program plan developed by an interdisciplinary team of professionals, and is not receiving all the Specialized Services he requires, specifically in the areas of Speech Therapy, Independent Living Skills and Behavioral Support services. His program is not continuous, aggressive and consistently implemented as there is no overall plan which outlines goals and objectives that are to be carried out throughout his day.

Staff at Marbridge receive additional training in providing services to individuals with I/DD. According to the administrator at Marbridge, about 80 residents have I/DD, and about 55-60 of them are PASRR eligible**.** Two service coordinators are responsible for all the PASRR clients. The facility administrator said the habilitative services available through PASRR are very beneficial to individuals, and in particular, he cited Behavioral Support services. He also said that Independent Living Skills Training (ILST) is a widely used service at Marbridge. However, he complained the PASRR program is not adequately funded. He said nursing facilities are incurring deficits because they are not fully reimbursed for contracting with outside therapists for habilitative services, such as physical therapy, occupational therapy and speech therapy. Nursing facility staff further stated that although some residents might benefit from specialized day habilitation services, none are receiving them. A major impediment appears to be the lack of necessary transportation services. The few day habilitation providers that are available either do not offer transportation services to and from the nursing facilities, or do not offer wheelchair-accessible transportation, thereby limiting the availability of the program.

RB has suffered due to a lack of needed Specialized Services. Further, he has suffered harm, and remains at serious risk of harm, as evidenced by his lengthy hospitalization in 2016 for aspiration pneumonia and the speech therapist's finding that staff are not consistently implementing his aspiration protocol. He also continues to exhibit compulsive behaviors and would benefit from an assessment and services from Behavioral Services. These behaviors interfere with his ability to perform other activities and place him at risk for harm from other residents due to his intrusion into private spaces.

Individual: PA
Walnut Hills Nursing and Rehabilitation Center
Austin, TX Review Date: February 9, 2017

PA is a 73-year-old woman who has resided at the nursing facility since 1/21/2009. Prior to her admission she lived near family in a mobile home and was able to meet her daily needs, including cooking her own meals. She is close to her great-aunt and looks forward to her phone calls and visits. PA also has a corporate guardian who attends some of her meetings and is in contact with the service coordinator. PA is described as liking to participate in activities, reading, crossword puzzles, jewelry and socializing with others. She becomes tearful at times and makes inappropriate comments, such as telling people she loves them. She has diagnoses of episodic mood disorder, mild intellectual disability, delusional disorder and depressive disorder. When she arrived at the nursing facility, she was walking with support. Her mobility changed dramatically after a fall and hip fracture on 9/20/2014. She had a hip replacement, but became wheelchair dependent. PA repeatedly states that she wants to walk again.

When I arrived, PA was sitting in the hallway in her wheelchair, dressed neatly and appropriately. She engaged in conversation with me, though sometimes her responses were not necessarily on target to the questions. She repeatedly said that she "loved" me and my colleague. When we told her we needed to leave, she burst into tears. We helped her maneuver in her wheelchair to the dining room, where she joined several friends at a table. One woman, another resident, told her that she would be okay and held her hand. PA's tears subsided after a few moments. In addition to meeting with the nursing facility staff and PA's service coordinator during my visit, I also spoke with PA's corporate guardian on the phone. She had planned to be at the meeting but was stuck in traffic and did not come. The guardian said she would like PA to receive Specialized Services of PT, OT and independent living skills (ILST). As discussed below, the guardian previously requested ISLT, which has never been provided.

PA did not receive a comprehensive functional assessment conducted by an interdisciplinary team of professionals with experience working with individuals with I/DD. She had a PASRR Level 1, dated 11/1/14, which is positive for Intellectual Disability and Mental Illness. She had a PASRR Evaluation on 3/8/15, which affirms the intellectual disability and recommends service coordination. Assessments are primarily done by nursing facility staff or the service coordinator. The nursing facility assessments focus on medical/nursing concerns such as fall risk, skin integrity, bowel movements, medical conditions and self-care skills. They do not assess PA's specific developmental strengths and needs, nor do they describe the adaptive behaviors or independent living skills necessary to prevent or slow the loss of current optimal functional status, or acquire the behaviors she needs to function with as much self-determination and independence as possible. Any assessments she has had for physical therapy (PT) or occupational therapy (OT) are not done concurrently with updates to her individual service plan (ISP). The latest ISP in the records made available to me is dated 12/29/2014 – more than two years ago. It was developed a few months after PA's hip fracture. The information in this outdated ISP was provided by two nursing facility staff, the social worker and the MDS nurse. PA's outcome/goals were to walk with her walker and to eat in the dining room. PT and OT Specialized Services were recommended at that time. According to the current service coordinator, planning meetings are better coordinated now than in the past and occur jointly.

PA is not receiving the Specialized Services that she now requires to prevent regression of skills and maintain her current level of functioning. The only Specialized Service she has received over the past two years is service coordination. Previously, after her 2014 hip fracture and surgery, PA was authorized to receive Specialized Services in PT and OT. The service coordinator noted in her summary of the 12/29/2014 Service Planning Team meeting that she would monitor the delivery of service to ensure PA received the "maximum amount of specialized services" to meet her goal of walking with the aid of her walker. Initially, the therapies appeared to be effective. As of 1/21/2015, PA, assisted by a therapist, was using the walker to walk to the dining room for meals. But a month later, PT was stopped after PA had a urinary tract infection. On 2/26/2015, the rehabilitation therapist at the nursing facility suggested PA would never walk again and would be wheelchair-bound for the rest of her life. Compounding the problem was an infection (E.coli) that kept PA in isolation during the spring of 2015. On 9/8/2015, the service coordinator reported the nursing facility had no action plan to help PA walk again. At that time, PA was not receiving any skilled therapies and, according to the service coordinator, the Assistant Director of Nursing said PA was not a good candidate for habilitative services available through PASRR.

PA did not make progress toward her goal to walk with a walker. She has received intermittent, time-limited PT and OT therapies (not PASRR Specialized Services) on different occasions. At the time of my visit, she was receiving such time-limited PT services as a result of a recent fall. On 11/3/2016, she slid out of her wheelchair. She has had other intermittent rounds of services. For example, following a recommendation from her service planning team on 1/13/2016, she was evaluated by the rehabilitation staff and received PT for a couple of weeks until 2/04/2016. The rehabilitation therapist reported 5/11/2016 that PA was receiving of services for a few weeks to increase the number of times she got in and out of bed. She received additional PT services in July, and was discharged on 7/26/2016. The PT and OT services provided through insurance, not PASRR, have been intermittent and usually last about four weeks before PA is discharged. She would benefit from Specialized Services of PT and OT through PASRR as they would continue without interruption and enable her to build on the skills she receives from therapy.

PA also has had intermittent speech therapy (ST) through the nursing facility. On 12/1/2015, her guardian asked if ST could help PA with memory and cognitive skill building. PA had an evaluation in January of 2016 and a brief session of ST. She had a swallow study on 6/15/2015 which changed her liquids to thickened. She is on a feeding protocol and has a pureed diet as outlined in her nursing care plan. She independently feeds herself. In addition to speech, PA's guardian also has requested that she receive Independent Living Skills Training (ILST). However, PA has never received ILST. She would benefit from ILST services through the one-on-one attention she would receive from a provider trained in working with individuals with I/DD. She likes to be active and yet is unable to participate in all activities due to her mobility issues. She would benefit from acquiring skills in social interactions, choice and decision making.

PA also would benefit from the Specialized Service of behavioral supports. She is described as having inappropriate social behaviors, crying, yelling out and being infatuated with male staff. These behaviors have a negative impact on her social acceptance; she would benefit from learning to replace them with more socially acceptable behaviors that would lead to positive social interactions. In addition, PA would benefit from a customized manual wheelchair which would be lighter and easier to self-propel. She likes to be active and move about the nursing facility, but her manual chair is so heavy

that it is difficult to self-propel, and thereby restricts her ability to independently access activities, such as going to the dining room on her own.

PA is not receiving a continuous active treatment program which is consistently implemented, carries over across all settings and provides a plan that enables PA to acquire the behaviors to both function with as much self-determination as possible and prevent the loss of current optimal functional status. The intermittent nature of PT and OT has not helped her to achieve greater independence in walking, a skill she was capable of before her hip fracture. She has not learned to manage her inappropriate emotional behaviors. This causes her unnecessary sadness and impedes the formation of healthy relationships. The lack of a customized wheelchair impedes her ability to be more independent and engage in activities and relationships.

The nursing facility staff stated that they do not receive additional training in providing services to individuals with I/DD.

PA has suffered harm as a result of the lack of needed Specialized Services and active treatment. She has lost skills in mobility and is now totally dependent upon a wheelchair. Further, she has difficulty self-propelling the wheelchair, and is forced to depend on staff to help her access activities outside her room, including the dining room. As a result, PA has lost the independence that mobility provides. She continues to engage in inappropriate behaviors and has diminished social skills. Her self-care skills have also declined, leaving her more dependent upon staff for dressing, transfers and personal hygiene. Prior to her admission she was preparing her own meals, and now she needs assistance to make it to the dining room. The lack of independent living skills training has meant that she has not been able to engage in the activities she enjoyed in the past and has led to a life that is less meaningful and does not challenge the abilities that she possesses.

Individual: AC
Legend Oaks Nursing Facility
Kyle, TX Review Date: February 8, 2017

AC is a 63-year-old woman who has resided in Legend Oaks nursing facility since October 2013. Her mother, who has since died, was also a resident at the same nursing facility. Previously, AC lived with family members in the community. She has an active family and sees them frequently both in the facility and at their home. Her sister-in-law assists her in decision-making. When AC was admitted to the nursing facility, she was placed on hospice due to adult failure to thrive. She weighed 76 pounds, which was well below her ideal body weight. Since then, she has been discharged from hospice as she has gained weight and her immediate prognosis has improved.

AC is diagnosed with Parkinson's disease and, according to her sister-in-law, Stiff Person Syndrome. Stiff person syndrome is a rare neurological disorder with features of an autoimmune disorder. Symptoms may include muscle stiffness of the trunk and limbs and heightened sensitivity to noise, touch and emotional distress which can set off muscle spasms. (Genetic and Rare Disease Information Center, National Institute of Health; accessed 3/16/2017). AC was able to walk with a cane and perform her self-care needs with assistance prior to her admission to the nursing facility. The progression of the disease has resulted in contractures of her hands which limit her ability to perform self-care. She can stand for short periods of time with direct assistance, but is no longer able to walk. She uses a wheelchair for mobility. As the disease progresses, she will continue to lose functional abilities; it is expected that her esophagus will close and she will need a g-tube for nutrition.

At the time of my visit, she was attractively dressed, seated in her wheelchair. Her sister-in-law and the nursing facility social worker were present. AC was quiet, attentive and listened closely to the conversation. She responded appropriately to questions in a voice that is low in volume. She smiled easily and made small jokes. She stated that she liked living at the nursing facility and that she liked to visit her family. She said she didn't like occupational therapy (OT) because it hurt too much to do it.

AC did not receive a comprehensive functional assessment by an interdisciplinary team of professionals who are experienced in working with individuals with I/DD. Her assessments are done by the nursing facility staff and are primarily medical. She had an OT assessment, but it is not part of her initial assessment. She has an individual service plan (ISP), dated 10/26/2016, which was developed with input from her former service coordinator, and nursing staff, the activities director and the former social worker from the facility. The ISP plan is not coordinated with an OT assessment that flagged several areas of regression, or other assessments done by nursing staff that describe her functional abilities and address areas such as nutritional status, sensorimotor development, affective development, speech and language development, auditory functioning, cognitive development social development and adaptive behaviors or independent living skills necessary for her to be able to function in the community. The current social worker just started work the week of my visit and is unfamiliar with the PASRR program. Moreover, the service coordinator who convened the ISP meeting no longer works with AC, who recently was assigned a temporary service coordinator.

Other than intermittent service coordination, AC is not receiving necessary Specialized Services. She just started receiving physical therapy (PT); the record is not clear if it is through PASRR or through her insurance. AC had rehabilitative OT, through insurance, shortly after admission in 2013 for the

contracture of her hand, but she said it hurt and refused to continue treatment. She also had time-limited OT from 6/16/2016 until 8/10/2016 in response to a decline in eating skills and her increasingly contracted hands. AC needs ongoing habilitative OT for her contractures which will continue to deteriorate if this specialized service is not provided. She also receives psychotherapy through the nursing facility.

She would benefit from Independent Living Skills Training (ILST) services which would provide one-on-one attention, increased social interaction and the ability to access more community based activities and increase her ability to function in the community. Despite her ever increasing reliance on a wheelchair, she has not received a customized manual wheelchair, designed for her specific needs. She has not received service coordination consistently. She would benefit from consistent, on-going service coordination in order for her to develop a trusting relationship. Her family would like her to receive Specialized Services such as OT, PT, ILST and a customized manual wheelchair. As the prior service coordinator pointed out, AC would benefit from Specialized Services. AC's refusal to pursue services such as OT and PT seems primarily based on fear of pain. However, her condition is progressive and therapies would help prevent regression and help to lessen pain from the continuation of contractures.

AC is not receiving active treatment due to the lack of a comprehensive functional assessment, an individualized program plan and the near total lack of Specialized Services. She has received service coordination only intermittently and has just started PT in January 2017. She is not receiving a continuous program of services that are carried over throughout her day and which would prevent regression and current loss of optimal functional status.

Staff do not receive any specialized training relative to the particular needs of individuals with I/DD. There are about 15 residents at the nursing facility who have I/DD.

AC has suffered harm as a result of not receiving needed Specialized Services and a lack of active treatment. She has lost self-care skills in all areas. The OT assessment of 6/17/2016 shows significant regression in five areas over a five-month period from 1/17/2016 to 6/17/2016. She is no longer "independent "in one area, and now requires more assistance in all other areas. She no longer can walk but is dependent upon a wheelchair for mobility. Her hand contractures have increased. She has not benefitted from the ILST program and has not increased her skills in social interaction and functioning in the community. No one has addressed her refusal to accept PT and OT, and any opportunity for the benefits those services could have yielded over the past three years has been lost. It is critical to initiate services now.

Individual: JH
Heritage Park Nursing and Rehabilitation
Austin, TX Review Date: February 8, 2017

JH is a 59-year-old gentleman who has resided at Heritage Park since 8/04/2011. He transferred here from another facility, but in the past, he had lived in a group home. In fact, the activities director at Heritage Park worked at the same group home when he was living there. When we met JH, he was resting on his bed in his room which is located on a locked unit of the nursing facility. He has been on this unit for most of the past four years. The locked unit has approximately 20-24 individuals, and can include those who have mental health issues. JH is on the unit for safety reasons because the staff is concerned that he might wander. The unit consists of a long hall way with several semi-private rooms. At one end there is a small common space with a few tables and chairs. There is an activity room near the entrance of the locked unit, where several individuals were playing various games. There is also an outside patio area for the residents of the locked unit which can be accessed through this activity room.

JH has diagnoses of Alzheimer's disease, hypertension, hypothyroidism, unspecified convulsions, bi-polar disorder and osteoporosis. JH is non-verbal, but according to the records and interviews, he understands English and knows how to read. He was minimally responsive to our greetings and questions. He made sustained eye contact with me during our time with him. He got up from bed and walked a few feet to a common area where he sat at a table. He did not interact with any of the other residents who were in that area. He is described as quiet and prefers to be alone. He does not engage in many activities at the nursing facility but will look at magazines. His guardian told JH's Service Coordinator that he liked sports and he "was fond of reading sports magazines." In September of 2015, his team recommended that the nursing facility purchase a sports magazine subscription for him. Although this continues to be an outcome/goal for JH, at the time of my visit the facility had yet to purchase a subscription.

JH did not receive a comprehensive functional assessment developed by an interdisciplinary team of professionals who have experience working with individuals with I/DD. He had a PASRR Level I done on 7/20/2015 which affirms IDD and Mental Illness; the form indicates he was admitted for convalescent care but is otherwise blank. JH had a PASRR Evaluation done on 5/15/2015 which affirms I/DD and states that he requires assistance in self-care areas. It recommends Service Coordination, but no Specialized Services. There is a contradiction in the document in that the Mental Illness section is not filled out and yet six different mental health services are recommended. There is no record that JH is receiving any of those services, or that an assessment of his mental health or habilitative needs has been done.

According to the service coordinator, it is very difficult to schedule team meetings with the staff of the nursing facility. Facility staff generally do not attend the service coordinator's quarterly meetings. Despite her request, the service coordinator said she is not notified in advance of the facility's nursing care plan meetings. She reports that it is difficult to obtain information from the nursing facility staff regarding JH's progress or updates, and further, suggests that the nursing facility staff do not share information among themselves.

The ISP of 7/14/2015 has two outcomes/goals for JH: 1) continue feeling good and have independence in the nursing facility; and 2) form connections with other people. The ISP does not

describe how this will occur, who is responsible and what the measurements will indicate if the goal has been met. There are no services or interventions described or provided to assist JH achieve these goals.

Based upon a review of the records, interviews with staff and with JH, he is not receiving any Specialized Services. He did receive occupational therapy (OT), intermittently, in April-May 2015 and again in December 2015-January 2016, and speech therapy (ST) in January-February 2016. All services were time-limited, and provided through the nursing facility's standard rehabilitation program rather than on an ongoing basis, as needed, through the PASRR program. OT was discontinued due to his meeting short-term goals; physical therapy (PT) was discontinued based on a finding that his "maximum potential" was reached; and ST was discontinued with only some goals met. JH would benefit from ongoing Specialized Services in all three of these need areas. For example, Specialized Services in OT could address his bowel incontinence which was evident the day of our visit and referenced in service coordinator notes. OT would also help provide JH with increased independence in self-care skills, such as dressing, personal hygiene and dental hygiene. He is described at times as "disheveled" in appearance. In addition, the nursing facility staff say he would benefit from Specialized Services in PT to continue to work on his gait and balance.

JH also would benefit from continued support regarding his self-feeding skills, through OT and ST. In January 2016, speech therapy obtained a Modified Barium Swallow Study (MBSS) and provided dysphagia therapy to decrease the likelihood of aspiration. The MBSS showed that he has a mild pharyngeal dysphagia and remains a high risk for aspiration due to his impulsivity. Nursing facility notes indicate that he eats fast and "stuffs" his mouth with food. Despite this finding, the nursing plan of care does not mention an aspiration protocol or the ST recommendations for feeding. Significantly, his intermittent ST services ended before he achieved all of the ST goals around feeding. Aspiration is one of the most frequent contributors to death of individuals with I/DD; for people such as JH, an aspiration protocol, followed consistently by nursing staff, is critical to his well-being.

Other Specialized Services that would benefit JH, as described by nursing facility staff, are Independent Living Skills Training (ILST) and Behavioral Services. The nursing facility staff and service coordinator reported that JH likes 1:1 attention and often shadows favored staff. The ILST services would give him that attention while simultaneously providing an opportunity for him to get outside the facility and increase his social skills and independent living skills. It would also meet his identified need for a less stimulating environment by getting him out of the locked unit with 20 people for at least brief periods of time. An ILST provider could take JH to the library or a bookstore to get the sports magazines that the facility has yet to provide. In addition, JH would benefit from Behavioral Services since he is described in the nursing plan of care as having behaviors that are not socially acceptable and which could put him at a "significant risk for injury." He has psychiatric reviews of his psychotropic medications on a regular basis, and one of his psychotropic medications has been decreased, but he is not receiving behavioral therapy to reduce his behaviors.

JH is not receiving a continuous active treatment program of aggressive, consistent implementation of services which would enable him to acquire behaviors needed to function with as much self-determination and independence as possible. As discussed above, he does not receive any Specialized Services and only has intermittently received OT, PT and ST services. He would greatly benefit from receiving those services on an ongoing basis. Furthermore, he does not receive any services that would increase his abilities for social interaction and independent living skills. Other than

pharmacological treatment, he has not received any services, available through the Local Authority, to assist him in reducing some of his behaviors. He remains on a locked unit, for safety reasons, and spends most of his day moving about the unit or resting in bed. He participates in very few activities.

According to the social worker, staff at the nursing facility do not receive any additional training in providing services to individuals with I/DD. Any additional training they receive pertains to mental health.

JH has suffered harm due to lack of needed Specialized Services and the lack of active treatment. According to nursing facility staff, he has lost skills since he was admitted to the facility (used to feed himself), and deteriorated in other functional abilities. He has not received a comprehensive functional assessment so he did not receive a comprehensive program of Specialized Services that would have met his needs for greater self-determination and independence. As described above, Specialized Services would enable him to gain specific skills toward a more meaningful life. His environment is very minimal, a semi-private room on a locked unit with two small common areas. While there is a full time activities director, staff do not have the availability to provide the direct contact he desires and requires from to increase his skills. The lack of an aspiration protocol places him at serious potential danger if he should aspirate and contract aspiration pneumonia. The nursing facility staff demonstrated limited knowledge of the PASRR program, are not trained specifically in serving people with I/DD, do not regularly participate in the Service Planning Team meetings, and as a result, they do not provide JH with a program minimally approaching active treatment.

Individual: SSc
Copperas Cove LTC Partners
Copperas Cove, TX Review Date: February 6, 2017

SSc is a nearly 80-year-old woman who lives in Copperas Cove Long Term Care Partners. Based on interviews with nursing facility staff and records review, she has lived in the nursing facility since at least 2002, and possibly 2001 (History and Physical, 6/16/2016 and Individual Service Plan 5/26/2016). Prior to her admission to the nursing facility, she lived in a private home in Killeen. When I met SSc, she was sitting at the dining room table, alone. She was conversant and able to tell me what was important to her. She enjoys shopping, dancing, music, jewelry, makeup, reading magazines and watching television. She said she does not have friends at the nursing facility. She is able to self-propel her wheelchair, but said she would like to be stronger. She is a diabetic who takes insulin daily to control her blood sugar levels. Her sister, who previously was involved in her care, is unable to visit her due to her own health challenges.

Although SSc is doing better now, 2015 and into 2016 were very difficult years for her. On 12/20/2014, she fell and fractured her left hand. On 4/23/2015, she fell and fractured her left patella (knee). She had surgery to repair the fracture, including internal hardware, on 5/1/2015. After three days of hospitalization, she was sent back to the nursing facility, only to be re-admitted to the hospital on 5/8/2015 for dehydration and cellulitis, a bacterial skin infection. She was treated with fluids and antibiotics at the hospital, and returned to the nursing facility 5/12/2015. Less than a month later, on 6/9/2015, she was admitted to the hospital with cellulitis, secondary to the surgical site. To treat the infection, the site was re-opened, irrigated and debrided (removal of dead and/or contaminated material that may promote infection and impede healing. It is done either with enzymes, sharp instruments or mechanical means as in a whirlpool). During this admission, she also was diagnosed with renal failure, a urinary tract infection and MRSA, an antibiotic resistant infection. She was given intravenous antibiotics and discharged back to the nursing facility on 6/17/2015. She did not do well at the nursing facility, would not eat or drink, and was admitted to the hospital on 7/10/2015 for another surgical site debridement and irrigation. At this time, a peripheral intravenous (PICC) line was inserted for long-term antibiotic therapy and treatment of anemia.

Upon discharge, she returned to the nursing facility for a few months. But on 10/2/2015, she was back at the hospital for a third debridement and irrigation and removal of the internal hardware in her knee. This required reopening of the surgical site. The wound was positive for the growth of bacteria, and she was treated for sepsis with antibiotics. SSc received blood transfusions for her anemia, and on 10/5/2015, once again was discharged back to the nursing facility. She was placed on hospice in October 2015. However, she slowly improved, and as of 2/24/2016, was discharged from hospice. The knee continued to cause trouble, however, and on 6/14/2016, she returned to the hospital for another round of antibiotic treatment for a chronic infection of her left knee.

In addition, she was taken to the emergency room 8/11/2015 due to a fall that caused her to hit her face on the edge of a table. She did not have a fracture but she sustained a hematoma to her eye area. She was also sent to the emergency room on 9/01/2016 for a low blood sugar reading and non-responsiveness, and again for low blood sugar on 9/19/2016. Both times she was treated in the ER and released back to the nursing facility.

SSc has not been hospitalized since that visit of 9/19/2016. During these hospitalizations, her diabetes was not well controlled and she had fluctuating blood sugar levels. She also lost 30% of her weight. SSc is no longer able to walk at all; she is now wheelchair dependent, although she can self-propel. She also has diminished self-care skills. Over the last few months, she has improved somewhat and her weight has now stabilized.

SSc did not have a comprehensive functional assessment conducted by an interdisciplinary team of professionals experienced in serving individuals with I/DD. She had a PASRR Level I on 8/17/2014 that was positive for ID and DD. She had a PASRR Evaluation on 8/18/2014 which again affirms that she is eligible for PASRR services. It shows she was able to walk and independent in all areas of self-care but needs some assistance with eating, taking medications and nutrition. The only Specialized Service recommended is service coordination.

SSc has an Individual Service Plan (ISP), dated 5/26/2016, that was developed at a meeting attended by SSc and facility staff from nursing, social work, activities and dietary. Her ISP has one outcome: to choose activities of her choice. SSc is described as having several challenging behaviors such as hoarding and believing all men entering the facility are her boyfriends. She is easily angered by staff and other residents. However, she has not had an assessment by a behavior specialist. Further, she did not have an assessment of her strengths and needs by therapists or persons experienced in serving individuals with I/DD. She had a diagnostic review on 5/08/2016 which shows that she has mental retardation, severity unspecified, with no testing information or data to explain this assessment. There is no other information on the Diagnostic Review.

SSc is not receiving Specialized Services through the PASRR program, other than service coordination. Records state that Specialized Services have been discussed at team meetings but do not indicate if they were ever provided. At the time of SSc's ISP quarterly meeting on 9/01/2016, she was receiving time-limited PT and occupational therapy (OT) five times a week for strengthening and mobility. These nursing facility services were provided through her insurance (not PASRR). Unlike the continuing therapies that PASSR provides, these nursing facility services require a precipitating event. For example, SSc received time-limited OT in December 2014 subsequent to a fall, and again after her various surgeries, operations and hospitalizations in the spring and early summer of 2015. Her time-limited PT services, provided through the nursing facility, followed a similar pattern, and ended on 7/1/2015 because she did not meet her goals. Given the struggles SSc experienced during this time period, she would have benefitted from continuous PASRR therapies.

Similarly, speech therapy (ST) services, (provided through her insurance and not PASRR), were intermittent. Records indicate she had ST from February to April of 2016 when she was discharged because she was deemed to have "met maximum potential." She had ST again in June 2016 until August 2016, and again from September to October 2016 when she was again discharged as having attained the highest practical level. She had a bedside swallow study done on 2/16/2016 and 6/22/2016 without overt signs and symptoms of aspiration. She would benefit from continuous speech therapy in order to maintain her skills.

SSc is seen by a mental health clinic every two to four weeks for medication review. However, she does not have a behavior support plan to help her with her hoarding behaviors or anger at staff or other residents. She would benefit from BCBA services to help her develop more positive approaches. She has not been assessed for Independent Living Skills Training (ILST) even though she likely would

benefit from the attention of staff trained in working with her on a one-to-one basis to help her engage in more activities of her preference.

SSc is not receiving active treatment. She does not have a continuous, consistent, and aggressive habilitation program of Specialized Services. Her therapeutic services are delivered on an intermittent basis and there is minimal carry-over to other settings or by other staff working with her. She does not have a behavior support plan or the services of a BCBA therapist to assist with her challenging behaviors. Her ISP is primarily nursing-based and does not provide her with a comprehensive, developmental program designed to ensure that she is able to maintain her skills, independence and self-determination for as long as possible. The one outcome in her ISP – to choose activities – would be strengthened if she were receiving the benefits of the ILST program and the attention of a staff person trained in working with individuals with I/DD.

Staff of the nursing facility do not receive any additional training in working with individuals with I/DD.

SSc has suffered harm as a result of the lack of needed Specialized Services and active treatment. She has not consistently received PT and OT services, despite several falls resulting in fractures (hand and knee), and striking her head on a table. She had a lengthy and challenging recovery stemming from the original knee fracture, ultimately requiring multiple surgeries in 2015. Her diabetes was not well controlled during much of 2015 when she was repeatedly hospitalized for infections, anemia, renal failure, and three additional knee surgeries. Her health deteriorated to the point that she was placed on hospice in October 2015 until February 2016. She has lost skills since her PASRR Evaluation of 8/08/2014 when it was stated that she could walk and was independent in all areas except for eating, nutrition and taking medications. She now uses a wheelchair and requires extensive assistance in bed mobility, toilet use and personal hygiene.

Individual: SS
Southwood Care Center
Austin TX Review date: February 7, 2017

SS is an articulate woman who celebrated her 60th birthday 10 days after my visit. When we met with her at the facility, she was seated in her wheelchair, attractively dressed all in pink, and showed off her polished fingernails. She was wearing a pink safety helmet due to seizures. She discussed the recent sudden death of her mother just before Christmas. She described her close relationship with her mother, sister and two nieces. She talked about various family events she attended, such as her niece's high school graduation, and how much she enjoyed being with family members.

SS spoke softly but was very expressive as she detailed her preferences, hopes and dreams. She said she would like to attend a day habilitation program that emphasizes creative activities. Arts and crafts are among her favorite things to do; she also likes jewelry. She also said she would like to socialize more with people her own age, go to the movies, go dancing, and have a boyfriend. In addition, she said she would like to work, either as a waitress or hostess. She has a Metro Access card and uses the bus to go to Wal-Mart with staff from the nursing facility. During our visit, she was making a list for her next trip to Wal-Mart.

SS lived in group homes in the community for several years dating to at least 2004. Following hospitalization for treatment of an ankle injury on 5/20/2015, she was placed at Brush Country Nursing and Rehabilitation Center and Regency Village (same address) on 5/26/2015. She was transferred to Southwood Care Center on 2/17/2016 – her 59th birthday.

SS had a PASRR Level I done on 5/26/2015 which showed that she was positive for I/DD, and subsequent PASSR Level I screenings on 6/17/2015 and 4/8/16 which showed that she was positive for I/DD and DD. SS had a PASRR Evaluation on 5/27/2015 which recommended Local Authority services of service coordination and alternative placement, and Specialized Services of physical therapy (PT), occupational therapy (OT), and durable medical equipment, and another one on 6/19/2015, which recommended all the above, plus speech therapy (ST). Her Individual Service Plan of 6/04/2015 listed three goals / outcomes: to participate in group activities in the nursing facility; to obtain writing paper and a writing utensil so she can write letters; and, once SS has completed skilled therapy, to transition out of the nursing facility and back into her group home. She had three need areas related to her specialized services: cognitive safety and awareness (OT); assist in transfers and pivoting on a sliding board (PT); and swallowing (ST). The 2015 ISP does not describe any social development needs, despite her expressed preference for increased social interaction, and does not address adaptive behaviors or independent living skills.

SS had another PASRR Evaluation on 4/12/2016, after transferring to another nursing facility, Southwood Care Center. It identifies several need areas including nutrition, medical, ADLs, social/recreation, expressing interests and making judgments, independent living skills, and speech and language. It recommends Local Authority services of service coordination and alternate placement, and specialized services of PT, OT, ST and a Customized Manual Wheel Chair.

SS has never had a comprehensive assessment conducted by an interdisciplinary team of professionals with experience working with individuals with I/DD. While some of her needs and preferences were identified, the assessments that were in the record did not include input from

professionals in the identified need areas of physical therapy, occupational therapy and speech therapy. The assessments were done by the nursing facility staff and are related to medical/nursing care such as skin integrity, fall risk, self-care needs and similar. There was no nutritional assessment despite the identification of weight as a significant need area about which the nursing social worker, service coordinator, and SS's sister all expressed persistent concern. SS stated she would like to get a job in the community, but she is not receiving any help or any supported employment services from the LIDDA, even though this is an authorized type of Specialized Services. SS's need areas, specifically, independent living skills, were not addressed for almost two years. Employment training still has not been addressed.

SS is receiving some, but not all of the Specialized Services she requires to meet her needs and lead a meaningful life. At the time of our visit, SS was receiving PT three times a week and OT two times a week through PASRR Specialized Services. She started receiving some services shortly after she entered the first nursing facility due to her injured ankle. She received PT and OT services over the period from June 2015 to March 2016, and again in July and August of 2016. Skills worked on included transfers, toileting, ADLs (including dressing, posture, cognitive linguistic skills, swallowing and mastication), safety awareness and problem solving, balance and gait, car transfers and her customized manual wheelchair. She received time-limited speech therapy services from June 2015 to September 2015 and again in July and August of 2016. SS also received physiatry (physical medicine and rehabilitation) services from May 2015 until February 2016. It is not clear if these services were accessed through the PASRR Specialized Services or through the nursing facility's regular rehabilitation program. Nursing facility staff report that they have not been able to access the portal for PASRR Services due to a vacancy in the position authorized to access, and, as a result, few requests for Specialized Services are processed.

Although SS needs and was recommended for other Specialized Services, she has not been provided Day Habilitation Services, and up until this month, Independent Living Skills Training (ILST). Prior to my visit, SS had just recently met her ILST provider; she is looking forward to his return because she had yet to go outside with him. The service is expected to occur weekly. In addition, SS is not currently attending a day habilitation program, as she had in the past, despite this being a clear preference for her and part of her recommended services. Her sister, who is in the process of becoming her legally authorized representative, said that day habilitation is one of the three major issues that she asked staff to address several care plan meetings ago, but "nothing has happened." No effort has been made to provide SS with any form of vocational training or supported employment services, even though the Service Coordinator considered these services to be appropriate and available. In addition, SS is not receiving services related to weight management. She has gained almost 20 pounds in the last 3 months – and a total of 30 pounds since she was admitted to the nursing facility in May, 2015.

SS is not receiving a program of continuous active treatment which would enable her to acquire the behaviors necessary for her to function with as much self-determination and independence as possible. She does not have a comprehensive functional assessment developed by an interdisciplinary team of professionals who have experience working with individuals with I/DD. Her ISP does not have goals that meet all of her identified needs, specifically for social interaction and day habilitation services. While she has received some Specialized Services, she has not received those on a continuous basis nor have they been integrated throughout her day.

Staff at her current nursing facility do not receive training specific to providing services to individuals with I/DD. The nursing facility staff stated that staff have an additional two hours of training prior to starting work, in addition to meeting the certification requirements for a certified nursing assistant. In addition, facility staff are not well informed about PASRR services and specialized services. This raises serious concerns because a third of the approximately 75 residents at Southwood have IDD and would benefit from these services. According to nursing facility and LIDDA staff, almost none of these individuals receive any Specialized Services.

SS has suffered harm in the 20 months that she has resided in the nursing facilities due to the lack of continuous Specialized Services and active treatment. Prior to admission, she was able to walk short distances with a walker. While she has received some PT and OT services in the facilities, she is no longer able to walk and now uses the wheelchair for mobility. She has also gained substantial weight, further limiting her ability to be independent. SS would like to lose weight as she recognizes that it is curtailing her mobility. However, she is not on any weight reduction program. Further, until very recently, she has not had an Independent Living Skills service or other Specialized Service from the LIDDA, other than service coordination, despite a clear preference for social interaction with a peer group and the desire to engage in activities. And even though she excels at creative activities and previously enjoyed day habilitation services, she has not had such services since her admission to the nursing facility. She is a capable woman who has so much to contribute, yet she is at risk of losing the abilities and functions she once had.

Individual: AOl
Memorial Medical Center
San Antonio, Texas Review Date: February 15, 2017

AOl is a 73-year-old gentleman who has resided at the Memorial Medical Center nursing facility since April 20, 2012. He has a developmental disability as a result of a serious head injury he sustained in an accident at age 20. He also has dominant right-sided hemiplegia (paralysis) as a result of the head injury. Prior to his admission to the nursing facility, he first lived with his brother, and later, on his own, with assistance. At one point he was employed as a parking lot attendant, a job he enjoyed. He moved into the nursing facility due to family concerns about his safety and his ability to care for himself. He uses a wheelchair for mobility and likes to engage in activities at the nursing facility, including bingo and arts and crafts. He assists the activities director in decorating the facility for various events. As he explained, "It is something to do to distract you." AOl is able to read and speaks both Spanish and English. He recently transferred to another room as he had problems with the former roommate's reportedly territorial behavior. He is much happier in his current room and with his new roommate. AOl is described as a person with clear preferences, and once he refuses to participate, he will not change his mind. When I met with AOl and his sister, he expressed his likes and dislikes and talked about his former job as a parking lot attendant. He was responsive to our questions but did not expand upon his answers. His sister provided additional information.

AOl did not have a comprehensive functional assessment conducted by an interdisciplinary team of professionals who are experienced in working with individuals with I/DD. He had a PASRR Level I done on 8/30/2013 which is positive for Developmental Disability only. He had a PASRR Evaluation done on 1/22/2014 that affirms the developmental disability and states that he needs assistance in all areas except for vocational and academic/educational. It also recommends Specialized Services, including service coordination, physical therapy (PT), occupational therapy (OT), speech therapy (ST), a customized manual wheelchair (CMWC), and durable medical equipment (DME). He had multiple nursing facility assessments that are focused on his health status, such as skin integrity, fall risk, side rail assessment and elopement. He has had assessments done by OT and PT but they are not part of a comprehensive functional assessment and occur at the point of service throughout his time at the nursing facility. His current individual service plan (ISP) is dated 12/13/2016. On that day, his Service Planning Team discussed AOl's recent transition to a new room and a new roommate at the nursing facility. The summary notes from that SPT meeting do not discuss Specialized Services.

At my meeting with AOl, we talked about Independent Living Skills Training (ILST) which he has never had. He was obviously intrigued by the prospect of having a designated provider take him outside the facility. Both he and his sister would like to explore options under ILST, even if it only meant someone could push AOl in his wheelchair to the local park. Nursing facility staff and the service coordinator agreed that he would benefit from ILST services. It would provide him with one-on-one attention from a provider trained in working with individuals with developmental disabilities. AOl likes to be active and this service would provide activities specifically designed around his interests and preferences.

In the past, AOl was recommended for other Specialized Services. On 3/8/2016, his SPT recommended that he receive Specialized Services Assessments for OT and PT. At that time, the team

also discussed speech therapy and day habilitation, but AOl declined. The referrals for PT and OT assessments were to help him gain strength and mobility.

There seemed to be some resistance from nursing facility staff to AOl's team's recommendations for OT and PT in 2016. The PASRR SS Form documents that on 3/8/2016, the team recommended Specialized Services Assessments for both OT and PT. In response to the service coordinator's inquiry on 5/20/2016, the facility's director of rehabilitation said she was unaware AOl needed the assessments. On 7/22/2016, the director of rehabilitation said she "forgot" about his need for OT – for which AOl had yet to be assessed. By that date, AOl had been assessed for PT and services were underway, funded through his insurance. The director of rehabilitation said they could consider PASRR Specialized Services after AOl finished 8 weeks of PT under Medicare Part B. The records indicate that AOl started OT through Medicare Part B in late July 2016.

AOl has not received the Specialized Services he needs. He has never had ILST, and has only received PT and OT intermittently. Records indicate AOl received OT for about one month from 11/03/2015 to 12/10/2015, and from 7/27/2016 to 9/25/2016; he had PT from 2/18/2015 to 4/13/2015; from 11/14/2015 to 12/10/2015; and 6/2/2016 to 8/19/2016. The PT and OT referrals in 2016 were to address declines in his ability to transfer and ambulate. He was discharged from both PT and OT when a determination was made that he had reached highest practical level. The services in 2015 were through PASRR and in 2016 they were through his insurance. AOl would benefit from ongoing OT without the lengthy interruptions and service gaps. There are no refusals documented in the therapy notes despite statements in the ISP, progress notes and facility staff interviews that he consistently refuses services. He has a history of falls: he fell in September of 2015 and again on 2/16/2016 and 11/12/2016.

AOl has a customized manual wheelchair, acquired through PASRR in November 2014. Notably, it took nearly a year from the time the wheelchair was recommended to the time it was delivered to AOl.

The only Specialized Service that AOl has been receiving regularly over the years is service coordination, but it has not been consistent. As his sister remarked, he has been in the nursing facility for less than 5 years, yet he has had 4 or 5 different service coordinators, leading to a lack of continuity of services and communication. AOl is not receiving a continuous active treatment program of aggressive, consistent implementation of a program of specialized services that will help him to acquire the skills necessary to maintain his current level of functioning, as much independence as possible, and prevent of regression of his skills. Ongoing OT and PT will help maintain his transfer skills, wheelchair mobility, standing and muscle strength, and fine motor skills for self-care. Despite his nearly five years at the facility he has had only intermittent OT and PT services. He has never had ILST services which, if provided, will enable him to engage in activities that also assist in maintaining skills for greater self-care, relationships and outings that are challenging and interesting to him.

Staff are not provided additional training on providing services to individuals with a developmental disability.

AOl has been harmed by the lack Specialized Service and active treatment. He has many skills, including the ability to read in and speak two languages, and yet he is not receiving services that take into consideration his functioning level and provide for these strengths. He has experienced a gradual decline in functional abilities and yet has not received the consistent OT and PT that may have helped

maintain his level of functioning. Without these therapies he will continue to lose his level of functioning. The lack of continuous OT and PT, the failure to provide ILST services, and the turn-over in service coordinators, have negatively impacted the acquisition of skills and behaviors necessary for AOl to function with as much self-determination and independence as he is capable of doing.

Individual: AM
Luling Care Center
Luling, TX Review Date: February 14, 2017

AM is an 85-year-old woman who has resided at the Luling Care Center since 5/29/2013. Previously, she lived in two other nursing homes, and prior to those admissions, she lived in her own home in the community. She does not have any involved family; the Director of Nursing (DON) is her friend and her designated primary contact. The DON stated that they have been friends since 2007, and that this is the third nursing facility at which they have been together – the DON as staff and AM as resident.

AM likes to be active, enjoys rides in the country with the DON, seeing animals, getting dressed up and having her hair and nails done. She loves parties, celebrating her birthday and chocolate cake. She was voted the Valentine Party Queen last year. There are conflicting statements as to whether or not she was once married. Both the nursing facility staff and the service coordinator report that she has declined in the last six months, and now prefers to spend more time in bed, is less energetic, and has lost some weight. However, she still enjoys going out to the community and being involved in activities at the nursing facility. She is able to self-propel her wheelchair, verbalize her preferences, and engage in social interactions. She has diabetes that is well controlled; she does not take any medication for it. She is also diagnosed with Alzheimer's. She was hospitalized in February 2016 with pneumonia. She has had several falls and recently fell out of bed, but did not sustain any injuries. When I met with her, she responded to my questions and smiled frequently. She showed me pictures of when she was the Valentine Party Queen and other events. As I left the facility, she propelled her wheelchair down the hallway to the DON's office for a visit.

AM did not receive a comprehensive functional assessment conducted by an interdisciplinary team of professionals with experience in working with people with I/DD. She received a PASRR Level I on 8/01/2015 – two years after she was admitted to this nursing facility – which was positive for I/DD. She had a PASRR Evaluation on 9/23/2015 that recommends Specialized Services of service coordination and physical therapy (PT). It also indicates that AM is interested in enrolling in community-based programs for Day Activity and Health services, and Psychological Rehabilitation services.

AM has had various nursing facility assessments that tend to focus on health-related concerns such as skin integrity, fall risk, nutrition and self-care needs. She has had assessments from PT, occupational therapy (OT) and speech therapy (ST). However, these have been provided in response to specific changes in AM's functioning level, not as part of an initial comprehensive assessment. She has an Individual Service Plan, dated 1/13/2017. The service coordinator and the nursing facility do hold some of their meetings jointly, but they do not appear to collaborate well on services for AM. The recommendations from her service planning team are not necessarily followed. For example, on 4/28/2016, her team noted AM's need for continued skilled services and agreed to recommend referral for evaluation and treatment for PT, OT and ST PASSR Specialized Services. But at the next meeting on 7/28/2016, the rehabilitation therapist reported she had submitted the PASRR form for OT, but not for PT and ST.

AM is receiving some LIDDA Specialized Services, including service coordination and Independent Living Skills Training (ILST). She goes out weekly with her ILST provider staff for rides in the

community, trips to favorite stores and visits to a program called the Enrichment Center. She has had Behavioral Support services through PASRR, and just recently, these services were discontinued since she no longer exhibits challenging behaviors. Similarly, her OT services through PASRR also were recently discontinued. She has a customized manual wheelchair that she acquired through PASRR.

In addition, AM has received several time-limited therapies, although they have not been provided consistently. Based on the records provided, AM had OT services over different periods in 2016: from 2/24/2016 to 4/23/2016; 6/1/2016 to 8/31/2016; and a recertification extended services to 9/28/2016. Subsequent to falls, AM had PT in 2015 beginning in August and continuing into November. AM had a PT evaluation in February of 2016, and PT services from September to mid-November of 2016. She received speech therapy from 9/30/2015 to 1/27/2016; from 2/21/2016 to 4/21/2016; and again from 8/1/2016 to 8/31/2016.

These time-limited therapies have worked on increasing her strength, balance, transfer ability, swallowing and problem solving. However, she would benefit from the continuous provision of habilitative services to maintain her functioning and avoid any regression when the services are discontinued For example, on 9/12/2016, her PT Therapy Screen states that AM requires PT due to a "recent decline since coming off therapy."

AM has not received an active treatment program of Specialized Services which is continuous, aggressive and is carried over throughout her day. She has not received habilitative therapy to maintain her skills in ambulation, balance, strength and self-care needs. She enjoys socializing and going out into the community and could have benefitted from the ILST services earlier than April of 2016.

Staff do not receive any additional training on working with individuals with I/DD.

The failure to provide AM with ongoing, habilitative nursing facility Specialized Services, specifically, PT, OT and ST, has caused harm to AM, as she has not had the benefit of a sustained program of strength building, maintenance of balance and self-care skills. While her decline may be due to Alzheimer's disease, it is even more important that she receive habilitative services in order to maintain optimal functional status as the disease progresses.

Individual: EC

Marbridge Villa
Manchaca TX

Review Date: February 9, 2017

EC is a 63-year-old gentleman who has resided at the Marbridge Villa nursing facility since 4/04/2014. Prior to coming to the nursing facility, he lived in a private home. He is able to walk with the aid of a rolling walker, which he uses to get around the facility. Staff report that he does not like to be contained in one area, and he can be found in many parts of the facility. He is generally a happy man who enjoys being around people. He is non-verbal but will make eye contact and smile at others. He attends the activities at the facility, but he is usually more of an observer than a participant. He enjoys going on outings from the facility. His family is very involved, usually visiting him once a week. His sister is his guardian and participates in all of his planning meetings. He also goes on outings with his family. He participates in the Music and Memory program and enjoys listening to his music. He requires assistance for his self-care needs. When I was visiting, he joined me in the sensory room, with his walker. He also had his crayons and coloring book which he always carries with him. He seemed to engage in my questions, but was not able to respond, other than smiling. After a short while, he left the room. During my visit, I saw him several times, ambulating with his walker throughout the facility.

EC did not receive a comprehensive functional assessment by an interdisciplinary team of professionals. The record shows that he is PASRR eligible and that he had a PASRR Evaluation, as stated in the Service Coordinator Progress notes of 5/12/2014, but there was no PASRR Level I or PASRR Evaluation in the records received. The records also do not include physical therapy (PT), occupational therapy (OT) or speech therapy (ST) assessments. The nursing facility does assessments in areas such as skin integrity, fall risk, restraints, self-care needs, nutrition, pain, mobility, dehydration, Abnormal Involuntary Movements and brief mental status, but they are not done in collaboration with any disability professionals, and they do not identify his specific developmental strengths and needs, including adaptive behaviors or independent living skills necessary for him to be able to function in the community.

EC has an Individual Service Plan dated 6/15/2016. There is inconsistency in the plan. Under the section that lists EC's strengths and "what people like and admire" about him, it says that he is self-sufficient, yet the section that identifies his needs states that he is incontinent and requires assistance with self-care activities. One of the proposed "outcomes" in the plan is to learn about other goals for EC, but no other goals have been added. The service coordinator reports that the planning meetings are held jointly with the nursing facility meetings and a variety of relevant nursing facility staff attend the meetings. She stated that the nursing facility staff provide information as requested and generally follow up on requests.

EC is only receiving one Specialized Service – service coordination. Specialized Services have been offered to his family/guardian at the team meetings, including Independent Living Skills Training (ILST) and Day Habilitation Services, but they have declined these services. Family members represent that they do not feel his attention span is sufficient for these services. The social worker, who also cited his short attention span, suggested he might have some interest in community outings through ILST, but both she and the service coordinator thought day habilitation services would be outside his comfort zone. The service coordinator noted that limited transportation services prevent other residents at

Marbridge from using day habilitation services, and said transportation is also a factor in lining up ILST providers because they are not reimbursed for gas mileage.

EC would benefit from a PT assessment and ongoing PT because he has had a recent increase in falls, with 3 occurring in the quarter ending 9/05/2016, and 4 in the quarter ending 11/29/2016. Both the service coordinator and family members cited EC's constant motion and how he enjoys ambulating the halls and activity rooms throughout the nursing facility. However, his current ability to ambulate should not discount PT or OT services, especially for someone like EC who has experienced recent falls. PT and OT services could focus on increasing his muscle strength and balance abilities, both of which would help to make him more stable and less likely to fall. There is a recommendation for PT and OT assessments in his ISP of 6/15/2016, but no record of his receiving either assessment.

EC is not receiving continuous active treatment, consistently implemented across all his activities. He is not receiving PT and OT despite the recommendation for these assessments. An OT assessment would indicate whether or not he could gain, or continue to maintain, self-care skills. A PT assessment would evaluate his recent falls and determine if therapy could prevent further falls.

The staff of the nursing facility receive additional training specifically related to serving individuals with I/DD.

EC been harmed by the lack of needed Specialized Services and active treatment. He has suffered harm in that he had 7 falls during the end of 2016 as documented in the Long Term Care Assessments of 9/05/2016 and 11/29/2016 by Marbridge Villa, and still does not receive any ongoing Specialized Services to help reduce the likelihood of these falls.

Individual: GM
Floresville Nursing and Rehabilitation Center
Floresville, TX Review Date: February 14, 2017

GM is a 65-year-old gentleman who has resided at the nursing facility since April 15, 2009. He moved into the nursing facility at the same time as his mother and brother. Prior to their admission to the facility, they all lived together in their home in Floresville. GM's diagnoses include Alzheimer's, Parkinson's, intellectual and developmental disorder, major depressive disorder, and bipolar disorder. Due to the overall decline in his health, he was placed on hospice January 26, 2017 and given a prognosis of less than six months to live.

When GM was admitted to the facility he was able to walk, with a walker, and provide for his self-care needs with assistance. Over the years, he has engaged in disruptive behaviors; at times, he refuses treatment or medication, and is verbally abusive to staff and other residents.

Up until about six months ago, all three family members shared a room, and often ate their meals together and participated in the same activities together. Due to increasing tensions, it was determined that it would be best to separate them. GM now has a different room and new roommate. The family members do not spend as much time together, but often share meals in the dining room. At the time of my visit, GM was alone in his room. Though it was early afternoon, he was already in bed, tucked under a blanket featuring wildlife and outdoor scenes. He was minimally responsive to my questions, saying "yes," "no" and "thank you."

GM has had a significant decline in health status, starting in July 2016. Staff noted that he was drooling more, his hands were swollen, and he was more unsteady. He required additional staff assistance to complete his self-care needs. He often refused to get out of bed and his behaviors, including crying without explanation, increased. Staff said that his appetite diminished, and he began losing more weight. He has lost 50 pounds since August 2011, and at the time of my visit, weighed 197 pounds, still within his ideal body weight. He also had a series of nearly continuous infections. He has had bronchitis, cellulitis of his lower extremities, urinary tract infections and skin breakdown on both buttocks and his toes. He has been treated for these ailments, and although they appear to be resolved, they often return within a short time. Due to his overall decline and weight loss, he entered hospice services at the end of January 2017. The PASRR Director, who was acting as his service coordinator, is aware of and is monitoring his status.

GM never received a comprehensive functional assessment by an interdisciplinary team of professionals experienced in working with individuals with I/DD. His assessments were done by nursing facility staff and are primarily health-related. He had a PASRR Level I completed on 9/18/2015 – more than six years after he entered the nursing facility – that was positive for intellectual disability, developmental disability and mental illness. He had a PASRR Evaluation done on 9/25/2015 that shows that he requires assistance with his self-care needs and recommends service coordination, but no other Specialized Services. There was not an Individual Service Plan in the records reviewed. Assessments conducted at the nursing facility are for health-related topics such as skin integrity, fall assessment, dietary/nutrition and self-care skills. Of the records reviewed, none of the assessments discuss his specific developmental strengths and needs for services.

The PASRR director stated that she has met with the nursing facility staff and they try to coordinate their meetings.

Other than service coordination, GM has not been receiving any needed and recommended Specialized Services. As early as 5/30/2015, the nursing facility records acknowledge that GM would benefit from PT and OT. He also would have benefited from receiving OT, PT and a customized manual wheelchair when his PASRR Evaluation was done on 9/25/2015. At that time he was able to ambulate with assistance, but was beginning to show a decline in his self-care skills. The records contain occasional references to GM's participation in therapy in June and October of 2015, and suggest that he was referred for a PT/OT evaluation in August 2016.

He did receive rehabilitative skilled PT, OT and ST for a time-limited period in November 2015 after he was readmitted to the nursing facility subsequent to hospitalization for a small bowel obstruction. However, there is no indication that GM received the continuous therapies he needed over the years.

On 12/09/2016, GM informed the PASRR Director that he wanted to receive therapy services so he can be strong. At his Interdisciplinary Team meeting shortly after, on 12/14/2016, his team recommended that he receive an assessment for the Specialized Services of PT and OT through PASRR. Two days later, on 12/16/2016, a service coordination assessment recommended that he receive PT, OT and a customized manual wheel chair (CMWC), again through PASRR. He also said he would like the opportunity to go shopping or out to eat in the Floresville community. The records reviewed do not indicate that he received any of these services.

GM also would have benefitted from Behavioral Support services. He has presented with several challenging behaviors, such as refusing services and being verbally abusive toward others. He has received psychiatric services for review of his medications, but did not have a structured behavior plan that would have provided positive alternatives and staff training to address his underlying issues. Moreover, the family dynamics were not addressed until recently; behavioral supports would have helped him to work through his own needs and provided direction to staff on the best way to engage him in positive behaviors and reduce his negative behaviors.

GM did not receive an active treatment program of Specialized Services. He did not have a comprehensive functional assessment that would have been the basis for a program or plan of services that would have built upon his strengths and outlined goals to help him maintain his ambulation skills, increase his self-care skills, develop positive approaches to his behavioral challenges and address his refusal of services. In addition, the unusual dynamic of three family members living together in one room of the nursing facility would have been assessed for appropriateness sooner than it was. Further, a proper assessment would have identified the best approach for self-determination for GM. He has a seizure disorder, Alzheimer's disease and Parkinson's disease, and yet there is no record that he was seen by a neurologist. He had multiple infections over the last year, a general decline including significant weight loss and skin breakdown. A customized manual wheelchair would have been easier for him to self-propel. Specialized services such as PT and OT would have helped to keep him more active and maximize his optimal level of functioning.

There is no or little staff training specific to the needs of individuals with I/DD.

GM has suffered harm as a result of not receiving needed Specialized Services and a lack of active treatment. In the nearly eight years he has been a resident of the nursing facility, he has not received the necessary Specialized Services to slow the progression of loss of skills in ambulation and self-care, and to address his challenging behaviors, his refusal of services and the unusual family dynamics. The years prior to the recent decline could have been ones in which he had a life of greater independence and self-determination. They cannot be recovered.

Individual: AOv
SPJST Rest Home
Needville, TX Review Date: February 13, 2017

AOv is a 64-year-old woman who resides at the SPJST Rest Home in Needville. She was admitted in October 2009. Prior to coming to the facility, she lived at home with her parents until their deaths, and then with her sisters and their respective families. She has a large family that is very involved with her and her care. Two sisters were present during my visit with AOv and shared additional information.

AOv was articulate in her responses and smiled easily. She is quite proud that she is the President of the Resident Council and meets all new residents and holds council meetings. She assists the activities director with decorations and announcements. She likes bingo, coloring, children, animals, and going out shopping with her sisters. She is involved in most activities offered at the nursing facility. She showed us her room which was personalized with many family photos. She likes her roommate and they get along well.

AOv has some weakness of her right arm and leg, but she walks easily and is independent in her self-care. After each meal she does two walking laps around the inside of the facility in order to get exercise and maintain her strength. She also enjoys walking outside, which she does with a staff person. She has diabetes, but it is well controlled. She has a seizure disorder but has not had any recent seizures. Her health is described as generally good, with no falls in over six months.

AOv did not have a comprehensive assessment performed by an interdisciplinary team of professionals experienced in working with individuals with I/DD. She had a PASRR Level I done on 4/12/2013 – three-and-a-half years after her admission to the nursing facility – which provides very little information. Her PASRR Evaluation, done on 10/16/2013, showed that she is positive for IDD and mental illness, is independent in most skill areas, but requires oversight in nutrition, medical treatments, expressing interests, independent living skills and speech and language. No Specialized Services were recommended.

There is no information as to why she is determined to have a mental illness under PASRR (both PASRR documents are incomplete), and there are no other statements in any of the records I reviewed which would affirm this diagnosis. She had a determination of eligibility for mental retardation services in 12/09/2005 and was found eligible. She has an Individual Service Plan, dated 10/12/2016, in which the only outcomes/ goals are to manage her diabetes, drink water and walk. According to her ISP (which also is missing pages), her health has been stable, with no recent falls or seizures.

AOv has not received, but would benefit from, a comprehensive assessment by a professional with expertise in serving individuals with I/DD to identify strategies to help her to gain skills in self-care, including budgeting, meal preparation, shopping, and community engagement. An occupational therapy assessment through Specialized Services would determine what additional skills she could gain that would lead to greater independence and self-determination. In addition, she would benefit from a neurological assessment to determine if her seizure medication, Phenobarbital, could be reduced given that she has not had any seizures for some time.

Service coordination and the nursing facility staff work together to schedule their team meetings and generally collaborate on the service planning for AOv. But with the exception of service

coordination, AOv is not receiving any Specialized Services, and her team is not recommending any such services for her. She has many skills, is cooperative and motivated to learn. She would benefit from occupational therapy to acquire more skills in the areas of budgeting, purchasing her own items, telling time (she wears a watch and she tells time to the hour), and medication management. She enjoys being active and is very involved in the activities of the nursing facility. Independent Living Skills Training (ILST) would provide her with additional opportunities to access the community and increase her social interactions, and thereby gain skills directly related to independence and self-determination. An ILST provider who was trusted by the family and was a good match for AOv could expand her world beyond the facility.

AOv is receiving some services through the nursing facility (not PASRR) that are preventing any regression or loss of functional status. However, she is not receiving active treatment, since she is not provided opportunities to function with as much self-determination and independence as possible. She is very capable and could gain skills if she were provided Specialized Services, including OT and ILST.

General staff training at the nursing facility is provided through special presentations and on-line trainings. Trainings specific to I/DD are not generally provided to the regular staff.

AOv has been denied opportunities to grow and enhance her life – the very purpose of active treatment. As a result, she is suffering ongoing harm from a lack of appropriate habilitation through Specialized Services. She is a very social, very capable individual who is living in a very segregated environment. She would benefit from Specialized Services that would enable her to gain and exercise greater independence and self-determination.

Individual: GH
Oak Park Nursing and Rehabilitation
San Antonio, TX Review Date: February 5, 2017

GH is a 31-year-old gentleman who has resided in Oak Park Nursing and Rehabilitation Center since July, 2007. GH was admitted following hospitalization for a gunshot wound to his right temple when he was about 20 years old. He has been diagnosed as being in a persistent vegetative state. A persistent vegetative state is absence of responsiveness and awareness due to overwhelming dysfunction of the cerebral hemispheres with sufficient sparing of the diencephalon and brain stem to preserve cardiac function, motor reflexes and sleep-wake cycles. The person may have complex reflexes such as eye movements, yawning or involuntary movements and response to noxious stimuli, but show no awareness of self or environment. A vegetative state lasting more than one month is considered persistent. This does not imply permanent because in very rare cases the person can reach a minimally conscious state or higher level of consciousness. (Merck Manual, Professional Version, accessed 3/3/2017).

Prior to his injury, GH lived at home with his family and had no apparent disabilities. When I visited him at the facility, he was not responsive to my presence and did not indicate any response or reaction to his name or my questions. He was lying in bed, and was clean, dry and appeared comfortable. His right leg was bent at the knee; the staff report that his limbs will move at times, but any movement does not appear to be voluntary. He did not make eye contact or do any visual tracking. His right eye is partially sutured closed for protection and his left eye does not focus, but was moving involuntarily. GH breathes through a tracheostomy tube in his throat and has continuous oxygen. He receives all nutrition through a PEG tube. He is totally dependent upon staff for all care. He is able to be out of bed in a reclining wheel chair and it is reported that his family will propel him in the reclining chair around the facility. Family members come to visit often and are very involved in his life. His room is decorated with sports memorabilia; his television is on continuously to provide some stimulation. Staff speak to him whenever giving care, as does his family, but there are no reports that he is responsive. He has had a number of hospitalizations. He was in the hospital from 3/08/2014 until approximately 5/01/2014 for pneumonia and respiratory failure; he was on mechanical ventilation until December 2014. He was in the hospital from 10/18/2014 to 10/20/2014 for aspiration pneumonia. In addition, he was hospitalized from 11/14/2015 to approximately 11/21/2015 for pneumonia; from 5/08/2016 to 5/14/2016 for aspiration pneumonia, and from 10/30 to 10/31/2016 for a clogged PEG tube.

GH had a PASRR Evaluation on 10/21/2013. The evaluation affirms a developmental disability and recommends Local Authority services of service coordination, alternate placement and determination of intellectual disability. Recommended Specialized Services are occupational therapy (OT), physical therapy (PT), durable medical equipment (DME) and a customized manual wheelchair (CMWC). The other assessments, conducted by nursing facility staff, address skin integrity, nutrition and other daily care needs. GH did not have a comprehensive functional assessment, but would not benefit from it given his current health status, *i.e.*, persistent vegetative state.

GH is not receiving Specialized Services, other than service coordination, and probably would not benefit from them due to his current health status. In October, 2013, he received PT for 8 weeks, 5 times a week, and there was no improvement in his condition. He also received PT in May of 2014 after

a hospitalization with no improvement. He has a customized manual wheelchair but it is not clear if it was acquired through the PASRR program or insurance. He had a session of speech therapy from 3/11/2015 to 4/11/2015, 3 times a week, to increase his response to stimuli, but it was not successful. He receives one-on-one activities in his room from the activities therapist. He is currently receiving restorative therapy of passive range of motion of his extremities, massage of his hands and rolled washcloths to his hands, from the nursing staff. He has minimal contractures and has had no skin breakdowns despite his more than 10 years of quadriplegia. The team should remain vigilant regarding his need for PT in order to maintain his range of motion and skin integrity.

He does receive service coordination; the service coordinator visits monthly and offers PASRR services on a quarterly basis. The nursing facility RN and social worker attend the Interdisciplinary Team Meetings held by the service coordinator coordinate and work collaboratively together.

Due to the fact that he is in a persistent vegetative state, he would not benefit from active treatment.

Although staff training provided by the nursing facility is not focused on I/DD, it meets the needs of GH. The facility provides monthly training on a variety of subjects to all staff and will train on specific individual needs. Staff provide services to other individuals with I/DD, brain injuries and dementia.

The major impact on GH's quality of life is the ongoing persistent vegetative state, now exceeding 10 years. His needs are being met by the nursing facility staff and his closely involved family members. The ongoing service coordination provides him and his family with options for the future.

Individual: DP
Marbridge Villa
Manchaca, TX Review Date: February 9, 2017

DP is a 75-year-old gentleman who has resided at Marbridge Villa since August 22, 2014. Prior to living at the Villa, he lived on the same campus at Marbridge Ranch for 57 years. Marbridge Ranch provides services comparable to assisted living; Marbridge Villa is a nursing facility. His admission to the nursing facility was prompted by a general overall decline in health, functional level and dementia. He is an articulate, engaging and friendly man whose life has been enhanced during the past 9 months due to the introduction of Independent Living Skills Training services. Up until then, he spent many days and nights in his room, declined to participate in facility programs and insisted on eating by himself in his room.

Although he continues to enjoy lying in bed and watching cowboy movies, more recently DP is participating in some of the Life Enrichment programs at the nursing facility. He is ambulatory and uses a walker or cane for longer distances. He described one of the highlights of his week as going out with his Independent Living Skills Training (ILST) provider to Cabela's, the retailer that specializes in hunting, fishing, shooting, boating and other outdoor activities. While there, he uses the store-supplied electric scooter and circulates throughout the store, looking at the hunting and fishing displays. He says he was an avid hunter and fisherman and proudly described various hunting experiences. His room was decorated according to this theme. He also goes out, approximately weekly, with a volunteer from the Board of Directors, and enjoys this very much. He goes fishing at a nearby pond weekly, weather permitting.

DP is interested in attending a day habilitation program, and said his service coordinator is in the process of scheduling visits with potential providers, which he is looking forward to. He thinks he might like to participate in this program, which would also allow him to leave the facility more often.

DP did not receive a comprehensive assessment conducted by an interdisciplinary team of professionals who are experienced in working with individuals with I/DD. He had a PASRR Evaluation on 6/25/2014 which shows he is eligible for Specialized Services; the form (which is incomplete) does not indicate which specific Specialized Services he needs or would prefer. There was no PASRR Level I in the records I reviewed. There were numerous nursing facility assessments completed, regarding skin integrity, fall risk, contractures, pain, restraints, dehydration and malnutrition. These assessments were conducted primarily by nursing staff at the facility. He also had a Mental Retardation Diagnostic Review which shows that he has an intellectual disability, moderate. Within two months after his admission to the Villa, he had occupational therapy (OT) and physical therapy (PT) evaluations. The evaluations were not part of a collaborative planning effort to identify his specific developmental strengths and needs. His most recent Individual Service Plan (ISP), dated 8/17/2016, recommends the ILST services and PT services for shoulder pain. He has received the time-limited, rehabilitative PT, through the nursing facility.

The service coordinator reports that planning is done in collaboration with the nursing facility staff who, she said, are responsive to requests and will follow through on recommendations. Attendance at meetings usually consists of a variety of relevant professionals from the nursing facility staff.

DP is receiving some, but not all necessary Specialized Services. He receives service coordination on a regular basis. He is currently receiving ILST, once a week. The initial recommendation for ILST was made at the Service Planning Team (SPT) meeting of 9/09/2015 but the provider was not selected until late January 2016, more than four months later. And due to further delays related to transportation, DP and his ILST provider did not start making their trips to Cabela's until April of 2016. As noted above, prior to going out with his ILST provider, DP tended to spend a lot of time in his room, lying in bed. Initially, the Cabela's outing occurred once a month, but was recently increased to four times a month – *i.e.*, weekly, and DP definitely enjoys it. Although DP is also looking forward to visiting potential day habilitation providers, he will need to secure transportation in order to take advantage of this opportunity. At this point, no resident at the facility has received day habilitation services. The service coordinator and nursing facility staff said that they have difficulty accessing these services because the necessary transportation is not available.

The team has just recommended that DP be referred for a physical therapy (PT) assessment. It is important that this occur as soon as possible, since he has shown decline in functional skills in the past, apparently due to his inactivity. He received both PT and OT for a short period after admission to the Villa and his level of functioning improved in both areas. He has also received time-limited PT intermittently in the past three years in order to increase muscle strength, improve his gait and balance, and increase the distance traveled with his walker. But DP has never received any habilitative therapies or Specialized Services provided by the nursing facility.

DP is not receiving a program of continuous active treatment of Specialized Services, consistently implemented. The recommendation for ILST services was not made until 9/09/2015, despite his interest in outdoor activities such as hunting and fishing. It then took at least seven months to implement. Once implemented, it is clear that he enjoys the outings very much and is more active. He has just been referred to day habilitation services and states that he is looking forward to learning more about them. He has received time-limited PT and OT services, though not through the PASRR system.

Staff of the nursing facility receive training specific to the needs and characteristics of individuals with I/DD.

DP has been harmed by the lack of active treatment, and by the lack of certain Specialized Services, such as day habilitation, or delay of others, such as Independent Living Skills Training. DP's life has markedly improved since he began engaging in Independent Life Skills Training offered through PASSR. These services did not get underway in earnest until April of 2016 – 20 months after he was admitted to the Marbridge Villa nursing facility. There was no need for such an articulate, friendly gentleman to languish in bed, doing nothing, for so long, especially because the lengthy delay was due to the nursing facility questioning the purpose, need for, and reimbursement for Specialized Services, and the lack of training, guidance, and clarification from DADS. Even when the nursing facility agreed to support community Specialized Services, there were significant further delays due to transportation, accessibility, and provider capacity problems. He has lost the days of pleasure that he is now enjoying from his ILS excursions.

Individual: YG
Heritage Park Nursing and Rehabilitation
Austin, TX Review Date: February 8, 2017

YG is a 70-year-old gentleman who was admitted to Heritage Park Nursing and Rehabilitation Center on 1/07/2009. It appears he was transferred to Heritage Park from another nursing facility. Formerly a custodian at an elementary school, YG was admitted to a nursing facility after he suffered two strokes. He is close to his sister who lives in California, but keeps in touch with him and visits when she is in the area. He also has a cousin in the area who visits him and would like to take him to church on Sundays, but cannot do so because the nursing facility cannot or will not provide the necessary transportation and support. YG is described as a quiet person who makes his needs and preferences known. He can speak, but often chooses not to. He uses a wheelchair which he is able to self-propel. He attends some activities at the nursing facility, although he is described as more of an observer than a participant. He likes Bingo and music.

When we visited him, he was asleep in his room, which houses three people, even though it is the same size as other two-person rooms at Heritage Park. He and his previous roommate were good friends and the roommate reportedly was saddened when YG was moved to the other room because he required more assistance. YG generally gets along with everyone, but since his move from his other room, does not appear to be close to anyone. He is described as being able to read.

YG was hospitalized twice in 2016 as a result of seizures. His first hospitalization was on 3/18/2016 and the second hospitalization was from 10/17-10/24/2016. He was admitted with decreased oxygen saturation levels, lactic acidosis, hyponatremia and hypokalemia. His admitting problems were all resolved, but the hospital referred him to a urology clinic due to blood in his urine and the presence of an unknown soft tissue mass in the urinary bladder. It appears, from the physician progress notes, that YG saw an urologist, but it is not clear if he sees him on a scheduled basis. He has not had further incidents of blood in his urine.

YG did not receive a comprehensive functional assessment conducted by an interdisciplinary team of professionals with experience in working with individuals with I/DD. He had a PASRR Level I done on 7/20/2015 which affirms ID and mental illness. He has an Individual Service Plan (ISP) dated 4/16/2015. This is the initial ISP. YG was not recommended for any Specialized Services; his one outcome/goal was to obtain a Metro Access card. The record includes assessments by nursing staff and by other licensed professionals. However, these assessments were done at varying times and often in response to a specific episode, such as a hospitalization, and not as part of a collaborative effort to assess his strengths and needs and develop a plan of services.

Planning for services is done by the various professionals without the collaborative effort necessary to produce a comprehensive plan of care to meet his needs and respond to his preferences. With the exception of one nurse, nursing facility staff do not attend the Interdisciplinary Team Meetings designed, among other things, to review recommended Specialized Services. In addition, the Service Coordinator is not included in the nursing facility's care planning meetings. Despite her requests, she is not notified when they are scheduled. This appears to be due in large part to the frequent turnover and lack of communication among staff at the facility.

Nursing facility staff do not receive any training in providing services to individuals with I/DD. Beyond the minimum in-service training required, any additional training they receive is for mental health services. Nursing facility staff also demonstrated a limited understanding of certain Specialized Services available to individuals with I/DD. Specifically, at the time of my visit, the nursing facility social worker was not aware of the Independent Living Skills Training (ILST) available to YG.

YG is not receiving any Specialized Services, except service coordination. At both his ISP of 4/16/2015 and his PSS Form of 9/20/2016 YG's Service Planning Team has recommended no such services – only "service coordination" – even though nursing facility staff indicated he might benefit from community activities, including ILST and Day Habilitation, and from extended physical therapy (PT) and occupational therapy (OT). It took nearly a year and a half to achieve the sole outcome on his ISP – obtaining a Metro Access card so he can go to church with his cousin. The nursing facility did not submit the paperwork requesting this service for months after the goal was established, and a full year to arrange for a necessary interview. Notably, at the time of my visit – more than three months after he received the Metro Access card – YG had not used it and had not gone out in the community with his cousin. According to the nursing facility social worker, YG needs to be accompanied in the community by staff to assist with his ongoing incontinence, which the nursing facility will not provide. If he had Independent Living Skills Training, perhaps provider staff could accompany him on short trips to the community – trips where he could use the Metro Access card and get back in time to address toileting needs. The ILST services would also enable YG to participate in other community-based activities and increase his social interaction skills.

While YG has received some time-limited PT, OT and speech therapy (ST) through the nursing facility's rehabilitation program, he would benefit from ongoing habilitative PT and OT therapies to prevent deceleration of his self-care skills. YG received a modified barium swallow study while in ST which showed that he was not aspirating. He was provided with ST to improve his chewing and swallowing and to be able to progress from a pureed diet to a soft diet. While in OT, PT and ST, he was motivated to learn and was able to meet the goals set by his therapists. Goals in PT were to increase bed mobility, increase functional mobility and increase the distance in self-propelling his wheelchair. His OT goals were in self-feeding, personal hygiene and grooming, and dressing. Given his diagnosis of dementia, it is important that he receive regular Specialized Services to maintain his current level of functioning and provide for a meaningful life for as long as possible.

YG is not receiving a continuous active treatment program of specialized services that will enable him to acquire the behaviors necessary to function with as much self-determination and independence as possible. He did not receive a comprehensive functional assessment developed by an interdisciplinary team of professionals that meets his needs and preferences. His ISP does not include goals set by OT, PT and ST professionals. The planning processes among the various responsible parties of service coordination and nursing staff do not take place jointly, but are held separately. As a result, YG's health-related concerns are not addressed in his ISP in a coordinated fashion. The one outcome that was achieved, obtaining a Metro Access card, has not resulted in any change to his daily life as he has not been able to use it due to lack of appropriate staff support. The available Specialized Service of ILST would ameliorate this situation and improve the quality of his life.

YG has suffered harm as a result of his lack of social interaction and inability to spend time with his family. He has suffered harm due to the lack of active treatment, and particularly, the lack of

ongoing Specialized Services in the areas of OT and PT to maintain his skills, and the lack of a comprehensive plan of services that address his needs and stated preferences. With his diagnosis of dementia, it is important to maintain these skills as long as possible. Significantly, the one thing he requested – a Metro Access card so he could go to church with his cousin – has not been honored. Despite his enjoyment of activities, he continues to be denied the opportunity to go outside the nursing facility.

Attachment 1

Barbara T. Pilarcik
23 Apple Hill Road
Wilbraham, MA 01095
(413) 596-3555

Results:

Expanded services of The Association for Community Living through a merger with a family support agency, providing financial stability to those services and tripling their business. Agency services and financial stability increased through a 50% increase in agency budget, from $17 million annual budget to nearly $30 million annual budget in 7 years. Expanded adult family care model, autism services and services to individuals with complex medical conditions. Built 5 new fully accessible homes and ensured the successful passage of legislation that transfers state land and old 8 bed ICF/ID homes enabling the building of new 5 person homes. Developed and implemented a Leadership Institute providing leadership training to over 25 senior and middle managers.

Member of a national committee that obtained the successful passage of federal tax legislation clarifying that foster care provider stipends are excludable from federal income tax.

Testified as an expert witness in the *Rolland* law suit, resulting in hundreds of individuals leaving inappropriate placements in nursing homes for community residential settings.

Chair of the Complex Medical Needs Task Force, a collaborative project of the Department of Mental Retardation and the provider community. Obtained grant from the Massachusetts Developmental Disabilities Council and published a manual for providers, consumers, and their families to ensure smooth transitions from home to hospital. The manual has been requested by developmental disability providers throughout the US.

Developed and implemented an appeals process which resulted in successful resolution of 85% of client appeals for Region I, the Department of Mental Health.

Developed the first Human Rights Committee at Northampton State Hospital; set up the Human Rights Complaint system.

Resolved major management and quality problems at The Association For Community Living's ICFs/MR resulting in 5 years of "no deficiency" citations by the Department of Public Health.

Developed first community residential service for former Northampton State Hospital clients in Western Massachusetts.

Work Experience:
Consultant-current

Provide consultative services for expert witness in the field of developmental disabilities including litigation and quality reviews. Provide executive coaching, leadership development and clinical services and other skills necessary for the successful management of a human service agency.

Executive Director ***2009-2016***
The Association for Community Living, Springfield, MA

Responsible for overall operations and financial management of The Association, ensuring stability and growth. Included are planning and establishing priorities; developing and overseeing strategic initiatives, programs and The Association policies; building and maintaining relationships with constituents, funders and collaborators; and representing The Association on a local, regional and statewide basis. The Association has an annual operating budget of $30 million and serves over 1000 individuals and families in western Massachusetts. Services include residences, shared living settings, intensive foster care, family support, social-recreational, individual support and employment supports. The Association has approximately 600 employees.

Litigation Work:

- United States Department of Justice in Civil 1:10-CV-249-CAP, Georgia: 2015-current. Expert Witness.
- *Steward Interim Settlement Agreement;* United States Department of Justice and State of Texas; 2014-current.
- United States Department of Justice and Commonwealth of Virginia Settlement Agreement under *Olmstead*; 2012-current.
- *Evans* Court Monitor, Washington DC, June 2005-February 2016.
- Center for Public Representation, *Rolland* Law Suit: 1991-2003; expert witness for the plaintiffs in the class action lawsuit *Rolland vs. Cellucci*. Testified in federal court, gave depositions, and evaluated specialized services under Title XIX for members of the plaintiff class. Suit was settled through a consent decree, appealed and decided at the First Circuit in favor of the plaintiffs. Over 600 people were moved from nursing homes to community placements.

Director of Specialized Home Care and Intensive Residential Services ***1994-2009***
The Association for Community Living, Springfield, MA

Responsible for the direction, management and development of the two Divisions; establish program policy; manage program budget; negotiate contracts, develop liaisons and oversee the supervision and operation of all components in accordance with Association and external regulatory agencies' regulations, standards and policies. The two divisions provide residential services for 136 individuals with developmental disabilities; some of who have complex medical

needs. The divisions' budgets are over $7 million with the supervision of approximately 200 staff and over 100 care providers. Negotiate with four state agencies in two states.

Interim Executive Director ***1/1993 – 4/1993***
The Association for Community Living, Springfield, MA

Responsible for the overall management of the agency during the search for the new Executive Director. Provided leadership, overall operation and financial oversight.

Director, Intermediate Care Facilities ***1985 – 1992***
The Association for Community Living, Springfield, MA

Responsible for overall management of ICF/MR programs for people with mental retardation and physical handicaps; member of agency senior management team; chair; Agency Reorganization Committee; President, Massachusetts Association of ICF/MR Providers (3 years).

Interim Executive Director ***1990***
The Association for the Support of Human Services

Assumed directorship of this agency in order to stabilize daily operations, direct search for new executive director; repair relationships with funding sources, and provide leadership while maintaining existing position at The Association. The Board of Directors presented an award for "Outstanding Consultative Services".

Appeals Mediator ***1981-1985***
Massachusetts Department of Mental Health

Developed and implemented mediation process for the resolution of client appeals pursuant to state regulations; evaluated the Department's implementation of Individual Service Plan process; monitored implementation of client rights' regulations; trained staff in Human Rights. Organized and maintained the first Human Rights Committee at Northampton State Hospital. Conducted investigations of serious allegations at state facilities. Prepared depositions for Roger's hearings and monitored Roger's orders in the facility and the community.

Public Health Nursing ***1975 – 1981***
School Nurse: Town of Wilbraham
Camp Nurse: Wilder Day Camp

Responsible for the planning and development of health services, maintenance of health records, complying with Department of Public Health Records, staff education and first aid.

Regional Director ***1971 – 1973***
Massachusetts Association for Mental Health

Agency liaison to three local chapters of Massachusetts Association of Mental Health; organized and implemented fund raising campaign in four county area; program planning and development; agency policy and by-law development, development and management of the budget, volunteer services, legislative advocacy and community relations.

Staff Nurse – Obstetrics ***1965 – 1971***
Wesson Women's Hospital, Springfield, MA

Head Nurse, Staff Nurse ***1963 – 1965***
Woodside Psychiatric Hospital, Youngstown, OH

Consultations:

Expert Witness:
See page 2 under Litigation

Management Consultations:
American Training, Inc., Lawrence, Massachusetts
Vanguard Associates, Chicopee, Massachusetts
New Bedford Harbor Associates, New Bedford, Massachusetts
Franklin/Hampshire Area Office, Massachusetts Department of Mental Retardation
Riverbrook Residences, Stockbridge, Massachusetts
Mental Health Association, Springfield, Massachusetts

Grants:

Arc Mass Systems Change Grant
"The Bridge Project", Pioneer Valley United Way, seven years of funding.
"Supporting Individuals with Cognitive Limitations during Hospitalization", the Massachusetts Developmental Disabilities Council.
"Community Integration Project", the Community Foundation.
Purchase of wheelchair van, the Beveridge Foundation.
"Berkshire Community Integration Project, the Berkshire Taconic Community Foundation.
"Developing Supports for Kinship and Single Parent Families in the Berkshires", the Berkshire Life Foundation.

Leadership Roles:

President, Human Service Forum, 2014-2016
President, Western Massachusetts Service Providers, 2008-2010
Massachusetts ICF/MR Providers Organization, President, 3 years
Mental Health Association of Greater Springfield, President, 3 years
Springfield Area Board, Department of Mental Health, President, 2 years

UMass/Department of Mental Retardation Committee on Screening Guidelines for Health Care for people with developmental disabilities, 2001.
Editorial Board, *The International Journal for Nursing in Intellectual and Developmental Disabilities*, current.
Member, AAMR Professional Delegation to China, 2001.
Massachusetts Department of Mental Retardation Health Care Initiative Project, DMR Strategic Plan, 2003
Chair, Complex Medical Needs Task Force, 1998-2006.
Chair, Association of Developmental Disabilities Providers (ADDP)/Department of Mental Retardation (DMR) Health Care Partnership Committee, 2000-2005.
American Network of Community Options and Resources, Federal Taxation Legislation Committee, 1998-2001.
Baystate Medical Center Visiting Nurse and Hospice Association Ethics Committee, 1994-2002.
ADDP/DMR Shared Living Task Force, 1999-2001.

Presentations:

Shriver Center for Developmental Disabilities' Evaluation and Research state conference on Prevention, Risk and Safety, October, 2012
Massachusetts Association of Developmental Disabilities Providers: End of Life presentation, November 2007
Developmental Disabilities Nurses' Association 11th Annual Conference, March 2006.
Eleventh International Nursing Research Congress, Hawaii USA, 2005
Massachusetts Annual Shared Living Conference, 2001-2004, 2008.
National Association of Adult Foster Care Providers, 2001.
Massachusetts Department of Mental Retardation Human Rights Conference.
Massachusetts Association of Developmental Disabilities Providers Annual Conference.
Massachusetts Association of Developmental Disability Providers Conference on Shared Living.
Developmental Disabilities Nurses' Association 9th Annual National Conference.
The International Association for the Scientific Study of Intellectual Disabilities, XI International Congress, Seattle, WA, USA; XII International Congress, Montpellier, France; XIII International Conference, Cape Town, South Africa
Massachusetts Department of Mental Retardation: Statewide Quality Enhancement Surveyors Conference.
"Supporting People with Developmental Disabilities during Hospitalization" to over 500 professionals at various seminars.
Western New England College School of Law, Disability Law Clinic.
American International College, School of Nursing.
IASSID 2016 International Congress; Melbourne Australia; August 2016
IASSID USA Conference; Chicago Illinois; July 2016

Community Agencies:

Hawthorn Elder Services, Board Member, 2007-2011
Minnechaug Land Trust, 2008-current
Massachusetts Association for Mental Health, Executive Committee, Officer
Child and Family Services, Springfield, Board Member
Department of Social Services Advisory Board, Charter Member
Community Care Center, Springfield, Corporator, Officer
Springfield Comprehensive Mental Health Center, Board Member
Human Service Forum Long-Range Planning Committee
DMR Psychotropic Drug Review Committee
Mental Health Association, President, Board Member

Publications:

"Supporting Individuals with Cognitive Disabilities during Hospitalizations: A Training Manual".
"Services for People with Developmental Disabilities in China: An American Perspective" *International Journal of Nursing in Intellectual and Developmental Disabilities, Spring 2004 Issue;* www.ddna.org.

Academic Honors:

Sigma Theta Tau International Nursing Honor Society
Alpha Chi Honor Society
Highest Achievement in Psychiatric Nursing

Education:

BS in Nursing, American International College, Magna cum Laude
Trumbull Memorial Hospital School of Nursing, Highest Achievement in Psychiatric Nursing
MS Program, School of Public Health, University of Massachusetts, Amherst, 9 credits
RN licensed in Massachusetts, Inactive in Ohio

Attachment 2

Steward v. Smith
Case No. 5:10-cv-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

PRE-ADMISSION SCREENING AND RESIDENT REVIEW SPECIALIZED SERVICES AND ACTIVE TREATMENT REPORT OF BARBARA PILARCIK
Attachment 2

	Document	Bates No.
1.	Kathryn Dupree 2015 Annual Report of Compliance	DefE-00000601-672
2.	Kathryn Dupree Q1 2016 QSR	DefE-00000677-716
3.	Active Treatment Protocol from Rolland case	PL00000001-14
4.	Reviewer's and Quality Review Manual from Rolland case	PL00000015-41
5.	*Rolland v. Patrick* Active Treatment Follow-up Protocol	PL00000042-59
6.	QSR Matrix	PL00000060-136
7.	Rucker Letter to Judge Neiman re *Rolland v. Patrick*, 12/07/2007	PL00000767-768
8.	*Rolland v. Patrick* Active Treatment Protocol – 12/07/2007	PL00000769-840
9.	Attachment G - PASRR Requirements and Enhanced Community Coordination	DefE-00001859-1873
10.	LIDDA PASRR Reporting Manual	PL00000200-213
11.	40 T.A.C., Part 1, Ch. 19. Subch. BB: NF responsibilities related to PASRR	PL00000251-263
12.	*Rolland v. Patrick* Revised Active Treatment Standards	
13.	CMS Active Treatment Tags	
14.	CMS PASRR NF Survey Guidance, 9/28/07	
15.	42 C.F.R. § 483 - PASRR Regulations	
16.	LIDDA Records for AC	
17.	LIDDA Records for AM	

18.	Nursing Facility Records for AM	
19.	LIDDA Records for AOl	
20.	Nursing Facility Records for AOl	
21.	LIDDA Records for AOv	
22.	LIDDA Records for DP	
23.	Nursing Facility Records for DP	
24.	LIDDA Records for EC	
25.	Nursing Facility Records for EC	
26.	LIDDA Records for ES	
27.	Nursing Facility Records for ES	
28.	LIDDA Records for GH	
29.	Nursing Facility Records for GH	
30.	LIDDA Records for GM	
31.	Nursing Facility Records for GM	
32.	LIDDA Records for JH	
33.	Nursing Facility Records for JH	
34.	LIDDA Records for MM	
35.	Nursing Facility Records for MM	
36.	LIDDA Records for NT	
37.	Nursing Facility Records for NT	
38.	LIDDA Records for PA	
39.	Nursing Facility Order Summary Report for PA	
40.	LIDDA Records for RB	

41.	Nursing Facility Records for RB	
42.	LIDDA Records for SSc	
43.	Nursing Facility Records for SSc	
44.	LIDDA Records for SS	
45.	Nursing Facility Records for SS	
46.	LIDDA Records for YG	
47.	Nursing Facility Records for YG	
48.	PIRM QSR Outcome 2 Reports for AC, AM, AOl, AOv, DP, EC, ES, GH, GM, JH, MM, NLT, PA, RB, SSc, SS, and YG	
49.	GENETIC AND RARE DISEASE INFORMATION CENTER, NATIONAL INSTITUTE OF HEALTH, https://rarediseases.info.nih.gov/ (last visited March 16, 2017).	
50.	MERCK MANUAL, PROFESSIONAL VERSION, http://www.merckmanuals.com/professional (last visited March 3, 2017).	
51.	Diana Scott, RN, *Developmental Disabilities Adult Foster Care Training Manual*, *Fatal Four* 45-54, OREGON DEPARTMENT OF HUMAN SERVICES, https://www.oregon.gov/DHS/PROVIDERS-PARTNERS/LICENSING/IDD-FOSTER-HOMES/Documents/AFH%20Training%20Manual.pdf.	
52.	Andrew Skalsky, MD, *Prevention and Management of Limb Contractures in Neuromuscular Diseases*, HHS PUBLIC ACCESS (August 1, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482407/.	
53.	DRUGS .COM, www.drugs.com.	

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lilian Minor, *et al.*,	§	
Plaintiffs,	§	
v.	§	
CHARLES SMITH, Governor, *et al*.,	§	
Defendants.	§	
	§	CIV. NO. 5:10-CV-1025-OG
THE UNITED STATES OF AMERICA,	§	
Plaintiff-Intervenor,	§	
v.	§	
THE STATE OF TEXAS,	§	
Defendants.	§	

DECLARATION AND EXPERT DISCLOSURE OF RANDALL WEBSTER IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B) that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case:

1. My report describes the facts, data and other information I considered in forming my opinions.

2. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

3. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.

4. Within the last four (4) years, I have not testified as an expert, either in a deposition or at trial.

5. I have been retained by the Plaintiffs and the United States as a joint expert in the Steward v. Smith litigation. My compensation in this litigation is $125.00 per hour for my review, preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated:

Randall Webster 3/30/2017

Randall Webster

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY REPORT OF RANDALL WEBSTER

I. PURPOSE AND SCOPE OF REPORT

The Plaintiffs requested that I, along with another developmental disability expert, Nancy Weston, conduct a review of the practices and processes of the Local Intellectual and Developmental Disability Authorities (LIDDAs) pertaining to the Pre-Admission Screening and Resident Review (PASRR) federal requirements for screening, evaluation, and the provision of specialized services to individuals with intellectual and developmental disabilities (I/DD) in nursing facilities. The purpose of the review was to assess the LIDDAs' capacity and efforts to implement the recently redesigned PASRR program in Texas.

LIDDAs are statutorily-created, quasi-public entities that are responsible for determining eligibility for services for individuals with I/DD, and then arranging, providing, and coordinating those services. The State of Texas, through its Department of Aging and Developmental Services (DADS) and now through its Health and Human Services Commission (HHSC), regulates, oversees, and funds thirty-nine separate LIDDAs. The State has delegated to the LIDDAs the responsibility for implementing the federally-mandated PASRR screening, evaluation, diversion, transition, and specialized service program requirements.

The scope of the LIDDA review was to determine if:

(1) the LIDDAs were properly identifying, screening, and diverting persons with I/DD;
(2) the LIDDAs made professionally-adequate determinations of the need for specialized services that were based on comprehensive functional assessment of all relevant habilitative need areas;
(3) the LIDDAs provided, or ensured that the nursing facilities provided, all recommended specialized services
(4) the LIDDAs ensured that person received all needed specialized services with the frequency, intensity, duration, and continuity to constitute a program of Active Treatment; and
(5) the LIDDAs provided professionally-adequate planning, coordination, and monitoring of services in nursing facilities.[1]

II. BACKGROUND AND EXPERIENCE

I have thirty-nine years of experience in the field of services to individuals with an intellectual and/or developmental disability, including twenty-three years as the Director of an Area Office for the Department of Developmental Disabilities (DDS) in Massachusetts. As the Area Office Director, I managed the provision and procurement of services to individuals with a developmental disability, including residential services, day services, employment services,

[1] The scope of this review was limited to PASRR issues and did not include the LIDDAs' transition activities, although a brief discussion of transition issues was occasionally included.

respite services, emergency support services and family support services in the City of Fall River, Massachusetts and surrounding Towns. In that role, I also oversaw the functions of DDS service coordination program, which is available to every individual in the service area, including both individuals receiving services in the community as well as individuals with an I/DD diagnosis who are placed in nursing facilities through the PASRR process.

I was appointed Assistant Commissioner for Field Operations for DDS from 2010 until my retirement in 2014. In addition to general statewide oversight, service design and delivery and policy development, I was responsible for ensuring that any citizen of the Commonwealth of Massachusetts with an Intellectual disability or related condition residing in a nursing facility was either placed into a community setting from a nursing facility or, if remaining in a nursing facility, was receiving services that met the federal standard for Active Treatment. I had a lead role in promoting and achieving substantial compliance with the federal court order in *Rolland v. Patrick,* a case in Massachusetts very similar to this one that required the timely placement of individuals who lived in nursing facilities into the community and/or the provision of Active Treatment to those who remained. As a result of that lawsuit, it has been the intention of the Department since 1999 to implement an aggressive PASRR compliance effort. Since the inception, of that policy over 1,600 individuals were placed from nursing facilities into community residential settings as the preferred service setting, rather than having individuals remain in a nursing facility and receive Active Treatment. Currently there are fewer than 250 individuals residing in nursing facilities at any one time in the Commonwealth with an I/DD diagnosis. Included in our PASRR compliance efforts has been and continues to be a very aggressive diversion process to divert individuals from nursing facilities and the prompt placement of individuals approved through the PASRR process to return back to community living.

A detailed description of my background and experience is set forth in my *Curriculm Vitae,* which is included in this Report as Attachment A.

III. METHODOLOGY

A. Documents Reviewed

Documents were provided to me by Disability Rights Texas and the Center for Public Representation related to the State of Texas' PASRR design and compliance efforts. The documents provided included:

1. LIDDA PASRR Quarterly Reports submitted to Department of Aging and Disability Services (DADS);
2. the LIDDA PASRR Reporting Manual;
3. LIDDA Quality Reports and an statewide aggregate report for all LIDDAs for various quarters of 2016;
4. LIDDA Compliance Reports for a variety of LIDDAs;
5. Statewide summary of PASRR Education for LIDDA staff;
6. Listing of the number of PASRR clients associated with each LIDDA; and
7. Proposed amendments to the nursing facility PASRR rules.

Additionally, I reviewed documents available on the DADS' web site including:

1. PASRR Training Modules
2. Specialized Services Training Module
3. PASRR Level 1 instrument

4. PASRR/PE instrument
5. Web sites for the LIDDA's I visited from 1/30/17 to 2/3/17 were also reviewed.

A complete list of documents that I reviewed is set forth in Attachment B to this Report.

B. Programs Reviewed

Beginning on 1/30/17, I met with LIDDA staff in seven LIDDAs. I was informed by the plaintiffs that these LIDDAs were selected because they served all of the individuals who were part of a separate client review conducted by other experts. It is my understanding that I was asked to focus on these LIDDAs in order to assess, at a program level, the capacity and activities of the LIDDAs which were responsible for providing PASRR screening, evaluation, and services to the individuals in the client review. This approach to LIDDA selection provided a broad perspective on LIDDA practice, particularly because many of the findings detailed below were consistently present in the LIDDAs reviewed. It is, therefore, highly likely that my findings of these LIDDAs are representative of LIDDAs across the State of Texas.

The LIDDA staff were, in every instance, very cooperative during the meetings, made their relevant staff available, and shared relevant information and their experiences concerning the PASRR program. The meetings included groups of two (2) to fifteen (15) staff with various PASRR responsibilities, including the LIDDA Diversion Coordinator, PASRR Service Coordinator, Enhanced Community Coordinator, Nursing Facility Service Coordinators, and in many instances senior staff from the LIDDA. The LIDDAs I reviewed were:

1.The Harris Center for MH and IDD in Houston, Texas
2.Texana Center in Rosenberg, Texas
3.Metrocare Services in Dallas, Texas
4.MHMR of Tarrant County in Fort Worth, Texas
5.Pecan Valley Centers for BDHC in Granbury, Texas
6.Heart of Texas MHMR in Waco, Texas
7.Community Health Core in Longview, Texas

The purpose of the meetings was to explore the practices, processes and experiences of the LIDDA and its PASRR staff as they attempted to implement PASRR requirements as detailed in Section IV of the LIDDA Performance Standards, as well as relevant DADS and CMS PASRR rules, policies, and procedures. In order to ensure that the meetings with LIDDA staff addressed the same basic issues, I, together with Nancy Weston, developed a series of questions and we used these questions to ensure that we both gathered similar information.

IV. STANDARDS

A. Federal PASRR Requirements

There are many federal requirements that govern the PASRR program. CMS issued regulations in the early 1990s, and subsequent guidance concerning the standards, procedures, and processes that each State must use for its nursing facility PASRR program. 42 C.F.R. Sec. 483.100-138. These regulations describe the process for identifying and screening individuals with I/DD and related conditions; the procedures and criteria for diverting individuals from nursing facility admission; the fifteen habilitative need areas that must be assessed in evaluating whether the individual would benefit from specialized services; the treatment standards that must be met in providing specialized services; the ongoing coordination and monitoring of

nursing facilities and community providers to ensure that together, they deliver a consistent and continuous program of Active Treatment; and the State's authority and ultimate responsibility for ensuring that all of these requirements are met.

The purpose of the Level I PASRR is to determine if person has or is suspected of having an I/DD diagnosis; the purpose of the Level II PASRR is to confirm or deny the suspicion of I/DD and determine whether a nursing facility level of service and the provision of additional specialized services are needed. The PASRR regulations list fifteen separate need areas which must be considered as a part of the Level II review. The PASRR must be completed by a qualified I/DD professional.

Federal law requires a comprehensive functional assessment of all need areas identified through the initial interdisciplinary team meeting which must occur within thirty (30) days of admission (Section 483.440(c)(3)). Under federal regulations, such an assessment must be provided to every individual with I/DD in order to determine what habilitative needs the individual has, what services are required to address these needs, and how these services should be delivered. A comprehensive functional assessment is a professional standard for the care and habilitation of individuals with I/DD and is an essential foundational requirement for providing habilitation that constitutes Active Treatment.

The PASRR regulations require that the State (not the nursing facility or any other entity) must provide or arrange for the provision of specialized services to all nursing facility residents with I/DD who need these services Specialized services are defined by 483.120(a)(2) for I/DD individuals as "… the services specified by the state which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of 483.440(a)(1) [Active Treatment]."

Specialized services should be based on highly individualized goals, objectives and strategies derived from identifying an individual's needs as described by the comprehensive functional assessment and implemented through a program of Active Treatment program as defined in federal regulations, Sections 483.440(a)-(f)). Federal requirements for Active Treatment include an integrated process of planning, documentation, staff qualifications, team participation, goals, objectives and timelines as well as continuous monitoring and revision, as needed, of all needed habilitative services.

B. State PASRR Requirements

Texas has issued its own PASRR rules, which substantially track the federal ones concerning identifying, screening, and evaluating individuals with I/DD, prior to and after admission to a nursing facility. The rules assign these duties to the LIDDAs[2] and require them, through their service coordination program, to organize and lead service planning teams and to develop an Individual Service Plan (ISP) that includes all professionally-appropriate assessments (a comprehensive functional assessment), identifies all habilitative need areas, lists goals and timelines for addressing these need areas, describes the specialized services (including the amount, duration, and scope of such services) that will be provided to meet all identified need areas, identifies the providers responsible for offering these services, and incorporates a transition plan for individuals who would benefit from placement in the

[2] There are a few exceptions, such as for individuals referred to nursing facilities directly from hospitals, where LIDDAs do not have responsibility for all of these areas.

community. 40 TAC Ch. 19. The LIDDA service coordinators are responsible for monitoring the plan and ensuring that all needed specialized services are provided in a timely and consistent manner. The DADS PASRR Manual and related policies establish the state standards for this program.

Texas has limited specialized services to certain therapies and medical equipment provided by nursing facilities in the facility and certain community services provided by or through the LIDDAs typically outside of the facility. Nursing facilities routinely offer physical therapy, occupational therapy, and speech therapy designed to *rehabilitate* a condition (like a fall) for a time-limited period, as part of their basic nursing program and included in the nursing facility's daily rate. For individuals with I/DD who require these same therapies, or a customized wheelchair, on an ongoing basis for *habilitative* purposes – to maintain existing functioning or learn new skills – the nursing facility provides them as specialized services and is paid an additional rate, after approval by the State. The LIDDA must provide one specialized service – service coordination/transition assistance – and may offer day habilitation, independent living skills training, employment assistance, supported employment, and/or behavior support through its network of community provider agencies, subject to approval by the State. It is not clear whether day habilitation is a location and service category, and what activities are actually offered in the day habilitation facility. The LIDDA Performance Contract and DADS' specialized services policies and procedures establish the state standards for specialized services. Significantly, these state standards on specialized services never mention and apparently do not require a program of Active Treatment.

V. FINDINGS

The findings detailed in this section are based on a review of DADS/HHSC PASRR policies and procedures, the PASRR sections of DADS'/HHSC's Nursing Facility handbook, other documents listed in Attachment B, and information provided by the LIDDAs detailed in Section III (B) when interviewed from 1/30/2017 through 2/2/2017. I have reached the following findings.[3]

A. The Redesigned PASRR Process Reportedly Has Resulted in More Timely Screenings and Evaluations But Not Adequate Assessment of Habilitative Needs

1. LIDDAs reported that the PASRR Level I screenings (Level I) usually are done by a LIDDA designated PASRR reviewer when seeking admission from the community into a nursing facility. The review involves, where appropriate and available, assistance from a family member or members, friends or other people who have a familiarity with the individual such as neighbors. Screening is done by a hospital or the nursing facility for individuals being admitted from an acute care facility. This important first step in the federal PASRR requirements is intended to ensure that individuals with an I/DD diagnosis are identified prior to placement in a nursing facility. For individuals identified through this Level I process, it is a key first step to ensuring that they are able to receive a continuous program of needed interventions and services in sufficient number and frequency to support the individualized goals and objectives found in the individual's treatment plan, or that appropriate community alternatives are identified in order to avoid nursing facility placement.

[3] These findings were not independently confirmed by other sources such as claims data or client records.

2. Due to inconsistent performance related to PASRR Level II evaluations (PEs), DADS/HHSC initiated a policy in 2015 that ties payments to nursing facilities' compliance with PASRR requirements, including the requirement that PASRR Level II evaluations be completed prior to admission from the community. As a result, many LIDDA staff report that they now complete the PASRR/PE prior to admission to a nursing facility for individuals living in the community. I found occasional instances in my meetings with LIDDAs when that did not occur but, in general, the policy appears to be having the intended effect of PASRR/PE compliance. Because the PASRR/PE reviewer is supposed to examine all available information about the individual and conducts interviews with individuals knowledgeable about the person, it is an important opportunity to learn the strengths, needs, and preferences of the person, and to identify the types of habilitative services the individual will need to promote growth and prevent or decelerate any regression the person might experience. Having the PE done outside the nursing facility is crucial to have a clear understanding of the individual's skills and abilities prior to having the experience of living in an unfamiliar and possibly upsetting new living situation such as a nursing facility.

3. The Statewide PASRR/PE evaluation document, June, 2016 V.4 that I reviewed identified selected habilitative need areas in Section B of the PE and linked those need areas to certain specialized service types, but the need areas were broad categories that often were not fully addressed and were usually not completed by qualified I/DD professionals who made independent professional judgments about either needs or services. It did not appear, from the discussions with LIDDA staff, that the identification of needs, where it occurred, was based upon any type of professional assessment which would provide a basis for service planning and delivery. The PASRR/PE is intended to be a stepping off point to the development of a service plan but, because of the inadequacy of the need identification process and related lack of assessments for specialized services, the PE did not appear to provide an adequate start for the Service Planning Team as they consider service planning and delivery.

4. Persons seeking admission to a nursing facility from the community who can clearly communicate a preference to remain in the community reportedly are offered a diversion waiver slot but:

a. I did not find a systematic, well designed diversion strategy in most of the LIDDAs I interviewed. The PASRR Quarterly Reports summarizing diversion efforts confirm this finding. I found that successful diversions were relatively few and, according to LIDDA staff, often more the result of advocacy from an individual's family then from an aggressive diversion program. This finding helps explain why there is a low number of diversions reported by most LIDDAs in their quarterly reports to DADS/HHSC. It also may explain why, despite the claim of some LIDDAs that all people who come from the community are offered a diversion slot, the diversion numbers are low.

b. I found in a few LIDDAs that when a diversion slot was released for an individual who wanted to avoid a nursing facility placement through the PASRR/PE process, the individual would be encouraged to reject the slot because LIDDA staff did not know the individual and so could not effectively plan for the person's placement in what they considered was an adequate manner. In

one LIDDA, the agency had just appointed someone to the Diversion Coordinator function and admitted to having no diversions.

c. Moreover, this reported guarantee of a diversion slot was acknowledged as having the potentially unintended effect in some LIDDAs of some individuals and/or families seeking a nursing facility placement in order to gain immediate access to a waiver slot, thereby working around the State's lengthy Interest List and 12 year waiting list for a waiver program.

5. Persons seeking admission from a hospital or who have the screening and evaluation done by a nursing facility are never diverted since the PASRR/PE does not occur until after they are in the nursing facility. The State has limited diversion waiver slots for persons not yet admitted to a nursing facility. As mentioned in finding number 4, some essential elements needed to have a successful diversion program are not in place in many LIDDAs I visited.

B. Comprehensive Functional Assessments (CFA) of Habilitative Needs Are Almost Never Conducted and Do Not Provide a Basis for Service Planning or Delivery.

6. LIDDA staff acknowledged that they do not conduct a Comprehensive Functional Assessment (CFA) by licensed and/or qualified I/DD professionals that addresses all habilitative need areas. As mentioned in Finding A.3 this does not happen as part of, or an extension of the PASRR/PE, nor was it mentioned as part of the Service Planning Team meeting process (SPT). In fact, there was no awareness of the requirement of the completion of a CFA by any LIDDA staff in the interviews I conducted. The omission of a CFA is extremely problematic and inconsistent with professional standards because the relevant service planning hinges on a comprehensive assessment of all need areas to ensure that a service plan is developed which identifies all needed interventions and services in sufficient number and frequency and across all settings to meet the habilitative needs that are identified.

C. Specialized Services Are Not Available To Address An Individual's Needs As Identified In the PASRR/PE and by the Service Planning Team.

7. Planning and Identifying Needed Specialized Services

a. It is very difficult, if not impossible, for appropriate and individualized specialized services to be provided without the availability of a CFA as a basis for establishing habilitation goals, for determining which interventions are needed to meet those goals, and for describing the amount, frequency and duration of those services. LIDDA staff identified what they understood nursing facility and LIDDA specialized services to be based in part on a web-based training module provided by DADS/HHSC titled "PASRR Specialized Services Training" where specialized services were defined as "... support services in addition to nursing facility services that are identified through the PASRR (PE) process"; specialized services also are habilitative and may be identified through the interdisciplinary team process. Nowhere in the training or in discussions with LIDDA staff was there mention of assessed needs or even more importantly, a CFA. It seemed that LIDDA staff did understand this DADS/HHCS definition, but implementing that definition would not allow for the provision of specialized services as intended by federal requirements. Since they were never told that a CFA was a

requirement for the proper provision of specialized services, and since there was no mention of any other professionally-appropriate method for identifying an individual's strengths and needs (such as a report synthesizing the results of important assessments or a series of reports that could constitute a CFA), specialized services could not be appropriately identified and provided.

b. LIDDAs reported that only certain service categories or service types are identified in an individual's ISP. It is the understanding of most LIDDAs that the service type is the specialized service, rather than the interventions derived from the assessments conducted by professional staff associated with that service type on behalf of the individual. For example, when asked if day habilitation services were provided, some LIDDAs indicated they were available, for others they were not available, but in all instances there was the understanding that if day habilitation services were provided, the LIDDA was providing a specialized service. But as noted above, because there were not assessments that specified the types of service interventions that should be provided to respond to the individual's needs within a service category, there could not be an identification of specific interventions, with the needed frequency, intensity, and duration, that should be developed to address the individual's assessed need through a service type like day habilitation.

8. Nursing Facility Specialized Services

a. As noted above, specialized services must be based on the assessed needs of the individual by a qualified clinician or professional. Unlike specialized services provided by LIDDAs, the practice for accessing specialized services provided by the nursing facility must begin with an identification and assessment from the nursing facility therapist. Regardless of what the Service Planning Team discussed about the need for a particular nursing facility specialized service, the nursing facility therapist and/or nursing facility staff ultimately determine whether the specialized service will be provided. If it is requested, it must then be authorized by DADS/HHSC before the service can be provided, which has resulted in delays and even rejections by the state agency. Decisions of this nature should be made by the interdisciplinary team at the STP charged with creating a comprehensive individualized service plan, rather than the judgment of nursing facility specialized services clinician(s) – who may not be part of the team – and could be distant from the discussions and decisions of the STP.

b. I heard of several occasions where the nursing facilities were reluctant, or possibly resistant to seeking authorization form DADS/HHSC. The fundamental problem is that if the Service Planning Team identifies a particular need, it should be unnecessary to delay service provision until authorization is received. Such a delay is at the expense of the individual requiring the specialized service. Additionally, the process is cumbersome, since the nursing facility has to pay for the service up front, without assurance that timely payment will be received. Also affecting the decision of the clinician was that the nursing facility therapists may not participate in the PASRR and SPT process.

c. The role of the Service Coordinator is to monitor the delivery of all services, including specialized services, to an individual with an I/DD diagnosis in an nursing facility. This role is complicated by nursing facility resistance to participating in SPTs and requesting and then providing needed specialized services. This was acknowledged in some LIDDA interviews, while others said it had been a problem but the nursing facilities were becoming more cooperative. This dynamic further distracts the Service Coordinator from monitoring the delivery of nursing facility specialized services as well as all services provided to an individual in a nursing facility. As a result, nursing facility specialized services for habiliative purposes are not often ordered or provided.

9. LIDDA Specialized Services

a. One specialized service that I found consistently present provided by the LIDDAs was service coordination. Their role and function was consistent across all LIDDAs; however, there were a few LIDDAs where a Service Coordinator would provide other PASRR-related services, such as being a part-time Diversion Coordinator.

b. I was told of two instances where behavioral supports were being provided. In those instances, the nursing facility and LIDDA staff acknowledged that by not getting the service to the individual, the individual was in jeopardy of being removed from the nursing facility. These instances had in common the likelihood of the person being in jeopardy of being displaced. They did not appear to be the result of a structured service plan that incorporated specialized services into the ISP. I did not hear of other instances where behavior supports were being provided across the LIDDAs.

c. I heard of one individual receiving employment supports from one LIDDA. Otherwise I heard of no one else receiving supported employment or employment assistance as a specialized service.

d. There was consistently an extremely low number of people receiving day habilitation specialized services -- fewer than 10% on average across the LIDDAs. When available, these services are always out of the nursing facility, in a separate, center-based facility. There are many reasons for the low participation but key ones include:

(1) Day Habilitation programs do not consistently provide transportation to/from their facility and nursing facilities often do not want to provide transportation to the site-based facility due to costs associated with the commitment.

(2) The size the LIDDA service area makes the provision of this service very difficult to arrange and provide. In one LIDDA that tried to provide Day Habilitation services, the transportation took over 1.5 hours each way, requiring an early departure to get people home, allowing very little time for service delivery before they had to leave for the day. The program had to close for financial reasons.

(3) I found no instances where Day Habilitation was provided in a nursing facility, which meant that unless in a LIDDA could provide or arrange for off site, center-based Day Habilitation services, there was no access to this specialized service by individuals with an I/DD diagnosis.

e. There were very few individuals receiving the specialized service called Independent Living Skills Training (ILST). I found that very few LIDDAs were aware of the value of this habilitative service, and that there were very few providers qualified to provide this service. When I did find ILST used, it appeared to be mostly to get people out of the nursing facility, to give them a chance to pursue their "wants," and was not being provided based on assessed needs. Furthermore ILST was rarely provided in the nursing facility.

D. Active Treatment (AT) Is Not Provided Nor Is There an Understanding of AT as a Federal Requirement for Individuals in Nursing Facilities.

10. There was not an understanding by LIDDA PASRR staff of the concept of Active Treatment in nursing facilities nor of the requirements of federal regulations to provide an AT program in a nursing facility. Consequently LIDDA staff did not consider its relationship to a CFA, to the continuous provision of needed interventions and services, and to other related aspects of an AT program.

11. Similarly, there was no indication from these LIDDA staff that the nursing facility clinicians or direct care staff were aware of the requirement to provide an AT program for individuals with an I/DD diagnosis.

12. No one requested or monitored specialized services within the nursing facility to determine if the individual received a continuous, consistent program of AT that carried over from setting to setting.

13. There was no claim that AT, as defined in federal law, actually occurred in nursing facilities.

14. The fundamental planning process noted by most LIDDAs was a person centered approach where "wants, needs and desires" formed the core of the service planning process. With no comprehensive needs assessment, wants and desires formed the core of the service planning approach resulting in some staff supporting an individual's wants or desire to engage in many different activities, with none of these activities in any way related to AT or to the provision of habilitative services.

E. Service Coordination Is Provided As A LIDDA Specialized Service But Lacks The Structure and Focus Provided By an AT Program

15. Service Coordination designated staff regularly visited nursing facilities at least every thirty days, had discrete caseloads averaging about thirty individuals per PASRR Service Coordinator, and were familiar with individuals on their caseload. They all showed a great deal of enthusiasm for their work and concern for the individuals they were serving. I was told that every six months Service Coordination staff would ask

each individual on their caseload if they would like to be placed but had practically no transition support infrastructure to emphasize the importance and meaning of the community placement opportunity.

16. Transitioning of individuals who were moving from a nursing facility to a community placement involved the PASRR Service Coordinators as part of the team which would schedule and ensure the placement plan was comprehensive and well-coordinated. After that initial meeting with the placement team the individual being placed was typically removed from the PASRR Service Coordinator's caseload and transferred to another Service Coordinator. Although there were some transitions that took place across all LIDDAs they were few, and usually did not involve people who were in the nursing facility when the PASRR process was revised and implemented in 2013.

17. PASRR Service Coordinators were not aware of the AT requirement. There were some senior LIDDA administrative staff who had worked in the ICF service system who were aware of the concept of AT, but none of the individuals I met were working as LIDDA PASRR service coordinator and none were aware that AT was a federal PASRR requirement in nursing facilities. Some of these individuals agreed that the provision of AT would benefit the individuals with an I/DD diagnosis; however a few did not like the programmatic rigidity they felt was associated with AT. For these individuals there was a clear preference for the person centered, "wants, needs, desires" approach. When PASRR Service Coordinators were asked about the provision of services that would fall under the rubric of an AT program, like providing day habilitative services or ILST, most reported that, if available, nearly all individuals would benefit from these specialized services.

VI. CONCLUSION

The State of Texas has shown progress in addressing the implementation of PASRR related federal requirements that enable the identification of individuals with an I/DD diagnosis before they are admitted into a NF. However, the assessment and planning for, and the delivery of, specialized services is inadequate. In addition, the current system is far from meeting the federal requirements for AT. The result for individuals with an I/DD diagnosis in nursing facilities is that they are getting an inadequate array of services which are not reflective of an individual's assessed needs, as would be detailed in a comprehensive functional assessment. Absent a relevant series of meaningful assessments, it is highly unlikely that these individuals would ever receive all needed relevant individualized specialized services provided through an aggressive active treatment program.

Attachment A

Randall Webster

42 Parkview St.
South Weymouth, MA 02190

781-803-6210

EXPERIENCE

COMMONWEALTH OF MASSACHUSETTS 1977 - PRESENT

Consultant to Department of Developmental Services Special Projects 2014 - Present
Maintaining certain responsibilities I had prior to retiring in order to transition the new person into my former role. Additionally, have been working on key projects as assigned by the DDS Commissioner including contract management reform within DDS, maintaining a leadership role in Hutchinson v. Patrick Settlement Agreement working in conjunction with sister State agencies within Massachusetts including Mass Health, maintaining PASRR oversight role to ensure DDS' accomplishments in settling Rolland v. Patrick are maintained, consulting on CMS waiver re-writes and associated revenue implications and participating in rate setting initiatives on a consultative basis as the rates relate to DDS and/or Mass Health.

Assistant Commissioner for Operations 2011-2014
Responsible for overall operational policies and practices for the Department of Developmental Services (DDS) throughout the Commonwealth working under the direction of the Deputy Commissioner for DDS. Particular emphasis has been on waiver implementation and compliance, data management and integrity, resolution of the Rolland v. Patrick Settlement Agreement, participating in fiscal management initiatives including monitoring of expenditures and Chapter 257 compliance and day-to-day operational concerns of the Department with an annual budget of approximately 1.6 billion dollars.

Area Director Department of Developmental Services (and associated roles)— 1989 - 2011
Responsible for a variety of complex management functions related to procurement and service delivery of developmental services to over 850 eligible individuals of the DDS in the Fall River Area with a local budget of approximately $26,000,000. In this role I had routine interactions with families, Area Board members, legislators, service recipients, executive directors, direct care staff, administrators in leadership roles within DDS and occasionally EOHHS. I exercised my responsibilities within legislative statute and Executive Office direction.

In addition to my routine responsibilities as Area Director I was the lead Area Director in litigation related to BRI in the early 1990's, was in a senior role at Otis AFB during the Commonwealth's response to Hurricane Katrina known as "Operation Helping Hands" in 2005. I was the Acting Contracting Manager for the State DDS for over one year responsible for policy and direction of over $650,000,000 MM dollars. In that role I worked on contracting issues identified by the State Auditor and the Operational Services Division.

Cape Cod Assistant Area Director/Area Director - 1986-1988

Responsible for DMH and DMR (now DDS) clinical, administrative and personnel functions for the Cape Cod Area. Primary responsibility was with the DMH. Roles related to personnel management, service oversight and procurement and inpatient unit certification. Interacted with families, agency administrators, Area Boards and legislators.

Associate then Interim District Manager Region V DMH — 1981 - 1986
Responsible for supervision and oversight for mental health and developmental disability services for the Region V District of DMH. Significant budgetary and supervisory responsibility for service delivery all occurring at an Area level.

Region V Quality Assurance Director/Region V DMR Licensor — 1977 - 1981
Participated in the development of the initial licensing function for the DMH then moved into a broader role of quality Assurance Director of DMH Region V. Responsibilities included investigating significant events, assisting in certification of psychiatric units at Taunton State Hospital and overseeing of licensing function of DMH.

EDUCATION

M.S. Syracuse University - Rehabilitation Counseling 1983

M.A. Syracuse University - Education 1970

B.A. LeMoyne College - History 1969

COMMUNITY INVOLVEMENT

Plymouth-Carver Regional School Committee Member (1987 - 1993)

As elected Carver member to the Plymouth Caver Regional School District (Grades 7 - 12) managed the complex relationships associated with being the smaller Town in the relationship. In this role I was the key Carver member related to budget issues because the senior Carver member would not support Plymouth sponsored budget proposals and all budget items required an affirmative Carver vote for enactment. During that period worked with the senior Regional School Committee member toward the dissolution of the Region which did occur in 1993.

Carver K-6 School Committee Member (1992 - 1993)

Was elected to the Carver K-6 Committee in order to provide academic continuity since the Regional structure was going to dissolve. I wanted to make sure there was alignment between the local schools and the Regional system related to academics, collective bargaining, fiscal and administrative management.

Carver School Committee (K-12) (1993 -2008)

Member and, for many years, Chairperson, of the Carver School Committee. Generally, School Committees must have a collaborative, complementary relationship within Town government and the community. Often over 50% of the Town's budget (in Carver it was close to 75% of the Town's budget) goes to the schools which creates challenges and pressures that have to considered, respected and worked through for the betterment of the entire Town. In that context, then, I had direct ongoing relationships with the Selectmen, Town Manager, Capital Outlay Committee, Finance Committee and Building Committee (an on going appointment while on the School Committee). Within the Schools I was the direct contact between the Superintendent and School Committee and at times, the Superintendent and other Town Departments. Participated in collective bargaining with the teachers and other bargaining groups within the schools. Also, Chaired two Superintendent searches during my tenure as Chairperson.

Member Capital Outlay Committee and Carver School Building Committee As School Committee Designee to each Committee (1993 - 2008)

Coach Girls Soccer

Coached for over 15 years as my daughters (3) were growing (both Town Travel Teams and later Club Teams)

Awards

Lifetime Achievement Award Massachusetts Association of School Committees (2007).

Manuel Carballo Governor's Award for Excellence in Public Service (2013)

Certificate of Appreciation from Governor Romney for my role in "Operation Helping Hands" (Commonwealth's response to victims of Hurricane Katrina at Otis AF Base) (2005)

Attachment B

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY REPORT OF RANDALL WEBSTER
Attachment B

	Document	**Bates Number**
1.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q4 FY15	DefE-00000003
2.	NF Population Report 12/31/15 and cover email	DefE-00000030-32
3.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q1 FY16	DefE-00000034
4.	LIDDA Compliance Measure (LIDDA v. State (% of compliance))	DefE-00000049-00000470
5.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q1 FY 16	DefE-00000556
6.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Service Q2 FY16	DefE-00000557-559
7.	LIDDA PASRR Quality Report FY 16 Q1 with cover email	DefE-00000725-728
8.	PL2015-33 Top Non-Compliance Trends with the Preadmission Screening and Resident Review (PASRR) Requirements	PL00000137-139
9.	PL2015-16 Preadmission Screening and Resident Review (PASRR) Facility Requirements	PL00000140-142
10.	IL2015-61 Preadmission Screening and Resident Review Habilitative Specialized Services	PL00000143-144
11.	May 2016 Monthly report to stakeholder re slot utilization	PL00000145-184
12.	June 2016 Monthly report to stakeholders re slot utilization	PL00000185-188

13.	September 2016 Monthly report to stakeholders re slot utilization	PL00000189-192
14.	PASRR Provider Resources-LA FAQs-DADS website	PL00000193-195
15.	PASRR Specialized Service (PSS) Form	PL00000196-199
16.	LIDDA PASRR Reporting Manual	PL00000200-213
17.	LIDDA Performance Contract FY16-17	PL00000214-250
18.	Kathryn Dupree 2015 Annual Report of Compliance	DefE-00000601-672
19.	Kathryn Dupree Q1 2016 QSR	DefE-00000677-716
20.	QSR Matrix	PL00000060-136
21.	QSR Interview Protocol – Nursing Facility Members – Texas	PL00000882-900
22.	*Rolland v. Patrick* Active Treatment Protocol	PL00000001-14
23.	Reviewer's and Quality Review Manual from Rolland case	PL00000015-41
24.	Slot Type 90 FY 16-17	DefE-00000037
25.	Habilitative and Rehabilitative Services	DefE-00000769
26.	Analysis of PASSR Survey	DefE-00000791-793
27.	TMHP Portal Enhancements	DefE-00000855-859
28.	LIDDA Performance Contract FY16-17 and Attachments	DefE-00001706-1911
29.	Nursing Facility Diversion Protocol	DefE-00001936-1937
30.	HCS SW ILR #59 FY'12-'13 Enrollments as of 5/31/13	DefE-00029326
31.	Slot Type 63 FY 14-15 9/30/2013	DefE-00029681
32.	Specialized Services Request Process 4/15/16	DefE-00052224
33.	Minutes of LA Webinar 2/19/15	DefE-00054425-54428
34.	Minutes of LA Webinar 3/19/15	DefE-00054430-54433

35.	Minutes of LA Webinar 4/23/15	DefE-00054438-54442
36.	Minutes of LA Webinar 6/25/15	DefE-00054497-54503
37.	Minutes of LA Webinar 7/16/15	DefE-00054522-54528
38.	Minutes of LA Webinar 8/20/15	DefE-00054530-54535
39.	Minutes of LA Webinar 9/17/15	DefE-00054537-54544
40.	Minutes of LA Webinar 11/19/15	DefE-00054549-54553
41.	Minutes of LA Webinar 12/17/15	DefE-00055464-55468
42.	Minutes of LA Webinar 2/4/16	DefE-00055470-55484
43.	PASRR Quality Reporting Q1 FY16	DefE-00055545
44.	Quarterly PASRR Reporting - Harris County Q2 FY16	DefE-00056059-56064
45.	Quarterly PASRR Reporting - Harris County Q3 FY16	DefE-00056065-56071
46.	Quarterly PASRR Reporting - Harris County Q4 FY16	DefE-00056072-56077
47.	Quarterly PASRR Reporting - Texana Q2 FY16	DefE-00056224-56230
48.	Quarterly PASRR Reporting - Texana Q4 FY16	DefE-00056231-56237
49.	Quarterly PASRR Reporting - Texana Q3 FY16	DefE-00056238-56243
50.	Quarterly PASRR Reporting - Harris County Q1 FY16	DefE-00056476-56481
51.	Quarterly PASRR Reporting - Texana Q1 FY16	DefE-00056558-56563
52.	Quarterly PASRR Reporting - Community Healthcore Q2 FY16	DefE-00055839-55844
53.	Quarterly PASRR Reporting - Community Healthcore Q3 FY16	DefE-00055845-55849
54.	Quarterly PASRR Reporting - Community Healthcore Q4 FY16	DefE-00055850-55855
55.	Quarterly PASRR Reporting - Heart of Texas Q4 FY16	DefE-00055927-55932

56.	Quarterly PASRR Reporting - Heart of Texas Q3 FY16	DefE-00055933-55938
57.	Quarterly PASRR Reporting - Heart of Texas Q2 FY16	DefE-00055939-55944
58.	Quarterly PASRR Reporting - Metrocare Q2 FY16	DefE-00056007-56012
59.	Quarterly PASRR Reporting - Metrocare Q3 FY16	DefE-00056013-56018
60.	Quarterly PASRR Reporting - Metrocare Q4 FY16	DefE-00056019-56024
61.	Quarterly PASRR Reporting - Tarrant County Q2 FY16	DefE-00056078-56086
62.	Tarrant County Training Rosters Dec. 2015-Feb., 2016	DefE-00056087-56100
63.	Quarterly PASRR Reporting - Tarrant County Q3 FY16	DefE-00056101-56108
64.	Tarrant County Training Rosters Mar. 2016-May 2016	DefE-00056139-56148
65.	Quarterly PASRR Reporting - PCVBDH Q2 FY16	DefE-00056149-56154
66.	Quarterly PASRR Reporting - PCVBDH Q3 FY16	DefE-00056155-56159
67.	Quarterly PASRR Reporting - PCVBDH Q4 FY16	DefE-00056160-56165
68.	Quarterly PASRR Reporting - Community Healthcore Q1 FY16	DefE-00056405-56409
69.	Quarterly PASRR Reporting - Heart of Texas Q1 FY16	DefE-00056441-56445
70.	Quarterly PASRR Reporting - Heart of Texas Q1 FY16 Addendum	DefE-00056446
71.	Quarterly PASRR Reporting - Metrocare Q1 FY16	DefE-00056471-56475
72.	Quarterly PASRR Reporting - Tarrant County Q1 FY16	DefE-00056482-56492
73.	Tarrant County Training Rosters Sept. 2015-Nov. 2015	DefE-00056493-56509
74.	Quarterly PASRR Reporting - PCVBDH Q1 FY16	DefE-00056534-56539
75.	Tarrant County Training Rosters Sept. 2015-Nov. 2015 (2)	DefE-56510-56533
76.	IDT Meeting Documentation - July 7, 2015 PP Presentation	DefE-00000754

77.	TEXAS HEALTH AND HUMAN SERVICES, Nursing Facility Requirements for Licensure and Medicaid Certification Handbook, Subchapter BB, §§ 19.2701-19.2709, *available at* https://hhs.texas.gov/laws-regulations/handbooks/nursing-facility-requirements-licensure-medicaid-certification-handbook/nfrlmc-subchapter-bb-nursing-facility-responsibilites-related-preadmission-screening-resident-review	
78.	HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL, Nursing Facility Specialized Services Agenda Item (February 24, 2017), *available at* https://hhs.texas.gov/sites/hhs/files//documents/about-hhs/communications-events/meetings-events/council/02-24-17/3j-executive-council.pdf	
79.	40 T.A.C., Part 1, Ch. 19., Subch. BB: NF responsibilities related to PASRR	PL00000251-263
80.	40 T.A.C., Part 1, Ch. 17, Subch. A: PASRR General Provisions	PL00000264-285
81.	42 C.F.R. § 483 - PASRR Regulations	
82.	Health and Human Services Commission *Waiver Slot Enrollment Progress Report, March 2017*, TEXAS HEALTH AND HUMAN SERVICES, https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/reports-presentations/2017/waiver-slot-enrollment-report.pdf.	
83.	Health and Human Service Commission, *Report on Cost of Preadmission Screening and Resident Review, February 2017*, TEXAS HEALTH AND HUMAN SERVICES, https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/reports-presentations/2017/cost-of-pasrr-fy2016-feb2017.pdf.	
84.	PASRR Evaluation Form	PL00000672-703
85.	STATE OF TEXAS, https://texas.gov.	

86.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, https://www.dads.state.tx.us.	
87.	Texas Department of Aging and Disability Services, *Preadmission Screening and Resident Review (PASRR)*, Computer Based Training (posted July 17, 2015), https://www.dads.state.tx.us/business/CBT/PASRR/index.html.	
88.	Provider Letter No. 16-33 from Mary T. Henderson, Asst. Comm'r, Regulatory Services, to Nursing Facilities (Aug. 31, 2016), https://hhs.texas.gov/sites/hhs/files//documents/doing-business-with-hhs/provider-portal/letters/2016/letters/pl2016-33.pdf.	
89.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR Rules: TAC, Title 40, Part 1, Chapter 19, Subchapter BB*, Computer Based Training (posted Feb. 16, 2016) https://www.dads.state.tx.us/business/cbt/PASRRrules/index.html.	
90.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR Specialized Services Training*, Computer Based Training (posted Oct. 12, 2015), https://www.dads.state.tx.us/business/CBT/pasarrspecialized/SpecializedServices101215_print.html.	
91.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR PE: What Nursing Facilities Need to Know*, Computer Based Training (posted Dec. 29, 2015), https://www.dads.state.tx.us/business/CBT/PASRRPE/PE_print.html	
92.	Information Letter No. 12-72 from Geri Willems, Manager, PASRR/MERP to Nursing Facility staff (Aug. 2, 2012), https://www.dads.state.tx.us/providers/communications/2012/letters/IL2012-72.pdf	
93.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR PL1: Back to Basics*, Computer Based Training (posted Dec. 29, 2015), *available at*	

	https://www.dads.state.tx.us/business/CBT/PASRRPL1/PL114.html	
94.	THE HARRIS CENTER FOR MENTAL HEALTH AND IDD, http://www.mhmraharris.org/.	
95.	TEXANA, http://www.texanacenter.com/	
96.	METROCARE SERVICES, http://www.metrocareservices.org/.	
97.	MHMR TARRANT COUNTY, http://www.mhmrtc.org/.	
98.	PECAN VALLEY CENTERS FOR BEHAVIORAL AND DEVELOPMENTAL HEALTHCARE, http://www.pecanvalley.org.	
99.	HEART OF TEXAS REGION MENTAL HEALTH MENTAL RETARDATION CENTER, http://www.hotrmhmr.org/.	
100.	COMMUNITY HEALTHCORE, http://www.communityhealthcore.com/.	

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lilian Minor, *et al.*,	§	
Plaintiffs,	§	
v.	§	
CHARLES SMITH, Governor, *et al.*,	§	
Defendants.	§	
	§	CIV. NO. 5:10-CV-1025-OG
THE UNITED STATES OF AMERICA,	§	
Plaintiff-Intervenor,	§	
v.	§	
THE STATE OF TEXAS,	§	
Defendants.	§	

DECLARATION AND EXPERT DISCLOSURE OF NANCY WESTON IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B) that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case:

1. My report, which is attached, contains a complete statement of all of my opinions to be expressed as well as an explanation of the basis and reasons for those opinions.

2. My report describes the facts, data and other information I considered in forming my opinions.

3. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

4. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.

5. Within the l st four (4) years, I have not testified as an expert, either in a deposition or at trial.

6. My compensation in this litigation is $ 125.00 per hour for preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated:

Nancy L. Weston 3/31/17

Nancy Weston

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES AND SYSTEMIC OVERVIEW REPORT OF NANCY WESTON

I. PURPOSE AND SCOPE OF REPORT

I was asked by the Plaintiffs in this case to conduct two levels of review of Texas' Pre-Admission Screening and Resident Review (PASRR) program. First, I assessed the State's development, regulation, implementation, and oversight of the PASRR program that is operated by the Health and Human Services Commission (HHSC), and formerly through its Department of Aging and Developmental Services (DADS). Second, I reviewed the actual delivery of the PASRR program by the Local Intellectual and Developmental Disability Authorities (LIDDAs) that HHSC/DADS funds to provide PASRR screening, assessment, specialized services and service coordination to individuals with intellectual and developmental disabilities (IDD) in nursing facilities throughout Texas. At both levels, I focused on how the State's redesigned PASRR program that was first implemented in 2013 complies with federal and state standards.

II. BACKGROUND AND EXPERIENCE

I have thirty-six years of experience in the field of human services including twenty years with the Department of Mental Health in a clinical capacity and as the Assistant Director for a Partial Hospitalization Program overseeing service delivery, crisis intervention, and interagency partnership.

For the last sixteen years I have been with the Department of Developmental Services (DDS) in Massachusetts. I was hired in 2001 as the statewide Director of PASRR to develop and manage a statewide PASRR program, including the design of a federally compliant PASRR tool and process. This process includes the initial screening, evaluation, assessment, identification of specialized services and ensuring the provision of active treatment to people with IDD in nursing facilities. At that time, DDS was assuming the responsibility of PASRR which had previously been managed by a vendor agency. As the statewide Director of PASRR, I am responsible for the daily oversight and implementation of the PASRR process and its consistent administration by regional and central office PASRR screeners.

I have established and provide annual statewide PASRR trainings for target audiences of nursing facility administration and staff, hospital discharge planners, elder service providers, and state staff in partnership with MassHealth (the state Medicaid agency) and the Department of Mental Health in order to provide education and maximize nursing facility PASRR compliance.

In association with the Community First policy in Massachusetts, DDS policy and other initiatives, I managed the transition of nursing facility admissions for individuals with IDD from open ended approvals to abbreviated 90 day increments, effectively reducing nursing facility lengths of stay for mostly rehabilitative purposes and ensuring that people with IDD do not inappropriately remain in nursing facility settings. Through this effort, the statewide nursing facility census of individuals with IDD markedly decreased from 1600 to fewer than 200 mostly short-term nursing facility residents as of this writing.

Following a successful aggressive PASRR community placement effort, I assumed the additional role of Director of Nursing Facility Operations which includes oversight of a highly skilled Active Treatment team in the central office dedicated to ensuring appropriate delivery of specialized services resulting in active treatment in nursing facilities, as reviewed by Department of Public Health and DDS Quality Enhancement teams. A detailed description of my background and experience is set forth in my Curriculum Vitae, which is included in this Report as Attachment A.

III. METHODOLOGY

A. Texas PASRR System Review

I conducted a high level System Review of Texas' PASRR program to assess how, and to what extent, that program is reasonably designed to adhere to federal requirements, including regulations and policies issued by the Center for Medicare and Medicaid Services (CMS). I examined HHSC/DADS rules, policies, procedures, bulletins, and data, with particular reference to the identification and evaluation of individuals with IDD in nursing facilities; the assessment of habilitative and nursing needs as well as the appropriateness of admission to nursing facilities; the identification of the need for and provision of specialized services; the coordination of nursing facility and specialized services; the provision of active treatment; and the oversight and monitoring of the PASRR program by HHSC/DADS.

The focus of the Texas PASRR System Review was to determine if:

(1) The State's PASRR program is designed to provide individuals with IDD residing in nursing facilities the full range of specialized services that they need to meet their habilitative needs;

(2) The State's PASRR program is designed and implemented to ensure that individuals with IDD receive specialized services that are provided in an amount, duration and frequency sufficient to constitute active treatment including whether:

(a) The State has created and communicated a clear expectation that specialized services sufficient to constitute active treatment must be provided to individuals with IDD residing in nursing facilities who need such services;

(b) The State has developed and implemented an adequate infrastructure that provides specialized services to individuals with IDD in nursing facilities sufficient to constitute a program of active treatment; and

(c) The State regularly monitors and oversees its PASRR program, and the activities of the LIDDAs and nursing facilities, to ensure that they provide specialized services sufficient to constitute a program of active treatment to individuals with IDD who reside in nursing facilities.

Documents were provided to me by plaintiffs that related to Texas' PASRR design and compliance efforts. A complete list of documents that I reviewed is set forth in Attachment B to this report.

B. LIDDA Program Review

I, along with another developmental disability expert, Randall Webster, reviewed the LIDDAs' implementation of Texas' PASRR program. LIDDAs are thirty-nine statutorily-created, quasi-public entities that are responsible for determining eligibility for services for people with IDD, then coordinating and monitoring the provision of those services. The scope of the LIDDA review was to determine if:

(1) the LIDDAs were properly identifying and screening persons with IDD per PASRR;
(2) the LIDDAs made professionally adequate determinations of the need for specialized services that were based on a comprehensive functional assessment of all relevant habilitative need areas;
(3) the LIDDAs provided or ensured that the nursing facilities provided all recommended specialized services;
(4) the LIDDAs ensured that each person received all needed specialized services with the frequency, intensity, duration, and continuity to constitute a program of Active Treatment; and,
(5) the LIDDAs provided professionally-adequate planning, coordination, and monitoring of services in nursing facilities.[1]

Documents were provided to me by plaintiffs related to Texas' PASRR design and compliance efforts. A complete list of documents that I reviewed is set forth in Attachment B to this report.

Beginning on January 30, 2017, I met with LIDDA staff in eight LIDDAs. I was informed by the plaintiffs that these LIDDAs were selected because they served all of the people who were part of a separate client review conducted by other experts. It is my understanding that I was asked to focus on these LIDDAs in order to assess, at a program level, the capacity and activities of these LIDDAs which were responsible for providing PASRR screening and services

[1] The scope of this review was limited to PASRR issues and did not include the LIDDAs' transition activities although a brief discussion of transition issues was occasionally included.

to the people in the client review. My findings, detailed below, were consistently present in each of the LIDDAs reviewed.

I visited the following LIDDAs:

1. The Harris Center for Mental Health and IDD in Houston, Texas
2. Texana Center in Rosenberg, Texas
3. Camino Real in Lytle, Texas
4. Alamo Local Authority in San Antonio, Texas
5. Austin Travis County Integral Care in Austin, Texas
6. Hill Country MHDD in San Marcos, Texas
7. Central Counties Services in Temple, Texas
8. Bluebonnet Trails Community Services in Round Rock, Texas

All LIDDA staff interviewed were generous with their time and with sharing their knowledge and experience of Texas' PASRR process. Each LIDDA made available their staff people most familiar with PASRR and diversion practices such as diversion coordinators, PASRR service coordinators, and enhanced placement coordinators and occasionally senior LIDDA staff were present. At each LIDDA that I visited, I explored the practices, processes, and experience they each had. My conversations with the staff at the LIDDAs were generally guided by a series of questions that Randall Webster and I had developed together, prior to our visits to the LIDDAs, to make our separate visits compatible (we made the first two LIDDA visits together). This way, we were able to conduct our visits in a way that was consistent, even if there may be differences in our respective findings.

IV. STANDARDS

A. Federal PASRR Requirements

CMS issued regulations in 1992 and subsequent guidance concerning the criteria that describe the requirements for identifying and screening people with IDD and for diverting people with IDD from nursing facility admission. Each state must comply with these requirements. 42 C.F.R. Sec. 483.100 et seq. Among other requirements, there are Level I PASRR (Level I) and Level II PASRR (PE) screening and evaluation requirements. The purpose of the Level I screen is to determine if the person has or is suspected of having an IDD diagnosis; the purpose of the PE is to determine whether nursing facility level of services and specialized services are needed. 42 C.F.R. Sec. 483.128. These determinations of the need for nursing facility services and for specialized services must be made based on a consistent analysis of available data. Section 483.136 details that the minimum data basis for these findings must include information that permits the screener to assess the individual's medical problems and the level of impact these problems have on the individual's independent functioning.

Federal regulation requires Pre-Admission Screening of all people with IDD seeking a new admission to a Medicaid certified nursing facility. 42 C.F.R. Sec. 483.106. The only instance in which this is not the case is when a person is discharged from an acute care hospital to a nursing facility for convalescent care not to exceed 30 days.

Fifteen habilitative need areas are required to be assessed in the PASRR evaluation process, in order to determine whether the individual would benefit from specialized services and to be able to identify those specific services that will meet the assessed needs. The assessment, while less in-depth than a Comprehensive Functional Assessment, includes a review of the individual's clinical and service history (including prior IDD services and programs); a consideration of all medical, nursing, and service records; interviews with the individual, LAR if any, relevant professionals, and family members; and a careful consideration of the individual's habilitation needs. For each identified need, the PASRR reviewer, who must be a qualified IDD professional, should indicate on the assessment form if specialized services would be beneficial, or if a further, in-depth assessment would be helpful. 42 C.F.R. Sec. 483.136.

The assessment should also include a determination of whether the individual needs a nursing facility level of care and whether the individual's needs could be met in an alternative setting, such as an Intermediate Care Facility (ICF/IDD) or a community program, such as a waiver setting. The reasons for the determination should be documented on the PASRR form. If the PASRR reviewer determines that there is no other setting that can meet the individual's needs, and that the individual would benefit from specialized services, s/he then must determine whether the specific nursing facility to which admission is proposed has the capacity and ability to provide all necessary specialized services. Again, this determination and the reason therefore should be documented. 42 C.F.R. Secs. 483.128, 130, 132 and 136.

If the individual is admitted to the nursing facility, the individual must receive a comprehensive functional assessment of all habilitative need areas as a basis for planning and delivering specialized services. These assessments must be done by qualified professionals and then used by an interdisciplinary team to determine the exact type, amount, intensity, and durations of specialized services. The team must develop a detailed service plan that includes goals, timetables, providers, and the amount, intensity, and durations of specialized services. A qualified IDD professional must coordinate and monitor these services, modify the plan as needed, review and update it annually, and ensure that all identified services are actually provided. 42 C.F.R. Secs. 483.120 and 483.440.

B. Federal Active Treatment Requirements for Individuals with IDD in Nursing Facilities.

Active Treatment standards require that those identified specialized services must be provided and that there is ongoing coordination and monitoring of nursing facilities and community providers to ensure that together, they deliver a consistent and continuous program of Active Treatment. The PASRR regulations require that "[t]he State [not the nursing facility or any other entity] must provide or arrange for the provision of specialized services, in accordance with this subpart, to all NF residents with MI or [IDD] whose needs are such that continuous supervision, treatment and training by qualified . . . intellectual disability personnel is necessary, as identified by the screening. . . ." 42 C.F.R. Sec. 483.120(b). Specialized services are defined by 42 C.F.R. Sec. 483.120(a)(2) for people with IDD as meaning, " . . . the services specified by the state which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of [Active Treatment] 483.440(a)(1)."

Active Treatment is defined in Section 483.440 as "a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward (i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status."

But Active Treatment is not only a definition. It is also a process and, more importantly, a federal standard of care for individuals with IDD. That process and standard is described in Section 483.440(b)-(f). All of these requirements must be met in order for the individual to receive a program of Active Treatment. Federal requirements for Active Treatment include an integrated process of planning, documentation, team participation, goals, objectives and timelines as well as continuous monitoring and revision as indicated through the delivery of services. The basis of planning, goal development and objectives derive from the requirement that a comprehensive functional assessment as detailed within the regulations is completed for each individual.

CMS requires that states use a comprehensive, professionally-accepted process for assessing whether facilities provide a program of Active Treatment. The process is based upon a detailed list of standards – called "Tags" – for each element and requirement of Active Treatment. Each Tag includes specific questions, or Probes, to collect the relevant information needed to determine if the Tag is met. CMS also has established a scoring methodology for calculating whether a sufficient number of Tags are met to constitute a program of Active Treatment.

C. Interpretation and Application of Active Treatment

In Massachusetts, based upon recommendations from an independent expert, as well as the parties, a federal court approved a Revised Active Treatment Standard to assess whether Active Treatment was being provided to class members in that case (ATS). The ATS is a professionally-accepted and court-approved standard for measuring whether Active Treatment is being provided to individuals with IDD in nursing facilities. I am familiar with the ATS from my work in Massachusetts to measure whether Active Treatment was provided to people with IDD in nursing facilities.

D. Monitoring, Funding, and Oversight of PASRR Programs by State DD Entity

Texas has designated HHSC (and formerly DADS) as the state agency responsible for meeting its PASRR requirements. HHSC in turn contracts with and funds thirty nine LIDDAs as part of the state's effort to meet its PASRR requirements, including screening and evaluating for and provision and monitoring of specialized services for people with IDD. Federal regulations make clear that the state cannot delegate its statutory obligations and its ultimate responsibility to comply with the NHRA to the LIDDAS. 42 C.F.R. Sec. 483.106(e). The state must ensure that appropriate and timely screening and assessment, specialized services and ongoing coordination

and monitoring of nursing facilities and community providers provides a continuous active treatment program to adults with IDD in nursing facilities.

E. Texas PASRR Requirements

Texas PASRR rules substantially track federal PASRR requirements for identifying, screening, and evaluating people with IDD, prior to and after admission to a nursing facility. Texas assigns these duties to the LIDDAs and requires them, through their service coordination program, to organize and lead service planning teams and to develop Individual Service Plans (ISPs) that include all professionally-appropriate assessments, identify all habilitative need areas, lists goals and timelines for addressing these need areas, describe specialized services that will be provided to meet all identified need areas, identify the providers responsible for offering these services, and incorporate transition plans for people who would benefit from placement in the community. The LIDDA service coordinators monitor the plan and ensure that all needed specialized services are provided in a timely and consistent manner. 40 T.A.C. Sec. 17.101 *et seq*.

Nursing facilities services, without PASRR requirements added, are typically physical therapy, occupational therapy, and speech therapy designed to rehabilitate a condition (like a fall) for a time-limited period, as part of their basic nursing program and included in the nursing facility's daily rate. People with IDD may require therapies, such as physical therapy, speech therapy, or customized medical equipment, that fall in these same categories but for a different purpose: to maintain existing functioning or learn new skills. PASRR specialized services provided by the nursing facilities are required to address these habilitative purposes.

Texas has limited categories of specialized services to 1. certain therapies and medical equipment provided by nursing facilities in the facility and 2. certain community services provided by or through the LIDDAs generally outside of the facility. For specialized services provided by the nursing facilities, the nursing facility bills the state and is paid an additional rate, after approval by the State. Specialized services categories provided by the LIDDA for people with IDD in nursing facilities include service coordination and transition assistance, day habilitation, independent living skills training, employment assistance, supported employment, and behavior support. The LIDDA Performance Contract and HHSC's specialized services policies and procedures establish the state standards for specialized services. Significantly, these state standards are not consistent with, and in certain respects are substantially lower than, the federal ones.

V. FINDINGS

A. Findings of the System Review

The following findings result from a review of DADS/HHSC PASRR policies and procedures, the PASRR sections of the DADS/HHSC Nursing Facility Handbook, depositions of DADS/HHSC employees, and documents listed in Attachment B.

1. The Texas PASRR process is not designed to ensure that specialized services are provided to meet the habilitative needs of people with IDD in nursing facilities.

   a. The Texas PASRR process fails to identify all habilitative needs of people with IDD in nursing facilities who have been determined to need specialized services per the PE.

      i. Federal PASRR regulation specifies minimum data needs and process requirements for a determination of whether the nursing facility applicant or resident with IDD needs a continuous specialized services program in accordance with 42 C.F.R. Sec. 483.136. These requirements include the assessment of fifteen identified need areas. Texas has designed a PE that includes some but not all of the fifteen required need areas. Identification of medical problems and current medication are identified in Section D of the PE and other need areas are generally identified in the PE, Section B. Federally required and significant need areas omitted from the PE include self-monitoring of health status, the identification of inappropriate behaviors, and the impact of medical problems on the individual's independent functioning. Furthermore, the state has not communicated a requirement for a comprehensive functional assessment of need areas to complete the PE although comprehensive assessments are mandated by federal PASRR regulation. 42 C.F.R. Sec. 483.440(c)(3). Section B of Texas's PE form and process have been designed for the PASRR reviewer to simply check off whether a person needs or wants assistance in a federally required skill need area without a professional assessment to determine need.

      ii. The Texas service delivery system following the PASRR evaluation includes a nursing facility interdisciplinary team meeting (IDT) for the purpose of determining nursing facility specialized services. The only assessments of habilitative need included on the IDT form for data entry into the TMHP portal are Specialized Assessment Occupational Therapy, Specialized Assessment Physical Therapy, and Specialized Assessment Speech Therapy. For other areas of habilitative need, not related to nursing facility specialized services, assessments are not listed as an option on the IDT form.

      iii. The state has not provided a comprehensive functional assessment instrument and has not established a requirement for comprehensive functional assessments during the PASRR process or immediately following as a supplement to the initial evaluation, as mandated by PASRR regulations. 42 C.F.R. Sec. 483.120, 483.440(c)(1) and (3). Comprehensive functional assessments provide the foundational elements to service identification, planning, and delivery by establishing baseline functioning and the identification of skill need

areas. Without assessments in all required habilitation need areas, and not just those of occupational therapy, physical therapy, and speech therapy, there is no basis of determining need areas and the specialized services necessary to meet the needs of people with IDD in nursing facilities to help them to live as independently as possible and to prevent or decelerate regression or loss of abilities.

iv. I have reviewed the 2016 Quarter 1 PASRR QSR report in which the Expert Reviewer under the Interim Settlement Agreement, Kathryn Dupree, indicated that the limited assessments that are recommended at any point in the PASRR process "are still not being completed". Ms. Dupree found that all assessments recommended by the PE are only being completed at a rate of 6%". This systemic finding is consistent with, and probably related to, the deficiencies noted above.

b. Texas' structure for planning, providing, delivering, and monitoring specialized services is not reasonably calculated to ensure that individuals with IDD in nursing facilities receive all needed specialized services.

i. The structure of service planning lacks a single, integrated team and the development of a unified plan which may be carried out across settings and from all disciplines. The Texas service planning and delivery structure includes two distinct planning teams which creates a significant risk that the nursing facility and LIDDA specialized services are not properly planned and that the services, methods, and strategies of approach of each are not properly communicated or understood. Independent service planning by two separate teams creates a risk of fragmented service planning and delivery.

ii. The Texas service planning and delivery structure includes the nursing facility-led IDT and the LIDDA-led service planning team (SPT). These teams focus on separate areas of service delivery -- the IDT on nursing facility specialized services and the SPT on LIDDA specialized services, transition, and monitoring of all services. The separation of teams and professionals creates a lack of coordination of service delivery and creates a significant risk of different or inadequate service planning, delivery, and outcomes without a unified plan or approach.

iii. Funding sources create a potential unintended effect regarding the provision of specialized services. Federal reimbursement may be provided through Medicaid for nursing facility specialized services, but LIDDA specialized services, with the possible exception of service coordination, must be purchased only with state funds. Therefore, funding of LIDDA specialized services may produce financial

disincentives for LIDDAs and the state to recommend and implement LIDDA specialized services in the amount and duration needed.

iv. Nursing facilities are unable to provide nursing facility specialized services unless a nursing facility professional requests and obtains from HHSC/DADS written approval to provide the service. This creates a potentially significant gap between the identification and provision of services. It also creates the possibility of denial of clinically-needed services by a distant official who is not part of the IDT. If an authorization is not obtained prior to purchase or delivery of a nursing facility specialized service, or if a request for reimbursement is denied, the nursing facility is held responsible for the cost of the item of the service.

v. Funding of specialized services seems low as reflected in DADS Report of Cost of Spending in Pre-Admission Screening and Resident Review. In 2014, DADs reports that total spending for specialized services for people with IDD in nursing facilities was $334,061. In 2015, DADs reports that total spending for specialized services for people with IDD in nursing facilities was $1,469,747. In 2016, DADS reports that total spending for specialized services for people with IDD in nursing facilities was $3,695,891. With about 3,400 individuals with IDD in nursing facilities in 2016, this amounts to about $1,087 per person for the entire year. Since occupational and physical therapy is reimbursed at a rate of approximately $38/hour, even the higher 2016 expenditure rate still means, on average, that one individual would get one hour of occupational or physical therapy a week for only 29 weeks in the year. This level of funding does not seem reasonably sufficient to provide all needed specialized services to thousands of individuals with IDD in nursing facilities.

vi. Kathryn Dupree indicated in her 2016 Quarter 1 PASRR QSR report that Texas' PASRR process fails to provide a large majority of people with IDD living in nursing facilities with the range of specialized services that will meet their habilitative needs. Ms. Dupree found generally low levels of compliance and a lack of both nursing facility and LIDDA specialized services with little or no discussion of day habilitation or employment options. This systemic finding is consistent with, and probably related to, the deficiencies noted above.

c. The array of specialized services in Texas's PASRR program is not provided with the frequency, intensity, and duration required for habilitative specialized services for people with IDD in nursing facilities.

i. The Texas redesign of its PASRR process includes additional specialized service categories for people with IDD. Specialized

services for people with IDD in nursing facilities now consist of specialized services provided by nursing facilities—which are physical, occupational, and speech therapies; assessments for physical, occupational, and speech therapies; durable medical equipment; and customized manual wheelchairs—and specialized services provided by LIDDAs—which are service coordination, including alternative placement assistance, employment assistance, supported employment, day habilitation, independent living skills, and behavioral supports. However, in the absence of comprehensive functional assessments to identify areas of need, it is impossible to construct an adequate and professionally-appropriate service plan that reflects the individual's needs for training, habilitation, and skill development, including specific strategies for implementation such as the frequency, intensity, and duration of needed specialized services.

ii. Based on the QSR report, the expanded list of specialized services has not resulted in individuals with IDD in nursing facilities receiving needed specialized services to meet all habilitative needs. Utilization of specialized services is low. Kathryn Dupree reported that "The lack of both NF and LIDDA SS [specialized services] is apparent and there is little to no discussion of day habilitation or employment options." Measure 2-5, 2016 Quarter 1 PASRR QSR report at 10.

iii. Ms. Dupree's findings that Texas' PASRR process fails to provide a large majority of people with IDD living in nursing facilities with the range of specialized services that will meet their habilitative needs is consistent with the extremely low amounts reportedly spent for LIDDA-provided specialized services when compared with the much higher amounts identified by Texas in its budget requests for the redesigned PASRR program and expanded specialized services, that the state deemed necessary to meet the habilitative needs of people with IDD in nursing facilities.

iv. The Texas' Local Authority Procedural Development and Support (LPDS) manager responsible for procedure development and support to thirty-nine LIDDAs – which are responsible for the provision and monitoring of specialized services – is unaware of the array of specialized services for people with IDD residing in nursing facilities. She is also unaware of Ms. Dupree's findings that Texas' PASRR process fails to provide a large majority of people with IDD living in nursing facilities with the range of specialized services that will meet their habilitative needs. The LPDS unit manager and the only staff person in her unit with responsibility for support for LIDDAs provision of services to people with IDD in nursing facilities were both unfamiliar with specialized services and which ones are specified by the state. They were both more focused and familiar with data entry

portal procedures rather than service delivery, in spite of their unit's responsibility to develop procedures and support for LIDDAs.

v. Texas' LPDS manager is unaware of the impact of Ms. Dupree's findings that the Texas PASRR process fails to provide a large majority of people in nursing facilities with the range of specialized services that will meet their habilitative needs. Although aware of the outcome measures in the QSR report, the Texas LPDS manager or staff did not take action to address widespread systems failures.

2. The state PASRR process is not designed and implemented to ensure that individuals with IDD receive specialized services that are provided in the amount, duration, and frequency sufficient to constitute active treatment.

a. The state fails to communicate an expectation that nursing facility or LIDDA specialized services must be of a frequency, intensity, and duration as to create a program of active treatment. The LPDS manager and the pertinent unit staff person are unaware of the definition of active treatment and its relevance to individuals with IDD in nursing facilities. Neither the manager nor staff person in the LPDS unit are designated to develop procedures or provide support on the provision of active treatment.

b. The state has not communicated through webinars, calls, bulletins, or trainings an expectation that individuals with IDD in nursing facilities must be provided a continuous program of specialized services delivered consistently across settings sufficient to meet the active treatment standard. The LPDS unit does not provide any training or support regarding the provision of specialized services and the delivery of active treatment.

c. As noted above, the LPDS unit manager is unaware of the definition and of the concept of active treatment as it applies in nursing facilities, as well as the requirement in federal PASRR regulations that people with IDD residing in nursing facilities and recommended for specialized services through the PE must receive a continuous program of active treatment. The LPDS staff is unaware of the array of specialized services and is not familiar with the concept of active treatment.

d. The Texas PASRR process and subsequent service delivery system is not designed to support a rigorous program of active treatment.

i. The state does not have rules, regulations, or training materials concerning the federal active treatment standard in relation to the provision of specialized services. There are no references, explanations, or definitions of active treatment, or of the federal active treatment requirement in any descriptions of the Texas PASRR program.

ii. There are no policies and procedures to ensure that individuals with IDD residing in nursing facilities receive comprehensive functional assessments to identify need areas and determine appropriate specialized services to serve as a foundation for a program of active treatment.

iii. The state has not made reference to, or had discussions about, active treatment during monthly calls with the LIDDAs. The state has not trained LIDDA staff or developed policies or procedures regarding the provision of active treatment to individuals with IDD in nursing facilities.

iv. There are no policies, procedures, or expectations communicated by the state that require that specialized services provided either by the nursing facility or provided by the LIDDA are consistent, continuous, and carried over across settings, as required to provide a program of active treatment. There is no provision of training to nursing facility or LIDDA staff on the implementation and strategies of a plan required for staff of all disciplines to provide carryover of objectives across settings as required with active treatment.

v. There are no policies and procedures to ensure that the LIDDA service coordinators monitor and ensure that the specialized services provided by the nursing facility and the LIDDA are planned, coordinated, implemented, and monitored to ensure that they meet all federal active treatment requirements.

vi. As noted above, Texas' lack of a single, integrated team and service planning process creates a significant risk that nursing facility and LIDDA services are not properly planned and that each component of this delivery system is not necessarily aware of the services and activities of the other component. As a result, service delivery is likely to be fragmented, making it difficult to deliver active treatment.

vii. Again, the fact that nursing facility specialized services are eligible for federal reimbursement through Medicaid, but LIDDA specialized services (with the possible exception of service coordination) are funded entirely by state revenue, creates a disincentive to use LIDDA specialized services, which makes it difficult to deliver active treatment.

viii. A requirement for prior authorization for nursing facility specialized services before they can be provided creates unnecessary delay and the real possibility for denial of nursing facility specialized services which makes a program of active treatment difficult to provide.

e. The Texas PASRR system fails to monitor and oversee its PASRR program, and the activities of the LIDDAs and nursing facilities, to ensure that they provide specialized services sufficient to constitute a program of active treatment to individuals with IDD who reside in nursing facilities.

i. The state does not have an oversight mechanism to ensure the provision of active treatment to individuals with IDD residing in nursing facilities.

ii. Without the proper infrastructure to support the provision of specialized services to individuals with IDD in nursing facilities sufficient to constitute a program of active treatment, it is impossible for the state to ensure that such individuals receive active treatment.

iii. The IDD services unit manager for LPDS is generally unaware of Ms. Dupree's findings that the Texas PASRR system fails to identify habilitative needs and provide specialized services to meet those needs for the large majority of people with IDD in nursing facilities.

iv. Texas' IDD LPDS staff responsible for providing support and procedural development in Texas' PASRR system remain wholly unaware of this system-wide failure and have taken no action to address these findings of system-wide failure.

Many of these system findings are confirmed by my findings from the visits to the LIDDAs, set forth below.

B. Findings of the Program Review

The following findings result from a review of DADS/HHSC PASRR policies and procedures, the PASRR sections of DADS'/HHSC Nursing Facility Handbook, documents listed in Attachment B, and information provided by the LIDDAs.

PASRR Level I Screenings and Level II Assessments

1. PASRR Level I screenings are done by LIDDA PASRR staff for individuals seeking admission to a nursing facility directly from the community. Information for the completion of the Level I may be provided by physician's offices, family members, or involved others. PASRR Level I is generally completed by the nursing facility for individuals seeking admission from an acute care hospital. The PASRR Level I is required by federal regulation in order to identify individuals suspected of having an intellectual disability or related condition such as a developmental disability as the first phase of the PASRR process. Level I identification of a suspicion of ID or DD constitutes a referral for the PE which may result in diversion or the provision of needed services in a nursing facility.

2. LIDDAs reported that they are scheduling meetings and completing the PE within the required timeframes (72 hours for face-to-face meeting and seven days for completion of PE). The PE is often completed prior to admission for individuals seeking nursing facility admission from the community; however some nursing facilities have continued to admit directly from the community without the required pre-admission evaluation. LIDDAs frequently monitor the TMHP portal for Level I alerts for individuals who may have been admitted directly from the community and require a PE. As specified in DADs/HHSC 2015 policy, nursing facilities receive reimbursement for compliance with PASRR requirements, including the requirement for the completion of a PE for individuals seeking admission to a nursing facility from the community. LIDDAs interviewed attributed instances of direct nursing facility admissions to inadequate nursing facility education and enforcement regarding the PE requirement. Completion of the PE prior to admission for individuals in the community is necessary for the identification of potential diversion alternatives to nursing facility placement, or for establishing a foundation for nursing facility service planning.

3. LIDDAs reported that diversion waiver slots are generally available for individuals seeking a nursing facility admission by indicating a preference to remain in the community. Diversion waiver slots are automatically released by DADS/HHSC for individuals indicating a preference to remain in the community on their PE. Quarterly reporting and LIDDA interviews indicated very low numbers of diversions. Interviews indicate that waiver diversion slots may be sought out by individuals or families of individuals seeking an alternative to nursing facility placement but that education and information regarding diversion waiver slots is not widely available to people in the community. Several LIDDAs reported that outreach to and intake from people in their general revenue population has resulted in some people from the community obtaining diversion slots. However, LIDDA outreach and education regarding alternatives to nursing facility placement and the availability of waiver diversion slots is inconsistent amongst LIDDAs. Unnecessary nursing facility admissions may result from the inconsistent availability of information regarding diversion opportunities and a lack of an aggressive and systemic approach to diversion.

4. LIDDAs describe diversion as a pre-admission alternative to nursing facility placement. Diversion waiver slots are rarely released for persons seeking admission to a nursing facility from a hospital since the PE is not completed until after admission to the nursing facility. Infrequently, the PE for people seeking admission to a nursing facility from a hospital may indicate a preference for an individual to live in the community. It those situations, a diversion slot is immediately released by DADS/HHSC and the LIDDAs face challenges because of impractical timeframes and their unfamiliarity with the needs of the individual.

Comprehensive Functional Assessment

5. All LIDDAs reported that comprehensive functional assessments are not performed by qualified IDD professionals at any stage of planning, either during the PASRR evaluation or resulting from the interdisciplinary team meeting at the nursing facility. Most LIDDAs were unaware of the purpose of comprehensive functional assessments to identify specific habilitative need areas in order to prevent the loss or deceleration of skills in a nursing facility setting. Comprehensive functional assessments are supposed to identify specific habilitative need areas to be addressed through the delivery of specialized services. Since comprehensive functional assessments are not performed, habilitative needs cannot be properly identified for service planning.

Specialized Services

(a) Planning and Identifying Needed Specialized Services

6. Comprehensive functional assessments resulting in the identification of specific habilitation need areas are supposed to form the basis for all service planning. Without a foundational comprehensive functional assessment, the interdisciplinary team is without a sound, objective, professionally appropriate approach to identifying habilitative needs. In turn, these identified needs are not available to provide the basis for a service plan that includes habilitative goals directed towards the acquisition of skills, identification of individualized specialized services based on habilitative need areas, and specifications of the frequency, intensity, and duration of the services. LIDDAs simply had no basis for developing an individualized service plan, regardless of any general awareness of habilitative needs. Without a comprehensive functional assessment, appropriate specialized services cannot be provided.

7. LIDDAs report that ISPs include service categories such as day habilitation or independent living skills but without specific strategies for implementation or clinical interventions for individuals. These service categories did not have any relationship to identified habilitative need areas. The service categories described by the LIDDAs took the form of an activity or companionship rather than specialized services with goal-directed outcomes towards the acquisition or prevention of loss of skills in an individualized treatment plan.

(b) Nursing Facility Specialized Services

8. Following agreement by an interdisciplinary team of a need for nursing facility specialized service(s), the nursing facility therapist must make a request to DADS/HHSC for authorization for any specialized service. LIDDAs report that some nursing facility therapists identify nursing facility services independent of the interdisciplinary team, apparently deeming these services, such as occupational therapy, physical therapy, speech therapy, etc., to be medical and

therefore under the purview of the nursing facility staff alone. PASRR requires the nursing facility therapist to send a form requesting nursing facility specialized services into DADS/HHSC.

9. LIDDAs generally reported challenges with the process of nursing facilities requesting and obtaining authorization for nursing facility specialized services from DADS/HHSC. LIDDAs reported that nursing facilities did not prioritize the process, and they lose the form that was supposed to be sent to DADS/HHSC or they never send it at all, for example. Several LIDDAs reported repeated attempts to assist nursing facilities with submission of nursing facility specialized service requests. Some LIDDAs reported nursing facility resistance to making requests and to providing these specialized services due to availability of professional staff or financial burden on the facility. This often results in individuals not receiving nursing facility specialized services that have been recommended in the PE or agreed to by the interdisciplinary team.

10. Several LIDDAs noted a recent communication from DADS/HHSC instructing PASRR service coordinators to refrain from contacting DADS/HHSC for the purpose of inquiring into the status of the request for authorization for nursing facility services. This process change renders the service coordinator unable to fulfill their role of monitoring and tracking service delivery and to ensure the delivery of needed services. LIDDAs mostly reported that prior to this communication from DADS/HHSC they had authority to follow-up with contacts at HHSC who could address their concerns. Nursing facility reluctance or resistance along with LIDDA inability to provide follow-up for the purpose of ensuring service delivery results in ongoing failure to provide nursing facility specialized services.

(c) LIDDA Specialized Services

11. LIDDAs report that all individuals who have IDD and have had a PE have a recommendation for and are receiving LIDDA service coordination from a PASRR service coordinator. Due to LIDDA staffing patterns, service coordinators may at times fulfill additional roles such as diversion coordinator or enhanced placement coordinator.

12. Almost no one receives behavioral supports in nursing facilities. LIDDAs report instances of the development of behavioral plans which were unable to be implemented due to inadequate staffing and training needs of the nursing facility. Otherwise behavioral supports were generally not provided.

13. LIDDAs indicated that very few individuals are receiving supported employment specialized services. The few that received supported employment services work in factory settings.

14. Day habilitation is provided to a small percentage of individuals and in all instances the day habilitation service is provided in a center-based location outside of the nursing facility. Most LIDDA staff interviewed expressed that many more individuals would benefit from day habilitation specialized services; however, several barriers to the delivery of day habilitation services exist.

    a. Most often day habilitation centers are unable to provide transportation to and from their facility due to the lack of an accessible vehicle. Nursing facilities are often unwilling to provide transportation due to associated cost. Several LIDDAs reported significant transportation time related to few day habilitation centers being spread out in large geographic counties, resulting in day habilitation as undesirable even if recommended.

    b. Day habilitation centers typically do not have on-site nursing available for individuals with specific medical needs such as for monitoring of blood sugars for diabetes and monitoring for seizure activity. LIDDAs report that some day habilitation centers do not have accommodations such as an adult changing area or wheelchair accessibility, preventing individuals from attending who might benefit.

    c. LIDDAs indicated that day habilitation staff did not provide services in nursing facility settings to individuals who may need or be recommended for the services. In order to access day habilitation services, individuals must have the ability to travel to the day habilitation center and have few medical needs.

    d. While few individuals are receiving the specialized service of Independent Skills Training, some LIDDAs reported hiring staff as Independent Skills Trainers to expand this service. The provision of an independent skills trainer is not based on a comprehensive functional assessment identifying a specific habilitative need but rather is generally just an opportunity for socialization and community activity.

15. Independent living skills are rarely provided within the nursing facility setting although some LIDDA staff could see the potential benefit from utilizing these services for the purpose of addressing skill development.

16. Information about Community Living Options (CLO) is provided to individuals at the interdisciplinary team meeting and at six month intervals thereafter. This takes the form of a conversation with an individual regarding community living but does not involve robust, ongoing information involving education, including providing information about people who have made successful community transitions, family support, or community residential visits. A small percentage of individuals receive transition services.

Active Treatment

17. LIDDAs were aware of a requirement for a PASRR Level I and a PE but were unaware of a requirement to provide Active Treatment to individuals with IDD in nursing facilities. When interviewed and asked about specialized services and Active Treatment, most LIDDA staff asked for clarification as to its meaning.

18. The term Active Treatment was unfamiliar to most LIDDA staff. With prompts, some more experienced staff understood the concept in relation to the ICF model.

19. Specialized services within nursing facilities were not consistently provided and monitored as an integrated program of Active Treatment.

20. No LIDDA staff, including the more experienced staff that were familiar with the provision of Active Treatment, stated that Active Treatment, as defined by federal law, was occurring in a nursing facility.

21. In an attempt to address Active Treatment, LIDDA staff often referred to the daily schedule of activities offered in a nursing facility, displaying a fundamental misunderstanding of what Active Treatment is. These staff acknowledged that the activities were not were not part of a comprehensive, consistent, and continuous habilitative program.

Service Coordination

22. All individuals were assigned to LIDDA PASRR service coordinators who carried a caseload, visited the individuals once a month or more frequently, and were aware of and were monitoring their clients, but without the assessments and identification and provision of specific specialized services that are necessary under PASRR, as found above, to ensure Active Treatment.

23. LIDDA service coordinators were generally unfamiliar with the requirement of Active Treatment for people with IDD in nursing facilities.

24. Service coordinators acknowledged that there were difficulties in integrating facility reluctance for LIDDAs to be involved. Service coordinators agreed that Active Treatment, as they understood it from the ICF context, was not provided in nursing facilities.

VI. Conclusion

Viewing Texas' PASRR program from both the state agency level and the LIDDA level was instructive. There was remarkable consistency between my findings at both levels. Because the state fails to require, oversee, monitor, and ensure that PE evaluations appropriately identify all habilitative needs, that comprehensive functional assessments are conducted, that all needed

specialized services are provided, and that each individual with IDD in nursing facilities receive a program of active treatment, as defined by CMS, it is not surprising that LIDDAs do not meet these requirements. And to the extent that the state believes these actions are occurring, my visits to LIDDAs confirmed they are not.

Attachment A

Nancy L. Weston
A2-12 Lydon Lane
Halifax, Ma. 02338
(781) 243-9639

SUMMARY OF QUALIFICATIONS

Dedicated and respected professional with strength in presentation and in communicating. Excellent supervisory, clinical, and management skills. Special talent for fact finding, assessing needs, and presenting effective solutions to problems. Highly motivated, results oriented professional. Strong ability to provide program direction and leadership. Outstanding ability to foster team cohesion. Licensed social worker.

CAREER HIGHLIGHTS AND ACHIEVEMENTS

- Manage the statewide Active Treatment team. Ensure ongoing provision of active treatment in accordance with Active Treatment regulation and Department of Public Health review for individuals remaining in nursing facilities per PASRR. Provide supervision to Active Treatment clinical team coordinator and staff.

- Provided independent consultation with PASRR systems review and findings to Rucker, Powell, and Associates regarding the proposed plan by the state of Maine regarding the administration and oversight of PASRR in reference to the Van Meter v. Mayhew settlement agreement

- Manage statewide Rolland Settlement Agreement processes related to the overall provision of active treatment, community placement efforts, and ongoing communications with the independent Rolland court monitor. Provide direction to field staff regarding the required corrective action plans regarding the provision of active treatment for individuals residing in nursing facilities.

- Manage statewide PASRR (pre-admission screening and resident review) program for the Department of Developmental Services. Direct, manage, and supervise the statewide process by which individuals with intellectual and/or other developmental disabilities are screened for potential nursing facility admission as pursuant to Federal Law. Provide supervision to Statewide Nursing Facility Specialists regarding the implementation of the PASRR process and to ensure consistency and quality. Collaborate with and advise senior staff from DDS, DPH, and the Executive Office of Elder Affairs to strategize an effective interagency approach to meeting Federal regulations. Develop and implement formal training conferences and provide ongoing technical assistance to DDS staff, community elder service agencies, hospitals, nursing facilities, rehabilitation facilities, as well as to individuals with disabilities and their families. Collect and analyze data to identify trends that impact the Commonwealth's policy directions in relation to the provision of quality services to medically fragile persons with disabilities.

- Directed and managed operational activities of the Partial Hospital program at Quincy Mental Health Center, a Department of Mental Health (DMH) agency. Develop and maintain a therapeutic and effective program for acutely mentally ill clients

- Provided oversight and implementation of clinical intake screenings to determine appropriateness of referrals from hospitals, crisis teams, and other state and private agencies. Serve as a liaison to state and local agencies, hospitals, and referral centers.

- Directed, supervised, monitored, and evaluated therapeutic group treatment program. Assist staff in developing creative and flexible approaches to individuals presenting with complex problems requiring a high levels of clinical expertise.

- Served as a crisis liaison between Quincy Mental Health Center and the South Shore Mental Health Center crisis team. Represented Partial Hospital program in meetings with various agencies, hospital providers, and referral centers to encourage informational exchange of program activities at Quincy Mental Health Center. Develop and increase community network and promote marketing strategies to enhance the visibility of program to community and referring agencies.

- Promote and participated in quality assurance and other activities designed to improve client and staff safety, health promotions, and maintenance. Conducted quality assurance studies to ensure adherence to established quality assurance guidelines, and to monitor the delivery of services to clients served.

- Provided individual assessment and treatment to acute psychiatric clients with multiple emotional, developmental, physical, and psychosocial problems. Facilitate family and therapy groups, providing interventions to improve coping strategies, strengthen family and social relationships, and to assist clients in building supports. Presented problematic clinical cases to consulting psychiatrists and senior staff.

PROFESSIONAL HISTORY

DEPARTMENT OF DEVELOPMENTAL SERVICES
Director of PASRR and Nursing Facility Operations — January 2014 – Present
Independent consultant — May –June 2013
Massachusetts PASRR Director — February 2002- 2013
Central Office Nursing Facility Specialist — November 2001 –February, 2002

QUINCY MENTAL HEALTH CENTER, — 1984-2001
Partial Hospital Assistant Director, — 1995 - 2001
Program Coordinator, — 1991-1995
Crisis Liaison, — 1988-1991
Staff Social Worker, — 1984 – 1988

WESTWOOD LODGE / PEMBROKE HOSPITAL — 1983-1984
ERICH LINDEMANN MENTAL HEALTH CENTER — 1981-1983

EDUCATION: CURRY COLLEGE, Milton, MA.
B.A. Psychology and English

LICENSES AND CERTIFICATIONS
Social Work License, LSW

AWARDS AND RECOGNITIONS
Manuel Carballo Award for Excellence in Public Service

Attachment B

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES AND SYSTEMIC OVERVIEW REPORT OF NANCY WESTON
Attachment B

	Document	**Bates Number**
1.	PL2015-16 Preadmission Screening and Resident Review (PASRR) Facility Requirements	PL00000140-142
2.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q4 FY15	DefE-00000003
3.	NF Population Report 12/31/15 and cover email	DefE-00000030-32
4.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q1 FY16	DefE-00000034
5.	Service Coordination Roles and Responsibilities 09 24 15	DefE-00000038-46
6.	LIDDA Compliance Measure (LIDDA v. State (% of compliance))	DefE-00000049-00000470
7.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q1 FY 16	DefE-00000556
8.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Service Q2 FY16	DefE-00000557-559
9.	LIDDA PASRR Quality Report FY 16 Q1 with cover email	DefE-00000725-728
10.	PASRR Education for LIDDA Staff	DefE-00000730
11.	PL2015-33 Top Non-Compliance Trends with the Preadmission Screening and Resident Review (PASRR) Requirements	PL00000137-139
12.	IL2015-61 Preadmission Screening and Resident Review Habilitative Specialized Services	PL00000143-144

13.	May 2016 Monthly report to stakeholder re slot utilization	PL00000145-184
14.	June 2016 Monthly report to stakeholders re slot utilization	PL00000185-188
15.	September 2016 Monthly report to stakeholders re slot utilization	PL00000189-192
16.	PASRR Provider Resources-LA FAQs- DADS website	PL00000193-195
17.	PASRR Specialized Service (PSS) Form	PL00000196-199
18.	LIDDA PASRR Reporting Manual	PL00000200-213
19.	LIDDA Performance Contract FY16-17	PL00000214-250
20.	Slot Type 90 FY 16-17	DefE-00000037
21.	Habilitative and Rehabilitative Services	DefE-00000769
22.	Analysis of PASRR Survey	DefE-00000791-793
23.	TMHP Portal Enhancements	DefE-00000855-859
24.	LIDDA Performance Contract FY16-17 and Attachments	DefE-00001706-1911
25.	LIDDA Performance Contract and Attachments, FY 16-17	DefE-00001706-1911
26.	Nursing Facility Diversion Protocol	DefE-00001936-1937
27.	HCS SW ILR #59 FY '12-'13 Enrollments as of 5/31/13	DefE-00029326
28.	Slot Type 63 FY 14-15 9/30/2013	DefE-00029681
29.	Specialized Services Request Process 4/15/16	DefE-00052224
30.	Minutes of LA Webinar 2/19/15	DefE-00054425-54428
31.	Minutes of LA Webinar 3/19/15	DefE-00054430-54433
32.	Minutes of LA Webinar 4/23/15	DefE-00054438-54442
33.	Minutes of LA Webinar 6/25/15	DefE-00054497-54503
34.	Minutes of LA Webinar 7/16/15	DefE-00054522-54528
35.	Minutes of LA Webinar 8/20/15	DefE-00054530-54535

36.	Minutes of LA Webinar 9/17/15	DefE-00054537-54544
37.	Minutes of LA Webinar 11/19/15	DefE-00054549-54553
38.	Minutes of LA Webinar 12/17/15	DefE-00055464-55468
39.	Minutes of LA Webinar 2/4/16	DefE-00055470-55484
40.	PASRR Quality Reporting Q1 FY16	DefE-00055545
41.	Quarterly PASRR Reporting - ALA Q4 FY16	DefE-00055564-55569
42.	Quarterly PASRR Reporting - ALA Q2 FY16	DefE-00055570-55574
43.	Quarterly PASRR Reporting - ALA Q3 FY16	DefE-00055575-55580
44.	Quarterly PASRR Reporting - ATCIC Q2 FY16	DefE-00055616-55622
45.	Quarterly PASRR Reporting - ATCIC Q3 FY16	DefE-00055623-55630
46.	Quarterly PASRR Reporting - ATCIC Q3 FY16 Addendum	DefE-00055631-55633
47.	Quarterly PASRR Reporting - ATCIC Q4 FY16	DefE-00055634-55644
48.	Quarterly PASRR Reporting - ATCIC Q4 FY16 Addendum	DefE-00055691
49.	Quarterly PASRR Reporting - BBTCS Q2 FY16	DefE-00055692-55698
50.	Quarterly PASRR Reporting - BBTCS Q3 FY16	DefE-00055699-55705
51.	Quarterly PASRR Reporting - BBTCS Q4 FY16	DefE-00055706-55712
52.	Quarterly PASRR Reporting - Camino Real Q2 FY16	DefE-00055759-55764
53.	Quarterly PASRR Reporting - Camino Real Q3 FY16	DefE-00055765-55770
54.	Quarterly PASRR Reporting - Camino Real Q4 Fy16	DefE-00055771-55776
55.	Quarterly PASRR Reporting - Central Counties Svcs Q2 FY16	DefE-00055796-55801
56.	Quarterly PASRR Reporting - Central Counties Svcs Q3 FY16	DefE-00055802-55807

57.	Quarterly PASRR Reporting - Central Counties Svcs Q4 FY16	DefE-00055808-55812
58.	Quarterly PASRR Reporting - HCMHDD Q2 FY16	DefE-00055963-55968
59.	Quarterly PASRR Reporting - HCMHDD Q3 FY16	DefE-00055969-55974
60.	Quarterly PASRR Reporting HCMHDD Q4 FY16	DefE-00055975-55981
61.	Quarterly PASRR Reporting - Harris County Q2 FY16	DefE-00056059-56064
62.	Quarterly PASRR Reporting - Harris County Q3 FY16	DefE-00056065-56071
63.	Quarterly PASRR Reporting - Harris County Q4 FY16	DefE-00056072-56077
64.	Quarterly PASRR Reporting - Texana Q2 FY16	DefE-00056224-56230
65.	Quarterly PASRR Reporting - Texana Q4 FY16	DefE-00056231-56237
66.	Quarterly PASRR Reporting - Texana Q3 FY16	DefE-00056238-56243
67.	Quarterly PASRR Reporting - ALA Q1 FY16	DefE-00056337-56341
68.	Quarterly PASRR Reporting - ATCIC Q1 FY16	DefE-00056348-56354
69.	Quarterly PASRR Reporting - ATCIC Q1 FY16 Addendum	DefE-00056355-56357
70.	Quarterly PASRR Reporting - BBTCS Q1 FY16	DefE-00056364-56369
71.	Quarterly PASRR Reporting - Camino Real Q1 FY16	DefE-00056383-56387
72.	Quarterly PASRR Reporting - Central Counties Svcs Q1 FY16	DefE-00056388-56393
73.	Quarterly PASRR Reporting - HCMHDD Q1 FY16	DefE-00056459-56464
74.	Quarterly PASRR Reporting - Harris County Q1 FY16	DefE-00056476-56481
75.	Quarterly PASRR Reporting - Texana Q1 FY16	DefE-00056558-56563
76.	HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL, Nursing Facility Specialized Services Agenda Item (February 24, 2017), *available at*	

	https://hhs.texas.gov/sites/hhs/files//documents/about-hhs/communications-events/meetings-events/council/02-24-17/3j-executive-council.pdf	
77.	IDT Meeting Documentation, PowerPoint Presentation (July 7, 2015).	DefE-00000754
78.	TEXAS HEALTH AND HUMAN SERVICES, Nursing Facility Requirements for Licensure and Medicaid Certification Handbook, Subchapter BB, §§ 19.2701-19.2709, *available at* https://hhs.texas.gov/laws-regulations/handbooks/nursing-facility-requirements-licensure-medicaid-certification-handbook/nfrlmc-subchapter-bb-nursing-facility-responsibilites-related-preadmission-screening-resident-review	
79.	Habilitative Services definition	DefE-00000769
80.	PASRR: all about NF Specialized Services 2016 PP Presentation	DefE-00000834
81.	PASRR: All About the IDT and Changes to the PASRR Program 2016 PP Presentation	DefE-00000845
82.	DADS Recommendation for Legislative Priorities/LAR - Delivery of Specialized Services for Persons with IDD in Nursing Facilities	DefE-00030697
83.	Specialized Services Verification	DefE-00052220
84.	PASRR Specialized Services (PSS) Form	DefE-00080592
85.	Detailed Item by Item Guide for Completing the PASRR Specialized Services Form	DefE-00080597
86.	PASRR Rehabilitative v. Habilitative Therapy - DADS webpage	PL00000373-374
87.	Kathryn Dupree 2015 Annual Report of Compliance	DefE-00000601-672
88.	Kathryn Dupree Q1 2016 QSR	DefE-00000677-716
89.	QSR Matrix	PL00000060-136
90.	40 T.A.C., Part 1, Ch. 19. Subch. BB: NF responsibilities related to PASRR	PL00000251-263
91.	40 T.A.C., Part 1, Ch. 17, Subch. A: PASRR General Provisions	PL00000264-285

92.	QSR Interview Protocol - Nursing Facility Members – Texas	PL00000882-900
93.	42 C.F.R. § 483 - PASRR Regulations	
94.	Deposition of Stacy Lindsey (February 8, 2017)	
95.	Deposition of Mirenda Blevins (February 7, 2017)	
96.	HHSC IDD Organizational Chart dated 10/21/16	
97.	Deposition of Cathy Belliveau (February 2, 2017).	
98.	State Plan Amendment TX-11-54 approval letter from Bill Brooks, Associate Regional Administrator, Centers for Medicare & Medicaid Services to Billy Millwee, Deputy Executive Commissioner for Health Services, Texas Health and Human Services Commission (July 18, 2012), *available at* https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html (enter filters by state to "Texas," by Topic to "Program Administration," and search: "11-54").	
99.	HHSC 11-54 Responses to CMS 5/2/2012	
100.	Health and Human Services Commission *Waiver Slot Enrollment Progress Report, March 2017*, TEXAS HEALTH AND HUMAN SERVICES, https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/reports-presentations/2017/waiver-slot-enrollment-report.pdf.	
101.	Health and Human Service Commission, *Report on Cost of Preadmission Screening and Resident Review, February 2017*, TEXAS HEALTH AND HUMAN SERVICES, https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/reports-presentations/2017/cost-of-pasrr-fy2016-feb2017.pdf.	
102.	PASRR Evaluation Form	PL00000672-703
103.	LIDDA – Local Procedure Development Support Unit Staff Assignments	DefE-00054437

104.	Order Approving Revised Active Treatment Standards (*Rolland* Order), Civil Action No. 98-30208-KPN, Docket No. 456 (August 2, 2007), including the Revised Active Treatment Standard attached as Docket No. 456-2.	
105.	Nursing Facility Rehabilitative and Specialized Therapy Services Payment Rates, Effective March 1, 2008, TEX. HEALTH AND HUMAN SERVS. COMM'N, *available at* https://hhs.texas.gov/sites/hhs/files/documents/doing-business-with-hhs/providers/health/2008-nf-rehab-ss-rates.pdf	
106.	CTRS. FOR MEDICARE & MEDICAID SERVS., Minimum Data Sets 3.0 Public Reports, MDS 3.0 Frequency Report, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.html (select FY and Quarter).	
107.	TEXAS HEALTH AND HUMAN SERVICES COMMISSION, https://hhs.texas.gov/.	
108.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Intellectual or Developmental Disabilities (IDD) – Long-term Care, https://hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care.	
109.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Preadmission Screening and Resident Review (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr.	
110.	TEX. DEPT. OF AGING AND DISABILITY SERVS., https://www.dads.state.tx.us.	
111.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Local Intellectual and Developmental Disability Authorities Directory, https://www.dads.state.tx.us/contact/la.cfm.	
112.	THE HARRIS CENTER FOR MENTAL HEALTH AND IDD, http://www.mhmraharris.org/.	
113.	AUSTIN TRAVIS COUNTY INTEGRAL CARE, http://www.integralcare.org/.	
114.	ALAMO LOCAL AUTHORITY FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (ALA FOR	

	IDD), http://www.aacog.com/66/Alamo-Local-AuthorityIDD-Services.	
115.	BLUEBONNET TRAILS CMTY. SERVS., http://bbtrails.org/.	
116.	CAMINO REAL CMTY. SERVS., http://caminorealcs.org/	
117.	HILL COUNTRY MHDD CTRS., http://www.hillcountry.org/	
118.	TEXANA CTR., About Us, https://www.texanacenter.com/about-us/	
119.	CENTRAL COUNTIES SERVS., http://www.cccmhmr.org/	
120.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *PASRR Rules: TAC, Title 40, Part 1, Chapter 19, Subchapter BB*, Computer Based Training (posted Feb. 16, 2016) https://www.dads.state.tx.us/business/cbt/PASRRrules/index.html.	
121.	TEX. HEALTH AND HUMAN SERVS., LIDDA Performance Contract, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-developmental-disability-authority-lidda/lidda-performance-contract.	
122.	TEX. HEALTH AND HUMAN SERVS., LIDDA Performance Contract, Attachment B, https://hhs.texas.gov/sites/hhs/files/documents/doing-business-with-hhs/providers/long-term-care/lidda/attachmentb.pdf.	
123.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *PASRR PL1: Back to Basics*, Computer Based Training (posted Dec. 29, 2015), *available at* https://www.dads.state.tx.us/business/CBT/PASRRPL1/PL114.html.	
124.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *Preadmission Screening and Resident Review (PASRR)*, Computer Based Training (posted July 17, 2015), https://www.dads.state.tx.us/business/CBT/PASRR/index.html.	
125.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *PASRR Specialized Services Training*, Computer Based Training (posted Oct. 12, 2015), https://www.dads.state.tx.us/business/CBT/pasarrspecialized/SpecializedServices101215_print.html.	

126.	Provider Letter No. 16-41 from Mary T. Henderson, Asst. Comm'r, Regulatory Services, to Nursing Facilities (Sept. 9, 2016), https://www.dads.state.tx.us/providers/communications/2016/letters/PL2016-41.pdf.	
127.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR PE: What Nursing Facilities Need to Know*, Computer Based Training (posted Dec. 29, 2015), https://www.dads.state.tx.us/business/CBT/PASRRPE/PE_print.html.	
128.	Information Letter No. 13-08 from Geri Willems, Manager, PASRR/MERP to Nursing Facility Staff (Feb. 11, 2013), https://www.dads.state.tx.us/providers/communications/2013/letters/IL2013-08.pdf.	
129.	Information Letter No. 13-07 from Geri Willems, Manager, PASRR/MERP to Local Authorities (Feb. 11, 2013), https://www.dads.state.tx.us/providers/communications/2013/letters/IL2013-07.pdf.	
130.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *High Level Summary of DADS Budget for Fiscal Years 2016 - 2017 House Bill 1 - 84th Legislature, Regular Session*, https://www.dads.state.tx.us/news_info/publications/legislative/84thlegislature-hb1.pdf.	
131.	TEX. HEALTH AND HUMAN SERVS., Waivers, https://hhs.texas.gov/laws-regulations/policies-rules/waiversttps://hhs.texas.gov/laws-regulations/policies-rules.	
132.	TEX. HEALTH AND HUMAN SERVS., Billing FAQs (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-faqs/billing-faqs-pasrr.	
133.	TEX. HEALTH AND HUMAN SERVS., Local Authority FAQs (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-faqs/local-authority-faqs.	
134.	TEX. HEALTH AND HUMAN SERVS., Nursing Facility FAQs for PASRR, https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-faqs/nursing-facility-faqs-pasrr.	

135.	TEX. HEALTH AND HUMAN SERVS., Referring Entity FAQs (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-faqs/referring-entity-faqs.	
136.	TEX. HEALTH AND HUMAN SERVS., Preadmission Screening and Resident Review (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr.	
137.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, PASRR Level 1 Screening Forms Converted for Medicaid Nursing Facility Residents Without a PL1 (posted June 25, 2014), *available at* http://www.tmhp.com/News_Items/2014/06-June/PASRR%20Level%201%20Screening%20Forms%20Converted%20for%20Medicaid%20Nursing%20Facility%20Residents%20Without%20a%20PL1.pdf.	
138.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Nursing Facility Updates (posted May 23, 2014), *available at* http://www.tmhp.com/News_Items/2014/05%20May/Important%20Nursing%20Facility%20Updates.pdf.	
139.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Local Authority (LA)/Local Mental Health Authority (LMHA) Updates (posted May 23, 2014), *available at* http://www.tmhp.com/News_Items/2014/05%20May/Important%20Local%20Authority%20Local%20Mental%20Health%20Authority%20Updates.pdf	
140.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Nursing Facility Updates (posted April 28, 2014), *available at* http://www.tmhp.com/News_Items/2014/04-Apr/Important%20Updates%20for%20the%20Nursing%20Facility.pdf	
141.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Local Authority (LA)/Local Mental Health Authority (LMHA) Updates (posted April 28, 2014), *available at* http://www.tmhp.com/News_Items/2014/04-Apr/Important%20Updates%20for%20the%20Local%20Authority.pdf.	

142.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Changes to Preadmission Screening and Resident Review (PASRR) for the Nursing Facility (posted March 21, 2014), *available at* http://www.tmhp.com/News_Items/2014/03-Mar/Important%20Changes%20to%20Preadmission%20Screening%20and%20Resident%20Review%20%28PASRR%29%20for%20the%20Nursing%20Facility.pdf.	
143.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Changes to Preadmission Screening and Resident Review (PASRR) for the Local Authority (posted March 21, 2014), *available at* http://www.tmhp.com/News_Items/2014/03-Mar/Important%20Changes%20to%20Preadmission%20Screening%20and%20Resident%20Review%20%28PASRR%29%20for%20the%20Local%20Authority.pdf	
144.	Information Letter No. 16-19 from Elisa Garza, Asst. Comm'r, Access and Intake, Tex. Dept. of Aging and Disability Servs. to LIDDAs and LMHAs (July18, 2016), *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/IL2016-19.pdf.	
145.	Information Letter No. 16-10 from Elisa Garza, Asst. Comm'r, Access and Intake, Tex. Dept. of Aging and Disability Servs. to Nursing Facility Providers (March 22, 2016), *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/IL2016-10.pdf.	
146.	Information Letter No. 16-05 from Elisa Garza, Asst. Comm'r, Access and Intake, Tex. Dept. of Aging and Disability Servs. to Nursing Facilities (Feb. 24, 2016), *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/IL2016-05.pdf.	
147.	Information Letter No. 15-84 from Elisa Garza, Asst. Comm'r, Access and Intake, Tex. Dept. of Aging and Disability Servs. to Nursing Facilities (Dec. 31, 2015), *available at* https://www.dads.state.tx.us/providers/communications/2015/letters/IL2015-84.pdf.	
148.	Provider Letter No. 15-16 from Mary T. Henderson, Assistant Commissioner, Regulatory Services, Tex. Dept. of Aging and Disability Servs. (July 7, 2015), *available at*	

	https://www.dads.state.tx.us/providers/communications/2015/letters/PL2015-16.pdf.	
149.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, PASRR Level 1 Screening Forms Converted for Medicaid Nursing Facility Residents Without a PL1 (posted June 25, 2014), http://www.tmhp.com/News_Items/2014/06-June/PASRR%20Level%201%20Screening%20Forms%20Converted%20for%20Medicaid%20Nursing%20Facility%20Residents%20Without%20a%20PL1.pdf.	
150.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Nursing Facility Updates (posted May 23,2014), http://www.tmhp.com/News_Items/2014/05%20May/Important%20Nursing%20Facility%20Updates.pdf.	
151.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Changes to Preadmission Screening and Resident Review (PASRR) for the Nursing Facility (posted March 21, 2014), http://www.tmhp.com/News_Items/2014/03-Mar/Important%20Changes%20to%20Preadmission%20Screening%20and%20Resident%20Review%20(PASRR)%20for%20the%20Nursing%20Facility.pdf.	
152.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Day Activity and Health Services Provider Manual, Section 1000, Day Activity and Health Services Program Overview, (effective Nov. 7, 2014) *available at* https://hhs.texas.gov/laws-regulations/handbooks/day-activity-health-services-provider-manual/dahs-section-1000-day-activity-health-services-program-overview	
153.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Day Activity and Health Services Provider Manual, Section 7000, Monitoring (effective June 5. 2015), *available at* https://hhs.texas.gov/laws-regulations/handbooks/day-activity-health-services-provider-manual/dahs-section-7000-monitoring.	
154.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Person-Centered Planning (PCP) Training for Providers,	

	https://hhs.texas.gov/services/disability/person-centered-planning/person-centered-planning-waiver-program-providers/person-centered-planning-pcp-training-providers.	
155.	TEX. HEALTH AND HUMAN SERVS. COMM'N, LIDDA Transition Support Teams, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-developmental-disability-authority-lidda/lidda-transition-support-teams.	
156.	DEPT. OF AGING AND DISABILITY SERVS., ACCESS AND INTAKE, LOCAL AUTHORITIES SECTION, Service Definition Manual (updated May 2014), *available at* https://hhs.texas.gov/sites/hhs/files//documents/doing-business-with-hhs/providers/long-term-care/lidda/servicedefinitionmanual.pdf.	
157.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Contact LIDDA Program Staff, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-developmental-disability-authority-lidda/contact-lidda-program-staff.	
158.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Nursing Facilities (NF), https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf.	
159.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Local Intellectual and Development Disability Authority Handbook, https://hhs.texas.gov/laws-regulations/handbooks/local-intellectual-and-developmental-disability-authority-handbook.	
160.	TEX. DEPT. OF AGING AND DISABILITY SERVICES, Nursing Facility Directory (March 2017), https://hhs.texas.gov/sites/hhs/files/documents/doing-business-with-hhs/providers/long-term-care/nf/nf.pdf.	
161.	TEX. HEALTH AND HUMAN SERVS. COMM'N, How to Become a Nursing Facility Provider, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/how-become-a-nursing-facility-provider.	
162.	TEX. DEPT. OF AGING AND DISABILITY SERVICES, Consumer Rights and Services,	

	https://www.dads.state.tx.us/services/crs/incidentforms/.	
163.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Nursing Facility Frequently Asked Questions, https://hhs.texas.gov/services/health/medicaid-chip/provider-information/expansion-managed-care/nursing-facility-frequently-asked-questions.	
164.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Form 1013, Request to Change a Negative PASRR Level 1 (PL1), *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1013-request-change-a-negative-pasrr-level-1-pl1.	
165.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Form 1018, Specialized Services Customized Manual Wheelchair (CMWC) Authorization Request, *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1018-specialized-services-customized-manual-wheelchair-cmwc-authorization-request.	
166.	TEX. HEALTH AND HUMAN SERVS. COMM'N, Form 1018, Attachment 1, Specialized Services Customized Manual Wheelchair (CMWC) Authorization, *available at* https://hhs.texas.gov/sites/hhs/files//documents/laws-regulations/forms/1018/Attach1.pdf.	
167.	CTRS. FOR MEDICARE AND MEDICAID SERVS., MDS 3.0 Training (last updated Nov. 9, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html.	
168.	CTRS. FOR MEDICARE AND MEDICAID SERVS., MDS 3.0 for Nursing Homes and Swing Bed Providers (last updated March 6, 2015), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html.	
169.	CTRS. FOR MEDICARE AND MEDICAID SERVS., MDS 3.0 Technical Information (last updated Dec. 23, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.	

170.	CTRS. FOR MEDICARE AND MEDICAID SERVS., Nursing Home Quality Initiative, Spotlight (last updated July 25, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Spotlight.html.	
171.	CTRS. FOR MEDICARE AND MEDICAID SERVS., Skilled Nursing Facility Quality Reporting Program (IMPACT Act 2014) (last updated Dec. 6, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-IMPACT-Act-2014.html	
172.	CTRS. FOR MEDICARE AND MEDICAID SERVS., MDS 3.0 RAIL Manual (last updated March 20, 2017), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html	

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lillian Minor, *et al.*,

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

Case No. SA-5:10-CV-1025-OG

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

DECLARATION AND EXPERT DISCLOSURE OF DR. E. SALLY ROGERS IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B), that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case.

1. My report, which is attached, contains a complete statement of all of my opinions as well as an explanation of the basis and reasons for those opinions.

2. My report describes the facts, data and other information I considered in forming my opinions.

3. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

4. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.

5. Within the last four (4) years, I have not testified as an expert, either in a deposition or at trial.

6. I have been retained by the Plaintiffs and the United States as a joint expert in the *Steward v. Smith* litigation. My compensation in this litigation is $150.00 per hour for preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated: 3/28/17

Dr. E. Sally Rogers

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

SAMPLING REPORT OF DR. E. SALLY ROGERS

I. Purpose

I was asked by the plaintiffs' counsel to develop a set of procedures and a methodology for drawing a random and representative sample of PASRR-eligible class members with intellectual and/or developmental disabilities (I/DD) residing in nursing facilities in Texas for an expert review of their specialized service needs and treatment (the "Client Review").

In developing these research procedures and methods, I worked with the plaintiffs' counsel to understand, define and ensure the accuracy of the sampling frames needed to randomly select participants for expert review, to develop procedures for contacting individuals for participation, to ensure accurate tracking of both participants and non-participants in the review, and finally to calculate the representativeness of the samples. These procedures and methods were designed to ensure random, unbiased and representative samples that could be used to confidently generalize the findings of the reviews to the larger populations of interest.

II. Background/Qualifications

As noted in my Curriculum Vitae (attached hereto as Appendix 1), I am the Executive Director and Director of Research at the Center for Psychiatric Rehabilitation at Boston University (the Center), where I have been employed as a researcher for approximately 36 years. I have been the Director of Research since 1987 and the Executive Director since 2016. I am also Research Professor at Sargent College of Health and Rehabilitation Sciences at Boston University.

For the past 36 years, I have been engaged in the design and implementation of various research and evaluation projects developed to learn more about care and outcomes of individuals with psychiatric and other disabilities using a variety of research strategies. I use differing methodologies including clinical research, survey research, needs' assessment, measurement

design and development, program evaluation, and exploratory research. In addition to my work at the Center, I have taught research methods at Sargent College and to post-doctoral fellows who are in residence at the Center. I consult extensively on disability research projects. Much of my career at the Center and my consultation outside of the Center has focused on assessing the clinical and service needs and outcomes of individuals with psychiatric and other disabilities, as well as evaluations of whether those service and clinical needs have been met.

The Center for Psychiatric Rehabilitation is primarily a federally-funded research, training and services organization. In addition to the funding we receive from the federal government, we receive funding from private foundations and state governments to assist with the conduct of program evaluation or research. As an example, I recently completed an evaluation of a new service for difficult-to-serve individuals that was funded by the State of Massachusetts Attorney General's office after a class action lawsuit. Over the past several years I have been a consultant to the State of Florida, Department of Children and Families, and the United States Department of Justice to assist with clinical reviews of members in class action lawsuits in Florida, Massachusetts, Oregon and New Hampshire. In that capacity, I have both conducted client service reviews or overseen the sampling process for these reviews for state agencies that were defendants in systemic lawsuits or for plaintiffs. My research and reports have been accepted as reliable and useful by federal courts in conjunction with these cases.

III. Materials Reviewed

I reviewed three documents and one Excel list of class members which are identified in Appendix 2 to my report. This includes: 1) the FY 2015 and first quarter 2016 report of Kathryn DuPree, the former joint Expert Reviewer under the Interim Agreement in this case, detailing her QSR methodology, 2) the matrix of outcomes measured and indicators reviewed by Ms. DuPree, and 3) an Excel spreadsheet of the class members that were part of the review conducted by Ms. DuPree, subtracting out individuals who resided more than 70 miles from 5 urban areas except for individuals in five specific nursing facilities. The class members contained in the Excel spreadsheet and the QSR methodology formed the basis for my sampling.

IV. Methodology

I provided consultation to plaintiffs' counsel for the review which involved several steps. First, I consulted with plaintiffs' counsel to understand the purpose of the Client Review, to determine the sampling frame, to ensure that any lists or databases used for sampling were as accurate and comprehensive as possible, and to discuss procedures for arriving at a scientifically sound sampling methodology. The purpose of my consultation was to ensure that a random and representative sample was developed for the Client Review.

For several reasons, plaintiffs decided to perform a Client Review of class members who previously had been reviewed by Kathryn DuPree in her FY2015-2016 QSR activities, as detailed in her QSR Methodology and Findings. First, because Ms. DuPree was an independent expert who had been jointly selected by the parties as the Expert Reviewer under the former Interim Agreement in this case, there was confidence in her process and the overall findings from that process. Second, Ms. DuPree's review methodology was designed to produce an unbiased and representative sample and had been agreed to and deemed acceptable by all parties to this case, including various Texas state agencies. Third, by reviewing individuals from Ms. DuPree's sample a second time, it would be possible to determine if changes in status or needs were evident, and whether any previously identified deficiencies continued. Fourth, this approach allowed for a review that built upon, but analyzed in more in-depth, the adequacy of services as well as the provision of active treatment, which Ms. DuPree had not addressed in her QSR review. Although this methodology does not make the findings from the Client Review entirely generalizable to the class population as a whole – all individuals with I/DD in nursing facilities – with the same degree of reliability as the methodology used by Ms. DuPree, selecting from Ms. DuPree's QSR review sampling frame was a reasonable means for accomplishing plaintiffs' goals for the Client Review and does allow for a significant degree of reliability and generalizability of the findings from the review.

Additionally, I consulted with the plaintiffs about the practical, logistical, and resource need to limit the Client Review to individuals in Ms. DuPree's QSR review that resided in nursing facilities within 70 miles of five major urban areas. I advised plaintiffs that limiting the

Client Review in that way was reasonable given plaintiffs' limited staffing resources and time constraints.

In general, the procedures for drawing a sample for the participant review were as follows: 1) I received from plaintiffs' counsel an Excel spreadsheet in electronic copy listing all the individuals that had been sampled and reviewed by Ms. DuPree, less individuals who were in nursing facilities that were more than 70 miles from 5 major urban areas/cities, with the exception of five nursing facilities that were included because they housed a large number of class members or were relatively accessible, 2) the spreadsheet of clients was an accurate and comprehensive list of clients in that review with one unique entry/row per person; 3) using the Excel random sort function, I scrambled the list prior to sampling so that it was in random order and to prevent any systematic biases that could arise from how the list was compiled; 4) I selected a designated number of individuals randomly from the list using random selection software, including oversampling by a certain percentage; 5) I identified the randomly selected individuals on this electronic spreadsheet and returned it for use in the review. These steps were designed to provide an objective random list for the review, and one in which steps were taken to ensure randomness and representativeness, given the constraints faced.

The list of individuals to form the sampling frame contained n=141 unique individuals. In consultation with plaintiffs' counsel, I decided on the following sampling parameters: 90% confidence interval; 10% margin of error. I oversampled by a factor of 50% because of concerns about the ability to contact individuals in the sample, the likelihood that some individuals may have died or left the nursing facility, and the possibility that a significant percentage of individuals may not voluntarily agree to participate in the review. The target for the review to satisfy the 90% confidence level/10% margin of error was n=46. Using the Raosoft/Randomizer software (available online at www.raosoft.com and randomizer.org), I determined the sample size and to randomly select a list of n=69 individuals (n=46 needed to satisfy the 90/10 parameters + 23 or 50% oversampling in case of difficulty contacting or completing the review).

I instructed the plaintiffs' counsel to use this list of randomly selected individuals as follows: 1) they should proceed down the list in the order that individuals were randomly selected and identified by me to locate them for the review and to obtain permission to be

reviewed; 2) they should take careful notes about those individuals who were not locatable, who refused to participate, who were deceased, or who were in some way unable to participate in the review. This information would be used for later aggregation and examination of "non-responders" and other individuals who were selected but did not participate in the review; 3) when they satisfied the number required to perform their review using the above parameters, they would stop the review.

It is my understanding that all n=69 individuals identified in the random sampling process were contacted by letter and follow up calls and occasionally visits, where necessary, to participate in the review. Results of attempting to locate and obtain permission to review individuals were as follows: 2 individuals were deemed by DADS as not PASRR eligible; 1 individual had moved from the area; 3 individuals had left the nursing facility, and a total of 9 individuals had passed away. This reduced the number of individuals that could be reviewed by n=15. In total, n=27 individuals were reviewed. Given that n=27 individuals were ultimately reviewed, a re-calculation of the survey parameters is warranted. With the originally set parameter of a 90% confidence level, an n=27 yields a 14.28 margin of error. Subtracting out the n=15 who could not have been reviewed reduces the sampling frame from 141 to 126. Re-calculation of the margin of error with n=126 yields a margin of error of 14.09. Thus, it is safe to report that with a 90% confidence level, the final margin of error was approximately 14%.

V. Methodological Challenges

There are certain expected and predictable challenges to designing a research methodology for individuals with disabilities that must be taken into consideration and addressed, to the extent possible, in a case such as this. Such challenges often arise because of the situations and disabilities of the individuals involved, limitations on access to current information (such as moves, deaths) needed to create the sampling frame, as well as the inevitable challenges that come with accurately identifying sampling frames.

First, conducting reviews or surveys benefit from accurate identification of the sampling frames or the universe of programs and individuals served prior to drawing a random sample. Random selection of samples should begin with as accurate a list as possible of identified programs or participants— a list that purports to be current, comprehensive and non-duplicative,

and that contains only members of the class with the elements and characteristics identified for selection in the review. These requirements are important for ensuring a representative and random sample.

Second, there is a need to ensure voluntary participation in reviews that involve human subjects and particularly when vulnerable populations (such as the individuals in this class) are involved. This requires that the randomly sampled individuals be able and willing to provide consent and participate in the review. For individuals with intellectual and developmental disabilities, and particularly those who are institutionalized in nursing facilities, securing voluntary consent can be especially challenging.

Third, all research and evaluations are constrained by available human and financial resources. Studies done by public agencies are often undertaken with very limited funds and are required to make adjustments based upon available funding, deadlines, and realities. These challenges are common and somewhat predictable. Researchers develop strategies to address these challenges, and to draw samples and conduct studies that are considered reliable and useful despite these challenges. This is equally true here of the Client Review with which I assisted.

There were insufficient resources to review a random, representative sample of the entire universe of roughly 4,000 PASRR-eligible nursing facility residents with I/DD in the class. This would have required significant resources and time, given the number of persons who would have to be reviewed, given the time involved in reviewing each individual, and given the large geographical spread throughout Texas. Instead, a logical approach was to extend the work of the former Expert Reviewer, Ms. DuPree, using her review sample as the sampling frame, to take a sample of that cohort, and to limit the review to individuals who were within a 70 mile radius of an urban center because of geography and related time and resource constraints. Plaintiffs included individuals in five nursing facilities outside of this 70 mile geographic radius in order to have a larger sample frame. Even then, there were considerable challenges in locating individuals at different stages of the review process because some individuals were deceased, moved residences, or left the nursing facilities.

It is not technically possible to ensure that the final review is representative of non-participants who refused to consent to release of confidential information or to cooperate in the

review process. This is true in all evaluations that involve human subjects or program and services provided to human subjects, particularly when access to confidential medical information is needed. As in all such evaluations, other randomly-selected individuals who do not consent and thus are not reviewed may be assumed to be "non-participants at random" and, therefore, would not compromise representativeness. In addition, it may be assumed that the individuals who were deceased or moved before the review were also randomly unavailable or "non-participants at random". This helps ensure that no additional "selection biases" are introduced in the review other than those of refusal.

Oversampling is necessary when there are concerns about being able to locate individuals or when there are concerns about refusal or non-participation rates. Oversampling is done so that there are has sufficient numbers of randomly sampled entities to satisfy the target number for the survey or the review.

To ensure that the sample for the review of individuals was randomly selected and representative, the sampling methodology began with the DuPree QSR list which was a comprehensive and accurate list of individuals who participated in her review and to whom plaintiffs desired to generalize the review findings. From that list, individuals who lived more than 70 miles from an urban center were excluded other than the five facilities noted above. The resulting list was n=141. When I received that list from the plaintiffs' counsel, I randomly sorted the list using an Excel random sort function. This prevents any bias that could be introduced in the construction of the list (for example, recent service recipients added to the list last). I then used software to calculate parameters needed to ensure that the sample for each review would provide reliable findings. This means selecting the review parameters to maximize robustness and minimize error. I recommended a 90% confidence level and 10% margin of error. I then used Raosoft software for that purpose (available online at www.raosoft.com). I then used another software program (www.randomizer.org) to perform the actual selection of individuals in the database. This software works by first providing the size of the sampling frame, the desired confidence level and margin of error. It then identifies a row in a list as one that should be randomly selected. I used that information to highlight the unit as being part of the random sample. Together, these procedures ensured that a random sample was selected for each review. Once a random sample is identified, to ensure representativeness, the sample list(s) must be used.

These procedures help to ensure that the final sample reviewed is representative of the larger sampling frame.

I gave plaintiffs' counsel a list of randomly selected individuals from the sampling frame constructed for that review and plaintiffs' counsel was instructed to proceed down the list until they fulfilled the number needed given the chosen parameters. It is my understanding that plaintiffs sent letters to all 69 individuals on the list and follow up calls were made to any non-responders. In addition, I understand that personal visits were made to many individuals to help them understand the letters and the purpose of the Client Review.

As plaintiffs proceeded down the list, I instructed plaintiffs' counsel to make careful notes about why a randomly selected individual was not reviewed. An individual could have actively refused, not responded, moved out of the area, moved out of a nursing facility, no longer be PASRR eligible, or be deceased. In order to retain the random order of the list, plaintiffs' counsel was instructed to move to the next person on the list should one of these reasons for non-participation occur and keep careful track of those individuals who were randomly selected but not reviewed. I regularly communicated with the plaintiffs' counsel to ensure that they followed these instructions and am satisfied that they did. These procedures help to ensure that the final sample reviewed is representative of the larger sampling frame.

With a sample that is free from bias and with the confidence level and margin of error used, it is possible to be confident that the results of the review are representative of the targeted sampling frame. I am confident that the sampling methodology and procedures used in this review would allow the findings to be generalizable to the entire sample of those detailed in the QSR reports of FY2015 and FY 2016 promulgated by Ms. Kathryn DuPree.

VI. Conclusion.

I provided research consultation and guidance for the review of individuals with I/DD residing in nursing facilities in Texas. I worked carefully and closely with the plaintiffs' counsel to take the necessary steps to insure a systematic and unbiased approach to identifying persons for the review. Target parameters for these samples were set at the highest levels possible given geographic and other resource constraints for the review. In addition, I provided guidance in the

use of the lists of randomly selected programs and people to insure that biases were not introduced in the conduct of the reviews. Despite the limitations in resources, I am confident that the reviews were conducted with unbiased samples to the extent possible and that they are representative of the individuals originally reviewed by Ms. DuPree during her QSR reviews of FY 2015 and FY 2016.

Appendix 1

Curriculum Vitae
E. Sally Rogers

TABLE OF CONTENTS

CURRICULUM VITAE

Name: ERNA SALLY ROGERS

Education:

Degree	Year Granted	Institution	Major
Sc.D.	1980	Boston University	Rehabilitation Counseling
M.A.	1975	Seton Hall University	Rehabilitation Counseling
B.A.	1970	Temple University	Psychology

Professional Experience:

8/16 – present Executive Director, Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston, MA. Responsible for ensuring that the mission of the Center is carried forward; oversight and management of responsible the strategic, operational, and financial viability of all divisions of the Center, including service delivery, research, training and knowledge translation.

9/87 - present Director of Research, Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston, MA. Responsible for development of new research projects and management of existing research projects for the Center, including oversight of research design, data collection, data analysis, and writing of progress reports and journal articles to disseminate findings.

9/09 – present Co-Principal Investigator of two consecutive Research and Training Center grants (with Dr. Marianne Farkas) from the National Institute on Disability and Rehabilitation Research to improved employment outcomes for individuals with mental illness. As Co-Investigator and Director of Research, I oversee the implementation and completion of 5 research studies, including randomized clinical trials, planning of the study design and procedures, data collection, data monitoring, entry, analysis and interpretation. The goal is to improve work outcomes for persons with psychiatric disability. The grant totals $4.25 million dollars over 5 years.

9/07-8/12; 9/13-present Co-Principal Investigator, Advanced Research Training Grant (with Dr. Zlatka Russinova), Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University, Boston, MA. This grant from the National Institute on Disability and Rehabilitation Research for advanced training in rehabilitation research is designed to

recruit 6 fellows and train them to conduct research in psychiatric rehabilitation.

10/14-9/19 — Co-Principal Investigator, Disability Rehabilitation Research Project (Dr. Zlatka Russinova, PI). This grant, awarded by the National Institute on Disability and Rehabilitation Research is designed to improve the community life of individuals with severe mental illness. We will conduct several research projects to better understand the meaning of community participation and integration from various perspectives, to adapt an established photovoice intervention to promote community integration, to develop and validate a measure of community integration, and to test the effectiveness of this intervention (called Bridging Community Gaps) in a large randomized trial. My role on this grant is to direct two of the research projects and to assist the Principal Investigator in overseeing all aspects of the research and dissemination activities. This grant is for 5 years and totals $2.25 million.

09/12 – 09/14 — Principal Investigator, Health and Disability Research Institute at the Boston University School of Public Health, sub-award to develop and test assessments for the National Institute of Health/Social Security Administration study of work function for individuals with serious mental illness. $253,000.

11/06-10/10 — Co-Principal Investigator, Field Initiated Research Project (with Dr. Zlatka Russinova). This grant, awarded by the National Institute on Disability and Rehabilitation Research is designed to culturally adapt a scale recently developed by the Center (Recovery Promoting Competence Scale) to be relevant to four Spanish speaking populations. My role on this grant is to oversee all aspects of the scientific activities of the study including the cultural adaptation of the scale, the psychometric testing, and the item response theory testing. This grant is for 3 years and totals $450,000.

11/05- 10/11 — Co-Principal Investigator, of a Knowledge Dissemination and Utilization grant (with Dr. Marianne Farkas). This grant is funded by the National Institute on Disability and Rehabilitation Research. My role on this grant is to work collaboratively with professional and consumer organizations and stakeholders to develop, test, and apply a process of research standards to rate the quality of disability research that in turn will allow end-users in the rehabilitation field to make informed choices based on the perceived rigor and use of the research available, and in so doing promote utilization of rehabilitation research. The grant is for 5 years and totals $2.5 million dollars.

05/05 – 09/05 — Principal Investigator, Department of Mental Health Grant to study satisfaction surveys and methodologies to assist the state to develop an

ongoing, annual assessment of consumers and other stakeholders, examine existing instruments and practices in other states, test instruments, and provide recommendations about assessments of service quality $45,000.

11/04- 9/10 — Co-Principal Investigator, Research and Training Center grant (with Dr. Marianne Farkas) from the National Institute on Disability and Rehabilitation Research to study recovery of individuals with mental illness. As Co-Investigator and Director of Research, I oversaw the implementation and completion of 5 research studies, including 4 randomized clinical trials, planning of the study design and procedures, data collection, data monitoring, entry, analysis and interpretation. The goal was to advance knowledge about the recovery of persons with psychiatric disability. The grant totaled $3.75 million dollars over 5 years.

04/04 – 05/05 — Principal Investigator, Tower Foundation award to assist Windhorse Associates, a residential program for individuals with psychiatric disabilities, to develop and implement a program evaluation system. $50,000.

9/98-05/03 — Principal Investigator, a multi-site study of consumer operated services funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). This multi-site grant was designed to study the effects of consumer-operated services in Missouri and other locations throughout the country. As PI, I was responsible for all research activities in this randomized clinical trial including the development and implementation of study procedures, the conduct of the trial, the data monitoring, entry and analysis. This study was conducted in Missouri and required the establishment of a research office with numerous research staff in St. Louis and frequent meetings with federal project officers and multi-site collaborators in Washington DC. This 4-year grant totaled approximately $2.3 million dollars.

9/97 – 12/98 — Co-Investigator, SAMHSA, a study of two housing approaches, Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University, Boston, MA. This Center for Mental Health Services grant was designed to study supported housing for persons with mental illness in Mobile, Alabama. My role was to study the effectiveness of various housing approaches for individuals with mental illness using a mixed methods approach of both quantitative and qualitative research strategies.

1/97 – 10/04 — Co-Principal Investigator, Research and Training Center (with Dr. Marianne Farkas). This grant from the National Institute on Disability and Rehabilitation Research had multiple research and training projects designed to advance knowledge about the recovery of persons with

psychiatric disability. I was responsible in my role as Co-Principal Investigator for the development and implementation of 9 research projects with varying research methodologies, including survey research, policy research, quasi-experimental trials, instrument development, and qualitative research. This was a five-year grant totaling $3.75 million dollars.

11/94 – 12/96 Co-Director, Research and Training Center, Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University, Boston, MA. With other Co-Director, responsible for the programmatic implementation and fiscal oversight of the Center's five-year research, training, and dissemination grant designed to improve the rehabilitation outcomes of persons with severe psychiatric disability.

3/92 – 1/03 Principal Investigator, Advanced Research Training Grant, Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University, Boston, MA. This grant from the National Institute on Disability and Rehabilitation Research for advanced training in rehabilitation research is designed to recruit 6 fellows with clinical doctorates and train them to conduct research in psychiatric rehabilitation. This grant was awarded twice, with funding grant totaling $1.4 million dollars.

3/81 - 8/87 Director of Data Management and Research Associate, Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University, Boston, MA. Responsible for directing data analysis and information management; supervising data entry, conducting statistical analysis; review, preparation, management, and implementation of research proposals.

6/78 - 3/85 Psychologist, Mount Pleasant Hospital, Lynn, MA. Responsible for providing, on a consultant basis, a comprehensive psychological evaluation to patients in an inpatient treatment facility for alcoholics. Evaluation consisted of administering a battery of tests for neuropsychological screening and intellectual and personality functioning- writing a psychological report including recommendations for the patient's treatment program. Also responsible for inpatient psychotherapy and supervision of Employee Assistance Program.

9/76 - 4/78 Psychology Technician/Research Assistant, Veterans Administration Out-patient Clinic (Neurology Service), Boston, MA. Responsibilities were divided between a research project and clinical service. Research responsibilities included: investigating the psychosocial impact of multiple sclerosis on veterans and their families- conducting interviews, conducting psychological and family assessments, administering tests. Also, assisted

in the preparation of a five-year grant proposal to continue the project. Clinical service responsibilities: provided individual and group counseling of veterans with multiple sclerosis.

Faculty Appointments:

1981 - 1992	Research Assistant Professor, College of Health and Rehabilitation Sciences: Sargent College, Boston University
1993 - 2014	Research Associate Professor, College of Health and Rehabilitation Sciences: Sargent, Boston University
2014 - present	Research Professor, College of Health and Rehabilitation Sciences: Sargent, Boston University

Teaching Responsibilities:

2005-present	Invited Lecturer, Sargent College
2004-2005	Post-Doctoral Seminar in Research Methods
1994-1998; 2003	RC708 Rehabilitation Research I - Introductory research course for masters and doctoral students. Course covered basics of scientific inquiry, research design, and interpretation of research results.
1992/1995/2000	RC805 Research Seminar - Research seminar for doctoral students, designed to prepare them for their doctoral thesis. Course covered design and development of research studies, reliability and validity of instruments, use of statistical tests.
1979	RC611 - Role of the Family in Rehabilitation. Team taught this course which is designed to provide rehabilitation practitioners with the knowledge and skills needed to effectively utilize the family in the rehabilitation process.

Professional Certifications:

Licensed Psychologist, Commonwealth of Massachusetts, #3053

Health Service Provider, Commonwealth of Massachusetts, 1993

Publications -- Peer Reviewed Articles:

Rogers, E. S., (In press). Peer support services: State of the workforce-state of the field in the US. Mental Health and Social Inclusion.

Rogers. E. S. & Swarbrick, P. (2016). Co-Editors and Editorial for a Special Issue of the Psychiatric Rehabilitation Journal entitled: *Peer Delivered Services: Current Trends and Innovations*, 39(1).

Rogers, E. S., Maru, M., Johnson, G., Cohee, J., Hinkel, J., & Hashemi, L (2016). A randomized trial of individual peer support for adults with psychiatric disabilities undergoing civil commitment. *Psychiatric Rehabilitation Journal, 39(3),248-255.*

Gordon, C., Gidugu, V., Rogers, E.S., DeRonck, J., & Zeidonis, D. (2016). Adapting Open Dialogue for Early-Onset Psychosis into the US Healthcare Environment: a Feasibility Study. *Psychiatric Services*, 67(11),1166-1168.

Rogers, E. S., Maru, M., Kash-MacDonald, M., Archer-Williams, M., Hashemi, L., & Boardman, J. (2016). A randomized clinical trial investigating the effect of a healthcare access model for individuals with severe psychiatric disabilities, *Community Mental Health Journal,* 52(6), 667-74.

Cronise, R., Teixeira, C., Rogers, E. S., & Harrington, S. (2016). The peer support workforce: Results of a national survey. *Psychiatric Rehabilitation Journal*, 39(3),211-221.

Teixeira, C., Santos, E., Abreu, M.V., & Rogers, E.S. (2015). Current status of psychiatric rehabilitation in Portugal: A national survey. *Psychiatric Rehabilitation Journal,* 38, 263-7. Epub doi: 10.1037/prj0000144.

Millner, U. C., Rogers, E. S., B, P., Costa, W. Pritchett, S., & Woods, T. (2015). Exploring the work lives of adults with serious mental illness from a vocational psychology perspective. *Journal of Counseling Psychology,* 62(4), 642-654.

Fang-Hang Chang, F. Helfrich, C., Coster, W., & Rogers, E. S. (2015). Factors associated with community participation among individuals who have experienced homelessness, *International Journal of Environmental Research in Public Health*, *12*(9), 11364-11378; doi:10.3390/ijerph120911364).

Marfeo, E., Eisen, S., Ni, P., Rasch, E., Rogers E.S, & Jette A. (2015). Do claimants over-report behavioral health dysfunction when filing for work disability benefits? *Work,* 51(2):187-94. PMID: 24594538.

Rogers, E. S., Russinova, Z., Maru, M., Restrepo-Toro, M., Cook, K. F., Rogers, J. D. (2015). Assessing Recovery-Promoting competencies of providers serving Latinos with serious mental illnesses. *Journal of Latino Psychology*, 3(4), 239-257.

Teixeira, C., Santos, E., Abreu, M.V., & Rogers, E.S. (2015). Current status of psychiatric rehabilitation in Portugal: A national survey. *Psychiatric Rehabilitation Journal,* 38, 263-7. Epub doi: 10.1037/prj0000144.

Gidugu, V. Rogers, E. S., Harrington, S., Maru, M., Johnson, G., Cohee, J., Hinkel, J. (2015). Individual Peer Support: A Qualitative Study of Mechanisms of its Effectiveness, C*ommunity Mental Health Journal,* 51, 445-452.

Chan, D., Helfrich, C., Hursh, N, Gopal, S., & Rogers, E. (2014). Measuring community integration using Geographic Information Systems (GIS) and participatory mapping for people who were once homeless. *Health & Place*, 27, 92-101.

Russinova, Z., Rogers, E.S., Gagne, C., Bloch, P., Drake, K., & Mueser, K. (2014). A randomized controlled trial of a peer-run anti-stigma photovoice intervention. *Psychiatric Services, 65(2),* 242-246.

Johnson, G., Magee, C., Maru, M., Norman, K., Rogers, E.S., & Thompson, K. (2014). The personal and societal benefits of providing peer support: a survey of peer support specialists. *Psychiatric Services,* 65, 678-680.

Anthony, W., Ellison, M., Rogers, E. S. Mizock, L., & Lyass, A. (2013). Implementing and evaluating goal setting in a statewide psychiatric rehabilitation program. Rehabilitation Counseling Bulletin, 57(4), 228-237.

Russinova, Z., Rogers, E.S., Cook, K., Ellison, M.L., & Lyass, A. (2013). Conceptualization and measurement of mental health providers' recovery-promoting competence: The Recovery Promoting Relationships Scale (RPRS). *Psychiatric Rehabilitation Journal,* 36(1), 7-14.

Russinova, Z., Rogers, E.S., Ellison, M.L., Bloch, P., Lyass, A. & Wewiorski (2013). Predictors of financial self-sufficiency among Social Security beneficiaries with psychiatric disabilities. *Journal of Vocational Rehabilitation, 38*(1), 49-66.

Ellison, M. L., Rogers, E. S., Lyass, A., Massaro, J., Wewiorski, N., & Anthony, W. Statewide initiative of Intensive Psychiatric Rehabilitation: Outcomes and Relationship to Other Mental Health Service Use. (2011). *Psychiatric Rehabilitation Journal, 35, 9-19.*

Mesidor, M., Gidugu, V., Rogers, E., & Boardman, J. (2011). A qualitative study: Barriers and facilitators to health care access for individuals with psychiatric disabilities. *Psychiatric Rehabilitation Journal,* 34, 285-294.

Russinova, Z., Ellison, M., Rogers, E. S., Lyass, A. (2011). Recovery-promoting professional competencies: Perspectives of mental health consumers, consumer-providers and providers. *Psychiatric Rehabilitation Journal, 34(3)177-185.*

Rogers, E. S., Ralph, R. & Salzer, M. (2010). Validating the Empowerment Scale with a multi-site sample of consumers of mental health services. *Psychiatric Services*, 61(9), 933-939.

Dunn, E., Wewiorski, N., & Rogers, E. S. (2010). A qualitative investigation of individual and contextual factors associated with vocational recovery among people with serious mental illness. *Journal of Orthopsychiatry*, 80(2), 185-194.

Schutt, R. & Rogers, E. S. (2009). Empowerment and peer support: Structure and process of self help in a consumer run center for individuals with mental illness. *Journal of Community Psychology*, 37(6), 697-710.

Dunn, E., Rogers, E. S., Hutchinson, D., Lyass, A., MacDonald-Wilson, K., Wallace, L. & Norman, K. (2008). Results of an innovative university-based recovery education program for adults with psychiatric disabilities. *Administration and Policy in Mental Health and Mental Health Services Research*, 35(5), 357-369.

Dunn, E. C., Wewiorski, N. J. & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study. *Psychiatric Rehabilitation Journal*, 32(1), 59-62.

McCorkle, B., Rogers, E. S., Dunn, E. Lyass, A., & Wan, Y. (2008). Increasing social support for individuals with serious mental illness: Results of an evaluation of a social, adjunctive intervention. *Community Mental Health Journal*, 44: 359-366.

Ellison, M., Russinova, Z., Lyass, A., & Rogers, E. S. (2008). Professionals and Managers with Severe Mental Illness: Findings from a national survey. *Journal of Nervous and Mental Disease*, 196(3), 179-189.

Rogers, E. S., Teague, Ph.D., Lichtenstein, C, Campbell, J, Lyass, A. Chen, R., & Banks, S. (2007). The effects of participation in adjunctive consumer-operated programs on both personal and organizationally mediated empowerment: Results of a multi-site study. *Journal of Rehabilitation Research and Development*, 44(6), 785-800.

Hutchinson, D., Anthony, W.A., Massaro, J., & Rogers, E. S. (2007). Evaluation of a combined supported education and employment computer training program for persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal*,30,189-197.

Hutchinson, D. S., Anthony, W., Ashcraft, L., Johnson, G., Dunn, E., Lyass, A., & Rogers, E. S. (2006). The personal and vocational impact of training and employing people with psychiatric disabilities as providers. *Psychiatric Rehabilitation Journal*, 29(3), 205-213.

Rogers, E., Anthony, W., & Lyass, A. (2006). A randomized clinical trial of psychiatric vocational rehabilitation. *Rehabilitation Counseling Bulletin*, 49(3).143-156.

Rogers, E., Anthony, W., & Farkas, M. (2006). The Choose-Get-Keep Approach to Psychiatric rehabilitation. *Rehabilitation Psychology*. 51(3), 247-256.

Rogers, E. S., Anthony, W. A., & Lyass, A. (2004). The nature and dimensions of social support among individuals with severe mental illnesses. *Community Mental Health Journal*,40(5), 437-451.

MacDonald-Wilson, K.L., Rogers, E.S., Ellison, M.L., & Lyass, A. (2003). A study of the Social Security Work Incentives and their relation to motivation to work among persons with serious mental illnesses. *Rehabilitation Psychology,*48(4), 301-309.

Tsemberis, S., Rogers, E. S., Rodis, E., Eisenberg, R., Dushuttle, P., Skryha, V. (2003). Housing satisfaction for persons with psychiatric disabilities. *Journal of Community Psychology*, 31(6), 581-590.

Anthony. W., Rogers, E.S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, *39*(2), 101-114.

Kramer, P., Anthony, W. A., Rogers, E. S., & Kennard, W. A. (2003). Another Way of Avoiding the "Single Model Trap." *Psychiatric Rehabilitation Journal*, 26(4), 413-415.

MacDonald-Wilson, K. L., Rogers, E. S., & Massaro, J. (2003). Identifying functional limitations in work for people with psychiatric disabilities. *Journal of Vocational Rehabilitation,*18,15-24.

Russinova, Z., Wewiorski, N., Lyass, A., Rogers, E.S., & Massaro, J. (2002). Correlates of vocational recovery for persons with schizophrenia. *International Journal of Psychiatry,* 14, 303-311.

MacDonald-Wilson, K., Rogers, E. S., Massaro, J., Lyass, A. & Crean, T. (2002). An investigation of reasonable workplace accommodations for people with psychiatric disabilities: Quantitative findings from a multi-site study. *Community Mental Health Journal*, *38*(1), 35-50.

MacDonald-Wilson, K.L., Rogers, E.S. & Anthony, W.A. (2001). Unique issues in assessing work functioning among individuals with psychiatric disabilities. *Journal of Occupational Rehabilitation*, *11*(3), 217-232.

Rogers, E.S., Martin, R., Anthony, W.A., Massaro, J., Danley, K.S., & Penk, W. (2001). Assessing readiness for change among persons with severe mental illness, *Community Mental Health Journal*, *37*(2), 97-112.

Arns, P., Rogers, E. S., Cook, J., Mowbray, C., Members of IAPSRS Research Committee. (2001). The IAPSRS Toolkit: Its usefulness to PSR programs and its comparison with other Performance Measurement Systems. *Psychiatric Rehabilitation Journal*, *45*(1), 43-52.

Anthony, W., Brown, M., A., Rogers, E. S., & Derringer, S. (1999). A supported living/supported employment program for reducing the number of people in institutions. *Psychiatric Rehabilitation Journal*, *23*(1), 57-61.

Blankertz, L., Cook, J., Rogers, E. S., & Hughes, R. (1997). The five C's of choice: outcomes measures for individuals with serious and persistent mental illness. *Behavioral Healthcare Tomorrow*, *6*(4), 62-67.

Rogers, E. S., Chamberlin, J., Ellison, M., & Crean, T. (1997). A consumer-constructed scale to measure empowerment. *Psychiatric Services, 48*(8), 1042-1047.

Rogers, E. S. (1997). Cost-benefit analysis in vocational programs. *Psychiatric Rehabilitation Journal, 20*(3), 25-33.

Rogers, E. S., Anthony, W. A., Cohen, M., & Davies, R. R. (1997). Prediction of vocational outcomes using demographic and clinical indicators. *Community Mental Health Journal, 33*(2), 99-112.

Rogers, E. S., MacDonald-Wilson, K., Danley, K., Martin, R., & Anthony, W. (1997). A process analysis of supported employment services for persons with psychiatric disability: Implications for program design. *Journal of Vocational Rehabilitation, 8*(3), 233-242.

Diksa, E. & Rogers, E. S. (1996). Employee concerns about hiring persons with psychiatric disability: Results of a survey. *Rehabilitation Counseling Bulletin, 40*(l), 31-44.

Ellison, M.L., Danley, K.S., Crean, T., Rogers, E.S., & Colodzin, R. (1996). Involvement of people with psychiatric disabilities in state agencies of vocational rehabilitation: State agency survey. *Journal of Rehabilitation Administration, 20*(4), 319-334.

Chamberlin, J., Rogers, E. S. & Ellison, M. (1996). Self-help programs: A survey of their characteristics and their members. *Psychiatric Rehabilitation Journal, 19*(3), 33-42.

Anthony, W. A., Rogers, E. S., Cohen, M., & Davies, R. R. (1995). Relationship between psychiatric symptomatology, work skills and future vocational performance. *Hospital and Community Psychiatry, 46*(4), 353-358.

Ellison, M., Rogers, E. S., Sciarappa, K., Cohen, M. & Forbess, R. (1995). Characteristics of mental health case management: Results of a national survey. *Journal of Mental Health Administration, 22*(2), 101-112.

Rogers, E. S., Sciarappa, K., MacDonald-Wilson, K., Danley, K. (1995). A benefit-cost analysis of a supported employment model for persons with psychiatric disabilities. *Evaluation and Program Planning, 18*(2), 105-115.

Rogers, E. S. & Palmer-Erbs, V. (1994). Participatory action research: Implications for researchers in psychiatric rehabilitation. *Psychosocial Rehabilitation Journal, 18*(2), 3-12.

Rogers, E. S. (1994). Impact of the Americans with Disabilities Act upon research in psychiatric rehabilitation. *Journal of Disability Policy Studies, 5*(2), 25-43.

Rogers, E. S., Danley, K. D., Anthony, W. A., Martin, R., & Walsh, D. (1994). The residential needs and preferences of persons with serious mental illness: A comparison of consumers and family members. *Journal of Mental Health Administration, 21*(l), 42-51.

Danley, K., Rogers, E. S., MacDonald-Wilson, K., & Anthony, W. A. (1994). Supported employment for adults with psychiatric disability: Results of an innovative demonstration project. *Rehabilitation Psychology, 39*(2), 279-287.

Rogers, E. S. (1992). Impact of the Americans with Disabilities Act upon research in psychiatric rehabilitation. Commissioned paper. Washington, D.C.: National Council on Disability.

Brown, M. A., Ridgway, P., Anthony, W. A., & Rogers, E. S. (1991). A comparison of supported housing for voluntary and involuntary clients. *Hospital and Community Psychiatry 42*(11), 1150-1153.

Kielhofner, G., Henry, A., Walens, D., & Rogers, E. S. (1991). A generalizability study of the occupational performance history interview. *Occupational Therapy Journal of Research, 11*(5), 292-306.

Rogers, E. S., Sciarappa, K., & Anthony, W. A. (1991). Development and evaluation of situational assessment instruments and procedures for persons with psychiatric disability. *Vocational Evaluation and Work Adjustment Bulletin, 24*(2), 61-67.

Unger, K. V., Anthony, W. A., Sciarappa, K., & Rogers, E. S. (1991). Supported education program for young adults with long-term mental illness. *Hospital and Community Psychiatry, 42*(8), 838-842.

Nemec, P. B., Forbess, R., Cohen, M. R., Farkas, M. D., Rogers, E. S., & Anthony, W. A. (1991). Effectiveness of technical assistance in the development of psychiatric rehabilitation programs. *Journal of Mental Health Administration, 18*, 1-11.

Rogers, E.S., Anthony, W.A., Toole, J., & Brown, M.A. (1991). Vocational outcomes following psychosocial rehabilitation: A longitudinal study of three programs. *Journal of Vocational Rehabilitation*, 1(3), 21-29.

Zipple, A., Spaniol, L., & Rogers, E. S. (1990). Training mental health professionals to assist families of persons who are mentally ill. *Rehabilitation Psychology, 35*, 121-129.

Rogers, E. S., Anthony, W. A., & Danley, K. (1989). The impact of interagency collaboration on system and client outcome. *Rehabilitation Counseling Bulletin, 33*(2), 100-109.

Hursh, N., Rogers, E. S., & Anthony, W. A. (1988). Vocational evaluation with people who are psychiatrically disabled: Results of a national survey. *Vocational Evaluation and Work Adjustment Bulletin, 21*(4), 149-155.

Rogers, E. S., Anthony, W., & Jansen, M. (1988). Psychiatric rehabilitation as the preferred response to the needs of individuals with severe psychiatric disability. *Rehabilitation Psychology, 33*(1), 5-14.

Farkas, M. D., Rogers, E. S., & Thurer, S. (1987). Rehabilitation outcome for the recently deinstitutionalized psychiatric patient: The ones we left behind. *Hospital and Community Psychiatry*, *38*, 864-870.

Thurer, S., & Rogers, S. (1987). Perceptions of the mental health needs of the severely physically disabled. *Hospital and Community Psychiatry*, *38*(3) 282-286.

Rogers, E.S., Cohen, B.F., Danley, K.S, Hutchinson, D., & Anthony, W. A. (1986). Training mental health workers in psychiatric rehabilitation. *Schizophrenia Bulletin*, *12*, 709-719.

Rogers, S., Thurer, S., & Pelletier, R. (1986). The mental health needs of individuals with severe physical disability: The perspectives of rehabilitation administrators and rehabilitation counselors. *Rehabilitation Counseling Bulletin*, *29*, 240-250.

Pelletier, J., Rogers, S., & Thurer, S. (1985). The mental health needs of individuals with severe physical disability: A consumer advocate perspective. *Rehabilitation Literature*, *46*(7-8) 186-193.

Pelletier, J., Rogers, S., & Dellario, D. (1985). Barriers to the provision of mental health services to individuals with severe physical disabilities. *Journal of Counseling Psychology*, *32*(3) 422-430.

Davies, R. R., & Rogers, E. S. (1985). Social skills training with persons who are mentally retarded. *Mental Retardation*, *23*, 186-196.

Thurer, S., & Rogers, S. (1984). The mental health needs of physically disabled persons: Their perspective. *Rehabilitation Psychology*, *29*(4) 239-249.

Dellario, D. J., Anthony, W. A., & Rogers, E. S. (1983). Client-practitioner agreement in the assessment of severely psychiatrically disabled persons' functioning skills. *Rehabilitation Psychology*, *28*(4), 243-248.

Books and Book Chapters:

Rogers, E. S. & Delman, J. (2014). Research, Evaluation, and Evidence Based Practices. In P. Nemec & K. Furlong-Norman [Eds.]: *Best Practices in Psychiatric Rehabilitation.* McLean, VA: Psychiatric Rehabilitation Association.

Schultz, I & Rogers, E. S., (Eds.) (2011). *Handbook of Job Accommodation and Retention in Mental Health.* New York: Springer.

Rogers, E. S. & MacDonald Wilson, K., (2011). Vocational capacity of individuals with mental health disabilities. In: *Handbook of Job Accommodation and Retention in Mental Health*. I. Z. Schultz & E. S. Rogers, Eds. New York: Springer, pp.73-90.

Schultz, I. Z., Krupa, T., & Rogers, E. S. (2011). Towards best practices in accommodating and retaining persons with mental health disabilities at work: Answered and unanswered

questions. . In: *Handbook of Job Accommodation and Retention in Mental Health*. I. Z. Schultz & E. S. Rogers, Eds. New York: Springer, pp. 445-446.

MacDonald -Wilson, K., Russinova, Z., Rogers, E. S., Lin, C.H., Ferguson, T, Dong, S., & Kash MacDonald, M. (2011). Disclosure of mental health disabilities in the workplace. In: *Handbook of Job Accommodation and Retention in Mental Health*. I. Z. Schultz & E. S. Rogers, Eds. New York: Springer, pp. 191-218.

Rogers, E. S., & Farkas, M. (2008). Making the Grade: Identification of evidence-based communication messages (Chapter 12). In: J. Parker and E. Thorson (Eds.) Health Communication in the New Media Landscape. London: Springer. Pp. 325-340.

McCorkle, B., Rogers, E., Dunn, E., Wan, Y., & Lyass, A. (2005*). A Mixed Methods Study of the Benefits of Compeer Services.* In Compeer: Recovery Through the Healing Power of Friendship (B Skirboll, L. Bennett, and M. Klemens, Eds.) Meliora Press, an imprint of University of Rochester Press, pp. 157-161.

Rogers, E., Razzano, L., Rutkowski, D., & Courtenay, C. (2005). Vocational Rehabilitation Practices and Psychiatric Disability. In D. Dew & G. M. Allan (Eds.), *Report from the Study Group; 30th Institute on Rehabilitation Issues, Innovative Methods for Providing Services to Individuals with Psychiatric Disabilities*. Washington D.C.: Rehabilitation Services Administration, US Department of Education, pp. 49-79.

Rogers, E., Anthony, W., & Farkas, M. (2005). Recovery and evidence based practices. In C. Stout & R. Hayes (Eds.), *The evidence based practice: Methods, Models, and Tools for Mental Health Professionals.* New Jersey: John Wiley and Sons, Inc. pp.,199-219.

Russinova, Z., Wewiorski, N., Lyass, A., Rogers, E. S., & Massaro, J. M. (2005). Correlates of vocational recovery for persons with schizophrenia. In L. Davidson, C. Harding & L. Spaniol (Eds.), *Research on recovery from severe mental illnesses: 30 years of accumulating evidence and its implications for practice* (pp. 464-478). Boston, MA: Boston University, Center for Psychiatric Rehabilitation.

Danley, K., Rogers, E. S., & Nevas, D. (1989). A psychiatric rehabilitation approach to vocational rehabilitation. In M. D. Farkas & W. A. Anthony (Eds.), *Psychiatric Rehabilitation: Putting Concepts into Practice*. Johns Hopkins University Press.

Rogers, E. S., & MacDonald-Wilson, K. (1996). The vocational capacity of persons with psychiatric disorders. In: M. Glancy (Ed.). *Social Security Practice Guide*, Volume 4, Chapter 12. Matthew Bender & Co.

Power, P., & Rogers, E. S. (1978). Group counseling with multiple sclerosis patients. In R. Lasky, A. Dell Orto, & R. Marinelli (Eds.), *Group Counseling: A Rehabilitation and Health Care Perspective*. Scituate, MA: Duxbury Press.

Guest Editorships/Other Publications:

Rogers, E. S. & Swarbrick, P. (2016). Guest Co-Editors. Special issue on Peer Services. *Psychiatric Rehabilitation Journal.*

Johnston, M. Vanderheiden, G., Farkas, M, Rogers, E. S., Summers, J., & Westbrook, J. (2009). The Challenge of evidence in disability and rehabilitation research and practice: A position paper. Austin, TX: National Center for the Dissemination of Disability Research.

Rogers, E. S. (2003). Editor, Special Issue in Psychiatric Disability. *Journal of Vocational Rehabilitation.*

Rogers, E.S., Walsh, D., Danley, K.S., & Smith. (1991). *Massachusetts client preference assessment: Final report.* Boston, MA: Boston University, Center for Psychiatric Rehabilitation.

Rogers, E. S., Anthony, W., & Jansen, M. (1987). Editors, Special Issue on Psychiatric Rehabilitation. *Rehabilitation Psychology, 33*(l).

Rogers, E. S. (1980). The effects of structured experiential training on the psychosocial adjustment of severely disabled individuals. Boston University: Unpublished doctoral dissertation.

Research Instruments Developed:

Russinova, Z. Ellison, M. L. & Rogers, E. S. (2006). *Recovery Promoting Relationship Scale.* A 24-item instrument designed to measure the recovery promoting competencies and skills of mental health practitioners. Copyright, Trustees of Boston University. This instrument is being used in mental health programs nationally.

Sciarappa, K., & Rogers, E. S. (1997; Rogers et al., 2010). *Empowerment Scale*. A 28-item scale designed to measure construct of psychological empowerment. Copyright, Trustees of Boston University. The Empowerment Scale has been translated into Spanish, Italian, Dutch, Swedish and Japanese. It has been used in programs nationally and internationally, including mental health programs, federally funded studies, and by the Veterans Administration. Internationally, the Scale has been requested by the following countries for use: Switzerland, Italy, Japan, Thailand, the Philippines, the United Kingdom, Australia, the Netherlands, Scotland (for distribution through the National Health Service), Sweden (Hansson & Bjorkman, 2005), Pakistan, and Finland. The Empowerment Scale has been used in two multi-site, federally funded studies and is planned for use in a 20-country Pan European study that was conducted by King's College, Institute of Psychiatry in England.

Diksa, E. & Rogers, E. S. (1996). Survey of attitudes of employers towards individuals with mental illness. This instrument was developed to assess how employers view individuals with mental illness in a worker role as a means of determining how best to combat stigma in the workplace.

Rogers, E. S., Hursh N. C., Spaniol, L. J., Kielhofner, G., & Dellario, D. J. (1990). *Situational Assessment Tool.* A 35-item instrument designed to measure interpersonal skills and work adjustment skills of persons with psychiatric disability. Copyright, Trustees of Boston University. This instrument is being used in numerous vocational programs nationally as well as a currently funded NIH funded study on functional assessment.

Honors and Awards:

- 2015 Dincin Fellow by the Psychiatric Rehabilitation Association.
- First Place 2007 ARCA Research Award, American Rehabilitation Counseling Association, American Rehabilitation Counseling Association, for the following manuscript: A randomized clinical trial of vocation rehabilitation for people with psychiatric disabilities" published in the Rehabilitation Counseling Bulletin.
- Loeb Award, International Association of Psychosocial Rehabilitation Services, Award for Achievement in Research in Psychosocial Rehabilitation, 2000.
- Highest Scholastic Ranking of Graduates, Sargent College of Allied Health Professions, Boston University, 1981.
- Honorable Mention Research Award, American Association for Counseling and Development, ARCA Division, 1986.

Presentations to Professional Groups:

Rogers, E. Invited Speaker. Peer delivered services: State of the field and of the science. Telecare Annual Leader's Conference. Oakland CA, November 16, 2016.

Rogers, E. Discussant. Identifying the Benefits of Peer Support. National Institute of Mental Health 23rd Annual Mental Health Services Research Conference. Bethesda MD, August 1, 2016.

Cronise, R., Teixeira, C., Rogers, E. S., Harrington, S., & Bernstein, A. The Peer Specialist Workforce: Results of a National Survey. Presented at: the 17th Annual Summer Institute, Multisystem Approaches to Recovery and Resilience. Arizona State University Center for Applied Behavioral Health Policy, Sedona, Arizona, July 21, 2016.

Cronise, R., Teixeira, C., Rogers, E. S., Harrington, S., & Bernstein, A. The peer specialist workforce: results of a national survey. Presentation at the Psychiatric Rehabilitation Association National Conference, Boston MA, May 23, 2016.

Nicolellis, D., Teixeira, C., Russinova, Z., Rogers, E. S. & Rapp, J. Improving providers' competencies to promote vocational recovery among people with the lived experience of a

psychiatric condition. Presentation at the Psychiatric Rehabilitation Association National Conference, Boston MA, May 25, 2016.

Gordon, C., Arcure, K., Gidugu, V., & Rogers, E. S. Open Dialogue: A Recovery-Oriented Practice-The Collaborative Pathway. Presentation at the Psychiatric Rehabilitation Association National Conference, Boston MA, May 25, 2016.

Rogers, E. S. & Millner, U. Assessing the work functioning of individuals with psychiatric disabilities: Preliminary results from the validity studies of the Functional Assessment Battery. Presentation at the NARRTC national conference, Alexandria, VA, May 5, 2016.

Rogers, E. S. Webinar on Recovery Outcomes. Substance Abuse and Mental Health Services Administration BRSS TACS Policy Academy, March 21, 2016.

Millner, U.C., Russinova, Z., & Rogers, E.S. Taking steps: Understanding community as defined by individuals with psychiatric disabilities. Paper presented at the American Psychological Association Annual Convention, Toronto, Canada, August 6, 2015).

Teixeira, C., Russinova, Z., & Rogers, E. S. Providers' Competencies to Facilitate Vocational Recovery and Employment Outcomes. Presentation as part of the Symposium "Promising Approaches Promoting the Employment of Individuals with Serious Mental Illnesses" at the American Psychological Association Annual Convention, Toronto, Canada, August 6, 2015.

Rogers, E. S., Russinova, Millner, U. Gidugu, V., & Maru, M. Vocational recovery. Presentation at the University of Massachusetts Medical School Transitions Research and Training Center. Worcester, MA, June 18, 2015.

Rogers, E. S. & Maru, M. Vocational Peer Support: Findings from our randomized clinical trial. Recovery Innovations, Phoenix, AZ. May 28, 2015.

Rogers, E. S. Invited Presentation. Peer support research. The 2015 Bringing Recovery Supports to Scale Policy Academy Webinar, May 5, 2015.

Rogers, E. S. Russinova, Z., Maru, M., Nicolellis, D., Bloch, P. & Teixeira, C. Promising peer delivered practices designed to support vocational exploration and recovery. Presentation at the Annual Psychiatric Rehabilitation Association Meeting, Philadelphia, PA., June 2, 2015.

Rogers, E. S. & Maru, M. (2015). Peer delivered services: State of the art and state of the science. Presentation at NARRTC National Conference, Alexandria, VA, May 1, 2015.

Rogers, E. S., Millner, U. & Maru, M. Assessing the work functioning of individuals with psychiatric disabilities: Preliminary results from the validity studies of the Functional Assessment Battery. Presentation at the Health and Disability Institute, School of Public Health, Boston, MA., March 25, 2015.

Rogers, E. S. Invited presenter. Randomized trial of an integrated health and mental healthcare intervention. Podcast. http://

http://www.cmhsrp.uic.edu/health/summit14/documents/Improving%20Health%20and%20Well-Being%20for%20Adults%20in%20Public%20Mental%20Health%20Systems_S%20Rogers.mp3. Summit on Integrated Health Care, University of Illinois at Chicago RRTC. October, 16-17, 2014.

Rogers, E. S. Invited Speaker. Vocational Recovery Initiatives. Bedford Veteran Administration Grand Rounds, Bedford, MA., June 10, 2014.

Rogers, E. S. Invited speaker. Supported education for adults with psychiatric disabilities. Transitions RRTC State of the Sciences Conference, Washington, DC, September 24, 2013.

Rogers, E. S. Invited Speaker. Peer support services: State-of-the-Art. San Francisco Veterans' Administration Grand Rounds, San Francisco, CA, September 6, 2013.

Millner, U.C., Rogers, E.S., Bloch, P., Costa, W., Pritchard, S. & Woods, T. Connecting worlds: Exploring the meaning of work for adults with mental illness from a vocational psychology perspective. Poster presented at the 121st annual convention organized by the American Psychological Association, Honolulu, Hawaii, August 1, 2013.

Rogers, E. S. (2012). Invited Plenary Speaker. National Mental Health America National Conference: From Housing to Recovery, Tools to Support True Social Inclusion and Community Integration, Research on Supported Housing, Peer Support and Supported Education, Tulsa, OK, September 21, 2012.

Rogers, E. S. (2012). Peer delivered services: state of the art and the science. 11th World Congress, World Association of Psychosocial Rehabilitation, Milan Italy, November 11, 2012.

Rogers, E. S. (2012). Invited Presenter. Comparative Effectiveness Research and Mental Health. New Frontiers in disability-related Comparative Effectiveness Research, a conference sponsored by the Agency for Healthcare Quality and Research, Boston University, Boston, MA, June 22, 2012.

Farkas, M. & Rogers, E. S. (2012). Knowledge transfer process for systematic reviews: Grading research quality for stakeholder organizations. Presentation at NARRTC Conference, Alexandria, VA, April 27, 2012.

Rogers, E. S. Maru, M., Cohee, J., Hinkel, J., Effectiveness of peer delivered services for individuals completing a civil commitment. Presentation at the 36th Annual USPRA Conference, Boston, June 13, 2011.

Restrepo-Toro, M., Russinova, Z., Rogers, E.S., Maru, M., Diaz, L. (2011). Fostering therapeutic alliances using feedback from services recipients. Poster Session at the 36th Annual USPRA Conference, Boston, June 14, 2011.

Rogers, E. S., Gidugu, V., Bloch, P. (2011). Improving the Infrastructure of Employment Systems through Interagency Collaboration: Lessons from the New England State Medicaid Infrastructure Grants. Presentation at NARRTC Conference, Alexandria, VA, April 27, 2011.

Rogers, E. S., Boardman, J., Mesidor, M & Maru, M. Evaluation of a health access and integration intervention. Presented at the 35th USPRA Annual Conference: Expanding the Horizon of Psychiatric Rehabilitation. Boise, ID. June 14, 2010.

Ashcraft, L., Russinova, Z. & Rogers, E. Recovery Promoting Relationship Scale. Institute #4. Presented at the 35th USPRA Annual Conference: Expanding the Horizon of Psychiatric Rehabilitation. Boise, ID. June 16, 2010.

Rogers, E. S. & Huber, M. Recruitment and retention in disability research. Presentation to the NARRTC Annual Conference. Alexandria, VA, May 3, 2010.

Rogers, E. S. & Russinova, Z. Hope as an essential ingredient of recovery-promoting competencies for practitioners. Invited presentation. Bethesda, MD: SAMHSA Innovations Conference, April 30, 2009.

Rogers, E. S., Boardman, J., & MacDonald-Kash, M. Evaluation of a health access and integration intervention. Presented at the National Association of State Mental Health Program Directors Research Institute 19th Annual Conference on Integrated Healthcare Washington, DC. April 15, 2009.

Russinova, Z., Rogers, E., and Restrepo-Toro, M. Measuring recovery promoting competencies for English and Spanish speaking mental health populations. From Innovations to Practice: The promise and challenge of achieving recovery for all. Center for Psychiatric Rehabilitation Conference, Cambridge, MA, April 14, 2008.

Campbell, J., Teague, G., Rogers, E. S., Lyass, A. Consumer-Operated Service Programs Results. From Innovations to Practice: The promise and challenge of achieving recovery for all. Center for Psychiatric Rehabilitation Conference, Cambridge, MA, April 14, 2008.

Rogers, E. S. Disability Measurement and Disparities Research. National Association of Research and Training Centers, 30th Annual Conference, Washington DC, April 21, 2008.

Rogers, E. S. Identification of evidence based communication messages. Invited presentation at the University of Missouri Research and Training Center State-of-the-Science Conference entitled *Health Communication in the New Media Landscape*. Columbia Missouri, June 19, 2007.

Rogers, E. S. Empirical evidence of the physical health problems for individuals with severe mental illness**.** Presentation at *The Challenge of Promoting Health in Persons with Serious and Persistent Mental Illness*, a joint conference of the Boston University School of Medicine and the Center for Psychiatric Rehabilitation, Cambridge, Massachusetts, March 31, 2007.

Rogers, E. S. The broader landscape of rehabilitation and recovery. Grand Rounds presentation to the Departments of Psychiatry, Social Work and Psychology, Desert Vista Psychiatric Hospital, Phoenix, Arizona, February 15, 2007.

Rogers, E. S. Invited Speaker. Implementation and evaluation of a combined supported education and employment computer training program for persons with psychiatric disabilities. Presentation at the UPENN Collaborative on Community Integration and the National State of the Knowledge Conference on Increasing Community Integration of Individuals with Psychiatric Disabilities, Philadelphia, PA, September 20, 2006.

Rogers, E. S. Invited Speaker. The power of the relationship in promoting recovery: Measuring our impact. New York Association for Psychosocial Rehabilitation Services, September 27, 2006.

Rogers, E. S. Invited Speaker. How to Plan and Conduct a Program Evaluation. New York Association for Psychosocial Rehabilitation Services, September 28, 2006.

Bowers, A., Rogers, E. S., Dunn, E. & Wan, Y. A process and outcome evaluation of an innovative model of service delivery. Presentation at the Annual National USPRA Conference, Phoenix, AZ, June 6, 2006.

Rogers, E. S. Presentation on Participatory Action Research. National Association of Research and Training Centers, 28th Annual Conference, Washington DC, April 27, 2006.

Rogers, E. S. Invited Speaker. The broader landscape of rehabilitation and recovery. 10th Annual Conference: Neuro-cognitive Function, Treatment and Outcome in Schizophrenia: From science to Practice. Harvard Medical School, Department of Continuing Education and Department of Psychiatry at the Massachusetts Mental Health Center and Beth Israel Deaconess Medical Center. Fairmont Copley Plaza Hotel, Boston Massachusetts. April 8, 2006.

Rogers, E. S. Invited Speaker. Predictors of vocational rehabilitation among individuals with serious psychiatric disability. National Organization of Social Security Claimants' Representatives, Social Security Disability Conference. Boston Marriott Copley Place, Boston, Massachusetts, April 5, 2006.

Rogers, E. S. Invited Speaker. Recovery-Oriented Rehabilitation. Research Grand Rounds, Massachusetts Mental Health Center, Shattuck Hospital, Boston, MA, February 16, 2006.

Russinova, Z., Rogers, E. S., && Ellison, M. Conceptualization and assessment of mental health practitioners' recovery promoting competence. National Association of State Mental Health Program Directors, 16th Annual Conference, Baltimore, MD, February 12-14, 2006.

Rogers, E. S. Invited Speaker. Using large databases to examine outcomes for individuals with psychiatric disabilities. Panel Presentation for: Visioning an Institute on Disability and Education. University of Memphis, June 29, 2005.

Rogers, E. S., Wan, Y. M., Dunn, E., McCorkle, B. Increasing social support for individuals with serious mental illness: Results of a social, adjunctive intervention. 18th Annual National Institute of Mental Health Conference on Mental Health Services Research NIMH Conference on Mental Health Services Research, Bethesda, MD, July 19, 2005.

Rogers, E. S. Invited Speaker. Recovery oriented services. Presentation to the Mental Health and Disability Annual Conference of the Disability Statistics Center, Washington, DC, October 28th, 2002.

Rogers, E. S. & DeForest, K. Lessons learned from the SAMHSA consumer operated study. Center for Psychiatric Rehabilitation International Innovations Conference, Boston, MA, October 25th, 2002.

Mowbray, C. & Rogers, E. S. New advances in rehabilitation research. Center for Psychiatric Rehabilitation International Innovations Conference. October 25th, 2002, Boston, MA.

Rogers, E. S. Participatory Action Research. National Association of Research and Training Centers, Annual Conference, Washington DC, April, 2001.

Rogers, E. S. A randomized controlled study of psychiatric vocational rehabilitation. Presentation at the 4th biennial research seminar on work. Matrix Research and Training Center, Philadelphia, PA, October 12, 2000.

Rogers, E.S. Program Evaluation Institute. Presentation at the IAPSRS national conference, Washington, DC, May 2000.

Rogers, E.S. Psychiatric Rehabilitation. Invited presentation to a county-wide mental health conference, San Diego, CA, November 1999.

Rogers, E.S. Study of Consumer Operated Services. Presentation to the statewide mental health providers, Des Moines, IA, October 1999.

Rogers, E. S. Theory and practice of psychosocial rehabilitation: Critical reflections. Guest lecture at the Universidad International Mendez Pelayo, Valencia, Spain, June 1999.

Rogers, E. S. Round table presentation on current and future trends in psychosocial rehabilitation of persons with chronic mental illness at the Universidad International Mendez Pelayo, Valencia, Spain, June 1999.

Rogers, E.S. Program Evaluation. Presented at the IAPSRS National Conference, Orlando, FL, June 14, 1998.

Rogers, E.S. Developing an Outcome Management System: A two-day CARF workshop. Boston University, Sargent College of Health and Rehabilitation Sciences, Boston, MA., June 24-25, 1998.

Rogers, E.S. Psychiatric Rehabilitation. Invited presenter at a national conference entitled: "Facilitating Careers for Mental Health Consumers" Chicago, IL, April 13, 1998.

Rogers, E.S. Trends in psychiatric rehabilitation. Invited presentation at the National Association of Research and Training Center Directors. Washington, D.C., April 27, 1998.

Rogers, E.S. Psychiatric rehabilitation research. Presentation to the National Institute on Disability and Rehabilitation Research. Bethesda, MD, October 17, 1997.

Rogers, E.S. How to conduct program evaluation. Albert Treischman Center Annual Conference, Hyatt Regency Hotel, Cambridge, MA, March 20, 1997.

Rogers, E. S. How to develop a program evaluation initiative in your organization. Presented to the Massachusetts Council of Human Science Providers, Boston, MA, October 8, 1996.

Rogers, E. S. Advanced Research Institute. Presented at the IAPSRS National Conference, Detroit, MI, June 18, 1996.

Rogers, E. S. Outcome Research Round table. Presented at the World Association of Psychosocial Rehabilitation, Rotterdam, The Netherlands, April, 23, 1996.

Rogers, E. S. Vocational outcome research: Findings and implications for further research. Presented at the Boston University, Center for Psychiatric Rehabilitation Research Colloquium, Boston, MA, April 17, 1996.

Rogers, E. S. Measuring the cost effectiveness of vocational programs: Cost benefit analysis of vocational programs for persons with mental illness. Invited presentation at the First Annual National Research Seminar on Vocational Rehabilitation and Mental Illness, Matrix Research Institute, Philadelphia, PA, October 6, 1994.

Rogers, E. S. Models and strategies for training rehabilitation researchers. Invited presentation to the National Association of Research and Training Centers. Washington, D.C., April 25, 1993.

Rogers, E. S. Consumer involvement in research. Invited presentation to the Mental Health Research Study Group, Maine Department of Mental Health. Portland, ME, March 26, 1992.

Rogers, E. S. Impact of the Americans with Disability Act upon research in psychiatric rehabilitation. Invited address to the 1991 National Council on Disability, Forum of the Americans with Disabilities Act: New Orleans, LA, October 24, 1991.

Rogers, E. S., Sciarappa, K., Hutchinson, D., Barclay, K. Research on psychiatric rehabilitation: What have we learned and how can we use it? Presented at the 1991 Conference on Psychiatric Rehabilitation, Boston, MA, June 4, 1991.

Rogers, E. S., Anthony, W. A., & Cohen, M. C. Prediction of vocational outcomes based on clinical and demographic indicators. Presented at the 98th Annual American Psychological Association Convention, Boston, MA, August 12, 1990.

Nemec, P. N., Rogers, E. S., Mynks, D., Taylor, D., & Brown, M. E. Incorporating Psychiatric Rehabilitation into a clubhouse. Presented at the Third Annual National Psychiatric Rehabilitation Conference, Boston, MA, November 15, 1988.

Rogers, E. S., McNamara, S., & MacDonald-Wilson, K. Direct Skills Teaching in a community residence. Presented at the Third Annual National Psychiatric Rehabilitation Conference, Boston, MA, November 16, 1988.

Rogers, E. S. Predicting vocational outcomes in clients with psychiatric disability. Presented at the annual meeting of the National Association of Disability Examiners, Boston, November 2, 1988.

Rogers, E. S., Tower, C., & Butler, A. Situational assessment: the best method of vocational assessment. Presented at the 2nd Annual National Psychiatric Rehabilitation Conference, Boston, MA, November, 1987.

Rogers, E. S., Selden, D., & Butler, A. Situational assessment of work skills in the severely psychiatrically disabled. Presented at the 95th annual meeting of the American Psychological Association, New York City, September 1, 1987.

Rogers, E. S. Predicting the vocational capacity of mentally impaired claimants. Presented at the 16th Annual National Organization of Social Security Claimants Representatives Conference, Washington, D.C., June 18, 1987.

Thurer, S., & Rogers, E. S. Mental health needs of the severely physically disabled. Presented at the 94th annual meeting of the American Psychological Association, Washington, D.C., August 22, 1986.

Thurer, S., Farkas, M. D., & Rogers, E. S. Chronic mental patients after deinstitutionalization: Trends in living independence and vocational status. Presented at the 91st meeting of the American Psychological Association, Anaheim, CA, August 27, 1983.

Dellario, D., Farkas, M., & Rogers, E. S. Long term follow-up of psychiatrically disabled clients: A client function reference approach. Presented to the 60th annual meeting of the American Orthopsychiatric Association, Boston, MA, April 7, 1983.

Mentoring Activities

Post Doctoral Fellowship Grant

Between 1991 and 2001, I was Principal Investigator of the Advanced Rehabilitation Research Training Grant awarded by the National Institute on Disability and Rehabilitation Research. In

that role, I mentored approximately 15 post doctoral fellows. Included in that group was Dr. Zlatka Russinova who is currently a Senior Research Associate at the Center and Co-Principal Investigator (with me) on a Field Initiated award in 2006 by NIDRR. In addition, Dr. Nancy Wewiorski, a post-doctoral fellow, was a Research Associate at the Center for 4 years and is currently a researcher at the National Center on Homeless Families and Dr. David Webster, recipient of the Dudley Allen Sargent Award in 2006. A more recent post doctoral fellow, Dr. Uma Millner, was hired as a Research Specialist at the Center. A current fellow whom I mentor, Dr. Carina Teixeira, was awarded Dudley Allen Sargent College Research Fund in 2014.

Doctoral Dissertations Supervised - Member of Committee - Reader:

Year	Student Name	Dissertation Title	College
2013	Sara Feng Hang Cheng	Community participation among people who are homeless	College of Health and Rehabilitation Sciences: Sargent
2013	Dara Chan	Measuring community integration using geographic information systems (GIS) and participatory mapping techniques for people with disabilities who were once homeless	College of Health and Rehabilitation Sciences: Sargent
2012	Elizabeth Barfield Marfeo	Exploring mental health work related disability	Boston University School of Public Health
2005	Kim MacDonald Wilson	Feasibility of a self-report Interview of mental functions in the ICF: Cognitive interviewing with persons with work disabilities due to psychiatric conditions	College of Health and Rehabilitation Sciences: Sargent
2004	Amy Porter	Characteristics, Experiences and Earnings of Early Enrollees in Connecticut's Medicaid Buy-In Program	College of Health and Rehabilitation Sciences: Sargent
2000	Tom Puccio	Decision-making processes and factors in Catholic high school selection	Johnson & Wales University
1999	Anne Sullivan	A survey of binge eating disorders in overweight women with psychiatric disability	College of Health and Rehabilitation Sciences: Sargent
1998	Kim Gray	Analysis of seven factors to predict source use of persons with severe psychiatric disability	College of Health and Rehabilitation Sciences: Sargent

1997	Gerald Carmody	A study of teacher-student interaction patterns in the class	Boston University, School of Education
1996	Tom McCarthy	Use of a rehabilitation introduction group in MRC	College of Health and Rehabilitation Sciences: Sargent
1994	Edward Diksa	Employer attitudes toward hiring persons with psychiatric disability	College of Health and Rehabilitation Sciences: Sargent
1990	Rita Lossee	Variables related to weight loss maintenance	College of Health and Rehabilitation Sciences: Sargent
1986	Steven Spangler	Treatment outcome of patients in a comprehensive pain program: Influence of hopelessness and depression	College of Health and Rehabilitation Sciences: Sargent

Peer Review:

2015	Peer review of the scientific research application for the Workers Compensation Board of Manitoba's Research and Workplace Innovation Program (RWIP). The RWIP promotes and funds workplace innovation, scientific research, training and education, and knowledge transfer projects related to the prevention of occupational injuries and illnesses and the treatment and safe return-to-work of injured and ill workers.
2013	ZonMW-Dutch Applied Research program grant reviewer for “Societal participation with Boston Psychiatric Rehabilitation for patients with severe mental illness: a cost effectiveness study.
2012	Health Research Board, Dublin Ireland. Review of proposal entitled: “Does early detection and treatment of psychosis improve employment outcomes?” Niall Turner, PI
2004	Rutgers University, College of Medicine and Dentistry, Peer Review of proposal on supported employment
2004	New Zealand Mental Health Council proposal on rehabilitation and recovery of individuals with severe mental illness
2002	National Institute of Mental Health, Special Emphasis Panel on Developing Centers
1994	Veteran's Administration, Chicago, Illinois. Peer Review of proposal entitled: Treatment Outcomes in Alcoholics with Cognitive Impairment.

1989, 1991, 1993	National Institute on Disability and Rehabilitation Research. Served as peer reviewer for research grants.

Journal Reviewer:

1988-present	*Psychiatric Rehabilitation Journal*
1988-2004	Guest Research Column Editor, *Community Support Network News*
2002-present	*Journal of Vocational Rehabilitation*
2002-2003	Ad Hoc Reviewer, *Mental Health Services*
2002-2004	American Psychological Association, Publications Division
2003	Ad Hoc Reviewer *Journal of Rehabilitation Research and Development*
2004-present	Ad Hoc Reviewer *Schizophrenia Bulletin, Community Mental Health Journal* and *Journal of Nervous and Mental Disease, Social Psychiatry and Psychiatric Epidemiology, Psychiatric Services, Schizophrenia Research, Clinical Schizophrenia* and Related Psychosis, *Journal of Emotional and Behavioral Disorder, Journal of Mental Health*

Research Consultancies:

2015-preent	US Department of Justice, Evaluation Consultant for class action lawsuits involving individuals with disabilities.
2005-present	Center for Public Representation, Northhampton, MA. Evaluation consultant on the landmark Rosie D. class action lawsuit for children's mental health; on the New Hampshire class action lawsuit for adult mental health and on an Oregon class action lawsuit on employment services for individuals with developmental disabilities.
1985-2005	Adcare Hospital, Worcester, MA. Consultation to Dr. Patrice Muchowski to develop patient follow-up questionnaires and to analyze and interpret survey data.
1993 – 94/2000-05	State of Florida, Department of Children's and Families class action, Johnson v. Regier lawsuit for the treatment of individuals with severe mental illness in a state hospital and the development and execution of an audit protocol.
2000-2001	Logan Airport Safety Project. Evaluation Consultant to work team designed to improve air safety at Logan Airport.

2001 - 2005	Urban Institute, Washington DC. Research design consultant on a Social Security projects on the return to work of people with disabilities.
1997-1998	Work Family Directions. Consultant to design and validate a workplace survey
1994 - 1996	Dare Family Services, Inc. Consultation to develop a management information system to evaluate client outcomes.
1994 - 2000	Longwood Treatment Facility. Consultation to develop a program evaluation/MIS system to evaluate outcomes of program.
1993/1995	Massachusetts Rehabilitation Commission, Psychiatric Rehabilitation Training Program. Analysis of trainee knowledge and skills in psychiatric rehabilitation.
1992	Fairlawn Rehabilitation Hospital, Worcester, MA. Research consultant on Robert Wood Johnson Foundation Grant to develop a functional assessment instrument for out-patient rehabilitation settings.
1991 - 1995	Center for the Study of Communication and Deafness, School of Education, Boston University, Boston, MA. Consultation to Professor Robert Hoffmeister on analyses of tests designed to measure language among deaf children.
1990 - 1992	Barbara Nicholson, Ph.D., Professor of Social Work, Boston College, Boston, MA. Consultation to Dr. Nicholson who is a National Institute of Mental Health Faculty Scholar performing original survey research on the psychological and social adjustment of Southeast Asians.
1986 - 1994	Possibilities, Inc., Basking Ridge, NJ. Consultation on analysis of employee satisfaction surveys to this organizational development firm.
1986 - 1987	Massachusetts Mental Health Center, Developmental Disabilities Unit, Boston, NM. Consultation to Dr. Linda Isaacs and Dr. Rhoda Goodwin on a study of family adaptation and functioning among children with developmental disabilities.
1985 - 1986	Occupational Therapy Department, Sargent College, Boston University, Boston, MA. Consultation to Professor Gary Kielhofner regarding reliability and validity studies of a functional assessment instrument.
1984	Brockton Office of the Massachusetts Rehabilitation Commission, Brockton, MA. Consultant on staff development.

Research Consultancies to Doctoral, Masters' and Bachelors' Students:

2006	Consensus panel on meaning of empowerment for older adults with psychiatric disabilities, Jose Lopez, St Charles Hospital, London
1994	MaryBeth Pappas Gaines, M.A. candidate in education, University of Vermont. Thesis title: *Health Promotion, Environment and Social Cognitive Perception: A Study of the Relationships Among Self-Efficacy, Corporate Culture and Health Behavior change.*
1993	Eric Green, B.A. candidate in psychology, St. Anselm's College, Manchester, New Hampshire. Thesis title: *Effect of a Short-term Exercise Intervention in Anxiety Among College Students.*
1993	Deborah Dutton, Ph.D. candidate in psychology, University of Rhode Island. Dissertation title: *Effect of a Short-term Educational Intervention in Gender Stereotyping.*
1993	David Kalman, Ph.D. Candidate in Social Work, Simmons College, Boston, MA. Dissertation title: *Prediction of Alcoholic and Drug Abuse Among Adolescents.*
1992	Robert Hammaker, Ed.D. Candidate in Educational Leadership, School of Education, Boston University. Dissertation Title: *Assessing Mental Health Consumer Needs in Alaska.*
1991	Marguerite Franca-Terceira Psy.D. Candidate in Psychology, Rutgers University. Dissertation Title: *Fee Setting for Low-Income Clients: Decision Making Processes of Psychologists in Private Practice.*
1991	Lisa Gutkowski, M.S. Candidate in Occupational Therapy, University of Illinois at Chicago. Dissertation Title: *Assessing the Reliability of the Occupational Performance History Interview.*
1990	Michael Lavoie, Ph.D. Candidate in Psychology, California School of Professional Psychology. Dissertation Title: *Social Adjustment Among Traumatically Brain Injured.*
1990	Marge Terrafranca, Psy.D. Candidate in Psychology, Rutgers University. *Survey of the Private Practice of Psychologists.*
1987	Rodney Dismukes, Ph.D. Candidate in Psychology at Auburn University. Dissertation Title: *Relationship Between Social Support Systems and Outcomes of Brief Psychiatric Hospitalization.*
1986	Mary MacNamee, Ed.D. Candidate in Counseling Psychology at Columbia University, Teachers College. Dissertation Title: *Deaf and Hearing Persons Perceptions and Evaluation of Interpersonal Behavior in the American Deaf Culture.*

1986	Barbara Middleton, M.S. Candidate in Occupational Therapy, Boston University. Thesis Title: *Role Identity and Burnout Among Psychosocial Occupational Therapists*.

Committees, Board of Directors, and Related Professional Duties:

2011	Advisory Board, University of New Hampshire, Institute on Disability
2010	Dr. Steven Haley and Dr. Alan Jette Social Security Disability Determination Re-Design project
2009	Advisory Board, Center for Public Mental Health Research, Boston Medical School Department of Psychiatry
2006-present	Board of Directors, Adcare Educational Institute, Worcester, MA. Adcare Educational Institute is a non-profit entity devoted to enhancing educational and training experiences for professionals in the substance abuse field.
2006	Expert Panel on defining health and wellness for individuals with disabilities for the RRTC on Disability and Wellness at the Oregon Institute on Disability and Development.
2004-present	Advisory Council-University of Pennsylvania Research and Training Center.
2003-2004	Federal Rehabilitation Services Administration; IRI Conference-Invited Scholar
2001-present	President Elect, President and Past President, Member at Large, National Association of Rehabilitation Research and Training Centers
2000	Program Planning Committee, National Association of Rehabilitation Research and Training Centers for NARRTC 2000 Conference
1996-1998	Co-Chair, Research Committee, International Association of Psychosocial Rehabilitation Services
1994	Boston University, Sargent College, Human Subjects Committee
1994-2001	Research Committee, International Association of Psychosocial Rehabilitation Services

1988-2002; 2007-present Board of Directors, Adcare Educational Institute, Worcester, MA. Adcare Educational Institute is a non-profit entity devoted to enhancing

	educational and training experiences for professionals in the substance abuse field.
1990 - 1992	Research Committee, National Association of Research and Training Centers
1988-1999	*Community Support Network News*, Guest Research Column Editor

Other Committees:

Dudley Allan Sargent College of Health and Rehabilitation Science Research Awards; Sargent College of Health and Rehabilitation Sciences Strategic Planning Committee.

Appendix 2

Steward v. Smith
Case No. 5:10-cv-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

SAMPLING REPORT OF DR. E. SALLY ROGERS
Appendix 2

	Document	Bates No.
1.	Kathryn Dupree 2015 Annual Report of Compliance	DefE-00000601-672
2.	Kathryn Dupree Q1 2016 QSR	DefE-00000677-716
3.	QSR Matrix	PL00000060-136
4.	PIRM Sample Pool List	

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lillian Minor, *et al.*,

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

Case No. SA-5:10-CV-1025-OG

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

DECLARATION AND EXPERT DISCLOSURE OF VICKEY V. COLEMAN, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTTION

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B), that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case.

1. My report, which is attached, contains a complete statement of all of my opinions as well as an explanation of the basis and reasons for those opinions.
2. My report describes the facts, data and other information I considered in forming my opinions.
3. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.
4. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.
5. Within the last four (4) years, I have not testified as an expert, either in a deposition or at trial.
6. I have been retained by the Plaintiffs and the United States as a joint expert in the *Steward v. Smith* litigation. My compensation in this litigation is $150.00 per hour for my review, preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated:

Vickey V. Coleman 3/29/17
Vickey V. Coleman, Ph.D.

Exhibit A

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

PRE-ADMISSION SCREENING AND RESIDENT REVIEW SPECIALIZED SERVICES AND ACTIVE TREATMENT REPORT OF VICKEY V. COLEMAN, Ph.D.

I. PURPOSE/SCOPE

This report sets forth the findings of my review of a sample of individuals with intellectual and/or developmental disabilities (IDD) who reside in nursing facilities in Texas. The purpose of this review was to examine the effectiveness of the Pre-admission Screening and Resident Review (PASRR) process and the delivery of specialized services and active treatment for these individuals. The areas that I evaluated included: whether the individual received a comprehensive assessment and integrated service plan for habilitative needs; whether the individual receives all necessary specialized services; whether the individual receives a program of active treatment; and whether the individual is suffering any harm.

II. EXPERIENCE

I have more than 25 years of experience in the disability field, particularly working with individuals who have dual diagnoses of IDD coupled with mental illness. I am currently the State Director of the Office of Civil Rights and Customer-Focused Services for the Tennessee Department of Intellectual and Developmental Disabilities.

I have more than 10 years of experience conducting quality assurance reviews and protection from harm reviews for individuals with IDD in nursing facilities and other types of facilities. Although I have a diverse array of experience working with the IDD population, my experience specific to nursing facilities includes conducting quality assurance reviews of supports and services to persons at risk of admission to nursing facilities; overseeing the federal court-mandated Needs Assessment Process to match services with the actual needs of individuals with IDD in nursing facilities; facilitating the transition of individuals with IDD out of intermediate care facilities and nursing facilities; and monitoring the quality of supports for individuals with IDD who transitioned out of nursing facilities.

I have served as the senior associate to the federal court monitor in *United States v. Tennessee*, a class action case involving the Arlington Developmental Center. In this capacity, I conducted compliance reviews of hundreds of individuals with IDD residing in nursing facilities. In addition, I have conducted many reviews of individuals with IDD residing in state-operated and private Intermediate Care Facilities as well as individuals residing in community-based settings.

I also served as a Protection from Harm consultant for the United States Department of Justice for people with IDD and mental health challenges residing in nursing facilities and psychiatric facilities.

My curriculum vitae is attached as Appendix 1.

III. MATERIALS REVIEWED

It is my understanding that Disability Rights Texas (DRT) requested the nursing facility records and LIDDA service coordination and case management records for the sample of individuals with IDD in nursing facilities that I reviewed. Documents that were timely received by DRT in response to the records requests were uploaded into a HIPAA-compliant database.

I read the nursing facility and LIDDA case management records that were provided to me, as well as additional nursing facility records that I reviewed during my on-site visits for each individual. I also reviewed background documents concerning federal PASRR regulations and guidance, as well as Texas regulations and policies related to PASRR. Then I read information from relevant portions of Quality Service Reviews (QSRs) in 2015-16 that addressed the provision of specialized services for the individuals that I reviewed. A complete list of all the documents I reviewed is attached as Appendix 2.

IV. METHODOLOGY

It is my understanding that a research expert drew a random sample of individuals with IDD in nursing facilities who had been reviewed in 2015-2016 by Kathryn Dupree, the Expert Reviewer under the former Interim Agreement in this case who is now a consultant to DADS. I further understand that DRT contacted all individuals in the sample to obtain their consent to participate in the review, as well as to release their records from their nursing facility, LIDDA, and the State.

I conducted this review in conjunction with another expert, Barbara Pilarcik, R.N., who reviewed other individuals in the sample. I was asked to review 10 individual clients in eight (8) different nursing facilities in the Dallas, Waco, and East Texas areas. The individual reviews primarily focused on evaluating five key areas: assessments and service planning, specialized services, active treatment, staff training, and harm. To better assess these areas in a consistent manner, Ms. Pilarcik created a list of probes to guide the review process, based in part on an active treatment instrument used by a court-appointed monitor that was used in *Rolland v. Patrick* and that was adapted to the Texas PASRR system. We used the probes to ensure that our reviews, conducted separately, examined the same issues and applied the same criteria, based on the relevant federal and state standards, so that our findings could be aggregated across the sample.

For purposes of this review, supports and services were reviewed for each individual for a 2-year period (November 2014 – December 2016). My onsite reviews were conducted from February 6, 2017 to February 9, 2017. Using a person-centered approach to best inform my reviews, I examined multiple sources of information, including reviewing two (2) sets of clinical records (nursing facility and LIDDA), directly observing the nursing facility program, and interviewing the individual, any family member or guardian, where available, the LIDDA service coordinator, and the nursing facility staff who knew the person best. I saw all 10 individuals, but three were unable to communicate. Nevertheless, I met with others who knew these three individuals, and I reviewed all the available documentation.

After I conducted the onsite reviews, reviewed the relevant records, and formulated my opinions, I reviewed the QSR reports from Texas' consultants regarding the individuals that I visited. I considered the findings of those prior evaluations that were conducted in 2015-16, keeping in mind that the individual's needs and conditions may have changed, and that I did not apply the same evaluation criteria as the QSR. I completed a summary of my observations and findings concerning each individual's services and supports, which are set forth in Section VII of this report.

V. STANDARDS FOR ASSESSING PASRR AND SPECIALIZED SERVICES

In determining the adequacy of the PASRR evaluations, assessments and service planning, specialized services, and program of active treatment for each of the 10 individuals that I reviewed, I relied upon several standards. First and foremost, I used the federal and Texas PASRR rules, policies, and guidance issued by the federal Center for Medicare and Medicaid Services (CMS) and Texas Department of Aging and Disability Services (DADS) for PASRR Level I and Level II PASRR Evaluations. PASRR Level I screenings are completed for all individuals referred for admission to nursing facilities to determine if the individual may have an intellectual disability (ID) prior to age of 18 and/or a developmental disability (DD) prior to the age of 22. With some limited exceptions, a PASRR Level I identifying a suspected intellectual or developmental disability triggers completion of a PASRR Evaluation. A PASRR Evaluation confirms whether the individual has ID or DD, and if so, should assess among other things whether the needs of the individual can be met in the community and identify the specialized services the person needs if s/he is admitted to a nursing facility. According to federal regulations, the determination of the need for specialized services must be based upon an assessment of the individual's needs in each of 15 habilitation areas.

In addition, to determine exactly which specialized services are needed, as well as to determine the amount, duration, and scope of specialized services – like any other habilitative service or support – there must be a CFA or similar assessment. A CFA is the accepted, professional approach to determining service needs for individuals with IDD. The CFA should include, among other things, assessments of the individual's needs related to medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, inclusion, and involvement and integrated day activity needs. The CFA, in

combination with the PASRR Evaluation, should identify all habilitative as well as rehabilitative services needed by the individual to deliver a program of active treatment. It also facilitates effective communication and coordination of services and supports across disciplines.

The Individual Service Plan (ISP) is a professionally-accepted approach to planning, delivering, and monitoring habilitative services based on a CFA. A minimally adequate ISP contains individualized, measurable goals and objectives, specific services and interventions to achieve those goals, a description of the frequency, intensity, and duration of those services and interventions, the providers responsible for delivering each habilitative service, and a projected timetable for achieving each goal. A person-centered ISP serves as the roadmap guiding the delivery of services and supports for individuals.

Specialized services are those habilitative services for individuals with IDD which, in addition to standard nursing services, constitute a program of active treatment under federal standards. Texas' PASRR program divides specialized services into two categories, based upon funding source and delivery mechanism. Nursing facility specialized services, like therapies and equipment, are provided by the nursing facility and funded in significant part with federal Medicaid funds. LIDDA specialized services are provided by the LIDDA, usually outside of the nursing facility, and funded almost entirely with state dollars. The latter are particularly important to promote the goals of habilitation and facilitate a program of active treatment.

Active treatment is the accepted federal standard for supporting individuals with IDD. Active treatment is required by CMS in institutional settings that serve individuals with IDD, including nursing facilities. It is set forth in CMS regulations (42 CFR § 483.440), and measured by a series of tags, probes, and criteria that are mandated by CMS. Active treatment is the continuous, aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services directed toward the individual functioning with as much self-determination and independence as possible. It is also directed toward the prevention or deceleration of regression or loss of current optimal functional status. Active treatment consists of interventions and services in sufficient number and frequency to support the achievement of objectives identified in the person's ISP. Active treatment must occur across settings in every applicable aspect of the individual's daily life.

VI. SUMMARY OF FINDINGS

Quantitative data findings (N = 10)

Comprehensive Functional Assessments

None of the 10 individuals appears to have had a CFA consistent with federal requirements (42 CFR §483.440(c)(3)). A CFA was not available in either the nursing facility record or in the LIDDA service coordination records for any individual I reviewed.

PASRR Evaluations and Assessments for Specialized Services

At the time of my reviews, none of the 10 individuals was actively receiving PASRR specialized services, except service coordination. Notably, most the individuals reviewed had PASRR Level I Screenings and PASRR Evaluations, but 2 of the 10 (20%) were completed 8 to 14 years after their admissions. In many instances, I found that individuals who needed particular specialized services did not have those needs properly assessed and identified in their PASRR Evaluation. Six of the 10 (60%) individuals' PASRR Evaluations did not recommend any specialized services, other than service coordination. In the few instances when PASRR Evaluations recommended specialized services, they recommended incomplete packages of specialized services. Only three of the 10 (30%) individuals' PASRR evaluations recommended specialized services such as therapies and durable medical equipment, and none recommended any specialized services that would be provided by the LIDDA, like Independent Living Skills, community habilitation, or supported employment.

Provision of Specialized Services

Across the 10 individuals in my review, I found a significant unmet need for habilitative physical, occupational, and speech therapies. I found 8 of the 10 individuals (80%) needed habilitative physical therapy but were not receiving it. In many instances, individuals need this service to prevent falls, prevent pressure ulcers, and to maintain muscle strength and balance. For example, all 10 individuals in my review had mobility challenges and used wheelchairs as a tool for greater independence – an indication in my experience that individuals would benefit from physical therapy to maintain strength and stability and to prevent further loss of mobility. All 10 individuals in the sample had contractures or were at risk of contractures due to their physical limitations. I found 6 of the 10 individuals (60%) needed habilitative speech therapy but were not receiving it. In many instances, individuals need this service to identify and maintain their ability to communicate, maintain their ability to eat a regular diet instead of a pureed one, and to ameliorate their risk for choking and aspiration. For example, 6 individuals I reviewed had diagnoses of dysphagia or other swallowing-related disorders that, in my experience, would necessitate speech therapy. Similarly, 6 of the 10 (60%) had significant communication difficulties ranging from limited to no speech. One individual communicates through sign language and owns a communication device, yet, there were no nursing facility staff or the LIDDA service coordinator trained in American Sign Language and the individual's communication device could not be located on the day of the visit.

Across the 10 individuals in my review, I found a significant unmet need for daytime habilitative services that would teach individuals skills and assist them with maintaining existing skills. None of the individuals I reviewed was receiving any of the LIDDA specialized services other than service coordination.

Many also had no or very few meaningful leisure time activities aside from watching television, wandering through the nursing facilities, or sitting in the front lobby. Seven of the 10 (70%) individuals had not been outside the nursing home for community participation and involvement for years. None of the individuals enjoyed regular community outings.

Nevertheless, at least six of the 10 (60%) individuals had reports of and/or documentation indicating they would benefit from day habilitation and/or Independent Living Skills.

Despite the frequency and severity of needs of the individuals I reviewed, none of those individuals was receiving ongoing, consistent, habilitative physical therapy, speech therapy, or occupational therapy specialized services at the time of my visit. Failure to provide these services not only puts the individuals at risk for potential harm, but also impedes their ability to live an improved quality of life.

Active Treatment

None of the 10 individuals in the sample receives a program of specialized services that meets the requirements for active treatment services for persons with IDD. None receives a continuous, consistent, aggressive program of habilitation that designed to promote independence, increase functional skills, and/or prevent regression. Absent qualified and trained staff with knowledge of habilitation and IDD issues, achievement of active treatment is nearly impossible.

Harm

As reflected in the individual client narratives below, I identified many concerns related to the lack of ongoing specialized services and the total absence of active treatment. Each of the 10 individuals I reviewed is at some level of risk for harm. Many were experiencing ongoing, serious harm. Most of the harm stemmed from the lack of a Comprehensive Functional Assessment to identify actual habilitative needs, the failure to provide essential adaptive equipment and clinical therapy services, and the lost opportunity and sometimes actual regression due the absence of professionally-appropriate habilitation. Among the most serious systemic concerns were:

- Significant harm and risk of harm related to individuals' unmet need for habilitative speech therapy to mitigate individuals' risk of aspiration and choking, and weight loss;
- Significant harm and risk of harm related to individuals' unmet need for occupational and physical therapy to prevent painful and irreversible contractures, to prevent falls, to address mobility limitations or to prevent skin integrity problems; and
- Significant harm and risk of harm related to individuals' unmet need for habilitative speech therapy to allow individuals to communicate verbally or communicate with augmentative devices and express their needs and desires to staff.
- Significant harm and risk of harm related to individuals' unmet need for habilitative services provided through Day Habilitation to allow individuals to learn new skills, maintain existing skills, improve functioning, experience new activities, increase their independence, and engage with others in the community.

- Significant harm and risk of harm related to individuals' unmet need for supports, activities, and opportunities in the community that are provided through Independent Living Skills Training, in order to allow individuals to learn and maintain skills, participate in community activities, increase their independence and improve their ability to function in new settings, and engage with others in the community, including non-disabled peers.
- Significant harm and risk of harm related to individuals' unmet need for behavior support services to allow individuals to learn adaptive behaviors, improving functioning, avoid unnecessary psychotropic medications, and engage more appropriately with others.
- Significant harm and risk of harm related to individuals' unmet need for other services and supports provided by the LIDDA that allow individuals to participate in more integrated, age-appropriate activities, to increase independence and functioning, and to engage with others in the community, including non-disabled peers.

VII. INDIVIDUAL FINDINGS

D.M.

D.M. is a friendly and sociable 58-year old man who enjoys the company of others and likes being the center of attention. D.M. can express himself verbally and he initiates conversation and makes friends easily. On the day of my visit, D.M. was excited to meet with me and wanted to remain with me throughout the visit. D.M. was admitted to his current nursing facility outside of Fort Worth on February 13, 2014. D.M. uses a customized manual wheelchair and depends on others for mobility. D.M.'s primary diagnoses include spastic quadriplegic cerebral palsy, hypokalemia, unspecified dementia without behavioral disturbance, urinary tract infection, benign prostatic hyperplasia, osteoporosis, hematemesis, dysphagia, pain, gastro-esophageal reflux disease, and epilepsy. Other diagnoses include unspecified psychosis, unspecified intellectual disability, bipolar disorder, and major depressive disorder. D.M. has a close relationship with his father who resides in New York. D.M. typically talks to his father daily and depends on him for assistance with decision-making.

There was no Comprehensive Functional Assessment (CFA) in D.M.'s nursing facility records. The lack of a comprehensive plan or assessment of needs and strengths significantly hinders the ability of nursing facility staff and the service coordinator to consistently and appropriately guide delivery of D.M.'s services and supports. There was a PASRR Level I Screening completed on February 13, 2014 that noted evidence of mental illness, intellectual disability, and developmental disability. A PASRR Evaluation (PE) was also completed on February 17, 2014 that confirmed evidence of IDD. Recommendations from the PE included only service coordination, but no other LIDDA specialized services or any nursing facility specialized services. Although there were no recommendations in the PE for therapy specialized

services, according the nursing facility records, from 2014 – 2016, D.M. received specialized habilitative OT services to maximize his activities of daily living (ADL) and to assess safety and independence through wheelchair management, range of motion, self-care management, contracture management, neuromuscular re-education, and therapeutic exercises to improve his quality of life. However, in December 2015, OT specialized services were recommended through the nursing facility, yet documentation indicated these services were already occurring in 2015. D.M.'s September 2016 Individual Service Plan (ISP) indicated that specialized services for PT and OT were discontinued in 2015. On September 1, 2016, a PASRR Specialized Services Form was completed with recommendations for customized manual wheelchair and specialized assessments for occupational therapy (OT) and physical therapy (PT) by the nursing facility and only service coordination through the LIDDA. Notwithstanding these references in the various documents, a recertification for OT (1/10/17 – 2/7/17) noted "condition has potential to improve as a result of skilled rehab…as result of skilled therapeutic interventions." D.M.'s ISP appears to be reviewed on a regular basis by the Service Planning Team (SPT) but the ISP is not a part of the nursing facility records and is not integrated as part of his supports and services at the facility through the nursing facility care plan.

At the time of my visit, the only specialized service D.M. was receiving was service coordination. In 2014, D.M. had two dysphagia evaluations noting moderate dysphagia. The evaluation reports recommended drinking precautions, positioning, a number of prompts with each swallow, and noted that the speech therapist would develop a plan to treat dysphagia. Nevertheless, D.M. is not receiving speech therapy, which is a service intended to assist with strengthening an individual's oral structures and to recommend a specific diet texture and liquid consistency that is consistent with an individual's oral motor skills. This is important to minimize episodes of choking and aspiration. Swallowing problems and mealtime issues are a real safety concern for individuals such as D.M., and can lead to aspiration and even death. Typically speech therapists develop dining plans, mealtime instructions, or mealtime guidelines that include adaptive equipment needed as well as eating and drinking techniques that make eating a safe and enjoyable experience. D.M.'s dietary report notes he requires total assistance during meals and he uses a plate guard during meals. In late 2014 and early 2015, D.M. received time-limited speech services for dysphagia therapy to address oral function and swallowing dysfunction but he is no longer receiving those services.

Nursing facility records indicate D.M. also received time-limited physical therapy in 2015 for rehabilitation, but he is no longer receiving those services. In late December 2015 and in September 2016, there was a recommendation for completion of paperwork for occupational therapy specialized services through PASRR Specialized Services to maintain D.M.'s current abilities. However, except for receiving a customized manual wheelchair through PASRR, there is no evidence D.M. is receiving, or ever received, any other PASRR specialized services. On the day of my visit, the LIDDA PASRR Program Manager confirmed that D.M. was not receiving any PASRR services except service coordination and reported that there has recently been a gap in service coordination for D.M. due to staff turn-over at the LIDDA. Specialized services, including physical therapy, occupational therapy, and speech therapy are not provided to D.M. on a regular, continuous basis. Although the nursing facility nurse reported that D.M. is

receiving specialized habilitative OT services, at the time of the visit, that did not appear to be the case. The nursing facility records indicate that even when D.M. received time-limited nursing facility therapy services, there were interruptions in the delivery of those services. Those interruptions prevent D.M. from receiving the full benefit of those therapy services that he requires to enhance his functional ability to reach optimal independence and to prevent regression. In my professional experience, common concerns for individuals with intellectual and developmental disabilities can be addressed through the various therapies. Specifically, for D.M., barriers related to oral motor/mealtime/swallowing difficulties can be addressed through OT and ST; barriers related to mobility, transfers, alternate positioning, and wheelchair seating/positioning can be addressed through PT; barriers with contractures and use of upper extremities can be addressed through OT; and barriers with communication can be addressed through ST.

Despite references to behavioral concerns (e.g., anxiety, agitation, false beliefs, suspiciousness, mood changes) in the nursing facility record, there is no evidence that ongoing behavioral services are provided for D.M. or that he has ever had a behavioral assessment or behavioral plan. D.M. told me that he was interested in leaving the nursing facility and finding an alternative placement in the community. The PASRR Program Manager was not aware of, or considering, any alternative residential placement, independent living services, or any day services that might be appropriate for D.M.

D.M. is not receiving active treatment because D.M. does not consistently receive any therapeutic or specialized services, other than service coordination. He does not receive a continuous active treatment program that includes needed interventions and services in sufficient number and frequency. The PASSR Program Manager acknowledged that D.M. does not receive active treatment or anything like active treatment. She further noted that this is an ongoing issue in other nursing facilities. Although there is an ISP in D.M.'s record, there is no individualized plan for D.M. which would implement an aggressive, consistent program of specialized and generic training, treatment, health services, and related services necessary for him to function with as much self-determination and independence as possible and to prevent or decelerate regression or loss of current optimal functioning. Moreover, D.M. does not receive any LIDDA specialized services such as independent living skills or day habilitation that would allow him to develop skills to function more independently or to interact with others outside of the nursing facility.

There is no individual-specific training offered for direct care nursing facility staff who work directly with D.M. to better understand his needs, wants, and desires. Even the LIDDA PASRR program manager and D.M.'s service coordinator appeared to know little about D.M.'s needs or goals. Moreover, the absence of a coordinated plan that integrates both the ISP and nursing facility care plan and the lack of staff training seems to have resulted in a situation where nursing facility staff and D.M.'s service coordinator all lack meaningful knowledge about the services and supports that D.M. needs, what services are available to him or how to ensure consistent delivery of needed services and supports throughout the course of the day and across all settings where D.M. spends his time.

The lack of any specialized services to address D.M.'s habilitative needs has caused him, and continues to cause him, ongoing harm. D.M. is especially at risk of harm in the absence of a mealtime plan and mealtime oversight due to his history of dysphagia, pneumonia, choking, and aspiration. On the day of my visit, D.M. told me that the nursing facility staff leave in him bed because it takes him too long to get dressed. He also told me that nursing facility staff say he eats too slowly and often rush him to finish his meals. Most disturbingly, D.M. told me that the morning of my visit, the nursing facility staff person forced him to eat his breakfast in bed and instructed him to eat quickly. D.M. told me that was not able to use his divided plate in bed and food spilled on his clothes. During my visit, D.M. had several severe coughing incidents where he turned bright red and seemed to have difficulty catching his breath. D.M. was given cough medication by nursing facility staff at least two (2) times within a 30-minute timeframe while I was visiting with D.M. However, he continued to cough. Later, a staff person entered the room to take D.M. for a chest X-ray to check for aspiration. It is clear that the absence of a swallowing assessment, the lack of ongoing speech therapy, and the failure to provide D.M. with the training and supports he needs to safely consume food has caused him, and will continue to cause him a serious risk of harm and places him at a high risk of aspiration, choking, and possibly death.

C.C.

C.C. is a pleasant 49-year-old woman who resides in a nursing facility outside of Dallas. C.C. is sociable and friendly and she smiled often during my visit. She is wheelchair-dependent but able to self-propel. C.C. is non-verbal, but uses some sign language to communicate. She was admitted to the nursing facility from home on April 8, 2011. C.C.'s primary diagnoses include cerebral palsy, autism, generalized anxiety disorder, Type 2 diabetes mellitus, and major depression. C.C. receives numerous medications to address her medical needs. She also receives anti-depressant and anti-psychotic medications.

I identified a number of deficiencies in C.C.'s treatment and care. First, there was no Comprehensive Functional Assessment (CFA) available for review or any other integrated comprehensive assessment or planning documents that gave a clear picture of C.C.'s strengths, likes, dislikes, needs, and preferences. I reviewed a Minimum Data Set (MDS) identified as a "PASARR Screening" dated April 28, 2011, PASRR Level 1 Screening dated October 27, 2016, and PASRR Evaluation completed December 2014. The latter included recommended services of service coordination and nursing facility specialized services for physical therapy, occupational therapy, and speech therapy, but no LIDDA specialized services. In May 2011, the Inventory for Client and Agency Planning (ICAP) referral form also included a referral for clinical support services indicating there was a need for endorsement of sign language.

Although there was not a document identified as an Individual Service Plan (ISP) in the service coordination documents, there were Quarterly Service Team Meeting notes (dated 11/14/14, 2/4/15, 5/7/15, 12/6/15, 3/20/16, 7/1/16, 10/24/16), which included recommended services, outcomes/purposes, summary, and a review of the listed items. These Service Planning Team (SPT) notes, however, were not included in C.C.'s nursing facility records, and thus, not integrated as part of her supports and services at the facility.

C.C. is not receiving any specialized services. Although there is record documentation that she previously received nursing facility rehabilitative services for speech therapy, occupational therapy, and physical therapy, and all of these services were recommended in her December 2014 PASRR Evaluation, none of these services were being provided at the time of review and none were ever provided as habilitative specialized services. Instead, therapy services in the past were often terminated after the initial period of authorization ended. The service coordinator acknowledged that C.C. would benefit from therapies provided by the facility and had enjoyed receiving them in the past, yet, no therapy services were being provided.

C.C. only received therapies after an acute problem. For example, she fell in November 2016 and again in December 2016. Subsequently, C.C. received skilled physical therapy services during the month of December 2016. However, the therapy discharge summary dated December 27, 2016 noted that physical therapy was discontinued due to nursing facility therapy benefits having been exhausted. In October 2015, C.C. received a dysphagia evaluation due to coughing difficulties for three (3) weeks, a history of feeding difficulties, and choking. Speech therapy was provided only briefly following the 2015 swallowing assessment, which revealed moderate dysphagia and mild aspiration.

Critically, C.C. has not received ongoing, consistent speech therapy to help her communicate, and no staff at the nursing facility are trained to be able to communicate with her. In 2016, C.C. received speech therapy to address cognitive communication and to improve her ability to communicate self-care and medical needs as well as to communicate basic needs and wants. In the past, C.C. made progress using picture boards and sign language to communicate. Unfortunately, this service was discontinued when she exhausted her rehabilitation benefits and has never been provided on an ongoing basis for habilitation. In my experience, an individual who cannot communicate his/her wants and health and safety needs is at risk for not having the needs met. Therefore, speech services could be beneficial as the therapist can provide alternative and augmentative means for communicating. They can help give the person a voice. Importantly, per a 2011 Comprehensive Diagnostic Evaluation, it was noted that C.C. has developed an effective system of sign language for communication. The service coordinator also noted that C.C. uses sign language that "her and her mother made up to communicate with each other." However, none of the nursing facility staff are trained to use American Sign Language (ASL), although sign language is C.C.'s primary method of communication. And the augmentative communication device that C.C. owned for over a year (Dynavox) has never been used. During my onsite visit, I asked to see the device; however, it could not be located by any of the nursing facility staff, including the speech therapists. In January 2017, speech services were discontinued noting C.C. has reached maximum potential. However, it is unclear how or why this determination was made, especially when C.C. has no real means of communicating with staff, it is unclear to what extent staff are really able to understand her, and the nursing facility no longer uses the interventions that had helped C.C. communicate, such as picture boards and sign language. Therefore, it seems unlikely C.C. has reached her maximum potential. More important, recent record documentation notes that C.C. becomes frustrated when trying to communicate. This is hardly surprisingly because it is apparent that no one on staff at the facility has been adequately trained to communicate with her and C.C. herself appears unable to access or to receive training on her Dynavox.

As reflected in her medical records, C.C. needs behavioral supports and behavior management, but only receives psychotropic medications rather than specialized behavior services. Staff who work with C.C. are not trained to provide appropriate behavior interventions.

It appears that nursing facility therapy services are only offered on a time-limited basis, despite C.C.'s continuing need for many of these services, and no ongoing specialized services are provided to C.C. to address any of her physical, communication, or behavioral needs.

There is also no evidence that the service coordinator has meaningfully considered whether any habilitative services offered by the LIDDA might be appropriate for C.C. When asked whether C.C. might be appropriate for day habilitation services, the service coordinator told me that although she had considered that C.C. may be appropriate for day habilitation services, there was only one day habilitation provider in the area and that program was at maximum capacity for accepting individuals who use wheelchairs. The service coordinator was not aware of or considering any other day habilitation providers that might be appropriate for C.C. or other individuals who use a wheelchair.

C.C. does not receive active treatment. In addition, C.C. does not consistently receive any therapeutic or specialized services throughout the day. It is unsurprising that C.C. is not receiving active treatment because C.C. does not have any integrated comprehensive assessment or planning documents in her nursing facility record to guide active treatment. In the absence of these documents, there is no roadmap of training and services for C.C. Therefore, there is no documentation that nursing facility staff are implementing programs of specialized training, treatment, and related services. To emphasize, there are no clinical programs, plans, or guidelines in place for staff to implement.

As previously stated above, C.C. does not have staff trained to communicate with her using sign language which is documented as her primary means of communication. In addition, C.C. does not have access to her augmentative communication device. In my experience, this is a significant barrier because C.C. may have difficulty communicating an accurate picture of her feelings and symptoms due to limitations of expressive skills and she may not understand and may not be understood. Due to poor non-verbal conversation skills, individuals like C.C. become frustrated in their attempts to make their feelings and needs known and often act out their frustrations through inappropriate behaviors.

Based on reports from staff, the nursing facility staff supporting C.C. have not received training in understanding intellectual and developmental disabilities. There is no individual-specific training offered for staff who work directly with C.C. to better understand her needs, wants, and desires, or even to be able to communicate with her. Although the service coordinator arranged for an ASL interpreter to be present on the day of my onsite review, those working with C.C. have not been trained to appropriately and effectively communicate with her. Given the lack of staff training and C.C.'s inability to access her Dynavox, it is uncertain that C.C.'s needs and wishes are truly able to be communicated to and understood by the nursing facility staff. As previously stated, in my experience, when individuals with IDD are unable to communicate, they sometimes resort to behaviors like C.C.'s.

The lack of any specialized services to address any of C.C.'s habilitative needs and the lack of continuous therapeutic services has caused her, and continues to cause her, ongoing harm. The nursing facility record indicated that C.C. experienced a decline in ADLs and she fell multiple times. She has not had any recent emergency room visits or hospitalizations. However, C.C. is harmed by her inability to communicate with other individuals, and she is at risk of harm, including physical harm, due to nursing facility staff's inability to effectively and appropriately communicate with her. Failure to train staff on C.C.'s specific needs, the failure to provide her with an appropriate behavior assessment and/or behavioral interventions, and the failure to provide ongoing physical therapy to prevent falls and occupational therapy to improve functional skills creates additional harm and risk of harm. Finally, without continuous, ongoing speech services for mealtime oversight, C.C. is at risk of aspiration and other swallowing concerns as she is unable to chew her food.

B.C.

B.C. is a friendly 73-year old female who has a contagious smile. She was admitted to the nursing facility on January 18, 2011 due to a stomach disease and duodenal ulcer. Prior to her admission to the nursing facility, B.C. lived in a group home. She was admitted to the nursing facility after she required the insertion of a G-tube, but remains there despite the fact that the G-tube was removed in December 2014. Although B.C. has limited speech, she communicates verbally. She is wheelchair-dependent and requires total assistance from staff. B.C.'s primary diagnoses include spastic quadriplegic cerebral palsy, diabetes mellitus, GERD, constipation, an intellectual disability, and major depression. She receives an anti-depressant medication.

There was no Comprehensive Functional Assessment (CFA) available for review in B.C.'s nursing facility or case management records. The PASRR Level 1 Screening and the PASRR Evaluation identified B.C. as having an intellectual and developmental disability (IDD). There is no comprehensive individualized assessment that provided a clear picture of B.C.'s strengths, weaknesses, likes, dislikes, functional skills, and specific requirements for her medical, nursing, therapeutic, and specialized services. In the absence of a CFA, it is difficult to determine if all needed specialized services and supports are being recommended and provided. B.C.'s Individual Service Plan (ISP) is not a part of her nursing facility records. Failure to integrate the ISP with the nursing facility care plan leads to the risk of a lack of continuity of support and services. In addition, the staff persons who are working with B.C. are not implementing her ISP outcomes. Moreover, there are no habilitative programs and plans for the nursing facility staff to assist B.C. with her functional skills.

B.C. does not receive any specialized services, other than service coordination. The PASRR Evaluation (June 20, 2016) includes recommendations for specialized services for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services as well a customized wheelchair and durable medical equipment through the nursing facility. Although there was evidence that the service coordinator was conducting the required monthly visits as well as the quarterly Service Planning Team meetings, there is little evidence that the service coordinator is assisting B.C with receiving needed services and supports. Case management notes from May 2015 indicate that the former service coordinator had difficulty understanding B.C.

In the June 2015 Service Planning Team Meeting (SPT), there was a discussion about a communication device, but reportedly B.C. declined. At the time of my visit, there was no indication that any additional follow-up concerning a communication device occurred. Similarly, in June 2015, B.C. was evaluated for a new electric wheelchair, which she did not receive for six months. In September 2015, it was noted that PT would begin measuring B.C.'s contractures to determine whether PT would be appropriate. At the October 2015 SPT, there was another discussion regarding B.C. receiving OT. At that time, the nursing facility therapy department indicated that B.C. did not require OT services, but the physical therapist would measure B.C.'s contractures every 90 days to check for significant changes. Despite these commitments and B.C.'s needs, as of the day my visit, there was no evidence that follow up to

measure B.C.'s contractures had ever occurred. In addition, there was no evidence that the service coordinator monitored the plan for PT or OT contracture monitoring during any of her visits. On January 6, 2017, the physician ordered an occupational therapy evaluation and treatment to address ADL functioning and contractures. However, as of the day of my visit, there was no evidence that this order had been implemented. Despite several recommendations by the therapy department and B.C.'s physician regarding treatment and monitoring for contractures, on the day of my visit, the nursing facility director of nursing and social worker reported that due to B.C.'s significant contractures, she rarely gets out of bed. During a follow-up call (March 8, 2017), the PASRR manager informed me that there was a request for OT PASRR services on January 12, 2017, but the OT services had not begun.

In my professional opinion, B.C. would benefit from specialized services, including PT and OT for contractures management; speech therapy to capitalize on the verbal abilities she has and to increase her communication skills; as well as community integration to increase her social skills and offer more opportunities to experience her community. Although B.C.'s anti-depressant medication is monitored, like many individuals who have depression, B.C. could also benefit from a psychological assessment to determine if ongoing services are warranted.

B.C. does not receive active treatment. In the absence of specialized services, there is no implementation of an individualized continuous program which includes aggressive, consistent training, treatment, and programs that are directed to increase B.C.'s functional independence as much as possible while preventing or decelerating regression of her functional status. As previously stated, B.C. remains in bed all day due to her contractures. However, according to the nursing facility notes and reports from nursing facility staff, B.C. enjoys outings to the community, especially going to the movies, and nursing facility staff told me that B.C. is very sociable when she is in the community. However, there was no evidence that the service coordinator offered any specialized services through the Local Authority for B.C. to consider to become more actively involved in the community. I attempted to contact the service coordinator for B.C. to explore specifics about consideration of LIDDA specialized services. Although the service coordinator was not available, I spoke to the PASRR manager, who was not familiar with B.C. and was unable to obtain information about LIDDA specialized services from the available documentation.

B.C. has been harmed, and is at risk of further harm, due to lack of specialized services to address her medical complexities and her unaddressed interests in community participation. In particular, B.C. has been harmed by an increase in contractures which limits her ability to leave the nursing facility and even to get out of bed. She has also been harmed by not receiving services to help her improve her limited communication skills. B.C. is also at risk of aspiration due to lack of speech services to monitor her oral feeding following the removal of her G-tube. B.C. is at risk of future harm, particularly, a continued deterioration of her functional ability, if she does not receive ongoing specialized services, including PT and OT. Additionally, she is at risk of future harm for decubitus due to the extensive amount of time in bed and the absence of positioning and transfer plans.

S.W.

S.W. is a friendly 42-year old woman who enjoys her autonomy. S.W. was admitted to the nursing facility on March 5, 2012 following an acute hospitalization. Prior to her admission, S.W. resided at home with her family. She has a very close relationship with her family and her mother frequently visits her. S.W. enjoys going on outings with her family as well as on van rides with nursing facility staff. She uses a manual wheelchair as a means of mobility and has no difficulty maneuvering around the nursing facility independently. S.W. has limited verbal communication and generally makes her wishes known through gestures. S.W.'s primary diagnoses include a severe intellectual disability, cerebral palsy, spinal muscular atrophy, lupus, epilepsy, degenerative joint disease, and Raynaud's syndrome. She receives medications to address her medical needs.

There was no Comprehensive Functional Assessment (CFA) or other integrated assessment that clearly identifies S.W.'s strengths, weaknesses, preferences, likes, dislikes, and needs. The lack of a comprehensive plan or assessment of needs and strengths significantly hinders the ability of nursing facility staff and the service coordinator to consistently and appropriately guide delivery of D.M.'s services and supports. I reviewed PASRR Level I Screenings dated March 15, 2013 and August 7, 2015 and the PASRR Evaluation (PE). These documents confirmed that S.W. has intellectual and developmental disabilities. The PE recommended service coordination specialized services through LIDDA, but no other specialized services.

It appears that nursing facility therapy services are only offered on a time-limited basis. Nursing facility documentation suggests that S.W. has previously received nursing facility rehabilitative physical therapy (PT), occupational therapy (OT), and speech therapy (ST), but each for just a few months. PT was provided in 2015 to address stiffness and difficulty walking (August – September 2015, 3 times a week for 3 weeks). Gait training and manual therapy were the focus of PT. In addition, the PT services included active assistive and passive range of motion to prevent further decline with contractures. ST services were also provided briefly in 2012 to address dysphagia. S.W. also received a Modified Barium Swallow Study (MBSS) in May 2014 to assess whether S.W. could swallow a whole pill verses a crushed pill to determine if she could eat regular food instead of a mechanical soft diet texture. Although the MBSS results were inconclusive, skilled ST services were briefly provided in 2015 to focus on speech, language, feeding, and cognitive skills. A 2015 ST Evaluation noted that without ongoing speech therapy S.W. is at risk for decreased communication and feeding skills. S.W. also received intermittent OT services in late 2014, mid-2015, and mid-2016 to address a decrease in hand strength, contracture management, standing balance and endurance. Oddly, the OT discharge summary (5/6/16 -7/3/16) noted services ended due to "highest practical level achieved." Yet, there were multiple re-certifications (6/7/16 – 6/27/16; 6/28/16 – 7/17/16; and 8/29/16). A recent Physician Order Report (12/31/16 – 2/28/17) included an order for rehabilitation PT/OT/ST screening as appropriate. Additionally, in January 2017, there was a physician order for OT three (3) times a week for eight (8) weeks pending approval. However, there is no evidence that either Physician's Order was implemented.

S.W. has an Individual Service Plan (ISP) that is filed in her nursing facility records. The assistant director of nursing was not familiar with the ISP, stating he does not get involved in "that aspect." Furthermore, the ISP is not shared with key staff that work with S.W. S.W.'s ISP is a valuable tool to ensure services are provided and coordinated in a consistent individualized manner. Therefore, failure to ensure that all nursing facility staff working with S.W. are aware of and have read her ISP significantly impacts the delivery of appropriate supports and services as well as hinders S.W.'s ability to achieve her outcomes and goals.

The nursing facility staff have not received training in issues related to intellectual and developmental disabilities. This lack of understanding of the many facets of intellectual disabilities creates a challenge for staff working with individuals with IDD, including S.W. In addition, there is also no evidence that the LIDDA service coordinator has received adequate training to better equip her to assist S.W. with fully accessing all the specialized services offered through the LIDDA.

S.W. is not receiving any specialized services other than service coordination and a customized manual wheelchair that she received through PASRR in the spring of 2015. Based on my professional experience, S.W. would benefit from ongoing habilitative specialized services without interruption to fully gain the benefits of these services. In my professional experience with working with individuals with intellectual and developmental disabilities, therapy that is provided on a continual basis across settings is an essential aspect of supporting individuals to maintain a stable physical and nutritional status. Habilitative therapies address problems that may impact functional skills in mobility, transfers, oral-motor/mealtime, ADLs, range of motion, and can help prevent decline or increase independence in functional skills, thus leading to a better quality of life for persons with IDD.

The service coordination documentation indicates that for almost two (2) years prior to 2015, S.W.'s mother has expressed interest in S.W. attending a day habilitation program. However, as of the day of my visit, the service coordinator had not explored day habilitation options for S.W. In fact, during my visit, S.W.'s mother again expressed interest in exploration of day habilitation programs. The service coordinator indicated she would look into day habilitation options that might be appropriate for S.W. Her mother also expressed interest in S.W. going shopping and participating in other community activities. S.W.'s mother also told me that she had arranged for a Waco transit pass for S.W. so that she could have transportation, but the pass has been underused. Nursing facility record notes that S.W. enjoys going on van rides with staff and outings with her family. However, the service coordinator is not considering any other specialized services offered through the LIDDA for S.W.

Because S.W. is not receiving all needed specialized services, she is not receiving active treatment. Nursing facility staff working directly with S.W. are not aware of or implementing the ISP goals necessary to assist S.W. in achieving her desired outcomes. There is no evidence that S.W. is consistently involved in meaningful activities that would allow her to participate in more activities outside the nursing facility. S.W. is not receiving active treatment because there are no habilitative programs and plans for staff to assist S.W. with her functional skills. Services and supports S.W. does receive are not implemented continuously and consistently across

settings. For example, in December 2016, an acute plan of care noted that S.W. is a risk for spilling hot liquids due to generalized weakness. The nursing facility documentation indicated that S.W. should use a sippy cup for all liquids during meals and medications. However, S.W. did not use a sippy cup when given coffee to drink during my visit. Moreover, S.W.'s mother and service coordinator told me they were not aware that S.W. used a sippy cup.

S.W. is at risk of harm due to lack of ongoing habilitation services. Nursing facility documentation clearly notes that S.W. has experienced a decline in her walking abilities; a decrease in her hand strength; and a decrease in her swallowing. Therefore, failure to provide ongoing habilitative PT to assist S.W. to increase and maintain independence with mobility with less reliance on the wheelchair puts her at risk of ongoing and future harm. At the same time, failure to provide ongoing and consistent OT puts S.W. at risk of ongoing harm due to the likelihood of her hands becoming more contracted with decreased use. Due to S.W.'s diagnosis of dysphagia, failure to provide ongoing ST for oral-motor/swallowing puts her at risk of aspiration. Finally, failure to provide requested day habilitation services will result in the loss of any ability to gain skills in the community, to participate in community activities, and the loss of additional functional skills.

S.C.

S.C. is an unassuming 60-year old woman who prefers to spend time alone in the sunlight. S.C. was admitted to a nursing facility on November 1, 2013. S.C. is primarily non-verbal, but the nursing facility records indicate that she may have the ability to speak small words. S.C. independently ambulates with her wheelchair throughout the nursing facility. Based on reports from staff and the nursing facility record, S.C. pushes away in her wheelchair when she does not want to engage with staff or others. This gesture is the only understood means of communication with the staff at the nursing facility. S.C.'s primary diagnoses include autism, an unspecified intellectual disability, seizures, diabetes mellitus, aphasia, depression, schizophrenia, reflux, and osteoarthritis.

There was no Comprehensive Functional Assessment or Individual Service Plan available in the nursing facility record. The Minimum Data Set (MDS) and PASRR Level I Screening indicated that S.C. has an intellectual disability. Although not available for review in the service coordination documentation or nursing facility record, during a follow-up call, the service coordination manager told me that a PASRR Evaluation was completed on May 30, 2014 and there were no specialized services recommended. The lack of any integrated assessment or care plan prevents the nursing facility staff as well as the LIDDA service coordinator from providing consistent continuity of care, supports, and services for S.C.

S.C. is not receiving any specialized services other than service coordination. S.C. has received time-limited therapy services in the past following acute issues. For example, she was evaluated and received short term, episodic therapy services following hospitalizations for seizures and due to a significant weight loss. The LIDDA service coordinator documented that the Service Planning Team determined that S.C. would not benefit from specialized services, but there was no reason for this determination. Moreover, contrary to this determination, in November 2016, the physical therapist informed the service coordinator that S.C. would benefit from occupational therapy, speech therapy, and physical therapy, particularly due her dependence on the wheelchair and concern regarding maintaining her transfer skills. It was noted that the necessary paperwork would be completed and submitted to DADS. Yet, as of the day of my visit on February 6, 2017, there was no evidence that the necessary paperwork had been submitted or that there had been any follow up by the service coordinator regarding authorization for any of the recommended therapies. Thus, S.C. was not receiving any specialized services she needed on the day of my visit, or, per her nursing facility record, before that visit. Moreover, in January 2017, the physician ordered a physical therapy (PT) evaluation and treatment three times a week for six weeks for functional mobility training and modality use to assist S.C. to restore to highest level possible. Yet, as of the day of my visit, there was no indication that the order had been implemented as written.

S.C. also has had no training, supports, or habilitative services to improve her communication skills so that staff can effectively communicate with her. Nursing facility staff as well as the service coordinator manager indicated that although S.C. is largely non-verbal, she has limited words and she understands direction and statements from others, but she has not been provided any supports to respond. In my professional experience, people with limited to no

verbal communication skills are typically provided a speech therapy evaluation and services to identify supports such as augmentative communication devices, picture boards, and training that would allow them to communicate effectively. It is evident throughout the LIDDA service coordination records that the service coordinator is unable to communicate with S.C., so instead, the service coordinator communicates with nursing facility staff about S.C. Although the service coordinator seems to visit S.C. at least monthly "to satisfy PASRR program requirements," it appears that service coordination is more of a paper service rather than a meaningful coordination of services and supports targeted to S.C.'s particular needs. A follow-up call with the service coordination manager confirmed that S.C. does not receive any specialized services, except service coordination. However, the service coordinator told me that the nursing facility is in the process of getting S.C. a wheelchair. The service coordinator's manager informed me that S.C.'s previous service coordinator, who knew S.C.'s history, resigned in February 2017 and the newly assigned service coordinator has met S.C. only once.

Nursing facility records and verbal reports indicate that S.C. loves being outside; yet, there was no indication that she is given the opportunity to leave the facility to participate in outdoor activities in the community, such as visiting the park. Similarly, there is no indication that the service coordinator has considered day habilitation services or other services outside the nursing facility for S.C. In addition, nursing facility record indicates that S.C. occasionally exhibits behavioral outbursts such as yelling, hollering, making noises, and resisting care. She has also received as needed (PRN) Ativan to calm her. However, there is no evidence that behavioral assessment and ongoing services have been provided for S.C.

S.C. does not receive active treatment because S.C. is not receiving any specialized services. There was no ISP available for me to review in the nursing facility or service coordination records. In the absence of an ISP, there is no roadmap for the nursing facility staff to understand S.C.'s strengths, abilities, likes, dislikes, needs, and outcomes that she is working to achieve. There are no clinical programs, plans, or guidelines in place for staff to implement consistent, continuous services for S.C. The nursing facility record notes that S.C. enjoys spending her day sitting outside in the sun and fresh air, but even this limited activity has been reduced due to lack of staff to supervise S.C. Service coordination notes indicate that S.C. does not actively participate in any nursing facility activities. Although S.C. has the ability and potential to participate in more meaningful habilitation activities, she is not afforded that opportunity and has no likelihood of being able to receive the training and specialized services that she needs.

Nursing facility staff are not trained to understand intellectual and developmental disabilities. Not understanding the many facets of intellectual disability creates challenges for staff working with individuals with IDD. It becomes more difficult when an individual has communication challenges like S.C. It is unclear how the nursing facility staff, including medical staff, communicate with S.C. daily, particularly given that there is no individual-specific training offered to staff who work directly with S.C.

S.C. has experienced harm due to the numerous seizures and hospitalizations as well as significant weight loss. She is at risk of harm due to the lack of ongoing habilitation services.

The lack of specialized services, including physical therapy, speech therapy, and occupational therapy creates a risk of harm to S.C. because she has become more dependent on the wheelchair; she is unable to effectively communicate her needs and concerns to staff; and she depends on others for activities of daily living. S.C. will continue to be at risk of harm if specialized services to address her needs are not delivered with the frequency and intensity she needs and delivered consistently across all setting

D.G.

D.G. is an intelligent, articulate and candidly outspoken 58-year old woman, who easily makes friends. She is a mother and a grandmother who has a close relationship with her family. D.G. was admitted to the nursing facility in Waco on May 15, 2012. She reports residing in other nursing facilities prior to this admission. D.G. previously worked as a certified nursing assistant in a nursing facility. She requires total assistance and uses an electric customized wheelchair for mobility. D.G.'s primary diagnoses include multiple sclerosis, muscle weakness, seizures, diabetes, dysphagia, atherosclerotic heart disease, recurrent urinary tract infection, and psychotic disorder with delusions. She experiences depression and anxiety and receives medications to address these. She also receives counseling.

There was no Comprehensive Functional Assessment in D.G.'s nursing facility records. I reviewed PASRR Level I Screenings (12/5/13 and 1/26/15) and a PASRR Evaluation (PE) (2/14/15) that note D.G. has a developmental disability, but she does not have an intellectual disability. The PE notes that D.G. needs assistance with nutritional support, coordinating medical treatment, activities of daily living (ADLs), sensorimotor development, positioning, transferring, and hand/eye coordination. The PE recommends service coordination by the Local Authority, but no other LIDDA specialized services or any nursing facility specialized services. D.G. has an Individual Service Plan (ISP) that is included in the service coordination records and in the nursing facility records. Reports by the nursing facility staff and the service coordinator indicated there is a concerted effort to integrate services and supports.

At the time of my visit, D.G. was not receiving specialized services other than service coordination. However, D.G.'s ISP indicates that she received occupational therapy (OT) through PASRR (April 2016) and she found it to be beneficial. There is no indication why these specialized services ended. Record documentation indicates that D.G. received time-limited nursing facility OT services, physical therapy (PT) services, and speech therapy (ST) services, but these were not provided as habilitative services. For example, an April 2016 Service Planning Team Meeting summary indicates that D.G. received ST for writing (discontinued February 2016) and memory (discontinued June 2015). It is unclear why the speech therapist was working with D.G. on writing because in my experience this would be an area addressed by OT mainly because it is using her upper extremities. There was no indication in the record that writing was a means of communication, which is generally addressed by ST. The service coordinator told me that D.G. indicated she is making progress with her handwriting and that she is "hoping to work more on this with OT." In October, November, and December 2016, there were recommendations for PT for five (5) times a week for four (4) weeks for each month. On January 8, 2017, the physician ordered OT services five (5) times a week for four (4) weeks, but no ongoing habilitative therapies or other specialized services. The nursing facility record indicates that D.G. did receive a custom mattress through the PASRR program to prevent pressure ulcers. The service coordinator told me that D.G. could benefit from Independent Living Skills (ILS), but due to it being a new service offered by the LIDDA, the LIDDA is still working through the barriers to fully implement this service and she wasn't aware of when the service might be available to D.G.

Throughout D.G.'s nursing facility record, there is documentation indicating weaknesses in her hands resulting in decrease in ADLs as well as contractures, muscle weaknesses, intermittent joint and muscle pain, lack of coordination, recurrent seizures and UTIs. D.G. has also experienced issues with decubitus; yet, she is not receiving continuous ongoing OT and PT as specialized habilitative services to help increase independence in her functional abilities or to prevent further decline, which could lead to better quality of her life. D.G. told me that she enjoys participating in therapy. The service coordinator acknowledged that D.G. would benefit from continuous and consistent PASRR habilitative specialized services and discussed with the director of nursing and the therapy department about the need for an evaluation for these services. However, D.G. is not receiving these services because the therapists do not want to complete the paperwork to request the services from DADS. Moreover, it was noted in D.G.'s April 2016 ISP states that she was assessed for all PASRR specialized services, but she declined these services. This is contradictory to what D.G. told me during our meeting.

D.G. is not receiving active treatment because she is not receiving all needed specialized services, including ongoing OT, PT, and ST. In my professional opinion, D.G. could benefit from OT services to address contracture management as well as handwriting. Secondly, she could benefit from PT to address her mobility challenges, transfers, and wheelchair seating and positioning. Thirdly, D.G. could benefit from speech services to address dysphasia, swallowing issues, and oral/motor mealtime. There are no individualized plans in place for D.G. that would allow nursing facility staff to implement consistent programming necessary for her to function with as much self-determination and independence as possible to prevent loss of current optimal functioning. For example, D.G. does not have a wheelchair seating, transfer or positioning plan that provides guidance to staff on how to transfer her and how often. Such a plan is particularly important given her history of pressure ulcers. On the day of my visit, D.G. also told me that she had been lying in bed for the previous two (2) days due to a wound on her buttock. Having a positioning/transfer plan would help alleviate the possibility of developing pressure ulcers for individuals with mobility challenges, like D.G. D.G. wears splints, but there is no plan in place indicating when D.G. should wear the splints and for how long. D.G. was not wearing the splints on the day of my visit. She also has ankle braces. Finally, D.G. could benefit from services such as ILS and day habilitation to improve social interaction while learning more independent community skills.

D.G. is at risk of harm. In the past two (2) years, D.G. has had bladder surgery and placement of suprapubic catheter; she has been hospitalized for UTI sepsis; and she has a history of MRSA. She is a risk of ongoing and future harm of poor skin integrity issues such as pressure ulcers due to her limited mobility and total dependence of staff combined with lack of ongoing PT specialized services and the absence of appropriate plans and staff instructions. She is at risk of ongoing and future risk or harm due to the possibility of worsening contractures and decreased use of her hands without ongoing OT services and support plans, and staff training for splint use. She is at risk of social isolation due to depression and the lack of specialized services that would allow her to participate in community activities such as day habilitation.

H.J.

H.J. is an intelligent, confident, 67-year old man who resides in a nursing facility in Dallas. Prior to his admission to the nursing facility on November 14, 2011, and again on March 23, 2012, H.J. lived independently in his own home. H.J. is actively pursuing moving into his own apartment in an area that he lived for more than 25 years. He is calm, very articulate, and adamant about his desire to return to the community. Independence is important to him. H.J. primarily uses a wheelchair but he also has a prosthesis for his left leg. H.J.'s primary diagnoses include neoplasm, unspecified behavior of respiratory system, peripheral vascular disease, amputation above the knee, and convulsions. H.J. also experienced a gunshot injury to his neck at age 19 and has limited functional abilities due to amputated upper and lower extremities.

In January 2015, H.J. informed his service coordinator that he had moved at least four (4) times within the nursing facility and wanted to move back to the community. Yet, more than two (2) years later, H.J. remains in the nursing facility. There was no evidence that the LIDDA service coordinator has been done anything to facilitate H.J.'s transition to an alternative placement. On March 22, 2016, the service coordinator documented that H.J. was ineligible for IDD services through the LIDDA and assistance with a relocation specialist was recommended. The PASRR manager informed me that a relocation specialist is working with H.J. to obtain a low-income apartment, which is not a part of the PASRR alternative placement services.

There was no Comprehensive Functional Assessment, Individual Service Plan (ISP) or any other integrated comprehensive assessment or planning documents that give a clear picture of H.J.'s strengths, likes, dislikes, needs, and preferences. Failure to provide a roadmap to the delivery of supports and services prevents the nursing facility staff and the LIDDA service coordinator from adequately assisting H.J. with the services and supports he needs to maintain skills and prevent regression and to increase his independence to return to the community. Additionally, in the absence of a comprehensive, integrated nursing facility care plan or ISP, there is no person-centered approach in the delivery of consistent quality of services for H.J. The PASRR Level I Screening (April 7, 2013) confirms that H.J. has a developmental disability, but he does not have an intellectual disability. There was no PASRR Evaluation available for review. Oddly, in service coordinator's notes from March 2016 and in subsequent documentation, it was noted that H.J. was ineligible for IDD PASRR services in the nursing facility due to a documented "IQ 94."

H.J. is not receiving any specialized services other than service coordination. Nursing facility documentation suggests that H.J. reported that he did not want any specialized services, but fails to provide any reasons for H.J.'s refusal or any documentation about efforts to engage H.J. in specialized services from which he might benefit. In April 2016, the service coordinator noted H.J. no longer received PASRR services due to not meeting eligibility requirements and will be discharged from the program. Documentation similarly notes in November 2016 that H.J. is ineligible for PASRR services, despite continuing to receive service coordination. A follow-up call with the PASRR manager confirms that H.J. does not receive any specialized services through the LIDDA reportedly because he is not eligible for the PASRR specialized services in the nursing facility.

During my visit, H.J. expressed frustration regarding not having access to his motorized wheelchair. H.J. told me that his motorized wheelchair has been inoperable for approximately the last nine (9) months; yet, it was only recently sent for repair. This concern should have been more promptly addressed by H.J.'s service coordinator. H.J. told me that he needs his electric wheelchair when he moves into his new apartment so that he can be more independent and be more involved in the community. Per H.J., due to the amputation of his fingers on his right hand and amputation of his left leg he has a very difficult time and often gets tired trying to propel a manual wheelchair. H.J. also told me that in addition to not having access to his wheelchair, he also has difficulty using his prosthetic leg, something that has diminished his overall mobility. For these reasons, he currently prefers to remain in his room at the nursing facility.

Nursing facility records indicate that in 2016, due to repeated falls, H.J. received time-limited, skilled occupational therapy and physical therapy to work on his upper extremities, active range of motion, activities of daily living skills, self-care, strength, transfers, gait, and standing balance, respectively. Yet, as of the day of my visit, these services were no longer provided to H.J. In my professional opinion, H.J. would benefit from ongoing habilitation through physical therapy for functional mobility, and occupational therapy to increase functional use of his upper extremities, and independent living skills services because he desires to leave the nursing facility to live independently in his own apartment.

H.J. is not receiving active treatment. He is not receiving any specialized services other than support coordination from either the nursing facility or the LIDDA. H.J. does not participate in any activities in the nursing facility nor is he given opportunities to participate in activities in the community. H.J. told me that in the past he and others went into the community to shop for personal items and to buy things they wanted. However, H.J. reported these outings ended due to the death of a staff member. He reported that he missed going on the outings, as they were opportunities to exercise his independence and social opportunities.

The nursing facility staff have not received training in understanding intellectual and developmental disabilities. There was no evidence of individual-specific training for staff persons caring for H.J. Because the nursing facility care plan and ISP are not integrated or coordinated in any way, nursing facility staff persons are not knowledgeable about all of H.J.'s specific needs or his recommended services and supports. The nursing facility staff is unable to assist H.J. with achieving his ISP goals and the nursing facility direct care staff who care for H.J. do not have the guidelines or training to assist H.J. in improving and maintaining his independence in activities of daily living across of all settings.

H.J. is at risk of harm due to the lack of specialized services, including physical therapy, occupational therapy, and ILS. H.J. also suffers ongoing harm from falling. H.J. has several limitations related to amputations of his left leg and of fingers on his right hand that require the use of a motorized wheelchair, yet that wheelchair has been unavailable for the last nine months. Additionally, H.J. has not received adequate physical therapy to assist him with the appropriate use of his prosthesis and now declines to use it because it is uncomfortable and he feels unstable walking on it. Having resided at the nursing facility for more than two (2) years, he is at risk of significant loss of social relationships as well as mental and emotional harm.

J.S.

J.S. is a pleasant 22-year old man who resides in a nursing facility in eastern Texas. He was admitted to the nursing facility on November 1, 2005 at the age of 11 because his mother could no longer adequately care for him due to his declining health. J.S. has no speech but communicates through facial expressions. He responds to prompts to move his legs or feet as well as to sounds from music. He has cortical blindness. J.S. takes pride in his personal belongings and enjoys the company of his family and friends. A nursing facility activity progress note dated November 18, 2016 indicates that J.S. attends school in-house at bedside five times a week. He is wheelchair-dependent and requires hand splints for contractures management. J.S.'s diagnoses include an unspecified intellectual disability, cerebral palsy, dysphagia, seizures, microcephaly, and acute upper respiratory infections. J.S. received a tracheostomy in 2014 with the goal of improving his respiratory condition. However, record documentation notes J.S.'s health continues to decline as evidenced by multiple hospitalizations.

There was no Comprehensive Functional Assessment available for review in J.S.'s records. I reviewed the PASRR Level I Screening dated April 9 2013 and the PASRR Evaluation (PE) dated September 28, 2013. These documents confirmed that J.S. has intellectual and developmental disabilities. The PE recommended no specialized services to be provided by the nursing facility and only service coordination through LIDDA, but no other specialized services.

Although J.S. has an ISP, it is not included in the nursing facility records. The ISP includes one outcome "to have daily interaction with staff." J.S.'s ISP does not include any specialized services provided by the nursing facility. The nursing facility staff have not received training in issues related to intellectual and developmental disabilities. The MDS coordinator told me that staff training in understanding IDD is not a priority when working with individuals, like J.S., who are medically fragile.

J.S. is not receiving any specialized services other than service coordination. In December 2015, March 2016, and January 2017, J.S. received therapy screenings but no recommendations were made for occupational or physical therapy evaluations. However, nursing facility records noted that J.S. previously received time-limited nursing facility OT and PT services in 2015. These therapy services were discontinued due to "maximum potential achieved" and J.S. was referred to and received services from the Restorative Nursing Program. A February 2017 Care Plan Conference Summary notes that J.S. receives rehabilitation for hand and elbow splints, and passive range of motion for contracture management. On the day of my visit, J.S. was wearing his hand and elbow splints while sitting in his wheelchair in his bedroom. In January 2016, the nursing facility record noted that J.S. "was previously on OT caseload," but it is unclear whether these services were nursing facility OT services or specialized habilitative services. Moreover, despite having a diagnosis of dysphagia, there is no indication that J.S. has received or has been considered for speech therapy services. In my professional experience, a speech therapist can be beneficial in assessing swallowing and cognition for rehabilitation potential, providing dysphagia therapy; providing therapeutic interventions to help the individual to maintain oral nutrition safely, and recommending diet modifications or alternative feeding.

The service coordinator expressed that there was confusion at the LIDDA regarding the array of specialized services that were available. Thus, specialized services are not offered and/or recommended due to the lack of understanding what these services include.

J.S. does not receive active treatment because he is not receiving any specialized services, other than case management, and there are no habilitative plans and programs for staff to assist J.S. with his functional skills. Although this is true, in my professional opinion, due to J.S.'s multiple complexities and his compromised system, I do not think that active treatment is a reasonable goal for him as the risks outweigh the benefits.

J.S. is at risk of ongoing harm due to his limited mobility and total dependence on others for movement and lack of ongoing specialized services including OT and PT to provide passive range of motion to prevent further contractures. J.S. is at risk of harm due to his declining health. In past two (2) years, J.S. has been hospitalized at least three (3) times for significant hematuria, dysphagia, and pneumonia/sepsis. Nursing facility staff told me that J.S must be airlifted to the hospital from the nursing facility when he requires acute care, which also places him at risk of harm due to his complicated respiratory issues. Due to his tracheostomy, J.S. is at risk of infections.

N.H.

N.H. is a 24-year old man who was admitted from the hospital to the nursing facility on June 6, 1999. He was admitted at age 6 following a car accident. N.H. has resided at the nursing facility for 18 years and is in a permanent vegetative state due to a closed head injury. Although the nursing facility record notes "persistent;" due to the length of time N.H. has been in his current state, he is in a permanent vegetative state. Other diagnoses include an unspecified intellectual disability, cerebral palsy, contractures, respirator-dependent state, and tracheostomy status. He requires total assistance for all movements. N.H.'s Individual Service Plan (ISP) notes that he has a friendly spirit. On the day of my visit, N.H was asleep in bed, but was dressed based on his documented preferences. Based on reports, N.H. has some awareness and enjoys being touched.

There was no Comprehensive Functional Assessment available for review in N.H.'s records. I reviewed the PASRR Level 1 Screening 1 (4/9/13), the PASRR Evaluation (10/1/13), and the Minimum Data Set assessment (8/8/16). These documents confirmed that N.H. has intellectual and developmental disabilities. The PE recommended no specialized services by the nursing facility and service coordination through LIDDA, but no other specialized services.

Although N.H. has an ISP, it is not included in the nursing facility records. According to N.H.'s service coordinator, the ISP services are identical to those in the nursing facility plan of care and contain no additional goals, services or supports provided by either the LIDDA or other service providers. The ISP does not include any specialized services other than service coordination. However, the ISP does include the following adaptive aids for N.H.: a wheelchair, a vehicle lift, a shower chair, wedges, and floor mats. The nursing facility staff have not received training in issues related to intellectual and developmental disabilities. Nursing facility staff indicated that training in understanding IDD is not a priority when working with individuals, like N.H., who are extremely medically fragile.

N.H. is not receiving any specialized services other than service coordination. Approximately two (2) years ago (March 2015), N.H. briefly received nursing facility occupational therapy (OT) services to address muscle weaknesses. In April 2015, N.H. was assessed for contracture management to increase his splint wear schedule. Nursing facility records noted that in 2016, N.H. participated in the Restorative Nursing Program for contracture management for splint management. Yet, there was no evidence that this was still occurring. The service coordinator told me that given N.H.'s cognitive status, she did not feel he would benefit from any specialized services and she was not familiar with any alternative services or supports that might be appropriate for him. N.H.'s January 2017 ISP indicates that he receives bilateral passive range of motion at bedside; yet, there was no evidence that it is provided as a specialized service. The ISP only includes service coordination as specialized services provided to N.H. There was no explanation of why N.H. did not receive ongoing OT as a specialized service.

N.H. does not receive active treatment. However, because he is in permanent vegetative state, it is my professional opinion that active treatment is not a reasonable goal for N.H. because

he is unlikely to benefit from active treatment. However, I agree with the earlier nursing facility determination that N.H. would benefit from OT and believe that this therapy should be provided on an ongoing basis as a specialized service to prevent further deterioration. Documentation indicates that N.H. receives educational services at bedside as well as some bedside activities such as music, cartoons, and, story-time.

N.H. is at risk of harm for increased muscle weaknesses, for increased contractures, and for developing decubitus due to continuous confinement to his bed with very limited movement and lack of ongoing occupational therapy services to improve range of motion and to prevent further deterioration and increased contractures.

D.B.

D.B. is an outgoing, sociable, and candidly vocal 64-year-old woman who resides in a nursing a facility outside of Dallas. D.B. makes her needs, wants, and desires known and advocates for herself. She uses a wheelchair as a means of mobility, but has no difficulty maneuvering around. On the day of my visit, D.B. was neatly dressed and stating she anticipated my visit so she could tell her story. D.B. clearly articulated that she wanted to leave the nursing facility to move to another nursing facility near where a family member resides. D.B. was initially admitted to the nursing facility in 2010, moved home for a brief period, but was readmitted on January 2, 2015. D.B.'s primary diagnoses include a moderate intellectual disability, depression, anxiety, neuropathy diabetes mellitus, osteoarthritis, muscle weakness, and cancer (in remission). D.B. receives medications to address her medical needs. She also receives anti-anxiety and anti-depressant medications.

There was no Comprehensive Functional Assessment (CFA) or any other integrated comprehensive assessment or planning documents that gave a clear picture of D.B.'s strengths, likes, dislikes, needs, and preferences available for review. The nursing facility staff was not familiar with a CFA. I reviewed the Minimum Data Set, PASRR Screening and the PASRR Evaluation (PE). These documents confirmed that D.B. has an intellectual disability. The PE recommended occupational therapy (OT), physical therapy (PT), and durable medical equipment specialized services provided by the nursing facility and service coordination through the LIDDA.

D.B. has an Individual Service Plan (ISP) that is reviewed on a regular basis by the Service Planning Team (SPT). However, the ISP is not a part of the nursing facility records and is not integrated as part of her supports and services at the facility. Failure to integrate the ISP with the nursing facility care plan risks support and services being provided inconsistently.

D.B. is not receiving any specialized services, other than service coordination, despite a February 2015 PE that stated that D.B. needed specialized services provided through the PASRR program. A 2016 Service Coordination Assessment notes that D.B. does not receive any specialized counseling or therapies. Although D.B. has previously received time-limited occupational therapy, physical therapy, and speech therapy for rehabilitation – not ongoing habilitation – those services were discontinued in 2016. Despite receipt of the therapy services for short-term goals in the past, there are no plans or guidelines to address D.B.'s need for specialized services for transfers, walking, self-care management, or dining/eating. According to a December 2015 swallowing assessment, she has mild deficits with swallowing as well as mild dysphagia. Due to chewing difficulty, holding food in her mouth, and oral problems, D.B.'s diet order has been progressively downgraded over time from a regular diet to mechanical soft diet to a pureed diet. Chewing and swallowing problems can sometimes make it difficult to eat, which can cause dehydration or weight loss. In fact, D.B. lost more than 30 pounds within a 6-month timeframe. Nevertheless, she is not receiving speech therapy, which is a service intended to assist with strengthening individuals' oral structures and to recommend a specific diet texture

and liquid consistency that is tailored to an individual's oral motor skills. This is important in minimizing episodes of choking and aspiration. Swallowing problems and mealtime issues are a real safety concern for D.B.

Nursing facility records revealed that although D.B. received skilled physical therapy in 2015 and 2016 to address safety awareness and gait training due to risk of falls, these services were often interrupted. For example, a January – February 2015 discharge summary noted "highest practical level achieved." A December 2015 discharge summary noted "exhausted benefits." A February – April 2016 discharge summary noted "maximum potential achieved refer to RNP to maintain BLE strength and safety." Significantly, D.B. experienced more than ten (10) documented falls in 2016 and received skilled OT services in 2015 and 2016 to address falls, but has not received that service on a continuous, ongoing basis. Moreover, D.B. told me that she asked the nursing facility therapists for physical therapy because her legs have become weaker, but this request was refused without explanation. In addition, nursing facility records note that D.B. has an experienced a decrease in activities of daily living skills (ADLs) as well a decline in her ability to write her full name. Yet, as of the day of my visit, she was not receiving any specialized therapies to address this situation. Oddly, D.B.'s Transition Plan includes recommended community supports of specialized OT, PT, and ST.

In April 2015, D.B.'s legal representative informed the service coordinator that a vocational program would be beneficial for D.B. because she previously attended a segregated sheltered workshop and she was bored at nursing facility. D.B. expressed interest as well. Again, in October 2015, D.B. indicated that she wanted to attend a day habilitation program. However, on the day of my visit, almost two years later, when asked the status of D.B.'s request for a day habilitation program, the service coordinator told me that there was only one day habilitation provider in the area and that program was at maximum capacity for individuals who use wheelchairs. The service coordinator was not aware of, or considering any other, day habilitation providers that might be appropriate for D.B. or for other individuals who use a wheelchair. Individual Living Skills (ILS) were not considered for D.B. because the SPT felt, according to the nursing facility records, that D.B. would have "more behaviors." However, there is no evidence that D.B. has been evaluated for behavioral services to address any behaviors that would hinder her ability to participate in ILS and there is no behavior plan or behavior supports in place to assist D.B with any behavioral challenges. Perhaps most importantly, the service coordinator is not assisting D.B. with finding an alternative placement for day activities.

Nursing facility therapy services were offered to D.B., but only in response to an acute, adverse event, and only for rehabilitation purposes. D.B. is not receiving any specialized services to address her increasing limitations in her mobility and ADL skills, or her increasing difficulties in eating and swallowing safely.

Because D.B. is not receiving all needed specialized services, she clearly is not receiving active treatment. In addition, the failure to integrate the ISP with the nursing facility care plan, or even include it with the nursing facility record, has led to a lack of continuity of support and services that D.B. needs. Nursing facility staff working with D.B. are not aware of her ISP goals

and are therefore unable to implement the services and supports necessary to assist D.B. in achieving those goals. Furthermore, when D.B. receives time-limited therapy services, these services are only provided by the nursing facility therapists. Other nursing facility staff who care for D.B. are not trained to assist her with achieving her therapeutic goals. There are no habilitative programs or plans for staff to assist D.B. with her functional skills. Therefore, D.B. is not receiving active treatment, because even when certain therapies are available to D.B. they are not delivered in the amount and frequency that D.B. needs and they are not reinforced by the nursing facility staff.

The nursing facility staff have not received training in issues related to intellectual and developmental disabilities. This lack of understanding of the many facets of intellectual disabilities creates a challenge for staff working with individuals with IDD, including D.B. There is also no individual-specific training offered to staff who work directly with D.B.

D.B. is at risk of harm due to lack of ongoing habilitation services. Failure to provide ongoing mealtime oversight from speech therapists creates potential harm due to the identified complexities of D.B.'s swallowing, chewing, and medical issues. At the time of my visit, D.B. also did not have her dentures, which creates a heightened risk for harm during meals. She was also not wearing her eyeglasses. Since admission to the nursing facility, D.B. has had a decrease in mobility skills and as noted above, has had several significant falls during the last year; a decrease in eating with a significant decrease in weight (lost more than 30 pounds within a 6-month period); a decrease in activities of daily living; and a decrease in her ability to write her name. D.B. is at risk for future harm if specialized services to address her needs are not provided on a consistent basis across all settings.

Appendix 1

VICKEY V. COLEMAN

41 CALLAWAY COVE MEDINA, TENNESSEE 38355 (731) 234-2125 vcoleman35@bellsouth.net

EXECUTIVE SUMMARY

Accomplished professional social worker with higher executive government experience; 10+years of conducting quality assurance reviews and protection from harm reviews; instrumental in successful closure of state-operated institutions; experience with Federal litigations; in-depth knowledge of deinstitutionalization and transition processes; progressive leadership experience with excellent customer service skills

PROFESSIONAL EXPERIENCE

State of Tennessee, Department of Intellectual and Developmental Disabilities **10/11- Present**

DIDD Director of the Office of Civil Rights/Title VI Director 5/1/16 - Present
Interim Director of the Office of Civil Rights (10/4/15 to 5/1/16)

- Appointed by the Commissioner to serve as the Director of the Office of Civil Rights/Title VI Director to oversee departmental compliance with all civil rights laws and policies and conduct investigations of civil rights complaints filed with the department

- As a member of the Commissioner's Senior Management Leadership Team, serve as the Commissioner's Step One Appeal Designee to handle all Human Resources responsibilities related to written warning reviews and conducting Step One Appeal Discussions, etc, in accordance with state policies and procedures

- Serve as the contract manager for departmental contracts with the Arc of TN
- Provide administrative oversight to the Human Rights Committee

- Serve as an owner of the Leadership Accreditation Work Plan Group with the Council of Quality Leadership (CQL)

- Provide technical assistance for DIDD Regional Title VI coordinators to address regional trainings, tracking of civil rights complaints, and collecting civil rights related statistical data

State Director of Customer Focused-Services (Division of Advocacy Services & Complaint Resolution)

- As a member of the Commissioner's Senior Management Leadership Team appointed to develop a newly established unit from ground zero, utilized existing staff resources for cost containment to create a state-wide team responsible for advocating for the needs of service recipients and their family members and responding to and resolving all of the department's formal complaints, resulting in a reduction of statewide complaints by more than 50% during the first year

- As state director, developed a state-wide comprehensive reporting system that tracks and trend advocacy issues and formal complaints to submit to the Commissioner and Executive Leadership Team for systemic improvements in service delivery

- Coordinate and monitor the administration of over million dollar contract for independent advocacy services in Tennessee to ensure contract remains within allotted budget

- Serve as a charter member and chairperson on the Board of Directors of the West Tennessee Housing Foundation which provides oversight of more than $3 million to expend on housing supports for individuals with intellectual and developmental disabilities. Served as Board secretary from inception in 2011 through 2015

State of Tennessee, Department of Intellectual and Developmental Disabilities **07/12- 02/14**

Transition NOW Coordinator

- Appointed by the Commissioner to assume responsibilities as the coordinator and manager of an existing team; restructured the team to create the Transition NOW Initiative responsible for the facilitation of transitions of individuals who have intellectual and developmental disabilities (IDD) out of Intermediate Care Facilities and nursing homes

- Created a quality review system for the transition process and quality improvement efforts of individuals who have IDD, which resulted in the successful transition of approximate 100 individuals out of institutional placements and nursing home to community homes

- Appointed to facilitate the Court-mandated Needs Assessment Review Process which matched services with needs of individuals with intellectual and developmental disabilities residing in nursing homes

- Successfully executed the Federal Court-issued Exit Plan that resulted in the closure of the Federal litigation between the Federal Court, the Parties, and the Department of Intellectual and Developmental Disabilities

NKR & Associates, Inc. Delmar, New York **10/01-09/11**

Senior Associate (1/05– 09/11)

Research Associate (10/01–12/04)

- Appointed as Senior Associate to the Federal Court Monitor for the Arlington Class responsible for overseeing the supports and services to approximately 500 class members, who have intellectual and developmental disabilities and who resided in Arlington Developmental Center and community homes as well as provided supervision to Court Monitor's staff

- Conducted quality assurance reviews of supports and services as well as protection from harm reviews of class members in various community and institutional settings, including group homes, nursing homes, mental health facilities, State institutions, and family care homes and prepared comprehensive reports related to residential provider agencies' performance

- Monitored the arrangements for the successful transition of approximately 200 class members from Arlington Developmental Center to community homes through the closure of the institution in October 2010

Integrated Community Living in Tennessee Corporation, Jackson, Tennessee **3/00–9/01**

Regional Director (Jackson & Chattanooga) (5/01–9/01)

Program Manager/Incident Management Coordinator/Investigator (3/00–4/01)

- As Regional Director, responsible for budget management, census retention and growth, recruited and managed 50+ professional staff, wrote policies and procedures, monitored the implementation of support plans for individuals in the program; and served as the agency's Incident Management Coordinator and Abuse Investigator, certified State trainer, and public relations director

State of Tennessee-DMRS Western Regional Office, Jackson, Tennessee **3/98–3/00**

DMRS Regional Incident Management Coordinator

- Reviewed and approved community agencies' policies on incident management; provided technical assistance and training to staff of community provider agencies; coordinated activities related to substantiated reports of abuse and neglect in community living homes; and served as a member of the West TN Regional Abuse, Neglect Prevention Committee and the Division's on-call administrator on duty (AOD)

Nat T. Winston Developmental Center, Bolivar, Tennessee **12/93–2/98**

Program Coordinator & Incident Management Coordinator (7/96–2/98)

Residential Program Specialist/QMRP (12/94–7/96)

Counselor Associate II (12/93–12/94)

- As Program Coordinator, supervised 100+ staff persons working in the institution, which served persons with developmental and mental health disabilities; served as the institutions administrator on duty; and supervised and monitored the successful placement of 100+ individuals to community placement through closure of the institution in February 1998
- As Incident Management Coordinator, assisted in the development and implementation of institution policies and procedures for addressing injuries and other adverse events
- Served as Team Leader of the Interdisciplinary Team of approximately 36 residents and developed and implemented residents' support plans and skill acquisition programs

J.B. Summers Counseling Center, Somerville, Tennessee **2/90-11/93**

Adult Day Treatment Program Coordinator

- Supervised the daily operation and administration of day treatment program serving 30 individuals

EDUCATION

Walden University, Doctor of Philosophy: Public Health **2013**

University of Memphis, Master of Science: Counseling and Personnel Services **1996**

Tennessee State University, Bachelor of Science: Sociology; Minor Psychology **1988**

CERTIFICATIONS AND SPECIAL SKILLS

Rule 31 Listed General Civil Mediator

Protection from Harm Consultant for the United States Department of Justice (nursing homes and psychiatric facilities)

Graduate of 2015 Class of LEAD TN

Graduate of 2012 Class of Tennessee Government Management Institute (TGMI)

Graduate of 2005 Class of Leadership Hardeman County (a program to promote leadership and strategic skills for nominated county residents)

Certified Abuse and Neglect Investigator/Quality Mental Retardation Professional (QMRP)/Crisis Prevention Intervention (CPI)

COMMUNITY SERVICE

Delta Sigma Theta Sorority, Inc.

Diamond Life member of the largest Pan Hellenic public service organization in the country whose programs help uplift the community and the world at large. Served as the local chapter's assistant correspondence secretary and served as the sergeant-at-arm for 2 consecutive two-year terms

Board of Directors, Hardeman County Adult Basic Education Program
Former appointed board member responsible for overseeing a program with a focus of assisting individuals with obtaining Graduate Education Diploma (GED) and responsible for hiring and supervising the programmatic and operations functions

Antioch Baptist Church
Serve on the Leadership Team to assist the Pastoral Ministry in program development and improvement efforts and served as vice-president of Women's Fellowship for two years

Appendix 2

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

PRE-ADMISSION SCREENING AND RESIDENT REVIEW SPECIALIZED SERVICES AND ACTIVE TREATMENT REPORT OF VICKEY V. COLEMAN, Ph.D.

Appendix 2

	Document	Bates No.
1.	Kathryn Dupree 2015 Annual Report of Compliance	DefE-00000601-672
2.	Kathryn Dupree Q1 2016 QSR	DefE-00000677-716
3.	*Rolland v. Patrick* Active Treatment Protocol	PL00000001-14
4.	*Rolland v. Patrick* Reviewer's and Quality Review Manual	PL00000015-41
5.	*Rolland v. Patrick* Active Treatment Follow-up Protocol	PL00000042-59
6.	QSR Matrix	PL00000060-136
7.	Attachment G - PASRR Requirements and Enhanced Community Coordination	DefE-00001859-1873
8.	LIDDA PASRR Reporting Manual	PL00000200-213
9.	40 T.A.C., Part 1, Ch. 19. subch. BB: NF responsibilities related to PASRR	PL00000251-263
10.	*Rolland v. Patrick* Revised Active Treatment Standards	
11.	CMS Active Treatment Tags	
12.	CMS PASRR NF Survey Guidance, 9/28/07	
13.	42 C.F.R. § 483 - PASRR Regulations	
14.	LIDDA Records for BC	
15.	Nursing Facility Records for BC	
16.	LIDDA Records for CC	

17.	Nursing Facility Records for CC	
18.	LIDDA Records for DB	
19.	Nursing Facility Records for DB	
20.	LIDDA Records for DG	
21.	Nursing Facility Records for DG	
22.	LIDDA Records for DM	
23.	Nursing Facility Records for DM	
24.	LIDDA Records for HJ	
25.	Nursing Facility Records for HJ	
26.	LIDDA Records for JS	
27.	Nursing Facility Records for JS	
28.	LIDDA Records for NH	
29.	Nursing Facility Records for NH	
30.	LIDDA Records for SC	
31.	Nursing Facility Records for SC	
32.	LIDDA Records for SW	
33.	Nursing Facility Records for SW	
34.	PIRM QSR Outcome 2 Reports for BC, CC, DB, DG, DM, HJ, JS, NH, SC, SW	

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lillian Minor, *et al*.,

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

Case No. SA-5:10-CV-1025-OG

DECLARATION OF GARTH CORBETT REGARDING EXHIBITS IN SUPPORT OF PLAINTIFFS' MOTION AND MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

I, GARTH CORBETT, hereby declare:

1. I am an attorney with Disability Rights Texas and am one of the attorneys representing the Plaintiffs in the above-captioned matter. I make this Declaration in support of Plaintiffs' Motion and Memorandum of Law In Support of Motion for Preliminary Injunction. I am competent to testify to the matters stated herein and either have personal knowledge of the facts set forth below or they are from sources deemed reliable.

2. This Declaration has been prepared to authenticate pertinent exhibits attached to the Plaintiffs' Motion and Memorandum of Law in Support for Preliminary Injunction.

3. Attached hereto as Exhibit A is a true and accurate copy of the "PASRR QSR 2015 Annual Report of Compliance" (Bates No. DefE-00000601-623), dated June 8, 2016.

4. Attached hereto as Exhibit B is a true and accurate copy of the "2016 Quarter 1 PASRR QSR Compliance Status Report" (Bates No. DefE-00000675-715), dated July 7, 2016.

5. Attached hereto as Exhibit C is a true and accurate copy of "PASRR Requirements and Enhanced Community Coordination," Amendment Packet 2, Amended September 1, 2016" (Bates No. DefE-00001859).

6. Attached hereto as Exhibit D is a true and accurate copies of the 2012 State Plan Amendment, SPA TX 11-054 Approval Letter to Mr. Billy Millwee from Bill Brooks Associate Regional Administrator, Center for Medicare and Medicaid Services and attached Transmittal and Notice of Approval of State Plan Material, and approved State Plan Amendment pages (collectively referred to as "State Plan Amendment") dated July 18, 2012.

7. Attached hereto as Exhibit E is a true and accurate copies of the cover page and pages 32-33, and 93 of the "Texas Health and Human Services System, Consolidated Budget Request 2018-2019 Biennium," dated October 2016.

8. Attached hereto as Exhibit F is a true and accurate copy of pages 1, 2, 46, 47, 114- 123 of the Deposition of Stacey Lindsey dated February 8, 2017.

9. Attached hereto as Exhibit G are true and accurate copies of pages 1, 2, 46, 126 - 127 of the Deposition of Merinda Blevins dated February 7, 2017.

10. Attached hereto as Exhibit H are true and accurate copies of pages 1, 2, 57-58, 60, 96, 97, of the Deposition of Geri Willems dated February 3, 2017.

11. Attached hereto as Exhibit I are true and accurate copies of pages 1, 2, 22, 78, 126, 138, 144-145 of the Deposition of Cathy Belliveau dated February 2, 2017.

12. Attached hereto as Exhibit J is a true and accurate copy of the "Report on Cost of Preadmission Screening and Resident Review as Required By The 2016-17 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Special Provisions, Section 52): Health and Human Services Commission, February 2017."

13. Attached hereto as Exhibit K is a true and accurate copy of *Rolland v. Patrick*, Order Approving Revised Active Treatment Standards, Civil Action No. 98-30208-KPN ECF No. 456 (August 2, 2007) and attached Revised Active Treatment Standard, ECF No. 456-2.

Pursuant to 28 U.S.C. §1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 3rd day of April, 2017, at Austin, Texas.

Garth A. Corbett

Exhibit A

PASRR QSR 2015 ANNUAL REPORT of COMPLIANCE

FINAL REPORT

SUBMITTED BY: Kathryn du Pree, PASRR QSR Lead Reviewer

June 8, 2016

SECTION I: OVERALL FINDINGS

INTRODUCTION

The PASRR QSR process was initiated in January 2015. The process was designed based on Outcomes the State and Plaintiffs agreed to under the Steward Interim Agreement that was in effect through September 30, 2015. The QSR includes Measures, Indicators and Interpretive Guidelines to determine the State's compliance with the Outcomes that the State wants to achieve for the population of individuals that are eligible for PASRR services because of an intellectual disability or related condition. These are individuals that continue to reside in Nursing Facilities (NFs); have been diverted from admission to a NF; or that have been transitioned from a NF to the community with waiver or other community resources.

The Defendants and Plaintiffs worked with the Lead PASRR QSR Reviewer, who was the Expert Reviewer through the course of the Interim Agreement, to develop Measures for each of the six Outcomes. Compliance with the Measures and Outcomes would be determined through implementation of the QSR and accompanying reports from LIDDAs and DADS. A seventh Outcome addresses systemic expectations for Quality Assurance. It was determined that compliance with the Quality Assurance Outcome would be expected to start in 2016.

The six outcomes are as follows:

1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.
2. Individuals in the Target Population in nursing facilities will receive specialized services with the frequency, intensity, and duration necessary to meet their appropriately identified needs, consistent with their informed choices.
3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services , and placements in the most integrated setting to meet their needs, consistent with their informed choice.

4. Community Members will receive services in the most integrated setting, with the frequency, intensity, and duration necessary to meet their appropriately identified needs, consistent with their informed choice.
5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately identified needs, consistent with their informed choice.
6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately identified needs, consistent with their informed choice.

The QSR PROCESS

The QSR process is based on conducting Individual Reviews of a statistically valid randomly selected sample of NF and Community Members from the three target groups: Diversion, Transition, and Nursing Facility. The State wanted a sample of reasonable size and it was determined that a sample would be selected based on achieving confidence level of 90%. This would involve reviewing approximately 290 individuals. The samples were randomly selected on a quarterly basis by DADS CPI staff. The names were submitted to me and Crosswinds Consulting arranged the QSR review weeks for the QSR Review Teams. Each sample included more individuals than would be needed in case anyone needed to be cancelled and then substituted.

The 2015 QSR included 289 completed Individual Reviews. The QSR Teams reviewed:

- ***87 individuals that diverted***
- ***87 individuals that transitioned***
- ***115 individuals that resided in nursing facilities***

The confidence level was 95% for the Diversion and Transition Groups and 90% for the NF Group. It was higher than expected for the Diversion and Transition Groups because the original number for the sample was derived based on DADS projection that more individuals would be placed in the community in the bi-ennium using waiver resources than was achieved. Individuals were included in the sample that utilized STAR+PLUS and ICF-IDD resources as well as HCBS resources.

Local Intellectual and Developmental Disability Authorities (LIDDAs)-The goal was to review individuals served across all 39 of the LIDDAs. We were able to include 35 of the 39

LIDDAs. Those not included were Brazos, Emergence, Center for Life, and Texas Panhandle. These will be included as early as possible during 2016.

The following LIDDAS had 10 or more reviews completed during 2015: Alamo, Austin Travis, Community Healthcare, Heart of Texas, Tarrant, Dallas Metrocare, Harris County and Gulf Coast.

The following LIDDAs had 6-9 reviews completed during 2015: Central Counties, Lakes, Nueces, Spindletop, Denton, Gulf Bend, Pecan Valley, Hill Country, Texana, Texoma, Tri-County, and Tropical. The remaining LIDDAs had 5 or fewer reviews completed during 2015.

Debriefings were scheduled with LIDDAs after October 1 2015. These were conducted by the PASRR Lead Reviewer and Independent Reviewers in the fall for the LIDDAs that had 10 or more QSRs completed at that time. The remaining debriefings were done in March 2015 with LIDDAs that had 6-9 QSRs completed. The LIDDAs that had 5 or fewer QSRs completed received their reports and will be joining a Webinar on March 23, 206 to review the results of the 2015 QSR. These LIDDAs have been offered a debriefing after the webinar if they believe it will be helpful. Debriefings will be scheduled throughout 2016 to provide timely feedback to the LIDDAs to assist them with quality improvement.

Cancellations-We needed to cancel 38 Individual Reviews. These were cancelled for the following reasons:

- 9 individuals in NFs died
- 7 individuals no longer represented the Target Group for which they were originally chosen
- 6 individuals did not participate in community programs covered by the original agreement
- 5 individuals were not eligible for PASRR
- 3 individuals refused to participate
- 3 individuals had no known addresses
- 2 left the NF before 2014 when service coordination was required
- 2 moved after being identified in the sample and the distance was too great
- 1 was repeated in the sample

The QSR Process- the State hired an Expert Reviewer who worked jointly for the Parties until September 30, 2015 when the role was changed to PASRR QSR Lead Reviewer. Five Independent Reviewers were hired so that the QSRs could be conducted by trained, experienced independent reviewers who were not directly employed by the state. Teams were created with a clinician, and a generalist reviewer that has experience in person-centered planning, transition planning, program evaluation, and waiver services. The

clinicians for 2015 included a RN and two OTRs. The QSR includes a broad range of clinical, programmatic, service planning, service coordination and transition planning expectations. It was felt that each team needed two reviewers to bring the proper experience and expertise to the review process. All of the Independent Reviewers participated in QSR training before conducting QSRs. Reviewers were trained in the purpose of the state's PASRR implementation plan; the Outcomes, Measures, Indicators and Interpretive Guidelines; the QSR review and rating process; and the use of the rating tool, PASRR Individual Review Monitoring (PIRM). All ratings were reviewed by the Expert Reviewer/PASRR QSR Lead Reviewer for validity and consistent interpretation of the measures, indicators and guidelines.

The review process included extensive record review of PASRR evaluations, individual service plans, assessments, progress notes and service notes, as well as interviews and observations. Individuals, legally authorized representatives (LARs), Service Coordinators, and staff were interviewed using standard interview protocols.

The QSR was translated into an online interactive evaluation tool, the PIRM. It is used to data enter all ratings and has a scoring methodology to compute compliance at both the Measure and the Outcome levels. PIRM was developed by the IT Team in CPI. It was developed in a timely manner so it was in production by January 2015. The IT team has provided exceptional support and been very responsive throughout the year.

Training State Reviewers- DADS hired a QSR Manager in the summer. She and a nurse started their training in the early fall and continued throughout 2015 to prepare them to join the QSR Teams as full-fledged Reviewers in 2016. The training included classroom and onsite training with the Independent Reviewers.

STATISTICS ABOUT THE INDIVIDUALS REVIEWED

There is some interesting information about the individuals that were reviewed that may assist DADS as it seeks to achieve compliance with the six Outcomes and ensure that there is sufficient community capacity to meet the needs of the individuals who stay in or return to the community.

Individuals with behavioral and medical needs- The sample included 174 individuals that were Community Members. Thirty six of these individuals (21%) had significant behavioral challenges and thirty four of these individuals (20%) had significant medical concerns. Individuals that had histories of psychiatric hospitalizations or who had lost previous placements at ICF-IIDs of group homes were successfully transitioned or diverted. We met individuals that had tracheotomies, used oxygen, were receiving chemotherapy or undergoing dialysis being supported by providers. A significant number of the individuals with medical concerns lived in host homes often with a family member.

However there were twenty seven individuals (15%) that returned to the NF either because of poorly implemented transitions or health issues that occurred post transition or after the first 90 days of community living. This will be discussed in greater detail in the full 2015 Annual Compliance Report.

The QSR Teams reviewed 115 individuals residing in NFs. Forty six (40%) of these individuals refused transition and 14 (12%) refused service coordination. Individuals in NFs need ongoing information about community options and encouragement to visit community programs to be able to make informed decisions. The educational activities offered by the LIDDAs and the ability for these individuals to participate in community based specialized services including day habilitation, independent living skill development and employment are key to creating interest in community living.

COMPLIANCE FOR2015

Table 1 below summarizes the levels of compliance for each Outcome. This is based on QSR data and report. Specific findings and recommendations regarding LIDDA and DADS reports are included in ***Section II: DADS and LIDDA QSR Reports Summary and Findings for 2015***

Table 1- Compliance with the Outcomes

Outcome	2015 Compliance Level	Interim Compliance Expected	Full Compliance Expected
1-Diversion	***58%***	None	Year 2
2- NF Specialized Services	***36%***	50% Year 3 65% Year 4	Year 5
3- Transition	***35%***	None	Year 2
4- Community Services	***51%***	60% Year 3	Year 4
5- Service Coordination	***48%***	None	Year 3
6- Service Planning Team	***38%***	60% Year 3	Year 4

What are some of the challenges?

Meeting the federal and state PASRR rules, the contract expectations for the LIDDAs, and DADS commitment to improve the planning, assessment and service delivery processes for individual that are PASRR positive requires changes at every level and is particularly dependent on the strength of service coordination; the understanding and cooperation of the NFs to provide specialized services and accept the role and guidance of the Service Coordinator (SC); and waiver providers working cooperatively with SCs to assure comprehensive assessments, person-centered planning and services that reflect goals and objectives to increase independence and support a life of community interaction and inclusion. The role of the SC to lead SPTs at NFs is a new concept for NF staff as is the right of individuals to have the specialized services they need. Waiver providers are used to interacting with SCs but must learn to work with them in their enhanced role as the leader and facilitator of the SPT. The state has embraced Outcomes and Measures for this population that assures both NFs and waiver providers will fully assess all the needs of an individual including areas of risk; set goals and objectives for them based on assessment; assure that all needed services are available; and offer Community Members employment support or other community based integrated day activities. NF Members have full access to specialized services including employment and day habilitation.

Reviewers are not seeing PASRR Evaluators or the SPTs at NFs fully considering the benefits of all of the specialized services the state now offers. Confusion as to the differences in rehabilitative versus habilitative services including when to stop billing Medicare and start requesting specialized services funding remains unclear to NF staff. NF staff consistently report they do not know how to have these services authorized.

Neither NF nor community SPTs complete the full range of assessments that an individual needs including functional, independent living skill development, clinical and employment related assessments. These are foundational to planning services and developing measurable goals and objectives as part of an individual's service plan. The percentages of compliance are based on specific related Measures in the QSR.

Table 2 highlights the areas to improve in 2016

Area for Improvement	**Compliance for NF**	**Compliance for Community**
Accurately identify NF SS or community needs in PE	34%	44%
Provide specialized services	19%	N/A
Conduct comprehensive assessments	30%	35%
Engage in person-centered planning	39%	53%
Provide all necessary services	19%	52%
Conduct quarterly SPT meetings	37%	40%
Conduct semi-annual community education	15%-*QSR indicator result* 51%- *with report metrics and indicators*	N/A
Offer employment or integrated day	Included under specialized services	25%

Areas of strength in 2015

There are a number of accomplishments that were achieved in 2015 as evidenced by QSR results:

- 95% of individuals have Service Coordinators
- Very few individual refuse service coordination and all have the refusal documented
- 98% of individuals diverted or transitioned within 180 days of accepting a waiver slot or within the extension period granted by DADs with very few needing the extension

- 91% of individuals that transitioned had the services and supports they needed to live in the community in their initial ISP
- 96% of individuals that transitioned or diverted live in a home with no more than 4 individuals with an ID or DD

QSR REPORTS

There are three Compliance Reports included with this QSR Status Report for 2015. They are:

QSR Outcome Overall Compliance- summarizes the levels of compliance for each Outcome based on individual review ratings for the involved Target Groups and relevant LIDDA and DADS reports.

QSR Measure Overall Compliance- summarizes the levels of compliance for each Measure within each Outcome based on the individual review ratings for the involved Target Groups and relevant LIDDA and DADS reprots. Please note on this report that the compliance level for Measures 1-14, 3-14, and 4-13 are all 0%. These are the Measures that determine if individuals receive information about housing subsidies and rental assistance. These options are not available to individuals transitioning to waivers. Discussion of these subsidies was only relevant to three individuals but they were not offered this information. These Measures have been deleted from the 2016 QSR because it is not available to individuals that use waiver services or ICF-IIDs.

QSR Target Population Compliance- summarizes the level of compliance for each Target Group by Outcomes relevant to each Target Group. Table 3 provides a summary of these findings. LIDDAs are having the most success implementing PASRR QSR expectations for the Diversion Target Group and the least success for the NF Target Group. Compliance for Outcome 5, Service Coordination is 18% higher for Diversion than it is for Transition. Compliance for Outcome 6, the Service Planning Team is 10% higher for Diversion than it is for Transition

Table 3: Summary of Outcome Achievement by Target Group

Outcome	Diversion Compliance	Nursing Facility Compliance	Transition Compliance
1	67%	N/A	N/A
2	N/A	36%	36%

3	N/A	40%	41%
4	52%	N/A	50%
5	69%	49%	51%
6	47%	29%	37%

PASRR Individual Review Monitoring (PIRM)

Outcome Overall Compliance

Report Date:6/8/2016

This report displays:

- The percentage of **QSR Compliance** (without report metrics) for each **Outcome** based on *just* the findings recorded in PIRM (indicators only) for all closed Individual Review (IR) records that fall within the review period.
- The percentage of **Report Compliance** (without QSR indicator metrics) for each **Outcome** based on *just* the report metrics relevant to the Outcome
- The percentage of **Overall Compliance** (with report metrics considered) for each **Outcome** based on both the findings recorded in PIRM for all **closed** IR records that fall within the review period as well as actual report metric responses that pertain to the Measure

Review Year	Outcome	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
2015 (Closed Period)	OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	67%	47%	58%
	OUTCOME 2. Individuals in the Target Population in nursing facilities will receive specialized services with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	35%	48%	36%

Review Year	Outcome	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately-identified needs, consistent with their informed choice.	43%	39%	35%
	OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	51%	46%	51%
	OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	53%	8%	48%
	OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	38%		38%

PASRR Individual Review Monitoring (PIRM)

Measure Overall Compliance

Report Date:6/8/2016

This report displays:

- The percentage of **QSR Compliance** (without report metrics) for each **Measure** based on *just* the findings recorded in PIRM (indicators only) for all closed Individual Review (IR) records that fall within the review period.
- The percentage of Report Compliance (without the QSR indicator metric) for each Measure based on just the report metric that pertain to certain Measures
- The percentage of **Overall Compliance** for each **Measure** based on both the findings recorded in PIRM for all **closed** IR records that fall within the review period as well as actual report metric responses that pertain to the Measure
- **Note:** Some Measures are calculated using just report metrics. DADS and the PASRR QSR Lead Reviewer determined scoring methodology to be used to determine the level of compliance of each Measure relying on both QSR indicators and reports.

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
2015 (Closed Period)	Outcome Measure 1-1. A PASRR Level I screening is completed for individuals seeking admission to nursing facilities. DADS tracks and shares the results with the Local Authority (LIDDA) and the Diversion Coordinator if the individual needs a PASRR Level II evaluation.	98%		98%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 1-2. An individual in the TP seeking admission to a NF who is determined by a PASRR Level I to be in need of a PASRR Level II will receive a PASRR Level II evaluation completed by the LIDDA or other qualified entity with experience working with community based services for individuals with ID/DD, within the required timeframes.	89%		89%
	Outcome Measure 1-3. The PASRR Level II evaluation confirms whether the individual has ID or DD and if so, appropriately assesses whether the needs of the individual can be met in the community and accurately identifies, based on the information available, the specialized services the person needs if s/he is admitted to a NF. A report of the reviewer's decision is shared with the individual and his/her LAR.	41%		41%
	Outcome Measure 1-4. Individuals in the TP who need specialized services will only be admitted to a NF if the individual's needs for specialized services can be met by the NF, the LA, or both.	92%		92%
	Outcome Measure 1-5. Each LIDDA has a Diversion Coordinator who is responsible for identifying community services. The Diversion Coordinator is a professional who is experienced in coordinating and/or providing community services to people with I/DD, including people with complex medical needs.		38%	38%
	Outcome Measure 1-6. The Diversion Coordinator identifies available community living options, supports, and services to assist individuals in the TP to successfully live in the community, and provides information and assistance to SCs and other LIDDA staff who facilitate diversion for these individuals.		37%	37%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 1-7. The Diversion Coordinator coordinates education for SCs and other LIDDA staff to learn about available community services and strategies to avoid NF placement for the TP.		74%	74%
	Outcome Measure 1-8. Individuals Diverted from NF admission have access to information from DADS that describes the community services available to support them to live in the community.	94%		94%
	Outcome Measure 1-9. For members of the Target Population living in the community who can be diverted from NF admission, the SC or other LIDDA staff identify, arrange and coordinate all community options, services, and supports, for which the individual may be eligible and that are necessary to enable the individual to remain in the community and avoid admission to a NF. Services and supports will be consistent with an individual's or LAR's informed choice.	56%		56%
	Outcome Measure 1-10. All individuals seeking admission to a NF, who were identified through a PASRR Level II evaluation as having ID/DD and who wish to remain living in the community, will receive support, consistent with their individual choice, to participate with their Service Planning Team (SPT) in a planning process that identifies the community supports they need to remain in the community. The individual and the LAR are informed of community options that will meet the individual's needs.	54%		54%
	Outcome Measure 1-11. For individuals who are diverted from a NF placement, supports and services are made available to remain in the community, or to move to the community after a stay in a NF of fewer than 90 days. These supports and services recognize the needs and choices of the individual.	100%	59%	63%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 1-12. Individuals who are in the NF for up to 90 days prior to diversion will have an ISP, including a discharge plan that describes the necessary supports for the individual to move to the community, which is coordinated with the NFCPC by the SC. The ISP includes all specialized services the individual needs, including strategies for the individual to learn about community options, such as opportunities to visit community programs, and transition activities.	37%		37%
	Outcome Measure 1-13. Individuals who are placed in a NF for fewer than 90 days receive all specialized services that are needed, as specified in the ISP and the NFCPC. These services are based upon the PASRR Level II and the SPT assessments and reflect the individual's choices and preferences.	42%		42%
	Outcome Measure 1-14. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and that is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to individuals who are being diverted from NF placement or who are in a NF for fewer than 90 days, and makes appropriate referrals to these sources for these individuals.	0%		0%
	Outcome Measure 1-15. Within 45-75 days after an individual is admitted to a NF, the DC reviews whether community living options, services, and supports that provide an alternative to the NF placement have been explored. If alternatives have not been explored, the Diversion Coordinator ensures that the individual's SC coordinates this exploration.	75%	93%	89%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 1-16. No Community Member is served in a residential setting that serves more than 6 individuals with I/DD unless the SPT and Diversion Coordinator tried but could not address the barriers to such a placement and the individual or LAR made an informed decision to accept the placement.	97%		97%
	Outcome Measure 1-17. Any NF Member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LA, which contacts the individual within 30 days of this notification to discuss community options.	67%	13%	27%
	Outcome Measure 1-18. Using data, including the information reported in V.F.5 and V.F.6, DADS identifies frequent reasons for admission to NFs of individuals in the Target Population and takes steps to reduce such admissions and to remove barriers to diversion and transition for such individuals.		15%	15%
	Outcome Measure 2-1. All individuals in the Target Population (TP) have a Service Planning Team (SPT), convened and facilitated by the Service Coordinator (SC). The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her needs. The SC facilitates the coordination of services and supports the individual receives.	36%		36%
	Outcome Measure 2-2. SPTs for individuals in NFs include the LIDDA Service Coordinator, the individual and the LAR, nursing facility staff familiar with the individual's needs, providers of specialized services, and a community provider if a community placement is planned.	35%		35%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 2-3. The NF Member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual or LAR approves the content of the plan.	39%		39%
	Outcome Measure 2-4. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation and the integrated day activity needs of the individual.	30%		30%
	Outcome Measure 2-5. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF Member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of specialized services.	19%		19%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 2-6. At least semi-annually LIDDA's offer individuals who are in the NFs and their LARs receive education and information about community options that explain the benefits of community living, address their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community supports and services and may include opportunities for individuals to visit community programs and talk to individuals with I/DD living in the community and their families.	15%	87%	51%
	Outcome Measure 2-7. Upon admission to a NF and at least semi-annually, the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information with the individual and the LAR to better enable them to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide this community educational material.	48%		48%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 2-8. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of all the specialized service providers. The NFCPC includes those needed specialized services and supports that are the responsibilities of the NF. The SC facilitates and ensures the coordination of specialized services in the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual. The SPT ensures that the services in the ISP, including specialized services, are provided to the individual and are delivered in a consistent and coordinated manner reflective of the ISP.	27%		27%
	Outcome Measure 2-9. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	11%		11%
	Outcome Measure 2-10. LAs have caseloads for Service Coordinators based on a methodology that reflects the amount of time involved in the person-centered planning process; the transition process; and the coordination and monitoring responsibilities of service coordinators related to the provisions of the agreement.		8%	8%
	Outcome Measure 2-11. Each NF Member meets with his/her SC at least monthly to review his/her plan and its implementation.	46%		46%
	Outcome Measure 2-12. No NF Member may be moved to another NF unless the SPT and Diversion Coordinator could not address barriers to placement in a more integrated setting and the individual and LAR made an informed decision to accept the placement.	38%		38%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 2-13. Individuals in the TP who need specialized services will only be admitted to a NF if the individual's needs for specialized services can be met by the NF, the LA, or both.	75%		75%
	Outcome Measure 3-1. For individuals who have lived in a NF and who are moving or who have moved to the community, supports and services are made available to move to the community and to remain in the community. These supports and services recognize the needs and choices of the individual.	91%	59%	62%
	Outcome Measure 3-2. Any individual in a NF who should have been identified through a Level I screening to need a PASRR Level II evaluation but was not evaluated will receive a PASRR Level II completed by the LA.	50%		50%
	Outcome Measure 3-3. The PASRR Level II evaluation appropriately assesses whether the needs of the individual can be met in the community and identifies the specialized services the individual needs.	34%		34%
	Outcome Measure 3-4. Any NF Member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LA, which contacts the individual within 30 days of this notification to discuss community options.	73%	13%	28%
	Outcome Measure 3-5. All individuals in the TP have a SPT, convened and facilitated by the Service Coordinator. The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of services and supports the individual receives.	30%		30%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 3-6. The NF Member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual or LAR approves the plan.	35%		35%
	Outcome Measure 3-7. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	28%		28%
	Outcome Measure 3-8. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF member receives all of the specialized services identified in the ISP, including alternative placement assistance and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of all specialized services.	19%		19%
	Outcome Measure 3-9. The individual will move to the community within 180 days of the individual accepting the waiver slot, or selecting another program type, unless DADS grants an extension. DADS maintains data about the reasons for extensions and analyzes the data to identify relevant trends and patterns.	98%	44%	58%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 3-10. The SPT ensures that the ISP, including the CLDP, is coordinated with the NFCPC and monitors the implementation of the CLDP.	30%		30%
	Outcome Measure 3-11. The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities, services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	44%		44%
	Outcome Measure 3-12. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	11%		11%
	Outcome Measure 3-13. The State monitors all individuals who have been discharged from the NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.	61%		61%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 3-14. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to individuals who are moving to the community, and makes appropriate referrals to these sources for these individuals.	0%		0%
	Outcome Measure 4-1. All individuals in the TP have a Service Planning Team (SPT) convened and facilitated by the Service Coordinator (SC). The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessments of the adequacy of the services and supports provided to the person to meet his/her individual's needs. The SC facilitates the coordination of services and supports the individual receives.	40%		40%
	Outcome Measure 4-2. The community member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual and the LAR approve the content of the plan.	53%		53%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 4-3. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	35%		35%
	Outcome Measure 4-4. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The plan identifies the frequency, intensity, and duration of all services the Community Member receives. All services in the plan are implemented. The SPT monitors the provision of services.	52%		52%
	Outcome Measure 4-5. Each Community Member meets with his/her SC at least monthly to review his/her ISP and its implementation for the first 365 days after moving to a community program.	62%		62%
	Outcome Measure 4-6. After the individual has been in his/her community placement for 360 days, the SC meets with him/her at the frequency required by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	63%		63%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 4-7. For all community members, the SC inquires about recent Critical Incidents, increased physician visits, changes in the individual's health status, and medical crises and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's health status have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessments. The SC works with the SPT to arrange for any additional services and supports that are needed by the individual.	70%		70%
	Outcome Measure 4-8. The State annually uses available outcome data and other information about the delivery of medical, nursing and nutritional management services and supports to determine if these services are available in the community to all Community Members, including those with complex medical needs, and to identify any gaps in providing these services to Community Members in the most integrated settings.		25%	25%
	Outcome Measure 4-9. In collaboration with LAs and stakeholders, the State develops a plan to address gaps in medical, nursing and nutritional management services, including the capacity of small residential settings to meet the needs of Community Members with complex medical needs. Within available authority and resources, the State implements the plan within the timeframes set out in the plan.		25%	25%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 4-10. Residential and other providers have access to training, technical assistance, and support from a qualified registered nurse, advanced practice nurse, and/or medical doctor from each LIDDA to assist them to meet the needs of Community Members who have complex medical needs.		25%	25%
	Outcome Measure 4-11. The State develops collaborative relationships with healthcare providers to promote timely access to routine, preventive, and emergency clinical services in the most integrated setting for all Community Members, including those with complex medical needs.		25%	25%
	Outcome Measure 4-12. The State will ensure that Community Members have access to the existing array of day activities in the most integrated settings appropriate to their needs and desires. Integrated day activities include supported and competitive employment, community volunteer activities, community learning and recreational activities, and other integrated day activities.	26%	25%	25%
	Outcome Measure 4-13. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and that is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to community members and makes appropriate referrals to these sources for these individuals.	0%		0%
	Outcome Measure 4-14. No Community Member is served in a residential setting that serves more than 6 individuals with I/DD unless the SPT and Diversion Coordinator tried but could not address barriers to such a placement and the individual or LAR made an informed decision to accept the placement.	95%		95%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 4-15. The State monitors all individuals who have been discharged from a NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual, and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.	60%		60%
	Outcome Measure 4-16. Community members are given a choice of providers that have the capacity to meet their needs and can change service providers if they are dissatisfied with their services and supports, or their provider cannot meet their needs.	85%		85%
	Outcome Measure 4-17. The State annually collects and analyzes data regarding Community Members' change in providers, including information about the known reasons for the change.		100%	100%
	Outcome Measure 4-18. The State annually collects and analyzes data regarding Community Members' relocation within a provider's residential settings, including known reasons for the relocation.		100%	100%
	Outcome Measure 4-19. An individual who has an identified risk of behavioral or medical crisis has a crisis plan in his/her ISP that focuses on crisis prevention.	25%		25%
	Outcome Measure 5-1. All individuals in the Target Population (TP) who do not refuse service coordination will have a Service Coordinator who is employed by the Local Authority (LIDDA) or an entity other than a NF.	95%		95%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 5-2. All individuals in the TP have a Service Planning Team (SPT), convened and facilitated by the SC. The SPT meets at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of supports and services for the individual.	38%		38%
	Outcome Measure 5-3. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of the special service providers. The NFCPC includes those needed specialized services and supports that are the responsibility of the NF. The SC facilitates and ensures the coordination between the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual.	27%		27%
	Outcome Measure 5-4. Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF and/or for the first 180 days after moving to a community program.	53%		53%
	Outcome Measure 5-5. After an individual has been in his/her community placement for 180 days the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	88%		88%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 5-6. At least quarterly individuals who are in the NF's and their LARs receive education and information about community options that explain the benefits of community living, address their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community services and supports and may include opportunities for individuals to visit community programs and talk to individuals with ID living in the community and with their families.	15%		15%
	Outcome Measure 5-7. Upon admission to a NF and at least semi-annually the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information to better enable the individual and LAR to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide the community educational material.	48%		48%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 5-8. The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities, services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	44%		44%
	Outcome Measure 5-9. For all community members the SC inquires about recent Critical Incidents, increased physician visits, changes in the health status, and medical crises, and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's record have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessments. The SC works with the SPT to arrange for any additional services and supports that are needed by the individual.	66%		66%
	Outcome Measure 5-10. LAs have caseloads for Service Coordinators based on a methodology that reflects the amount of time involved in the person-centered planning process; the transition process; and the coordination and monitoring responsibilities of service coordinators related to the provisions of the agreement.		8%	8%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 6-1. All individuals in the Target Population have a Service Planning Team (SPT) convened and facilitated by the Service Coordinator (SC). The SPT meets at least quarterly to develop, review and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of services and supports the individual receives.	38%		38%
	Outcome Measure 6-2. The individual is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop the annual objectives to assist the individual to achieve these goals. The individual or LAR approves the content of the plan.	45%		45%
	Outcome Measure 6-3.The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	31%		31%
	Outcome Measure 6-4. SPT's for individuals in NFs include the LIDDA Service Coordinator, the individual and the LAR, nursing facility staff familiar with the individual's needs, providers of specialized services, and a community provider if a community placement is planned.	35%		35%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 6-5. The individual has an ISP that includes all of the services and supports including, integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF Member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of specialized services.	19%		19%
	Outcome Measure 6-6. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of all the specialized service providers. The NFCPC includes those specialized services that are the responsibilities of the NF. The SC facilitates and ensures the coordination of specialized services in the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual. The SPT ensures that the services in the ISP, including specialized services, are provided to the individual in a consistent and coordinated manner reflective of the ISP.	27%		27%
	Outcome Measure 6-7. Individuals in the TP who live in the community have a SPT whose members include those people who are specified in the program rules. The SPT is responsible to develop the ISP, ensure the ISP is implemented, and monitor that all services and supports in the plan are provided to the individual.	35%		35%
	Outcome Measure 6-8. Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF or for the first 365 days of community placement.	53%		53%

Review Year	Outcome Measure	QSR Compliance *(without report metrics)*	Report Compliance *(without indicator metrics)*	Overall Compliance
	Outcome Measure 6-9. After the individual has been in his/her community placement for 365 days, the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face- to- face contact is needed based on an assessment of the individual's risk factors.	87%		87%
	Outcome Measure 6-10. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	11%		11%

Exhibit B

2016 Quarter 1 PASRR QSR Compliance Status Report

I. The Results of the QSR Ratings

Introduction

This report is based on 76 Individual Reviews being conducted, rated and closed. This includes individuals from the following target categories:

- *Diversion-17*
- *Transition- 16*
- *Nursing Facility- 43*

Fewer individuals were identified in the Diversion and Transition populations in the first quarter sample. The need to add more individuals from these target groups started to be addressed in the second quarter sample and will be balanced throughout 2016 as long as the appropriate number of individuals are diverted or transitioned. It is important to remember when reviewing the compliance determinations that very few reviews have been done for the Diversion and Transition target populations to date.

QSRs for twenty- six LIDDAs are included in this first quarter. This includes two of the four LIDDAs that did not have a QSR in 2015. These LIDDAs are Brazos and Center for Life.

Following the narrative section of this report are two QSR Reports. These include a summary of overall compliance by Outcomes and a summary of overall compliance by Outcomes by Target Group. Each report includes information for 2016 Q1 and for 2015 as a point of comparison. There is a third report that is Attachment A. It is a summary of the overall compliance by Outcome Measures by Outcomes. I created it as an attachment because of its length. I have omitted the Measures that are reviewed by data from reports only to reduce the length of the report and make it more readable.

Quarterly reports for the first quarter were submitted by the LIDDAs and I have analyzed the data and summarized my findings in Section II of this report. This information will not be used for rating purposes until the annual review and the production of the Annual 2016 QSR Compliance Report.

Comparison of QSR findings between 2016 Q1 and 2015

The following table summarizes the achievement of compliance by each Outcome across all populations. It provides comparative information for 2015 and the first quarter of 2016. The greatest improvement is in Outcome 3, which increased by 10

percentage points to an overall compliance level of 53% followed by Outcome 1, which increased by 6 percentage points to an overall compliance level of 73%. Outcome 1 shows the highest level of compliance.

Outcomes 2 and 6 remained about the same changing by 1 and 2 percentage points respectively. Outcome 5 reduced its compliance level from 53% to a new level of 50%. The most significant reduction in the level of compliance was in Outcome 4, which dropped from 51% in 2015 to 45% in the first quarter of 2016.

Table 1

QSR Review Results by Outcome	**2015**	**2016**
Outcome	**Overall Compliance** *(without report metrics)*	**Overall Compliance** *(without report metrics)*
OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	67%	73%
OUTCOME 2. Individuals in the Target Population in nursing facilities will receive specialized services with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	35%	36%
OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	43%	53%
OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	51%	45%

OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	53%	50%
OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	38%	36%

The second table summarizes compliance for each target group by Outcome. This table provides information about each target group and its contribution to the levels of compliance for each outcome. The Diversion Target Group is particularly interesting. While compliance with Outcome 1 has increased this quarter, the levels of compliance for all other outcomes for the Diversion individuals in the sample has reduced by 7 percentage points to 22%, affecting Outcome 6 the most significantly.

The NF Target Group has improved its compliance with Outcome 3 by 13 percentage points and reduced compliance in the other Outcomes but not significantly.

The Transition Target Group has seen the most dramatic increase in compliance with improvement in Outcomes 2, 3, 5, and 6. Compliance increased in Outcomes 2 and 3 by 10 and 16 percentage points respectively. The level of compliance only reduced for Outcome 4 for this target population. The reduction was from 50% to 43%.

Table 2

QSR Review Results by Outcome by Target Population 2015 2016

Outcome	Compliance *(Without report metrics)*	Compliance *(Without report metrics)*
Diversion		
OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	67%	73%
OUTCOME 2. Individuals in the Target Population in nursing facilities will receive specialized services with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	N/A	N/A
OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	N/A	N/A
OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	52%	45%
OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	69%	60%

OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	47%	25%
Nursing Facility		
OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	N/A	N/A
OUTCOME 2. Individuals in the Target Population in nursing facilities will receive specialized services with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	36%	33%
OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	40%	53%
OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	N/A	N/A
OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	49%	46%

OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	29%	30%
Transition		
OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	N/A	N/A
OUTCOME 2. Individuals in the Target Population in nursing facilities will receive specialized services with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	36%	46%
OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	41%	57%
OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	50%	43%
OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	51%	58%

OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	37%	38%

Comparison of QSR Findings at the Indicator Level

DADS requested and was provided a report that breaks the compliance results down to the indicator level. It was never the intention of the QSR to rate compliance at the indicator level but it is useful for the department to be able to analyze the specific areas within a measure that need improvement. The following analysis provides information about key indicators within measures based on this report. The report is an excel spreadsheet and is not included in this report. It has been provided separately to the administrative team.

Outcome 1-Diversion

Outcome Measure 1-3
Q1 data is demonstrating a reduction in the compliance with the PEs including recommendations for specialized services if the individual was to be admitted to a NF (8 percentage point change) and the determination of the services the individual needs to remain in the community (5 percentage point change). This may be attributable to the fact that this population no longer includes anyone admitted to a NF and the team is naturally planning for the community services the individual needs and may not note what these supports are on the PE.

Recommendations- DADS should issue instructions to LIDDAs to clarify DADS expectations.

Outcome Measure 1-9

Q1 data is demonstrating a significant reduction in compliance with the requirements for the initial ISP from 55% to 24% and that the ISP identifies the necessary frequency, intensity and duration of services (80% to 20%). This may be also impacted by the change in this population and now the need for a meaningful day program or employment is a consideration for everyone. Also if the PE recommended any clinical services we expect the SPT to follow up on these services in the community. The supports and services planned are also not assisting the individual to achieve their goals (21% to 12%).

Measure 1-10
This Measure has been separated into two measures for 2016 to separate the requirements of the person centered planning process from the assessments to parallel the approach we took in the design of the measures for the other outcomes. In the 2016 QSR the planning requirements are still in 1-10. The assessment requirements are part of a new measure, 1-19. There are changes in findings as follows:

- Indicator 13: 93% to 82% (receiving information to meet their needs)
- Indicator 209: 53% to 29% (meetings scheduled at times convenient for the individual). This is Not Met if there are not quarterly meetings.
- Indicator 210: 61% to 29% (individual provided meaningful supports to participate in the SPT meetings). This is also impacted if there are no quarterlies.

Measure 1-19
These indicators need to be compared with indicators in 1-10 in 2015. Many of these indicators are met less frequently in 2016. Indicators 216, 217, 221, and 222 all score less than 10% in Q1. They are related to following through on the assessment recommended by the PE, completing assessments needed to develop the ISP, and addressing health related concerns as a team. There are many individuals for whom no functional assessment is done or any of the clinical assessments that are recommended.

Recommendations- DADS needs to clarify its expectations to LIDDAs and providers for using assessments as the basis for designing the ISP. All providers complete the ICAP as a means to establish a funding level. While this is a basic needs assessment it would be a starting point for teams to review the capabilities and need areas of an individual and design a plan that included actual goals and objectives to help individuals become more independent, develop skills or maintain skills they possess. There are a few providers that use more robust assessments. This may be a quality improvement area that would benefit from a work group that included waiver provider and LIDDA represented.

Outcome 2- Nursing Home Specialized Services

Measure 2-1

Indicators regarding quarterly meetings, SPT members attending meetings, and addressing changes in a timely manner are all improved. Areas regarding SC facilitating services; SPT members submitting progress reports to meetings they cannot attend; revising the ISP; reviewing risk factors; and convening more SPT meetings as indicated by the individual's changing needs are all less frequently achieved.

Recommendations- It is apparent from our reviews that Service Coordinators are still not thoroughly trained in the expectations of PASRR. DADS should develop the curriculum it expects LIDDAs to use to train new SCs and should expect each LIDDA to confirm all existing SCs are trained in the curriculum as well. In addition to the basic expectations for monthly visits and quarterly meetings the training should stress the importance and need for specialized services; explain the responsibilities of facilitating service delivery including meaningful monthly review of the implementation of services and progress towards achieving goals; clarify the expectations for assessments; and explain the expectation for risk assessment, risk review and the implications of risk for program planning.

Measure 2-2
Indicator 46 compliance has increased from 35% to 40%, which addresses the composition of the SPT.

Measure 2-3
Overall there is improvement in the indicators associated with this measure about the person-centered process. Reductions in performance are in the areas of the individual or LAR approving the ISP, (43%-38% for individuals participating in transition, and 63-48% for individuals refusing transition); inviting others to the SPT meeting; and the SC being knowledgeable of the individual (52%-25% for individuals participating in transition and 53%-35% for individuals refusing transition). The indicator about others being invited to the meetings does not affect many people so this difference is not noteworthy at this point in the year. I think the change in the SCs knowledge about the individual's needs is impacted by the change and turnover of SCs and the fact that we now expect them to be knowledgeable of the individuals' needs for the expanded list of specialized services (SS) and making sure the team addresses these need areas. The list of specialized services was greatly expanded in July 2015. We expect the SC to be knowledgeable of how this expanded list addresses the needs and preferences of the individuals.

Measure 2-4
These indicators determine if the individual's ISP is based on assessments in all areas of need, not just those areas related to SS. All assessments recommended by the PE are still not being completed (6%). However there is improvement in assessments recommended by the SPT (16%-33%), assessments recommended by the LAR (28%-50%) and the use of previously completed assessments (27%-100%). The individuals reviewed in Q1 have worse achievement in the areas of assessments

identifying all of their needs and strengths. This is influenced by all of the PE assessments not being completed.

Measure 2-5
These indicators determine if the individual's ISP includes all supports and services. The reviews conducted in Q1 have generally low levels of compliance except for specialized services being provided by qualified professionals. Scores are a little lower than in 2015 but were not high in either time period. The lack of both NF and LIDDA SS is apparent and there is little to no discussion of day habilitation or employment options.

Measure 2-6
These indicators determine if the LIDDA is providing semi-annual education events (changed from quarterly). There is improvement from 14% to 38% and improvement in individuals being informed of the events (61%-67%).

Measure 2-7
These indicators determine if the SC is developing the CLO. The percentage of compliance has dropped for CLOs being done semi-annually (56% -47%) but the content has improved (38%-56%) as has the specificity of the strategies to address concerns (10%-35%).

Measure 2-9
This is rarely rated, as SPT's are not formally recommending continued stay in NFs. No one in the first quarter review had this recommendation made.

Measure 2-11
These indicators determine if the SC is visiting monthly, talking to the LAR, determining satisfaction and reviewing the implementation of the ISP. The discussion of satisfaction has improved (51%-57%) but the actual review of the plan's implementation has reduced (39%-26%).

Measure 2-13
This indicator determines if the LIDDA and NF confirm that they can meet the specialized service needs of the individual. For the NF this is determined by the NF completing the appropriate section on the PL1. The compliance has reduced (75%-40%).

Outcome 3-Transition

Measure 3-1
This remains at 100%

Measure 3-3
These indicators determine if the PE recommends the SS needed and includes information about what the person needs to live in the community. All three indicators score at a lower level of compliance this quarter. The determination of SS needs and community service needs are both at only 9% compared with 22% and 31% respectively in 2015. The results of the PE are being shared with individuals and LARs less frequently: 26% compared with 49% previously.

Recommendations- DADS has recently developed a standard letter for LIDDAs to inform individuals of the PE findings and the SS that are recommended. DADS reports its plan to share this with the LIDDAs in June and expects it to be used from this date. Many LARs and individuals have never been told the full range of SS available or which ones were recommended for them. The PE evaluators should be instructed to complete Section F of the PE fully to describe the services the individual will need in the community and to recommend all of the SS the individual may benefit from receiving so assessments can be conducted. At this point few if any evaluators list all SS that the individual's needs indicate should be assessed.

Measure 3-4
These indicators determine if the MDS Section Q process is used effectively. It rarely is relevant because the individuals interested in transition have been identified through the PE process and are working with the SC. However, it is fully met at 100% for Q1.

Measure 3-9
100% of individuals that transitioned from a NF did so in 180 days as required.

Measure 3-10
These indicators determine if the ISP including the CLDP is coordinated with the NFCPC and if the SPT oversees the implementation of the CLDP. There has been improvement on both indicators: 17%-64% for the coordination of the two plans, and 44%-53% for the SPT overseeing the CLDP.

Measure 3-11
These four indicators determine the implementation of the CLDP and that it is appropriately shared with the NF staff. There is significant improvement in three of the indicators (49%-72%, 45%-53%, and 41%-63%). The indicator measuring whether the CLDP is appropriately shared with NF staff has reduced from 41%-35%.

Measure 3-13
These indicators determine the SC's involvement in the post move activities and follow up on the implementation of the CLDP to assure a successful transition. The indicators for the number and use of the post move visits are scored lower in 2016 Q1 (55%-41%, 69%-53%) than in 2015. However there were improvements in the

SPT arranging additional needed supports (26%-38%) and the CLDP's value in helping the individual to stay in the community (81%-94%).

Outcome 4- Community Services

Measure 4-1
These indicators determine whether the SPT meets quarterly and addresses the initial and changing needs of the individual. Quarterly meetings are not occurring regularly nor are all providers attending. This impacts most of the thirteen indicators. All have reduced in the levels of compliance.

Measure 4-2
These indicators address the requirements to use a person-centered process to develop goals and objectives. Performance is reduced in all indicators under this measure. The indicators are impacted when regular meetings do not occur and goals and objectives are not in the plan. Compliance with Indicators 158 and 159, which determine if SCs meet before and after SPT meetings that the individual or LAR do not attend, is 0% but were relevant to only 2 individuals.

Measure 4-3
These indicators determine the use of assessments to design the supports and services in the ISP. Other than the use of previous completed assessments, and the relevancy of the assessments that were completed and completed by professionals, there is less compliance with the indicators. Assessments are not done in all areas; don't reflect the individual's needs and strengths; and are not used to design goals and objectives. There were no assessments related to vocation or community activity participation in Q1.

Measure 4-4
These indicators determine if the ISP has all the services in it the individual needs to participate in the community and maximize their potential. There is only improvement in the area of having a plan to address behavioral or medical crises (10%-25%). A few other indicators are equal but services are not reflecting the individuals' preferences as well; not including all services needed, which is affected by a lack of a viable day program or employment; or providing services that maximize potential, which dropped from 22% to 9%.

Recommendations for 4-2,4-3 and 4-4 – DADS needs to issue guidance and provide training to LIDDAs and waiver providers to clearly explain its expectations for assessments and to teach staff how to design meaningful goals and measurable objectives. Individuals need to be referred fro employment when appropriate and DADS needs to define community engagement or inclusionary activities.

Measure 4-7
These indicators determine if the SC and team effectively address health concerns and review critical incidents. Compliance has reduced across nine of the twelve

indicators by more than 5%. Clinical services that are needed are not being provided (47%-17%). Availability of health care specialists is reduced (78%-57%). The SC is not assuring timely health assessments (78%-57%); following up on health concerns (41%-27%); nor is the SPT reviewing health concerns effectively (36%-17%).

Measure 4-12
These indicators determine whether individuals are offered employment or integrated day services. No one in Q1 has been offered any type of day service that is not congregated day habilitation.

Measure 4-14
These indicators determine if individuals lives with six or fewer individuals with I/DD. The compliance is 100%. No one who was reviewed in Q1 lives with more than four individuals.

Measure 4-16
These indicators determine if individuals are given a choice of providers to meet their needs and can change providers if needed or desired. More individuals visited providers (80%-86%) as part of the transition process in Q1. Al individuals that desired to move did so based on their own or their LAR's choice (71%-100%). The state continues to well in this area except for the capacity of the system to assure providers can meet the needs of individuals with behavioral challenges where compliance reduced in Q1 (65%-25%).

Measure 4-19
These three indicators determine if individuals who have a risk of a behavioral or medical crisis have been reviewed and if their plan addressed this eventuality. There is improvement from 20% to 38%.

Outcome 5- Service Coordination

Measure 5-1
These two indicators determine if there is documentation that an individual has refused service coordination and if all other individuals have a SC assigned by the LIDDA. Both indicators have a lower level of compliance in this quarter. For those who refuse service coordination the percentage of compliance is 75% compared to 93% in 2015, although it is pertinent to only a few individuals. The indicator about having a SC assigned has a compliance level of 86% compared to 94% in 2015. If an individual had two or more months in the review period without a SC assigned the indicator is Not Met.

Measure 5-5

This indicator determines if there is an active SC after the first six months. Compliance has increased from 88%-93%.

Other Measures under Outcome 5 have been reviewed under previous outcomes.

Outcome 6- Service Planning Team

Measure 6-3
There is an additional indicator determining if all assessments have been completed by the SPT. This was rated as 16% compliance in 2015 and has dropped to 1%.

Measure 6-9
These indicators determine the oversight of the SPT to assure ISP implementation. This has been reduced to three indicators in the 2016 QSR. Compliance is less for all three primarily because SPTs lack representation from all providers, especially day providers and do not meet regularly to oversee the implementation of the ISPs.

All other measures under Outcome 6 have been reviewed under previous outcomes.

Conclusion

The compliance is reduced in many important areas. The lack of achievement of the Measures is primarily due to the following themes, which were also apparent in 2015. These are:

- A lack of a thorough understanding of the service coordination role by SCs
- Insufficient recommendations for specialized services by PE evaluators and poor follow up by NF SPTs to address these needs
- A lack of assessments in all of the need areas of target population members
- ISPs that do not include goals and measurable objectives that address the individuals' needs or include their preferences
- A lack of referrals for employment services and little availability of other integrated day service opportunities

II. Review of the LIDDA Quarterly Reports

Outcome Measure 1-6

The Diversion Coordinator identifies available community living options, supports and services to assist individuals in the TP to successfully live in the community, and provides information and assistance to SCs and other staff who facilitate diversion for these individuals.

Compliance Indicators: These responsibilities will be included in the job descriptions for the Diversion Coordinators. The Diversion Coordinators will provide this information and support to the SCs and other LIDDAA staff involved in diversion planning ongoing to respond to the needs of these staff as they assist individuals who want to be diverted from a NF placement

Review Methodology: Diversion Coordinators will prepare quarterly reports to DADS and the Lead Reviewer that details the frequency and types of assistance provided to service coordinators and other staff to assist them with identifying needed community services and supports for individuals in the Target Population seeking community-based services.

The Lead Reviewer will review the quarterly reports to determine if they contain the required elements set out in the Compliance Indicators section above. The Reviewers will ask service coordinators about the assistance they receive from the Diversion Coordinator during the interviews with them for individual reviews of individuals who were diverted. This information will be shared with the Expert Reviewer to assist in making the compliance determination.

Findings

LIDDAS reported on pre-move barriers, assistance provided and the number of individuals that moved. They also reported on post move barriers, assistance provided and the number of individuals that stayed in the community or returned to a NF. Data is included in Tables 3 and 4.

Table 3: Reports on Pre-move barriers

Issue	Number	Percentage
LIDDAS Reporting Issues	24	
Assistance provided	24	**100%**
Individuals Impacted	73	
# Of Individuals that moved	9	**12%**
# Of individuals remaining in NF	64	**87%**

Table 4: Reports on Post –move barriers

Outcome for individuals	Number	Percentage
Individuals remaining in community	7	**77%**
Individuals returning to NF	2	**23%**

The barriers identified across both the pre-move and post-move groups include variety of issues. Those issues that present as barriers most frequently are:

- *Medical needs of consumers 12*
- *Family and Guardianship 15*
- *Provider cooperation 12*
- *NF cooperation 12*
- *Essential supports/provider capacity/lack of resources 19*
- *Behavioral needs 2*
- *DID 5*

Of the 64 individuals that remained in a NF, eight individuals decided to remain in the NF without an identified barrier

Although the LIDDAs offered some level of assistance the outcomes for individuals were not positive as was true in 2015. Most did not have the opportunity to transition. This quarter showed an improvement in the percentage of individuals that stayed in the community once transitioned. Many families and LARS are still hesitant about community placement but are at least interested in pursuing community transition. LIDDAS continue to provide information about waiver services but in many cases there is no evidence that the specific concerns have been identified and addressed. Many of the comments about families are that they cannot

find a provider they believe will be suitable, which may be more an issue of provider capacity. Delays in home modifications and the availability of adaptive aids are barriers. It is troubling that so many individuals were kept from transition because of the lack of essential, medical and behavioral support services. I am determining overall compliance by the average of the compliance percentages in the tables above for assistance provided, meeting the outcome of transitioning, and maintain individuals in the community.

Compliance: 63%

Recommendations- DADS and the LIDDAS are trying to address the needs of the individuals that have complex medical needs through the work of the Medical, Psychiatric and Behavioral Program Teams and providing technical assistance and training by qualified health professionals at the LIDDAs. Other areas creating barriers to transition and diversion include provider capacity, provider and NF cooperation, and family and LAR concerns. LIDDAS need to work with their SCs to develop more comprehensive Community Living Option (CLO) plans that more specifically identify these concerns and have a targeted approach to address them on an individual basis, including assisting them to find appropriate providers. Individuals and LARs select the provider they wish to provide the services and all HCS waiver providers are expected to meet everyone needs. It remains apparent from the provider issues identified by the LIDDAs, the QSR Reviewers' experiences, and the reasons some individuals move between providers that providers cannot always meet all needs adequately. DADS should work in cooperation with LIDDAs to identify what the areas of capacity and cooperation are among providers and develop strategies to address general provider capacity to address other areas of need in addition to medical, including behavioral support and the need for accessible housing.

Outcome Measure 1-7

The Diversion Coordinator coordinates education for SCs and other LIDDA staff to learn about available community services and strategies to avoid NF placement for the TP.

Compliance Indicators: The DC will:

- Develop and implement procedures by which he/she solicits information from service coordinators and other relevant Local Authority staff to determine their needs for education about the availability of community services in the LIDDAA catchment area and strategies to avoid placement in NFs for members of the Target Population;
- Identify other relevant LIDDAA staff who will require education in addition to service coordinators
- Identify the topics that will be addressed through educational opportunities

- Provide education about the topic areas identified through information solicitation from Service Coordinators and other relevant Local Authority staff;
- Have a methodology to provide education to Service Coordinators and other relevant staff that may include individual supervision/discussion with these staff, group training sessions, webinars or written materials.
- Provide education throughout the year so that all service coordinators and other identified LIDDAA staff have initial training no later than April 2015 and newly hired service coordinators and other relevant LA staff are trained within the first two months of employment.

Review Methodology: LIDDA will submit quarterly report to DADS and the Lead Reviewer that addresses the Compliance Indicators. The Lead Reviewer will review reports to determine if they contain all elements specified in the Compliance Indicators section above.

Findings

LIDDAS all report they have a procedure to elicit information to determine the training needs of staff with the exception of Texas Panhandle. LIDDAs continue to not report whether all existing SCs were trained by 4/15/15, or are trained now. However, all but one LIDDA were still training existing SCs in Q1. Without DADS clarifying what is required as initial training it is difficult to ascertain if all of these topics are enhanced training. Many of the topics seem essential to perform the job including specialized services, SPT meeting requirements, PASRR policies and procedures, completing ISP transition plans, and completing the CLO. There is not sufficient evidence that LIDDAs have fully trained either existing or all newly hired SCs. DADS should ask for confirmation from each LIDDA that all existing SCs hired by December 2015 have received required training. Going forward the LIDDAs would then only report how many new SCs were hired and confirm they were trained within the first two months of employment.

All LIDDAs are providing training but not all are including other LIDDA staff in addition to SCs. Thirteen LIDDAs report only training SCs. LIDDAs also include a wide range of topics with some offering much more extensive training than others. All eighteen LIDDAs that hired new SCs report training them. Concho Valley's training list is not comprehensive. All LIDDAs report sufficient training time for the topics covered.

Table 5: LIDDA Training and Education

Activity	Q1 Compliance Percentage
Methodology to identify training needs	97%
LIDDA staff identified	67%
Educational topics identified	100%
Education provided	100%
All SCs trained	No Report-0%
New SC's trained	100%

Compliance: 77%

Recommendations- DADS should identify the core topics that LIDDA staff involved in PASRR service coordination and provision should be trained and by when the LIDDAs should accomplish this. Clear expectations should be set for which other LIDDA staff in addition to SCs should be trained in various aspects of PASRR. Since it has not been done LIDDA's should confirm for DADS that all existing SCs have been trained, in what topics and by what date. DADS should audit this training as part of its performance reviews especially in light of the discrepancy of the reports from the LIDDAs and the anecdotal information given to QSR reviewers when interviewing SCs.

Outcome Measure 1-15

Within 45-75 days after an individual is admitted to a NF, the DC reviews whether community living options, services, and supports that provide an alternative to the NF placement have been explored. If alternatives have not been explored, the Diversion Coordinator ensures that the individual's SC coordinates this exploration.

Compliance Indicators: The LIDDA Diversion Coordinator will develop and implement a procedure by which he/she will review the provision of relevant information about community living options for each individual in the Target Population admitted to a nursing facility within 75 days of admission. The procedure will include specific steps to be followed if it is identified that this information has not been reviewed with the individual within 75 days of admission.

The DC will have the list of community living options, services and supports that the SC is exploring with the individual and the LAR within 75 days of admission. The DC

will review these with the SC to ensure that the options, supports and services are appropriate for the individual. The DC will ensure the SC explores other options if the current options, services and supports are not sufficient for the individual to transition to the community within 90 days of admission.

Review Methodology: LIDDAs will submit quarterly reports to DADS and to the Lead Reviewer that includes a list of all individuals who were diverted within 90 days of admission to a nursing facility, the date the DC reviewed the transition status and the actions the DC took to assure a successful diversion within 90 days of admission.

Findings
The LIDDAs reported specifically on the number of individuals that expressed an interest in moving and the actions that were taken to assist them. Thirty-three LIDDAs had individuals identify their desire to move and all provided dates that the plans were reviewed by the Diversion Coordinator. Six LIDDAs do not report anyone interested in transition but four report admissions during this period and all have individuals in NFs with the possible exception of Nueces that did not report.

Twenty-six of the LIDDAs (79%) DCs provided some assistance within the 45-75 day requirement. Of these twenty-six LIDDAs, nineteen Diversion Coordinators reviewed the individual's transition plans within 45-75 days of the individual expressing an interest in transitioning. One hundred twenty six individuals expressed an interest in transitioning. The DC reviewed these requests within the required time period 95% of the time and provided guidance 95% of the time. While the actions reported were appropriate the following outcomes were reported:

- 33 individuals transitioned (26%)
- 44 individuals have not moved within 90 days of expressing their interest (35%)
- 49 individuals are still in the transition process within 90 days (39%)

Compliance: 95%

Recommendations- Outcome Measure 1-15 is no longer required in the 2016 version of the QSR because the definition of diversion no longer includes individuals admitted to NFs. However DADS should continue this LIDDA report. It is helpful if community transition planning starts immediately for individuals who are interested in returning to the community so they stay positive about this possibility and engage early in the planning process. The LIDDAs are already interpreting it as a responsibility to report on the planning for anyone that identifies an interest in transitioning during the quarter regardless of admission date. The report provides a means to check on the work of Diversion Coordinators and to communicate barriers to community transition to DADS leadership in a timely way. These barriers can be shared with the various work groups and LIDDA leadership to engage appropriate

stakeholders and decision makers in planning and implementing strategies to remove the barriers. DADS may also want to follow up with the LIDDAs that do not report any involvement by DCs or involvement with very few individuals.

Outcome Measures 1-17, 3-4

Any NF Member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LIDDA, which contacts the individual within 30 days of this notification to discuss community options.

Compliance Indicator-DADS will require the LIDDAs or Relocation Specialists to report on the number of individuals who express an interest in learning about the community through the MDS Section Q process. The report will include verification that contact was made within 30 days and not the outcome of the contact.

Review Methodology-The State will submit quarterly reports to the PASRR QSR Lead Reviewer who will verify that the timeframes were met and follow up was planned for anyone who wished to begin transition planning.

Findings
Sixty-five individuals were identified through the MDS Section Q during the 2nd Quarter of FY2016, as having an interest in learning about the community. Forty-six (71%) of these individuals received community service information within 30 days of the MDS report and nineteen of these individuals were contacted and received the information after the 30 day expectation.

Of these individuals:

- 25 were recipients of an automatically released HCS slot, of which eight are enrolled or pre-enrolled; two are still deciding; and fifteen declined the slots.
- 3 were in the NF on temporary discharge from a HCS program and planned to return
- 1 was in the NF on a temporary discharge from a HCS program and chose to remain in the NF
- 1 other individual enrolled in the HCS waiver and is pending discharge from the NF
- 6 individuals decided to pursue transition after listening to the community presentation but are in early stages of transition
- 29 individuals decided to remain in the NF after listening to the community presentation

Twenty of sixty-five individuals who asked for community information through the MDS Section Q process have transitioned to the community or are planning to transition. Follow up has been planned with all twenty individuals (100%).

Compliance: 85%

Recommendations- DADS should address issues of timeliness with the specific LIDDAs that did not meet the 30 day requirement for contacting individuals who expressed an interest in community education and transition.

Outcome Measure 2-6, 5-6

At least semi-annually, individuals who are in the NFs and their LARs receive education and information about community options that explain the benefits of community living, address concerns about community living, and assist them to make informed decisions about whether to move to the community. This information is provided by people knowledgeable about community supports and services and may include opportunities for individuals to visit community programs and talk to individuals with I/DD living in the community and their families.

Compliance Indicators: The Local Authority Diversion Coordinator will develop and implement a procedure by which he/she will provide or arrange ongoing education at least semi-annually for individuals in the target population in nursing facilities and their LARs regarding availability of and access to community resources available to them in the Local Authority service area. The DC has a process to elicit the input of SCs to determine what type of educational activities may be most beneficial to NF Members. These educational opportunities include, but are not limited to, presentations at the NFs by community providers, LIDDA staff, self-advocates and individuals and their family members who have successfully transitioned from an institutional to a community-based residential setting, and may include opportunities to visit community residential and integrated day activities. Each individual in the NF and his or her LAR has the opportunity to participate in a community educational opportunity semi-annually. The SC or DC informs individuals and LARs of these opportunities and it is documented in the individual's CLO/ISP.

Review Methodology: The Diversion Coordinators will prepare quarterly reports to DADS and the Lead Reviewer that summarizes these educational opportunities. The Lead Reviewer will review the reports to determine if they contain the required elements set out in the Compliance Indicators section above.

Findings

Thirty-seven of the thirty-nine LIDDA provided educational opportunities this quarter. One of these LIDDAs has not provided any opportunities since DADS required it.

The LIDDAS reported topics that were presented during the quarter, who provided the training and how many individuals attended the sessions. PASRR and Enhanced SCs, Diversion Coordinators, PASSRR SC Supervisors and Managers provided

training. Education was offered through presentations, program tours and peer-to-peer discussions. Six LIDDAs offered opportunities for peer-to-peer interaction.

However, the findings of the QSR do not support the reports from the LIDDAs. A total of 36 individuals had no documentation that they were notified by the LIDDA of these events and no documentation in the CLO that they chose or refused to attend. These reviews included Austin (6), Tarrant (5), Alamo (3), Hill (3), Nueces (3), Texoma (3), Community Healthcore (3) and Dallas Metrocare (2). Only Nueces reported no education this quarter in the Quarterly Reports from the LIDDAs. An additional eight LIDDAs had one review in which there was no related documentation

Thirty-seven LIDDAs reported the following attendance for the 1st Quarter of FY16:

Table 6: Quarterly Education by LIDDAs

Number of Attendees	Number of LIDDAs	Comments
0	4	HOT, Center for Life, Helen Farabee, Central Plains (all different from 2015)
1-5	11	
6-10	6	
11-20	7	
21- 50	2	Access, Brazos
51 or more	7	Community Healthcore, Burke, Tri County, Bluebonnet (*these 4 also had similar numbers in 2015)* Spindletop, Metrocare, Texoma

Compliance: 97% (based on only 1 LIDDA not providing community education across 2 quarters)

Recommendations- If there continues to be a discrepancy in the data from the QSR versus the reports from the LIDDAs DADs should request documentation that verifies that invitations were issued to NF members.

Attachment A

Comparison of Outcome Measures in 2015 and 2016

Outcome Measure	2015 Overall Compliance *(without report metrics)*	2016 Overall Compliance *(without report metrics)*
Outcome Measure 1-1. A PASRR Level I screening is completed for individuals seeking admission to nursing facilities. DADS tracks and shares the results with the Local Authority (LIDDA) and the Diversion Coordinator if the individual needs a PASRR Level II evaluation.	98%	97%
Outcome Measure 1-2. An individual in the TP seeking admission to a NF who is determined by a PASRR Level I to be in need of a PASRR Level II will receive a PASRR Level II evaluation completed by the LIDDA or other qualified entity with experience working with community based services for individuals with ID/D, within the required timeframes.	89%	94%
Outcome Measure 1-3. The PASRR Level II evaluation confirms whether the individual has ID or DD and if so, appropriately assesses whether the needs of the individual can be met in the community and accurately identifies, based on the information available, the specialized services the person needs if s/he is admitted to a NF. A report of the reviewer's decision is shared with the individual and his/her LAR.	41%	36%

Outcome Measure 1-8. Individuals Diverted from NF admission have access to information from DADS that describes the community services available to support them to live in the community.	94%	100%
Outcome Measure 1-9. For members of the Target Population living in the community who can be diverted from NF admission, the SC or other LIDDA staff identify, arrange and coordinate all community options, services, and supports, for which the individual may be eligible and that are necessary to enable the individual to remain in the community and avoid admission to a NF. Services and supports will be consistent with an individual's or LAR's informed choice.	56%	36%
Outcome Measure 1-10. All individuals seeking admission to a NF, who were identified through a PASRR Level II evaluation as having ID/DD and who wish to remain living in the community, will receive support, consistent with their individual choice, to participate with their Service Planning Team (SPT) in a planning process that identifies the community supports they need to remain in the community. The individual and the LAR are informed of community options that will meet the individual's needs. (*Wording is from the revision made in 2016. The wording in the 2015 QSR combined what is now in 1-10 and 1-19.)*	54%	51%
Outcome Measure 1-11. For individuals who are diverted from a NF placement, supports and services are made available to remain in the community, or to move to the community after a stay in a NF of fewer than 90 days. These supports and services recognize the needs and choices of the individual.	100%	100%
Outcome Measure 1-16. No Community Member is served in a residential setting that serves more than 6 individuals with ID/D unless the SPT and Diversion Coordinator tried but could not address the barriers to such a placement and the individual or LAR made an informed decision to accept the placement.	97%	100%

Outcome Measure 1-19. The planning process used by the SPT includes assessments of medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, integrated day activity needs, and a review of health related incidents.	Not a separate measure in 2015 but part of 1-10	46%
Outcome Measure 2-1. All individuals in the Target Population (TP) have a Service Planning Team (SPT), convened and facilitated by the Service Coordinator (SC). The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her needs. The SC facilitates the coordination of services and supports the individual receives.	36%	35%
Outcome Measure 2-2. SPTs for individuals in NFs include the LIDDA Service Coordinator, the individual and the LAR, nursing facility staff familiar with the individual's needs, providers of specialized services, and a community provider if a community placement is planned.	35%	40%
Outcome Measure 2-3. The NF Member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual or LAR approves the content of the plan.	39%	43%

Outcome Measure 2-4. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation and the integrated day activity needs of the individual.	30%	40%
Outcome Measure 2-5. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF Member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of specialized services.	19%	11%
Outcome Measure 2-6. At least semi-annually LIDDA's offer individuals who are in the NFs and their LARs receive education and information about community options that explain the benefits of community living, address their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community supports and services and may include opportunities for individuals to visit community programs and talk to individuals with ID/D living in the community and their families.	15%	36%

Outcome Measure 2-7. Upon admission to a NF and at least semi-annually, the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information with the individual and the LAR to better enable them to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide this community educational material.	48%	57%
Outcome Measure 2-8. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of all the specialized service providers. The NFCPC includes those needed specialized services and supports that are the responsibilities of the NF. The SC facilitates and ensures the coordination of specialized services in the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual. The SPT ensures that the services in the ISP, including specialized services, are provided to the individual and are delivered in a consistent and coordinated manner reflective of the ISP.	27%	21%
Outcome Measure 2-9. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	11%	N/A
Outcome Measure 2-11. Each NF Member meets with his/her SC at least monthly to review his/her plan and its implementation.	46%	41%

Outcome Measure 2-13. Individuals in the TP who need specialized services will only be admitted to a NF if the individual's needs for specialized services can be met by the NF, the LA, or both.	75%	40%
Outcome Measure 3-1. For individuals who have lived in a NF and who are moving or who have moved to the community, supports and services are made available to move to the community and to remain in the community. These supports and services recognize the needs and choices of the individual.	91%	100%
Outcome Measure 3-3. The PASRR Level II evaluation appropriately assesses whether the needs of the individual can be met in the community and identifies the specialized services the individual needs.	34%	15%
Outcome Measure 3-4. Any NF Member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LA, which contacts the individual within 30 days of this notification to discuss community options.	73%	100%
Outcome Measure 3-5. All individuals in the TP have a SPT, convened and facilitated by the Service Coordinator. The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of services and supports the individual receives.	30%	32%
Outcome Measure 3-6. The NF Member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual or LAR approves the plan.	35%	40%

Outcome Measure 3-7. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	28%	43%
Outcome Measure 3-8. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF member receives all of the specialized services identified in the ISP, including alternative placement assistance and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of all specialized services.	19%	9%
Outcome Measure 3-9. The individual will move to the community within 180 days of the individual accepting the waiver slot, or selecting another program type, unless DADS grants an extension. DADS maintains data about the reasons for extensions and analyzes the data to identify relevant trends and patterns.	98%	100%
Outcome Measure 3-10. The SPT ensures that the ISP, including the CLDP, is coordinated with the NFCPC and monitors the implementation of the CLDP.	30%	53%

Outcome Measure 3-11. The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities; services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	44%	40%
Outcome Measure 3-12. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	11%	N/A
Outcome Measure 3-13. The State monitors all individuals who have been discharged from the NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.	61%	55%

Outcome Measure 4-1. All individuals in the TP have a Service Planning Team (SPT) convened and facilitated by the Service Coordinator (SC). The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessments of the adequacy of the services and supports provided to the person to meet his/her individual's needs. The SC facilitates the coordination of services and supports the individual receives.	40%	14%
Outcome Measure 4-2. The community member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual and the LAR approve the content of the plan.	53%	34%
Outcome Measure 4-3. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	35%	32%
Outcome Measure 4-4. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The plan identifies the frequency, intensity, and duration of all services the Community Member receives. All services in the plan are implemented. The SPT monitors the provision of services.	52%	33%

Outcome Measure 4-5. Each Community Member meets with his/her SC at least monthly to review his/her ISP and its implementation for the first 365 days after moving to a community program.	62%	41%
Outcome Measure 4-7. For all community members, the SC inquires about recent Critical Incidents, increased physician visits, changes in the individual's health status, and medical crises and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's health status have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessments. The SC works with the SPT to arrange for any additional services and supports that are needed by the individual.	70%	57%
Outcome Measure 4-12. The State will ensure that Community Members have access to the existing array of day activities in the most integrated settings appropriate to their needs and desires. Integrated day activities include supported and competitive employment, community volunteer activities, community learning and recreational activities, and other integrated day activities.	26%	0%
Outcome Measure 4-14. No Community Member is served in a residential setting that serves more than 6 individuals with ID/D unless the SPT and Diversion Coordinator tried but could not address barriers to such a placement and the individual or LAR made an informed decision to accept the placement.	95%	100%

Outcome Measure 4-15. The State monitors all individuals who have been discharged from a NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual, and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.	60%	55%
Outcome Measure 4-16. Community members are given a choice of providers that have the capacity to meet their needs and can change service providers if they are dissatisfied with their services and supports, or their provider cannot meet their needs.	85%	87%
Outcome Measure 4-19. An individual who has an identified risk of behavioral or medical crisis has a crisis plan in his/her ISP that focuses on crisis prevention.	25%	38%
Outcome Measure 5-1. All individuals in the Target Population (TP) who do not refuse service coordination will have a Service Coordinator who is employed by the Local Authority (LIDDA) or an entity other than a NF.	95%	86%
Outcome Measure 5-2. All individuals in the TP have a Service Planning Team (SPT), convened and facilitated by the SC. The SPT meets at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of supports and services for the individual.	38%	27%

Outcome Measure 5-3. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of the special service providers. The NFCPC includes those needed specialized services and supports that are the responsibility of the NF. The SC facilitates and ensures the coordination between the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual.	27%	21%
Outcome Measure 5-4. Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF and/or for the first 180 days after moving to a community program.	53%	40%
Outcome Measure 5-5. After an individual has been in his/her community placement for 180 days the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	88%	93%
Outcome Measure 5-6. At least quarterly individuals who are in the NF's and their LARs receive education and information about community options that explain the benefits of community living, address their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community services and supports and may include opportunities for individuals to visit community programs and talk to individuals with ID/D living in the community and with their families.	15%	36%

Outcome Measure 5-7. Upon admission to a NF and at least semi-annually the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information to better enable the individual and LAR to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide the community educational material.	48%	57%
Outcome Measure 5-8. The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities; services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	44%	40%

Outcome Measure 5-9. For all community members the SC inquires about recent Critical Incidents, increased physician visits, changes in the health status, and medical crises, and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's record have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessments. The SC works with the SPT to arrange for any additional services and supports that are needed by the individual.	66%	54%
Outcome Measure 6-1. All individuals in the Target Population have a Service Planning Team (SPT) convened and facilitated by the Service Coordinator (SC). The SPT meets at least quarterly to develop, review and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of services and supports the individual receives.	38%	27%
Outcome Measure 6-2. The individual is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop the annual objectives to assist the individual to achieve these goals. The individual or LAR approves the content of the plan.	45%	40%

Outcome Measure 6-3.The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	31%	33%
Outcome Measure 6-4. SPT's for individuals in NFs include the LIDDA Service Coordinator, the individual and the LAR, nursing facility staff familiar with the individual's needs, providers of specialized services, and a community provider if a community placement is planned.	35%	40%
Outcome Measure 6-5. The individual has an ISP that includes all of the services and supports including, integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF Member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of specialized services.	19%	10%

Outcome Measure 6-6. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of all the specialized service providers. The NFCPC includes those specialized services that are the responsibilities of the NF. The SC facilitates and ensures the coordination of specialized services in the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual. The SPT ensures that the services in the ISP, including specialized services, are provided to the individual in a consistent and coordinated manner reflective of the ISP.	27%	21%
Outcome Measure 6-7. Individuals in the TP who live in the community have a SPT whose members include those people who are specified in the program rules. The SPT is responsible to develop the ISP, ensure the ISP is implemented, and monitor that all services and supports in the plan are provided to the individual.	35%	11%
Outcome Measure 6-8. Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF or for the first 365 days of community placement.	53%	40%
Outcome Measure 6-9. After the individual has been in his/her community placement for 365 days, the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face- to- face contact is needed based on an assessment of the individual's risk factors.	87%	100%
Outcome Measure 6-10. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	11%	N/A

Exhibit C

ATTACHMENT G
PASRR Requirements and Enhanced Community Coordination

I. Requirements for a LIDDA relating to Individuals Residing in a Nursing Facility

A. Definition of terms used in Section I of this Attachment G:

1. "Individual" means an individual 21 years of age or older with an intellectual disability, related condition, or both, who is a Medicaid recipient.

2. "Individual in a nursing facility" means an individual who is admitted to and residing in a nursing facility and has been referred for a stay greater than 30 consecutive days.

B. Pre Admission Screening and Resident Review (PASRR)

The LIDDA must:

1. Comply with all PASRR requirements set forth in the LIDDA's Medicaid Provider Agreement for the Provision of Intellectual Disability Service Coordination and PASRR and 40 Texas Administrative Code (TAC), Chapter 17. If, during a PASRR Evaluation, the LIDDA suspects an individual of having ID or DD but is unable to confirm the individual has a diagnosis of ID or DD due to lack of records or access to family history, the LIDDA must ensure compliance with the requirements in Section I.B.1.a-c of this Attachment G.

    a. The LIDDA staff conducting the PE must:
        i. complete a "referral" in Section F1000 of the PE:
            I) in Section F1000A, mark 19 for "Other";
            II) in Section F1000B, enter a statement that the individual is being referred for a Determination of Intellectual Disability (DID);
            III) enter the phone number of the LIDDA staff completing the PE in F1000C;
            IV) in Section F1000D, enter the "date of referral" for the DID; and
            V) mark the PE negative to indicate the individual does not have ID or DD (i.e., in Sections B0100 and B0200, enter "No"); and
        ii. not send the individual or LAR a notice of denial of eligibility for specialized services and an opportunity for a fair hearing.

    b. The LIDDA must:
        i. within 45 calendar days after the "date of referral" entered in Section F1000D, ensure a DID is conducted on the individual in accordance with DADS rules governing diagnostic assessment (40 TAC, Chapter 5, Subchapter D); and

ii. within 30 calendar days after the DID is conducted, submit a copy of the written DID report to the DADS PASRR unit via the Secure File Transfer Protocol (SFTP) file folder named "PASRR Reporting."

c. The LIDDA must:
   i. If the DID report indicates the individual does not have ID or DD, then the LIDDA must:
      I) enter a note on the previously completed negative PE by clicking on the "add note" button on the yellow Form Action bar of the PE and state that the individual does not have ID or DD per the result of the DID; and
      II) send the individual or LAR a notice of denial of eligibility for specialized services and an opportunity for a fair hearing.
   ii. If the DID report indicates the individual has ID or DD, then, within seven calendar days after the DID report is completed, the LIDDA must complete a new PE for the individual and mark it positive to indicate the individual has ID or DD.

2. Within five working days after the initial interdisciplinary team (IDT) meeting, document the following information in the Long Term Services (LTS) online portal:
   a. Confirm if representatives of the LIDDA attended the IDT meeting, either in person or by telephone; and
   b. Either agree or disagree that the specialized services listed in the LTS online portal for an individual were those that were agreed upon during the individual's IDT meeting.

C. Nursing Facility Diversion

1. The LIDDA must designate a staff member as the Diversion Coordinator who:
   a. is at least credentialed as a qualified intellectual disabilities professional (QIDP); and
   b. has experience in coordinating or providing services to individuals with IDD, including those with complex medical needs, in the community.

2. The LIDDA must ensure that the Diversion Coordinator performs the following duties:
   a. Identify available community living options, services, and supports to assist individuals to successfully live in the community;
   b. Provide information and assistance to service coordinators and other LIDDA staff who are facilitating diversion for individuals at risk of admission to a nursing facility and for individuals transitioning to the community from a nursing facility;
   c. Coordinate educational activities for service coordinators and other LIDDA staff about available community services and about strategies to avoid nursing facility placement;

d. Within 45-75 calendar days after an individual is admitted into a nursing facility, review the individual's admission to ensure that community living options, services and supports that could provide an alternative to nursing facility placement have been explored and if not, refer the individual to his or her service coordinator for that purpose;
e. On a quarterly basis, as indicated in the PASRR Reporting Manual, report to DADS the number of individuals admitted to nursing facilities, diverted from nursing facilities, and residing in a nursing facility for more than 90 days; and
f. On a quarterly basis, as indicated in the PASRR Reporting Manual, provide DADS with information about barriers individuals have experienced in moving from a nursing facility to the community.

3. When conducting a PASRR Evaluation (PE), the LIDDA must inform the individual referred for admission to a nursing facility, their family, and the legally authorized representative (LAR) of the community options, services, and supports for which the individual may be eligible. The LIDDA, under the direction of the Diversion Coordinator, must identify, arrange, and coordinate access to these services in order to avoid admission to a nursing facility, wherever possible and consistent with an individual's informed choice.

4. The LIDDA's initiation of enrollment in HCS as a diversion from admission to a nursing facility must occur before the individual's admission to a nursing facility when, consistent with the PE, community living options, services, and/or supports provide an appropriate alternate placement to avoid admission to a nursing facility, consistent with the individual's choice.

5. The LIDDA must ensure no individual in a nursing facility will be served in another nursing facility or in a residential setting that serves more than four individuals, and that no individual who has transitioned from a nursing facility will be served in a residential setting that serves more than six individuals, unless the Diversion Coordinator:
   a. In consultation with the individual's service planning team (SPT), attempted and was unable to address barriers to placement in a more integrated setting; and
   b. Verified that the individual, family, and/or LAR made an informed decision regarding alternate living options.

D. Service Coordination

1. The LIDDA must assign a service coordinator to an individual in a nursing facility within 30 calendar days after completion of the individual's PE.
   a. If the individual refuses service coordination, the service coordinator must use Form 1044 (Refusal of Service Coordination for Individuals Residing in Nursing Facilities) to document the refusal, obtain necessary signatures

and maintain documentation copy of the completed form in the individual's record.

b. For an individual who refuses service coordination, the LIDDA must ensure the individual receives information about the range of community living options (CLO) using DADS developed materials during the individual's initial meeting with a service coordinator and at least annually thereafter, documenting the discussion on DADS Form 1039 (Community Living Options);

2. The LIDDA must ensure the assigned service coordinator for an individual in a nursing facility:
   a. Meets face-to-face with the individual on a monthly basis, or more frequently, if needed;
   b. Within 30 calendar days after the completion of the PE, facilitates the development of the individual's ISP on Form 1041 (Individual Service Plan/Transition Plan – NF) with the individual's service planning team (SPT), including documenting SPT discussions;
   c. Facilitates revisions to the individual's ISP on Form 1041 (Individual Service Plan/Transition Plan – NF), as needed, including documenting SPT discussions;
   d. Facilitates coordination between an individual's ISP and the nursing facility's plan of care;
   e. Facilitates the coordination of the individual's specialized services; and
   f. Monitors the delivery of all services and supports provided to the individual.

3. The LIDDA must ensure the assigned service coordinator for an individual in a nursing facility convenes the individual's SPT at least quarterly, or more frequently if requested by the individual or LAR, or if there is a change in service needs. Quarterly SPT meetings must take place every three months in accordance with the instructions for Form 1041 (Individual Service Plan/Transition Plan – NF).

4. The assigned service coordinator must complete the *PASRR Specialized Services Form* for every SPT meeting (initial, quarterly, and any updates). The LIDDA must submit the information on the completed form via the Long-Term Care Portal.

5. The LIDDA must ensure the assigned service coordinator for an individual in a nursing facility:
   a. Provides information and discusses with the individual and LAR about the range of community living options (CLO) using DADS developed materials during the individuals initial meeting with the service coordinator and at least semi-annually thereafter, documenting the discussion on DADS Form 1039 (Community Living Options);

b. Facilitates visits to community programs, when appropriate, and addresses concerns about community living with the SPT; and
c. Offers the individual and LAR opportunities for educational and informational activities described in Section I.F.2. of this attachment.

6. The LIDDA must ensure the assigned service coordinator completes Section 9 (Transition Plan to the Community) Phase I of the individual service plan (DADS Form 1041) for an individual in a nursing facility:
   a. whose MDS 3.0 indicates the individual is interested in speaking with someone about transitioning to the community;
   b. whose PASRR evaluation reflects that the individual's needs can be met in an appropriate community setting; or
   c. who expresses an interest in transitioning to the community.

E. Service Planning Team

1. For an individual in a nursing facility for whom the LIDDA provides service coordination, the LIDDA must ensure the individual's SPT includes the following persons:
   a. the individual being served;
   b. his or her LAR, if any;
   c. the service coordinator;
   d a nursing facility staff familiar with the individual's needs;
   e. persons providing specialized services for the individual;
   f. DADS contracted relocation specialist, if the individual desires to move to the community;
   g. a representative from the community Medicaid program provider, if one has been selected; and
   h. other participants such as:
      i. a concerned person whose inclusion is requested by the individual or the LAR; and
      ii. at the discretion of the LIDDA, other persons who are directly involved in the delivery of services to individuals with IDD.

2. The SPT must ensure an individual in a nursing facility, regardless of whether he or she has an LAR, participates in the SPT to the fullest extent possible and will receive the support necessary to do so, including, but not limited to, communication supports.

3. The LIDDA must ensure the SPT:
   a. develops an ISP using Form 1041 (Individual Service Plan/Transition Plan – NF) that:
      i. Is individualized and developed through a person-centered process;
      ii. Identifies the individual's:
         I) strengths;

II) preferences;
III) psychiatric, behavioral, nutritional management, and support needs; and
IV) desired outcomes;

iii. Identifies the specific specialized services to be provided to the individual, including the amount, intensity, and frequency of each specialized service; and

iv. Identifies the services and supports that are needed to meet the individual's needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting possible;

b. is responsible for planning, ensuring the implementation of, and monitoring all specialized services identified in the ISP, and transition planning in coordination with the nursing facility's care planning team;

c. ensures the individual's ISP, including specialized services, is integrated into the nursing facility's plan of care and that specialized services are planned, provided, and monitored in a consistent manner, and integrated with the services provided by the nursing facility; and

d. assesses the adequacy of the services and supports that the individual is receiving; and

e. monitors the individual's ISP to make timely additional referrals, service changes, and amendments to the plan as needed.

F. Administrative Requirements

1. Upon notice from and in a format approved by DADS, the LIDDA must provide data and other information related to the services and requirements described in this Attachment G.

2. At least semi-annually, the LIDDA must provide or arrange for the provision of educational or informational activities addressing community living options for individuals in nursing facilities in the LIDDAs local service area and their families. These activities may include family-to-family and peer-to-peer programs, providing information about the benefits of community living options, facilitating visits in such settings, and offering opportunities to meet with other individuals who are living, working, and receiving services in integrated settings, with their families, and with community providers.
   a. These educational or informational activities must be provided by persons who are knowledgeable about community services and supports.
   b. These activities must not be provided by nursing facility staff or others with a contractual relationship with nursing facilities.

c. The LIDDA must maintain documentation related to an offer of and attendance at educational or informational activities in the record for each individual in a nursing facility.
d. The LIDDA must maintain evidence of the content of and attendance at each semi-annual educational or informational activity.

3. The LIDDA must maintain a list of all individuals in a nursing facility who express an interest in transitioning to the community to any employee, contractor, or provider of specialized services. For each individual on the list, the LIDDA must notify the service coordinator to discuss community living options.

4. For an individual in a nursing facility, the LIDDA must request reimbursement for the delivery of specialized services provided by the LIDDA in accordance with DADS instructions on DADS Form 1048 (Summary Sheet for Services to Individuals with IDD in a Nursing Facility).

5. For an individual in a nursing facility receiving service coordination who is not transitioning to the community, the LIDDA must fund service coordination using the Nursing Facility PASRR Service Coordination allocation set forth in Attachment C (Allocation Schedule).

6. For an individual in a nursing facility receiving service coordination who is transitioning to the community, the LIDDA must fund service coordination through Targeted Case Management.

II. Enhanced Community Coordination.

A. Qualifications and Duties of Enhanced Community Coordinator

For all individuals diverting or transitioning from a nursing facility (NF) or state supported living center (SSLC) as required in Sections III and IV of this Attachment G, the LIDDA shall ensure:

1. the individual is assigned an enhanced community coordinator who:
   a. meets the qualifications of a service coordinator in accordance with 40 TAC, §2.559 (Minimum Qualifications); and
   b. has extensive experience in providing service coordination to individuals with IDD, including those who have complex medical needs; and

2. the assigned enhanced community coordinator:
   a. complies with the rules governing service coordination for an individual with an intellectual disability (40 TAC, Chapter 2, Local Authority Responsibilities, Subchapter L, Service Coordination for Individuals with an Intellectual Disability);

b. provides intensive and flexible support to achieve success in a community setting, including arranging for support needed to prevent and manage a crisis, such as a Transition Support Team or crisis respite;
c. provides pre- and post-transition services;
d. monitors the individual as required by Sections III and IV of this Attachment G for one year after transition or diversion; and
e. maintains a case load of no more than 30 individuals regardless of whether the community coordinator provides service coordination to other individuals who are not covered under the provisions of this Attachment G.

B. Use of Designated Funds for Enhanced Community Coordination.

The LIDDA shall utilize designated funds, as submitted and approved by DADS, to enhance an individual's natural supports and promote successful community living, such as:

1. One-time emergency assistance:
   a. Rental or utility assistance;
   b. Food or nutritional supplements;
   c. Clothing; and
   d. Medication;

2. Items to address an individual's special needs, including minor home modifications not funded by other sources;

3. Transportation to and from trial visits with community providers; and

4. Educational tuition assistance, such as vocational programs through community colleges so an individual can develop job skills.

C. Reporting

The LIDDA shall submit quarterly reporting to the Performance Contracts mailbox by the 15th of the month that follows the previous fiscal quarter using a format prescribed by DADS. A quarterly report must contain:

1. A narrative of the results of the provision of enhanced community coordination, including positive and negative outcomes and barriers encountered during the provision of enhanced community coordination;

2. A list of the names of individuals receiving enhanced community coordination at any time during the quarter being reported and the date they began receiving enhanced community coordination; and

3. An expenditure report including but not limited to salaries, employee benefits, training, travel and other operating expenses.

D. Payments

1. Contingent on the Centers for Medicare and Medicaid approving Money Follows the Person funding, DADS will pay LIDDA an amount not to exceed the allocation provided to the LIDDA to provide enhanced community coordination as stated in this Attachment G. Funds will be paid in compliance with the OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (UGG), which may be found online at: http://www.ecfr.gov/cgi-bin/text-idx?node=2:1.1.2.2.1&rgn=div5.

2. Under these requirements, the LIDDA may request payment be provided in advance or may submit requests for reimbursement of costs.
   a. Under 2 CFR §200.305, Reimbursement is the preferred method when the requirements in paragraph (b) cannot be met, when the federal awarding agency sets a specific condition per §200.207 (Specific conditions), or when a non-federal entity requests payment by reimbursement. Requests for advance payment are subject to the financial management standards test and requirements established by UGG. An advance payment request must:
      i. be limited to cash needed to meet the immediate needs of the grant project;
      ii. minimize time between advances and payments for grants activities; and
      iii. be deposited in a separate interest bearing account and interest earned on grant funds must be returned to the federal government.
   b. If the LIDDA requests reimbursement for costs, the LIDDA must submit an invoice, no later than the 15th day of the month that follows the month of service delivery, on a template provided by DADS and include supporting documentation as described by DADS.

III. Enhanced Community Coordination for Individuals Diverting or Transitioning from an NF.

A. HCS as a diversion from NF admission

For an individual enrolling in HCS as a diversion from NF admission, the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual enrolls in HCS:
   a. develops, and revises as necessary, using DADS Form 1050 (Diversion Plan) with an individual's service planning team (SPT), as defined in rules governing the HCS program in 40 TAC, §9.153 (Definitions);
   b. using all available assessments, develops, and revises as necessary, with the individual's SPT an HCS Person-Directed Plan (PDP) Form 8665

(Person-Directed Plan), that identifies the individual's strengths and preferences, and medical, nursing, nutritional management, clinical, and support needs; and

c. conducts a pre-move site review using DADS Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed.

2. for one year after an individual has diverted to the HCS waiver program:
   a. conducts service planning team meetings at least quarterly, or more frequently if there is a change in an individual's needs or if requested by the individual or LAR;
   b. revises the HCS PDP, as necessary, and coordinates the individual's services and supports;
   c. conducts at least monthly face-to-face visits with an individual, or more frequently if determined by the SPT based on risk factors, and monitors the delivery of all services and supports;
   d. conducts onsite visits of community service delivery sites to determine whether supports continue to be in place and any areas of concern are being addressed using DADS Form 1043 (Post-Move Monitoring);
   e. inquires about any recent hospitalizations, emergency department contacts, increased physician visits, or other crises, including medical crises, and if the individual experiences such, convenes the SPT to identify all necessary revisions to the individual's HCS PDP to address additional need for services;
   f. ensures an individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
   g. records health care status sufficient to readily identify when changes in the individual's status occurs;
   h. conducts service planning, ensures implementation of services, and monitors all services identified on the HCS PDP, including:
      i. reviewing the HCS program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met; and
      ii. monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and
   i. monitors an individual while on suspension from the HCS waiver program at least monthly and provide reports to DADS upon request.

B. Transition to HCS from NF

1. For an individual 21 years of age or older who is transitioning to HCS from an NF, the LIDDA shall, before the individual transitions from the NF, ensure the assigned enhanced community coordinator:

a. develops, implements, monitors, and revises as necessary, Section 9 (Transition Plan to the Community) Phases II and III of the individual service plan, DADS Form 1041 (Individual Service Plan/Transition Plan - NF) with an individual's SPT, as defined in rules governing the HCS program in 40 TAC, §9.153 (Definitions);
b. provides increased coordination and interaction with an NF's care planning team and the assigned relocation specialist;
c. facilitates trial visits to providers in the community for the individual, including overnight visits where feasible, as requested by the individual or LAR;
d. using all available assessments, develops, and revises as necessary, with the individual's SPT an HCS Person-Directed Plan (PDP) Form 8665 (Person-Directed Plan), that identifies the individual's strengths and preferences, and medical, nursing, nutritional management, clinical, and support needs; and
e. conducts a pre-move site review using DADS Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed and ensure all essential supports identified on the transition plan are in place before the individual transitions.

2. For an individual of any age who transitioned to HCS from an NF, the LIDDA shall, for at least one year after the individual has transitioned, ensure the assigned enhanced community coordinator:
   a. for an individual under the age of 21 years, communicate with an appropriate staff of the entity that was responsible for transitioning the individual from the nursing facility (for FYs 2016 and 2017, the entity is EveryChild, Inc.) to gather all necessary information and documents to ensure a successful transition for the individual;
   b. conducts service planning team meetings at least quarterly, or more frequently if there is a change in an individual's needs or if requested by the individual or LAR;
   c. revises the service plan, as necessary, on the HCS PDP and coordinates the individual's services and supports;
   d. conducts at least monthly face-to-face visits with an individual, or more frequently if determined by the SPT based on risk factors, and monitors the delivery of all services and supports;
   e. conducts onsite visits of community service delivery sites to determine whether supports continue to be in place and any areas of concern are being addressed using DADS Form 1043 (Post-Move Monitoring);
   f. Inquires about any recent hospitalizations, emergency department contacts, increased physician visits, or other crises, including medical crises, and if the individual experiences such, convenes the SPT to identify all necessary revisions to the individual's HCS PDP to address additional need for services;

g. ensures an individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
h. records health care status sufficient to readily identify when changes in the individual's status occurs;
i. conducts service planning, ensures implementation of services, and monitors all services identified on the HCS PDP, including:
   i. reviewing the HCS program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met; and
   ii. monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and
j. monitors an individual while on suspension from the HCS waiver program at least monthly and provide reports to DADS upon request.

C. Transition to a Community Medicaid Program from NF

For an individual 21 years of age or older who is transitioning from an NF to a community Medicaid program (i.e., a community ICF/IID or a Medicaid waiver program other than HCS), the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual transitions from the NF:
   a. develops, implements, monitors, and revises as necessary, Section 9 (Transition Plan to the Community) Phases II and III of the individual service plan, DADS Form 1041 (Individual Service Plan/Transition Plan - NF) with an individual's SPT;
   b. provides increased coordination and interaction with an NF's care planning team and, if the individual is transitioning to a Medicaid waiver program other than HCS, the assigned relocation specialist;
   c. facilitates trial visits to providers in the community that offer residential services (for example, an ICF/IID, a Star+Plus waiver assisted living facility) for the individual, including overnight visits where feasible, as requested by the individual or LAR;
   d. provides all available assessments to the selected community Medicaid program provider; and
   e. conducts a pre-move site review using DADS Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed and ensure all essential supports identified on the transition plan are in place before the individual transitions.

2. for at least one year after the individual has transitioned to a community Medicaid program conducts the following activities to determine whether necessary services and supports are being provided and areas of concern

are being addressed and to assess the individual's adjustment to community life and the individual's (and LAR's) satisfaction with community life:

a. post-move monitoring using DADS Form 1043 (Post-Move Monitoring); and
b. face-to-face service coordination contacts monthly during the first six months following the individual's move from the NF, and quarterly during the second six months following the individual's move.

IV. Enhanced Community Coordination for Individuals Diverting or Transitioning from a State Supported Living Center

A. HCS as a Diversion from SSLC Admission

For an individual enrolling in HCS as a diversion from SSLC admission, the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual enrolls in HCS:
   a. develops, and revises as necessary, using DADS Form 1050 (Diversion Plan) with an individual's service planning team (SPT);
   b. using all available assessments develop the HCS PDP; and
   c. conducts a pre-move site review using DADS Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed.

2. for one year after an individual has diverted to the HCS waiver program:
   a. conducts service planning team meetings at least quarterly, or more frequently if there is a change in the individual's needs or if requested by the individual or LAR;
   b. conducts at least monthly face-to-face visits with the individual and monitors the delivery of all services and supports by:
      i. conducts post-move monitoring using DADS Form 1043 (Post-Move Site Review) to determine whether supports are in place and any areas of concern are being addressed;
      ii. ensuring the individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
      iii. reviewing the HCS program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met;
      iv. monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and
      v. monitoring an individual while on suspension from the HCS waiver program at least monthly and provide reports to DADS upon request.

B. Transition to HCS from SSLC

For an individual transitioning to HCS from an SSLC, the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual transitions from the SSLC:
   a. participates in developing the CLDP with SSLC staff as required by 40 TAC, §2.278 (Community Living/Discharge Plan by Alternate Living Arrangements);
   b. uses all available assessments to develop the HCS PDP;
   c. participates in the pre-move site review conducted by SSLC staff to determine whether supports are in place and any areas of concern are being addressed; and
   d. complies with the requirements contained in 40 TAC, §2.277(b)-(d) (relating to Arrangements for the Move to an Alternate Living Arrangement of an Individual Residing in a State MR Facility) using DADS Form 8630 (Continuity of Care);

2. for one year after the individual has transitioned to HCS:
   a. conducts at least monthly face-to-face visits with an individual for one-year;
   b. complies with the monitoring activities and agreement portions set forth in the CLDP;
   c. conducts periodic monitoring (i.e., every 90 days) and, using a DADS-prescribed format, develops written reports of monitoring that addresses specific findings for any significant monitoring activity, including:
      i. psychiatric or medical hospitalization;
      ii. any visits to an emergency room within the period being reported;
      iii. death;
      iv. arrest or incarceration;
      v. any contacts with law enforcement within the period being reported;
      vi. unable to locate or left program;
      vii. HCS program provider issue – change of homes;
      viii. HCS program provider issue – closure;
      ix. HCS program provider issue – confirmed abuse, neglect or exploitation;
      x. HCS program provider issue – change of program provider; and
      xi. return to the SSLC; and
   d. submits the written reports required in 2.c. above to the SSLC admission placement coordinator (APC), DADS, and the HCS program provider.

C. Transition from SSLC to a setting other than HCS

For an individual transitioning from an SSLC to setting other than HCS (such as a community ICF/IID or family's home), the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual transitions from the SSLC:
   a. participates in developing the CLDP with SSLC staff as required by 40 TAC, §2.278 (Community Living/Discharge Plan by Alternate Living Arrangements); and
   b. participates in the pre-move site review conducted by SSLC staff to determine whether supports are in place and any areas of concern are being addressed; and
   c. complies with the requirements contained in 40 TAC, §2.277(b)-(d) (relating to Arrangements for the Move to an Alternate Living Arrangement of an Individual Residing in a State MR Facility) using DADS Form 8630 (Continuity of Care); and

2. for one year after the individual has transitioned from an SSLC:
   a. complies with the monitoring activities and agreement portions set forth in the CLDP; and
   b. conducts periodic monitoring (i.e., every 90 calendar days) and, using a DADS-prescribed format, develops written reports of monitoring that addresses specific findings for any significant monitoring activity, including:
      i. psychiatric or medical hospitalization;
      ii. any visits to an emergency room within the period being reported;
      iii. death;
      iv. arrest or incarceration;
      v. any contacts with law enforcement within the period being reported;
      vi. unable to locate, left community program, moved out-of-state;
      vii. move to another residence;
      viii. community program provider issue – closure;
      ix. community program provider issue – confirmed abuse, neglect or exploitation;
      x. community program provider issue – change of program provider; and
      xi. return to the SSLC; and
   c. submits written reports required in Section C. 2.b. of this Attachment G to the SSLC admission placement coordinator (APC) and DADS.

Exhibit D

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Room 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH, REGION VI

July 18, 2012

Our Reference: SPA TX 11-054

Mr. Billy Millwee
Deputy Executive Commissioner for Health Services
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

Dear Mr. Millwee:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 11-054, dated September 30, 2011. This state plan amendment defines the Level II evaluation provided to all individuals suspected of having mental illness or an intellectual developmental disability seeking admission to a Medicaid certified nursing facility under the Preadmission Screening and Resident Review (PASRR) program. This state plan amendment also identifies specialized services that will be available when determined to be needed through the PASRR evaluation process. The State has indicated that it will submit a state plan amendment for the reimbursement methodology under the nursing facility rate in the future.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of February 1, 2013. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

If you have any questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,

Bill Brooks
Associate Regional Administrator

cc: Emily Zalkovsky, Policy Development Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

Revised 5-3-2012

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **11-054**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **February 1, 2013**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 483.100-483.138

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2013** **$0**
b. FFY **2014** **$0**
c. FFY **2015** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT TO BLOCKS 8 & 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 & 9

10. SUBJECT OF AMENDMENT:
The proposed amendment defines the preadmission screening and resident review (PASRR) Level II evaluation and identifies specialized services available only to individuals who are PASRR-eligible.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Billy R. Millwee**

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: **September 30, 2011**

16. RETURN TO:
Billy R. Millwee
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 30 September, 2011

18. DATE APPROVED: 18 July 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 February, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Bill Brooks

22. TITLE: Associate Regional Administartor
Division of Medicaid & Children's Health

23. REMARKS:

FORM CMS - 179 (07-92)

PASRR: Level II Evaluation

The preadmission screening and resident review (PASRR) Level II evaluation is provided to all individuals who are suspected of having mental illness (MI) or an intellectual or developmental disability[1] who seek admission to a Medicaid-certified nursing facility (NF). The PASRR Level II evaluation accomplishes the following tasks:

1. Confirms that an individual meets the PASRR definition of MI or has an intellectual or developmental disability.
2. Determines whether the individual's needs could be met in a setting other than a NF.
3. Determines if the individual has a medical necessity for admission to the NF.
4. Identifies all specialized services from which the individual can benefit while receiving services in a NF.

The PASRR Level II evaluation includes both preadmission and resident review evaluations.

STATE Texas
DATE REC'D 9-30-11
DATE APPV'D 7-18-12
DATE EFF 2-1-13
HCFA 179 11-54
A

[1] This term has the same meaning as "mental retardation," defined at 42 C.F.R. § 483.102(b)(3).

79s

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

Citation		4.39 Preadmission Screening and Resident Review in Nursing Facilities
Secs. 1902(a)(28)(D)(i); 1905(a); 1919(b)(3)(F) and 1919(e)(7) of the Social Security Act		(a) The Medicaid agency has in effect a written agreement with the state mental heath and mental retardation authorities that meet the requirements of 42 CFR 431.621(c)
		(b) The State operates a preadmission and resident review program that meets the requirements of 42 CFR 431.100-138
		(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or resident review until such individuals are screened or reviewed.
		(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State Plan" the cost of NF services to individuals who are found not to require NF services.
	X	(e) Attachment 4.39 specifies the State's definition of specialized services.

SUPERSEDES: TN- 93-10

STATE Texas
DATE REC'D 9-30-11
DATE APPV'D 7-18-12
DATE EFF 2-1-13
HCFA 179 11-54

A

4a. Nursing Facility Services for Individuals 21 Years of Age or Older (continued)

Customized adaptive aids are aids that enable an individual to retain or increase the ability to perform activities of daily living or perceive, control, or communicate with the environment in which the individual lives. Customized adaptive aids are intended for use by only the individual for whom the aid is purchased.

Customized adaptive aids are available to individuals with intellectual and developmental disabilities[1] who are receiving services in a nursing facility and have been found through the preadmission screening and resident review process to need a customized adaptive aid. Prior authorization must be obtained from the Health and Human Services Commission before purchase of any customized adaptive aid.

(A) To be eligible for reimbursement for a customized adaptive aid, the nursing facility, prior to the purchase of the aid, must obtain an evaluation of the resident by a physical, occupational, or speech-language therapist licensed in the State of Texas. This evaluation must contain all of the following criteria:
   i. Specific item being recommended.
   ii. Description of how this item will meet the specific needs of this individual.
   iii. Description of specific training needs for use of this device including training needs of the individual, nursing facility staff, and family (when applicable).

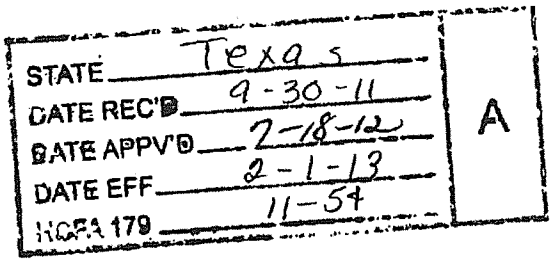
(B) The nursing facility must provide a statement of medical necessity for this customized adaptive aid from the resident's primary care physician in order to obtain prior authorization.

STATE Texas	A
DATE REC'D 9-30-11	
DATE APPV'D 7-18-12	
DATE EFF 2-1-13	
HCFA 179 11-54	

[1] This term has the same meaning as "mental retardation," defined at 42 C.F.R. § 483.102(b)(3).

4a. Nursing Facility Services for Individuals 21 Years of Age or Older (continued)

Enhanced therapy services are available as a specialized service to individuals with intellectual and developmental disabilities[1] residing in nursing facilities who have been found through the preadmission screening and resident review process to need these services. Physical therapy, occupational therapy, and speech therapy will be provided to eligible individuals as required to maintain the individual's optimum condition.



[1] This term has the same meaning as "mental retardation," defined at 42 C.F.R. § 483.102(b)(3).

4a. Nursing Facility Services for Individuals 21 Years of Age or Older (continued)

Customized adaptive aids are aids that enable an individual to retain or increase the ability to perform activities of daily living or perceive, control, or communicate with the environment in which the individual lives. Customized adaptive aids are intended for use by only the individual for whom the aid is purchased.

Customized adaptive aids are available to individuals with intellectual and developmental disabilities[1] who are receiving services in a nursing facility and have been found through the preadmission screening and resident review process to need a customized adaptive aid. Prior authorization must be obtained from the Health and Human Services Commission before purchase of any customized adaptive aid.

(B) To be eligible for reimbursement for a customized adaptive aid, the nursing facility, prior to the purchase of the aid, must obtain an evaluation of the resident by a physical, occupational, or speech-language therapist licensed in the State of Texas. This evaluation must contain all of the following criteria:
   i. Specific item being recommended.
   ii. Description of how this item will meet the specific needs of this individual.
   iii. Description of specific training needs for use of this device including training needs of the individual, nursing facility staff, and family (when applicable).

(B) The nursing facility must provide a statement of medical necessity for this customized adaptive aid from the resident's primary care physician in order to obtain prior authorization.

STATE Texas
DATE REC'D 9-30-11
DATE APPV'D 2-18-12
DATE EFF 2-1-13
HCFA 179 11-54
A

[1] This term has the same meaning as "mental retardation," defined at 42 C.F.R. § 483.102(b)(3).

4a. Nursing Facility Services for Individuals 21 Years of Age or Older (continued)

Enhanced therapy services are available as a specialized service to individuals with intellectual and developmental disabilities[1] residing in nursing facilities who have been found through the preadmission screening and resident review process to need these services. Physical therapy, occupational therapy, and speech therapy will be provided to eligible individuals as required to maintain the individual's optimum condition.

STATE Texas
DATE REC'D 9-30-11
DATE APPV'D 7-18-12
DATE EFF 2-1-13
HCFA 179 11-54

A

[1] This term has the same meaning as "mental retardation," defined at 42 C.F.R. § 483.102(b)(3).

Exhibit E

TEXAS
Health and Human
Services System

Consolidated Budget Request

2018 - 2019 Biennium

Health and Human Services Commission

Department of Family and Protective Services

Department of State Health Services

October 2016

- **Exceptional Item #4 Maintain Medicaid Waiver Program at Fiscal Year 2017 Levels.** This item provides waiver funding based on the end of the year population level. The budget instruction requirement of agencies to request an average of the two previous years as the base for the following biennium does not consider "ramping up" of individuals throughout the biennium. The end of year population count will ensure waiver programs have necessary funds towards the end of the biennium.

- **Exceptional Item #15 Reducing Community Programs Interest List (formerly Community Expansion).** HHSC is requesting an increase in funding for an additional 19,010 slots for community services formerly administered by DADS legacy agency, including HCS, Medically Dependent Children Program (MDCP), Texas Home Living (TxHmL), Community Living Assistance and Supports Services (CLASS), Deaf- Blind with Multiple Disabilities (DBMD) and Title XX individuals above the SSI level.

- **Exceptional Item #40 Community Day Habilitation Programs - HCBS Requirements.** HHSC requests funds to assist community-based providers and their subcontracted day habilitation providers to make changes to day habilitation services to meet CMS HCBS settings rule requirements related to community integration, setting choice, right to privacy, dignity and respect and individual autonomy.

- **Exceptional Item #42 Quality Reporting System Updates.** HHSC is seeking funds to replace the current Quality Reporting System. The 15 year old system has multiple data input sources, and the current data storage process makes it challenging to upload quality information on the HHSC website for public use.

- **Exceptional Items #41 Community Critical Incident Reporting System** HHSC is requesting funds to purchase a system to collect consistent critical incident information across multiple 1915(c) community-based programs required to meet CMS assurances related to health and welfare.

- **Exceptional Item #43 PASRR LTC Online Portal Quality Improvements.** HHSC requests funds to add functionality to the LTC Portal related to individuals who receive specialized services in nursing facilities as required by federal law in the Pre-admission Screening and Review (PASRR) program. Currently, compliance information is tracked manually. This item would eliminate the need for manual tracking of nursing facility compliance and would ensure quality services are delivered.

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)

The ICF/IID program is a Medicaid-funded program that provides 24-hour residential services

Information Technology Systems Needs

The Health and Human Services Commission Information Technology organization provides leadership and direction across the HHS System related to automated systems to achieve an efficient and effective health and human services system for Texans. To continue to fulfill this purpose, fifteen exceptional items are included in the HHSC LAR (see **Figure IV.2**). These items cross multiple agencies and represent the most critical information technology needs to enable Health and Human Services programs to provide client services in the most efficient manner possible.

Figure IV.2

HHSC Information Technology Exceptional Items FY 2018-2019 ($ in millions)			
Item #	**Description**	**Biennial GR**	**Biennial AF**
41	Critical Incident Reporting	$ 1.3	$ 2.5
42	Quality Reporting System (QRS)	$ 0.6	$ 1.2
43	LTC Online Portal Specialized Services System Quality Improvements	$ 4.1	$ 16.5
44	Rehab Works Replacement Solution	$ 3.3	$ 3.3
45	Avatar Support (Electronic Medical Records System in State Hospitals)	$ 6.1	$ 6.1
46	Maintain State Hospital Technology for Patient Care-Hospital Record at RGSC	$ 2.0	$ 2.0
47	Hospital Infrastructure	$ 2.0	$ 2.0
48	TIERS Transition	$ 4.2	$ 12.1
49	Social Security Number Removal	$ 0.7	$ 7.1
50	HHS Electronic Discovery Solution	$ 6.1	$ 8.3
51	HHS Cybersecurity Project	$ 3.5	$ 4.8
52	DIR Data Center Services	$ 38.2	$ 59.7
53	Legacy System Modernization – Non-DCS IT Infrastructure	$ 33.7	$ 43.6
54	Seat Management (leases of personal computers)	$ 7.1	$ 7.4
55	Enterprise Identity and Access Management	$ 2.0	$ 2.7
	HHSC IT Exceptional Item Total	**$ 114.8**	**$ 179.4**

Each HHSC item is described separately below. In addition to these HHSC exceptional items, HHS agencies included in their agency-specific LARs information technology projects that do not impact multiple agencies. Those items are also described below.

HHSC Exceptional Item #41-Critical Incident Reporting ($1.3 million GR/ $2.5 million AF)

This item provides funding to develop a consistent incident management system across the 1915(c) waiver and intermediate care facilities for individuals with an intellectual disability or

related condition (ICFs/IID). ICFs/IID are required, under current rules, to track reportable incidents on an individual basis within eight different categories. However, DADS only requires monthly aggregate reporting of a minimal set of incident data for the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) programs and does not require the same reporting for Community Living Assistance and Support Services (CLASS) and the Deaf-Blind with Multiple Disabilities (DBMD) Program. In order to receive federal funding for 1915(c) and ICF/IID programs, the Centers for Medicare and Medicaid Services (CMS) also requires states to have an incident management system that effectively tracks those incidents through resolution and prevents further similar incidents to the extent possible.

HHSC Exceptional Item #42- Quality Reporting System (QRS) ($0.6 million GR/ $1.2 million AF)

This item provides funding to develop an improved Long-Term Care Quality Reporting System (QRS) to implement management actions from the Sunset Advisory Commission. The Commission called for DADS to make more consistent information available for all provider types, give every provider an overall rating using a five-star system, publicize current and historical enforcement data on individual providers, and include staffing information such as turnover and staff-to-resident ratios for each provider.

HHSC Exceptional Item #43- LTC Online Portal Specialized Services System Quality Improvements ($4.1 million GR/ $16.5 million AF)

This item funds improvements to the Long-Term Care (LTC) online portal Preadmission Screening and Resident Review (PASRR) forms and functionality. The LTC online portal, part of Texas' Medicaid Management Information System implemented in 2006, is a system with a web portal for service providers to submit claims, service authorization forms, corrections and inquiries. Additional functionality is needed pertaining to individuals receiving specialized services as required by federal law in the PASRR process to ensure nursing facility providers comply with program requirements for timely and accurate completion.

HHSC Exceptional Item #44- ReHabWorks Replacement Solution ($3.3 million GR/ $3.3 million AF)

ReHabWorks was a case-review system used by DARS for Vocational Rehabilitation, Blindness Education, Screening, and Treatment (BEST), Comprehensive Rehabilitation Services (CRS), and Blind Children's Vocational Discovery and Development Program (BCVDDP). On September 1, 2016, the Texas Workforce Commission assumed responsibility for ReHabWorks, supporting both TWC and HHSC programs. With this exceptional item, HHSC will seek an "off-the-shelf" software solution requiring minimal customization, interface development, and data conversion, including end-user utilities for configuration, to replace ReHabWorks for BEST, CRS and BCVDDP, as TWC will no longer support the legacy DARS programs at HHSC.

Exhibit F

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, et al. Plaintiffs	)	
vs.	)	CASE NO. 5:10-CV-1025-OG
GREG ABBOTT, Governor of the State of Texas, et al, Defendants	)	

THE UNITED STATES OF AMERICA, Plaintiff-Intervenor	)	
vs.	)	
THE STATE OF TEXAS, Defendant	)	

****

ORAL VIDEOTAPED DEPOSITION

STACY LINDSEY

February 8, 2017

****

ORAL VIDEOTAPED DEPOSITION OF STACY LINDSEY, produced as a witness at the instance of the Plaintiffs and duly sworn, was taken in the above-styled and numbered cause on the 8th day of February, 2017, from 9:18 a.m. to 5:47 p.m., before April Balcombe, Certified Shorthand Reporter and Certified Realtime Reporter, in

and for the State of Texas, reported by computerized stenotype machine at the offices of Office of the Attorney General, 300 West 15th Street, 11th Floor, Room 1104C, Austin, Texas 78701, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

A. No.

Q. Do you understand the active treatment requirement for people with IDD in nursing facilities?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MS. STAUB) Have you heard the term "active treatment" before?

A. Yes.

Q. And what does it mean to you?

MS. FORE: Objection. Form.

Q. (BY MS. STAUB) In the context of PASRR and people with IDD in nursing facilities.

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MS. STAUB) Are you familiar with the term "specialized services"?

A. Yes.

Q. And do you understand that there are specified, specialized services that are available to people with IDD in nursing facilities, right?

MS. FORE: Objection. Form.

A. Yes.

Q. (BY MS. STAUB) And there is an array of specialized services that are provided by nursing facilities to people with IDD in nursing facilities; is

that right?

MS. FORE: Objection. Form.

A. Yes.

Q. (BY MS. STAUB) And there is an array of specialized services that are provided by the local authority or those who contract with the local authority to people with IDD in nursing facilities; is that right?

MS. FORE: Objection. Form.

A. Yes.

Q. (BY MS. STAUB) And do you know what those specialized services are on both sides of that, the nursing facility and the -- I will call it nursing facility specialized services and non-nursing facility specialized services?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Do you -- or what is your understanding of the purposes of the provision of specialized services to people, adults with IDD in nursing facilities?

MS. FORE: Objection. Form.

A. Can you repeat that?

Q. (BY MS. STAUB) What is your understanding of the purpose of specialized services for adults with IDD in nursing facilities?

in what this report contains, right?

A. Yes.

Q. And if I can focus your attention on the six outcomes from the first page that this report is analyzing. The second outcome. Do you see number two on the first page?

A. Yes.

Q. Could you read that?

A. "Individuals in the target population and nursing facilities will receive specialized services with the frequency, intensity, and duration necessary to meet their appropriate identified needs consistent with their informed choices."

Q. Just to make a correction, that is "to meet their appropriately need, identified needs."

A. Oh, sorry.

Q. That correction is right?

A. "Appropriately" is correct. Yes.

Q. And your unit provides support and develops procedures for local authorities who have service coordinators who monitor specialized services to the PASRR population in nursing facilities, right?

MS. FORE: Objection. Form.

A. Can you repeat that?

Q. (BY MS. STAUB) Your unit provides supports and

develops procedures for local authorities whose service coordinators monitor specialized services for people with IDD in nursing facilities, right?

A. Yes.

MS. FORE: Objection. Form.

Q. (BY MS. STAUB) Is that right?

A. Yes.

Q. I couldn't hear.

And this outcome that Kathryn Dupree is looking at here is directly connected to that support in those procedures, right?

MS. FORE: Objection. Form.

A. Yes.

Q. (BY MS. STAUB) Okay. So just taking the second of the six outcomes that are identified in this report and flipping to page 5 of the exhibit which is 605, the Bates number. Do you see the section entitled Compliance for 2015?

A. Yes.

Q. And it says, "The Table 1 below summarizes the level of compliance for each outcome." Do you see that?

A. Yes.

Q. And what is the 2015 compliance level for outcome to nursing facility specialized services?

MS. FORE: Objection. Form.

A. The report states under outcome 2, Nursing Facility Specialized Services, the 2015 compliance level was 36 percent.

Q. (BY MS. STAUB) And is that something that you were aware of before you just said that right now, that this was the -- that was the percentage level --

MS. FORE: Objection. Form.

Q. (BY MS. STAUB) -- for the 2015 report?

A. I don't recall.

Q. And does 36 percent compliance level for 2015 with respect to outcome 2 that you read, nursing facility specialized services, does that -- is that of concern to you as the unit manager for LPDS?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MS. STAUB) What do you need to know in order to decide if that's a concern to you?

MS. FORE: Objection. Form.

A. The measures under that outcome, what was being rated under that outcome.

Q. (BY MS. STAUB) And if I represent to you that the measures under this outcome are set forth in this report, are you interested in reading the rest of the report to see how that 36 percent compliance level was arrived at?

A. Yes.

Q. All right. Let's go to -- let me -- before I go on, I don't pretend that in this deposition I can explore the depth of this report with you, Ms. Lindsey. I have too much respect for you and for the process. But I am going to point out a couple of things that underscore that outcome, 36 percent.

So let's go to page -- we start on page 11 of the exhibit, which is Defendant's E-611. You see the page that says "PASRR individual review monitoring measure overall compliance this report displays." Do you see that on this page?

A. Yes.

Q. And below that is the beginning of a chart -- some text and beginning of a chart saying "review year outcome measure, QSR compliance report, compliance and overall compliance." Do you see that?

A. Yes.

Q. I am going to take you through to the part of the chart on page 17 of the exhibit -- I am sorry, 16 -- that goes to the outcome measures directly related to outcome 2. They are enumerated 2-1, 2-2, and on the page I referenced, 2-3, 2-4, and 2-5.

Will you look at outcome measure 2-4. Do you see that on page 16 for Bates number 616?

A. Yes.

Q. All right. Can you read outcome measure 2-4?

A. "The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the time frames established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral therapy, independent living, community participation, and the integrated day activity needs of the individual."

Q. With respect to that outcome measure, as the manager of the LPDS unit in IDD services, were you aware that Kathryn Dupree was measuring assessments of need and time frames and the details set forth here? Were you aware that she was conducting a review of that outcome measure?

A. Yes.

Q. You were aware that she was reviewing that outcome measure?

MS. FORE: Objection. Form.

A. Yes.

Q. (BY MS. STAUB) And were you aware that the compliance -- QSR compliance without metrics on that

outcome measure was 30 percent?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Do you recall if that outcome, 30 percent, reported here was part of the piece of the copy that you reviewed?

A. I don't recall.

Q. Or that the overall compliance was measured at 30 percent?

MS. FORE: Objection. Form.

Q. (BY MS. STAUB) For that measure.

A. I don't recall.

MS. FORE: Objection. Form.

Q. (BY MS. STAUB) Do you think it's important for you to understand what was studied under outcome 2 and how these measures were arrived at in terms of your role providing support and developing procedures for LIDDAs?

A. Yes.

Q. And if you look at the first part, the introduction again of this exhibit, page 2, DFE-602, could you read outcome 5 in the same way you read outcome 2?

A. "Individuals in the target population who do not refuse service coordination will receive service coordination from trained service coordinators with the

frequency necessary to meet the individuals' appropriately identified needs consistent with their informed choice."

Q. And were you aware that that was an outcome that Ms. Dupree was measuring in her review?

A. Yes.

Q. You were aware that she was studying it? That's what the S means?

A. Yes.

Q. And did you try to find out, you know, what the outcome was, what the -- what the review showed, compliance-wise?

A. Yes.

Q. And did you?

A. Yes.

Q. So you learned the outcome of -- well, I am not going to use that word.

You learned the compliance measurement that is in this report from Kathryn Dupree with respect to outcome 5?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MS. STAUB) Okay. What did you learn about that outcome 5?

A. Again, as stated before, I saw pieces of

documents that looked very similar.

Q. Right. But I think you just answered my question. I said, did you find out what the outcome -- what the compliance level was for outcome 5, and you said yes. So I wanted to find out what did you learn and when did you learn it.

MS. FORE: Objection. Form.

A. I don't recall specifically.

Q. (BY MS. STAUB) Do you remember what the percentage was of compliance?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Do you recall looking through any of the measures with respect to outcome 5?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Do you know if the report that you saw pieces of was the 2015 report or a 2016 report?

A. I have seen both.

Q. You have seen both.

And you don't recall seeing this whole report; you just saw pieces of it?

A. That's correct.

Q. And what, if anything, did you and your unit do in response to the results that you saw?

MS. FORE: Objection. Form.

Q. (BY MS. STAUB) Whatever ones they were.

A. Can you repeat what you -- the last few words? I didn't hear you.

Q. In response to what you learned from the 2015 report, whatever you learned from it, you can't recall, but whatever you did learn, what, if anything, did you and your department -- your unit do with that information?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Did you develop any new procedures?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Did you provide any support to the LIDDAs to help them provide services to people in nursing facilities?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Did you make any of the outcomes measurements that you became aware of in the 2015 report a topic of any webinar?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Did you incorporate it into any training material that you provide to service coordinators at the local authorities?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Is there any records or documents that you have in your unit that reflect any action that your unit took in response to the information that you were privy to in Kathryn Dupree's report, 2015?

MS. FORE: Objection. Form.

A. I don't recall.

Q. (BY MS. STAUB) Is there anything you can look at to refresh your recollection?

A. I don't remember.

Q. I want to bring your attention to the same exhibit, page 6 internally, Defendant's E-606. There are three paragraphs on that page beginning with "what are some of the challenges." Do you see that?

A. Yes.

Q. Okay. Could you read the first sentence, please?

A. The first sentence of what?

Q. Of the page.

A. Okay. "Meeting the federal and state PASRR

Exhibit G

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, et al. Plaintiffs	)	
vs.	)	CASE NO. 5:10-CV-1025-OG
GREG ABBOTT, Governor of the State of Texas, et al, Defendants	)	

THE UNITED STATES OF AMERICA, Plaintiff-Intervenor	)	
vs.	)	
THE STATE OF TEXAS, Defendant	)	

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ORAL VIDEOTAPED DEPOSITION

MENDY BLEVINS

February 7, 2017

****

ORAL VIDEOTAPED DEPOSITION OF MENDY BLEVINS, produced as a witness at the instance of the Plaintiffs and duly sworn, was taken in the above-styled and numbered cause on the 7th day of February, 2017, from 9:04 a.m. to 5:13 p.m., before April Balcombe, Certified Shorthand Reporter and Certified Realtime Reporter, in

and for the State of Texas, reported by computerized stenotype machine at the offices of Office of the Attorney General, 300 West 15th Street, 11th Floor, Room 1104C, Austin, Texas 78701, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

MS. FORE: Objection. Form.

Q. (BY MR. SILLERS) Who would know?

MS. FORE: Objection. Form.

A. Likely, the PASRR unit.

Q. (BY MR. SILLERS) Is it your understanding the specialized services that are needed for each individual are decided upon during the IDT?

A. That is my understanding.

Q. Do you know what "active treatment" is?

MS. FORE: Objection. Form.

A. I've heard the term, but I am not sure.

Q. (BY MR. SILLERS) Okay. When did you hear the term?

A. In conversations at work.

Q. Do you have any idea what it means?

MS. FORE: Objection. Form.

A. In reference to --

Q. (BY MR. SILLERS) What we've been talking about today.

A. I don't know. I don't know.

Q. Could you walk me through the process of the IDT?

What is an IDT?

A. It's an interdisciplinary team meeting.

Q. And when does it occur?

Q. Do you know if the State is measuring in any way compliance with the requirements of the law with respect to nursing facilities and -- and the services that people get?

A. I don't know.

MS. FORE: Objection. Form.

Q. (BY MR. SILLERS) Have you ever heard of a QSR process?

A. Yes.

Q. How -- when have you heard of that?

A. In meetings and discussions, not a whole lot.

Q. What do you know about the results of the QSR?

A. I --

MS. FORE: Objection. Form.

A. -- never seen a report. I don't know.

Q. (BY MR. SILLERS) You've never seen a report?

A. Huh-uh.

Q. Who's in charge of developing the QSR?

A. I --

MS. FORE: Objection. Form.

A. I'm not sure who is responsible. I know from sitting in a meeting, I've heard the name Kathryn Dupree, but I have not been privy to any conversations with her any -- of any meetings.

Q. (BY MR. SILLERS) What do you know or what's

your understanding of what the QSR is supposed to do?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MR. SILLERS) You have no idea what the QSR is supposed to do?

MS. FORE: Objection. Form.

A. I do not know.

Q. (BY MR. SILLERS) Would you be interested to know?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MR. SILLERS) Would you be interested in Texas measuring compliance with its requirements under the law in your area?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MR. SILLERS) You don't know whether you'd be interested or you don't know what the results are?

A. I don't --

MS. FORE: Objection. Form.

Q. (BY MR. SILLERS) Would you be interested --

A. I don't know --

MS. FORE: Counsel, can we not -- let's -- let's all just take a breath. And if you could ask your question and give her time to answer, I think it will

Exhibit H

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, et al. Plaintiffs	)	
vs.	)	CASE NO. 5:10-CV-1025-OG
GREG ABBOTT, Governor of the State of Texas, et al, Defendants	)	

THE UNITED STATES OF AMERICA, Plaintiff-Intervenor	)	
vs.	)	
THE STATE OF TEXAS, Defendant	)	

****

ORAL VIDEOTAPED DEPOSITION

GERI WILLEMS

February 3, 2017

****

ORAL VIDEOTAPED DEPOSITION OF GERI WILLEMS, produced as a witness at the instance of the Plaintiffs and duly sworn, was taken in the above-styled and numbered cause on the 3rd day of February, 2017, from 9:09 a.m. to 1:44 p.m., before April Balcombe, Certified Shorthand Reporter and Certified Realtime Reporter, in and for the

State of Texas, reported by computerized stenotype machine at the offices of Office of the Attorney General, 300 West 15th Street, 11th Floor, Room 1104C, Austin, Texas 78701, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

A. Very infrequently.

Q. (BY MS. TONER) How many times would you say that's happened in the last year?

A. Once.

Q. And what happened in that situation?

A. There's more discussion. There is an option to have another independent assessment completed for that service from yet another therapist.

Q. Anything else?

A. No.

Q. I want to talk to you now about the Service Planning Team, the SPT.

What is the role of the SPT?

A. The SPT is actually in another unit, not part of my unit. I only have a working knowledge.

Q. Uh-huh. And what unit is that?

A. The SPT is convened by the service coordinator, so that is in that same unit, the Policy Development Support -- Policy and Procedures Development Support unit.

Q. So you said the service coordinator convenes the SPT. Do you know who is required to attend the SPT meeting?

A. I am not familiar with all of the mandatory participants.

Q. And are you familiar with the ISP?

A. It is not a form that is in my unit. I know it's an individual service plan.

Q. Uh-huh.

And do you know the role of the service coordinator in developing the ISP?

A. I do not.

Q. Going back to the specialized services that the nursing facility's required to provide, do you know if nursing facility personnel are required to have any specific training related to the specialized services they provide?

MS. FORE: Objection. Form.

A. I do not know the training that occurs in nursing facilities related to specialized services.

Q. (BY MS. TONER) So you don't know if direct support staff are required to be trained in any way to carry out the individual's specialized services?

MS. FORE: Objection. Form.

A. I do not.

Q. (BY MS. TONER) Are you familiar with "active treatment"?

MS. FORE: Objection. Form.

A. I have a working knowledge of "active treatment."

staff?

MS. FORE: Objection. Form.

A. The service coordinator is responsible for nursing facility coordination.

Q. (BY MS. TONER) And what about coordination with community providers outside of the nursing facility?

MS. FORE: Objection. Form.

A. The service coordinator is responsible for specialized services provided to individuals, PASRR individuals.

Q. (BY MS. TONER) And do you know if any data is collected by the State concerning active treatment?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MS. TONER) And do you know if any data is collected concerning whether specialized services are consistent for individuals?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MS. TONER) And do you know if any data is collected about whether specialized services are coordinated among nursing facilities and other providers?

MS. FORE: Objection. Form.

A. I don't know.

A. The director is Michelle Dionne-Vahalik.

Q. Do you review the QSR data at all?

A. I review the QSR data related to the areas that fall within my unit. And in total, but focus on that.

Q. And do you review drafts of the PASRR QSR Compliance Report? This document?

A. Is it -- I am sorry. I can't see that far.

Q. The document you have in front of you, Exhibit 6, for this --

A. This one?

Q. Yes. So that quarterly PASRR QSR Compliance Status Reports, do you review drafts of those?

A. I've seen them in the past.

Q. Do you routinely review them each quarter?

A. I don't, no.

Q. And do you receive the final versions of the QSR Compliance Status Reports each quarter?

A. I don't.

Q. You don't.

Do you know when the last quarterly QSR Compliance Status Report was issued?

A. Restate your question.

Q. Uh-huh.

A. Are you asking for a month or a ...

Q. So this one looks like it's the quarter one of

two -- 2016, 2016 quarter one PASRR QSR Status Report.

Do you know if there are any quarterly reports that are more recent than the one that's in front of you?

A. I don't.

Q. You don't know?

A. I don't know.

Q. So I want to draw your attention to page 8 of this document.

Under the section that begins -- that's headed "Measure 1-19." It's about halfway, two-thirds of the way down the page.

A. Uh-huh.

Q. The last sentence of that paragraph says, "There are many individuals for whom no functional assessment is done or any of the clinical assessments that are recommended."

Do you know what that means?

A. Functional assessment. I'm not sure what that's in relation to. The clinical assessments would be those that would be for the nursing facility, PASRR, specialized services.

Q. And does your unit track any issues or problems related to assessments?

MS. FORE: Objection. Form.

Exhibit I

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, et al. Plaintiffs	)	
vs.	)	CASE NO. 5:10-CV-1025-OG
GREG ABBOTT, Governor of the State of Texas, et al, Defendants	)	

THE UNITED STATES OF AMERICA, Plaintiff-Intervenor	)	
vs.	)	
THE STATE OF TEXAS, Defendant	)	

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ORAL VIDEOTAPED DEPOSITION

CATHY BELLIVEAU

February 2, 2017

****

ORAL VIDEOTAPED DEPOSITION OF CATHY BELLIVEAU, produced as a witness at the instance of the Plaintiffs and duly sworn, was taken in the above-styled and numbered cause on the 2nd day of February, 2017, from 9:14 a.m. to 1:53 p.m., before April Balcombe, Certified Shorthand Reporter and Certified Realtime Reporter, in

and for the State of Texas, reported by computerized stenotype machine at the offices of Office of the Attorney General, 300 West 15th Street, 11th Floor, Room 1104C, Austin, Texas 78701, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

Q. (BY MR. CORBETT) Okay. What is that information or data that you're researching and what sort of trends are you trying to discern?

A. When asked by management, I give them spreadsheets based on IDT dates and attendees or -- it depends on what I'm asked for.

Q. So the spreadsheets and the IDT data has all of the data in terms of a particular IDT meeting; is that correct?

A. No.

Q. Okay. What does it have?

A. Individuals, the date of the meeting, the date that it was submitted into the portal, and confirmation by the local authority of that meeting.

Q. Anything about the specialized services that were developed at that meeting?

A. No.

Q. Is that information collected by anyone?

A. I don't know.

Q. And you said that your -- you will develop the data if you're asked by management to do that?

A. Yes.

Q. How often does that occur, that management asks you to provide data regarding IDT data and data moving; who was in attendance?

A. It depends.

Q. Well, give me the "it depends." Who?

MS. FORE: Objection. Form.

A. Are you speaking of the PASRR unit or at DADS as a whole?

Q. (BY MR. CORBETT) I'm talking about the PASRR unit.

A. It will be Geri Willems and Terry Hernandez.

Q. What's Terry Hernandez' title?

A. Program manager. She's a lead.

Q. "Specialized Services Authorization and Tracking," what's that?

MS. FORE: Objection. Form.

A. The PASRR unit reviews specialized services requests and provides for PASRR services authorization.

Q. (BY MR. CORBETT) Do they do survey and monitoring in terms of the delivery of specialized services?

A. What do you mean by "survey and monitoring"?

Q. Do they monitor the implementation of specialized services, the quality and the --

A. I don't know.

Q. -- frequency and --

A. I don't know.

Q. -- appropriateness?

A. Receive the services they are -- agreed to, yes.

Q. (BY MR. CORBETT) Do you know if DADS, HHS, or TMHP have a role in ensuring that persons with ID or DD in nursing homes receive active treatment?

MS. FORE: Objection. Form.

A. TMHP receive -- I don't know about TMHP.

Q. (BY MR. CORBETT) How about HHS?

A. Yes.

Q. And DADS?

MS. FORE: Objection. Form.

A. DADS, who's now -- yes. The same, yes.

Q. (BY MR. CORBETT) Okay. And do you know if there are any barriers to providing a continuous and consistent program of active treatment to individuals in nursing homes?

MS. FORE: Objection. Form.

A. I don't know.

Q. (BY MR. CORBETT) Now, after the PE is complete and the individual is found to be PASRR-eligible, what happens next?

MS. FORE: Objection. Form.

A. It depends.

Can you be more specific, please?

Q. (BY MR. CORBETT) Well, so the PE comes back

indicates that the person doesn't need or requires specialized services, do they have a right to appeal that?

MS. FORE: Objection. Form.

A. A resident review would be another PASRR evaluation. If the PASRR evaluation comes back negative, then they would have a right to, yes.

Q. (BY MR. CORBETT) Have you heard the term quality assurance initiatives when in the context of PASRR?

A. No.

Q. Are you familiar with the 2016 quarterly QSR Compliance Status Report?

A. No.

MR. CORBETT: I'll mark this. What are we up to, 4?

(Exhibit 4 marked).

Q. (BY MR. CORBETT) Have you seen this letter before?

A. Yes.

Q. Okay. How did you come to see the letter?

A. It came through a signature from Regulatory for us to look at.

Q. Does Regulatory send you provider letters that apply to PASRR for you to look at?

A. I can't speak to surveys. However, we continue to look at some of these issues in the portal and in the reports, yes.

Q. (BY MR. CORBETT) And have your post monitoring on the portal, does that get issued in a report or a memo to anyone?

MS. FORE: Objection. Form.

A. It gets issued on a spreadsheet that gets recorded -- or reported to Geri.

MR. CORBETT: Okay. Can we take a five-minute break? I'm real close.

MR. JACKSON: You want to take a break?

MR. CORBETT: Yes.

MR. JACKSON: We're off -- you want to go off the record?

MR. CORBETT: Yeah, please.

THE VIDEOGRAPHER: We're going to go off the record.

THE REPORTER: Off the record.

THE VIDEOGRAPHER: We're going off the record. The time is now 1:31.

(Recess from 1:31 to 1:47 p.m.)

THE VIDEOGRAPHER: Back on the record at 1:47.

Q. (BY MR. CORBETT) Ms. Belliveau, do you know

what a Service Planning Team is?

A. No.

Q. Are you aware of any upcoming PASRR trainings for nursing facilities, LIDDAs, or other service providers at DADS or HHSC is planning on having in the future?

MS. FORE: Objection. Form.

A. For PASRR?

Q. (BY MR. CORBETT) Yes, ma'am.

A. We are pending one for the IDT. We're waiting for a particular enhancement approval to go through before we go forward with it.

So it's written. I just need to wait for final approval.

Q. And what training is this going to be on?

A. It's going to be on the IDT process.

Q. IDT process.

A. It will be focused on nursing facilities, but local authorities can also attend.

Q. Okay. And did you say this was a training that you wrote?

A. Yes, sir.

Q. And in what form is the training going to be presented?

A. It's going to be a recorded webinar with Q&A

Exhibit J

[redacted]

Report on Cost of Preadmission Screening and Resident Review

As Required By
The 2016-17 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015
(Article II, Health and Human Services Commission, Special Provisions, Section 52)

[redacted]

Health and Human Services Commission
February 2017

Contents

1. Executive Summary

The 2016-2017 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission [HHSC], Special Provisions, Section 52), required the Department of Aging and Disability Services (DADS) and the Department of State Health Services (DSHS) to provide a joint report on the costs of complying with Preadmission Screening and Resident Review (PASRR) federal requirements. The report must include a ten-year funding history, starting with expenditures in fiscal year 2010 and projecting expenditures in future years.

Senate Bill 200, 84th Legislature, Regular Session, 2015, required the transfer of the DSHS Mental Health and Substance Abuse division and certain divisions at DADS, which administered these programs, to HHSC on September 1, 2016. As a result, HHSC is now responsible for the PASRR program and is required to submit a report by December 1, 2016.

The information in this report represents costs associated with the PASRR program, beginning with the planning phase of a complete redesign of the PASRR program in December 2010 to the present and projected costs into 2019. Information in the background section of this report details areas identified for improvement by the Centers for Medicare & Medicaid Services (CMS), which were addressed through the PASRR redesign. The cost associated with the redesigned PASRR program from fiscal year 2010 to fiscal year 2016 was $30,608,456 all funds.

The costs in this report also reflect additional changes the state implemented to strengthen compliance with state and federal requirements for the PASRR program, including increased staffing for operating and monitoring the program. From fiscal year 2010 to 2016, the cost for DADS and DSHS staff assigned to the PASRR redesign was $4,694,112 all funds ($2,269,133 state general revenue and $2,424,979 federal funds). There were also changes to the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care Portal (LTC Portal) to enhance quality monitoring of specialized services initiation and delivery. During this same time period, the cost for these changes to the LTC Portal was $6,997,477 all funds ($803,285 state general revenue and $6,194,192 federal funds).

This report also contains projection of costs from fiscal year 2017 through 2019. The state anticipates continued costs during this time frame to be approximately $87,671,879 all funds ($39,131,246 state general revenue and $48,540,633 federal funds).

2. Introduction

Each state is required to comply with the PASRR regulations outlined in Title 42, Part 483, Subpart C of the Code of Federal Regulations. The PASRR regulations apply to all individuals seeking admission to a Medicaid-certified nursing facility, regardless of age, diagnosis, or funding source. A PASRR Level I screening must be completed to identify:

- Individuals who have a mental illness (MI) or an intellectual or developmental disability (IDD), also known as a related condition
- The appropriateness of the individual's placement in a nursing facility
- The individual's eligibility for specialized services

PASRR is used as a tool for states to identify individuals with MI or IDD. Once an individual is identified, the PASRR process includes an assessment of whether the individual would benefit from residing in a community-based setting instead of an institution. PASRR can also advance person-centered care planning by assuring psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care.

3. Background

PASRR was created as part of the Federal Nursing Home Reform Act from the Omnibus Budget Reconciliation Act of 1987 and mandated a minimal set of standards related to the care and rights of individuals residing in nursing facilities. PASRR requires all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness and/or intellectual disability, be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings), and receive the services they need in those settings. With the implementation of PASRR, nursing facilities were required to not only treat medical needs, but to address mental health issues, IDD, and develop an individualized plan of care.

In December 2009, CMS contacted the Texas state Medicaid director and identified several areas of concern with the state's PASRR policies. CMS alleged these policies were not aligned with the following federal standards:

- Nursing facility staff should not have been performing the PASRR Level II evaluations since this was a conflict of interest and violated federal regulation.
- The PASRR Level II evaluation did not include the evaluation form and the recommendations for specialized services prior to admission to the nursing facility.
- In response to a resident review, the state did not provide information about when PASRR Level II evaluations were completed, except an implication the Minimum Data Set (MDS) Significant Change in Status Assessment[1] fulfilled this requirement.

Taking these concerns into consideration and recognizing the benefits to the PASRR population, the state amended its PASRR policies to more effectively and efficiently identify individuals with IDD, assess and provide needed specialized services, and divert or transition individuals

[1] The **Minimum Data Set** (MDS) is part of a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.

into the community and away from an institutional setting. The changes included but were not limited to the following:

- Making each Local Intellectual and Developmental Disability Authority (LIDDA) and Local Mental Health Authority (LMHA) responsible for completing the PASRR Level II Evaluations
- Requiring identification of specialized services for each individual before admission to a nursing facility
- Implementing an automated function to notify LIDDAs and LMHAs to complete a PASRR Level II evaluation for a resident review when a nursing facility completes a MDS Significant Change in Status Assessment

In January 2010, the State of Texas initiated a redesign of the PASRR process in order to build a more comprehensive program identifying all individuals with a positive PASRR Level II evaluation eligible for specialized services in order to meet their needs, enhance their quality of life, and promote their independence.

4. Program Description

All individuals seeking entry into a Medicaid-certified nursing facility must have a PASRR Level I screening completed prior to admission, regardless of their funding source, age, or disability, by the referring entity. The referring entity is the entity referring an individual to a nursing facility, such as a hospital, attending physician, legally authorized representative (LAR) or other personal representative selected by the individual, a family member of the individual, or a representative from an emergency placement source (e.g., law enforcement).

If the PASRR Level I screening is positive — meaning the individual may have an MI or IDD — the LMHA or LIDDA must complete and submit a PASRR Level II evaluation within seven days after receiving an alert from the LTC Portal.

If the PASSR Level I screening is negative — meaning the individual is not suspected of having an MI or IDD — the nursing facility enters the PASRR Level I into the LTC Portal, and the PASRR process ends for that individual.

HHSC contracts with LIDDAs and LMHAs to complete PASRR Level II evaluations and to assess individuals in their respective priority populations. For all individuals with a positive PASRR Level II evaluation, the nursing facility must convene an Interdisciplinary Team (IDT) meeting within 14 days of admission. The IDT consists of the following: the resident and/or the LAR, a Registered Nurse from the nursing facility, and a representative of the LMHA or LIDDA. The purpose of the IDT meeting is to review the specialized services recommended for the individual and the specialized services the individual, or LAR on the individual's behalf, want to receive. Once the IDT comes to a consensus on which specialized services the individual will receive, the nursing facility, LIDDAs and LMHAs have 30 days from the IDT meeting to initiate PASRR specialized services.

The nursing facility must document member participation and the specialized services agreed upon and the LMHA or LIDDA must confirm attendance and agreement with the specialized

services discussed. After submitting a request to HHSC and obtaining pre-authorization for specialized services, the nursing facility delivers the specialized services.

A LIDDA will assign a service coordinator within 30 days of completing a positive PASRR Level II evaluation for individuals with IDD and convenes a service planning team (SPT) meeting. The SPT develops an individual service plan. The service coordinator facilitates initiation of LIDDA specialized services and coordinates all of the resident's specialized services with the SPT. An LMHA will conduct a comprehensive assessment including completion of the Uniform Assessment to determine the appropriate level of care. The individual is then authorized into care, a treatment plan is created, and PASRR specialized services are provided.

The following are the specialized services included in the array.

- Provided by the nursing facility:
  - Physical therapy
  - Speech therapy
  - Occupational therapy
  - Customized manual wheelchairs
  - Durable medical equipment (DME) which includes gait trainers, standing boards, special needs car seat or travel restraint, specialized/treated pressure reducing support surface/mattress, positioning wedges, prosthetic devices, and orthotic devices.

- Provided by the LIDDA:
  - Service coordination, including alternate placement
  - Employment assistance
  - Supported employment
  - Day habilitation
  - Independent living skills
  - Behavioral supports

- Provided by the LMHA:
  - Psychiatric diagnostic examination
  - Medication training
  - Case management
  - Counseling
  - Skills training
  - Psychosocial rehabilitation

5. Costs Associated with PASRR Federal Requirements

The costs associated with PASRR federal requirements are largely driven by the number of PASRR Level II evaluations completed, specialized services provided, diversion/transition slots, the information technology (IT) systems that support PASRR activities, quality assurance activities, and associated full-time equivalents (FTEs).

5.1 Number of PASRR Level II Evaluations

As a result of the conversion process, there was a significant increase in the number of PASRR Level II evaluations completed in comparison to other fiscal years. The costs related to complying with PASRR federal requirements are based on the number of PASRR Level II evaluations submitted and a unit rate. Projected figures are based on the mean costs over the previous three fiscal years, incorporating a 0.5 migration scenario. The net migration rate represents the difference between individuals coming into Texas and those leaving Texas during a specified time. The 0.5 migration rate assumes future rates will be half the rate recorded from 2000 – 2010. The State Demographer suggests the 0.5 scenario is the most appropriate for long-term planning and is the standard projection methodology used by HHSC.

Table 1 displays the number of PASRR Level II evaluations submitted between fiscal years 2013 and 2016 related to a diagnosis of MI, IDD, and dual MI and IDD.

Table 1. Number of PASRR Level II Evaluations Submitted Fiscal Years 2013 to 2016

Fiscal Year	MI Only	IDD Only	Dual Evaluations**	Total
2013*	2,212	603	532	**3,347**
2014	16,949	3,355	7,296	**27,600**
2015	8,548	2,259	5,790	**16,597**
2016	7,373	1,946	1,549	**10,868**

Note: These figures represent number of evaluations performed, not unique individuals.
*In fiscal year 2013, data collection began after May 24, 2013.
**Dual Evaluations include PASRR Level II MI and IDD Evaluations
Source: Legacy DADS Data Warehouse.

As the population grows and ages, the number of individuals accessing nursing facility care will increase. Based on the median number of PASRR Level II evaluations completed over the previous 3.25 fiscal years, and incorporating the 0.5 migration scenario, Tables 2, 3, and 4 below show the actual numbers and projections for fiscal years 2017 through 2019. In addition, projections assume 15 percent of completed PASRR Level II evaluations will result in a positive assessment, a mean figure having held relatively steady over the previous 3.25 years.

Table 2. Actual and Projected Numbers of Completed MI PASRR Level II Evaluations and Positive MI PASRR Level II Evaluations

Fiscal Year*	MI PASRR Evaluations	Positive MI PASRR Evaluations
2013	2,212	1,187
2014	16,949	6,736
2015	8,548	1,090
2016	7,373	1,315

Fiscal Year*	MI PASRR Evaluations	Positive MI PASRR Evaluations
2017±	8,804	1,321
2018±	8,918	1,338
2019±	9,034	1,355
Total	**61,838**	**14,342**

± Dates reflect projected evaluations.
*In fiscal year 2013, data collection began after May 24, 2013.
Source: Legacy DADS Data Warehouse

Table 3. Actual and Projected Numbers of Completed IDD PASRR Level II Evaluations and Positive ID and DD PASRR Level II Evaluations

Fiscal Year	IDD PASRR Evaluations	Positive IDD PASRR Evaluations
2013*	603	367
2014	3,355	1,969
2015	2,259	1,503
2016	1,946	1,464
2017±	2,288	1,487
2018±	2,318	1,507
2019±	2,348	1,526
Total	**15,117**	**9,823**

± Dates reflect projected evaluations.
*In fiscal year 2013, data collection began after May 24, 2013.
Source: Legacy DADS Data Warehouse

In Table 4, projected figures are based on the median number of Dual (MI and IDD) PASRR evaluations completed over the previous 3.25 fiscal years, incorporating the 0.5 Migration scenario. In addition, it assumes 13 percent of completed dual PASRR evaluations will result in a positive MI assessment and 47 percent will result in a positive IDD assessment, a mean figure having held relatively steady over the previous 3.25 years.

Table 4. Actual and Projected Numbers of Completed Dual (MI and IDD) PASRR Level II Evaluations

Fiscal Year	Dual PASRR Evaluations	Dual PASRR Evaluations – MI	Dual PASSR Evaluations – IDD
2013*	532	127	252
2014	7,296	727	2,325
2015	5,790	258	1,065
2016	1,549	235	986
2017±	2,460	320	150
2018±	2,492	324	152
2019±	2,524	328	154
Total	**22,643**	**2,319**	**5,084**

*In fiscal year 2013, data collection began after May 24, 2013.
Source: Legacy DADS Data Warehouse

5.2 Mental Illness PASRR Level II Evaluations

The information presented in Table 5 reflects the current and projected expenditures related to the completion of PASRR Level II evaluations for MI only. The projected figures for fiscal years 2017 through 2019 are based on the mean costs over the previous three fiscal years, incorporating a 0.5 migration scenario.[2]

The costs related to complying with PASRR federal requirements are based on a prospective uniform statewide reimbursement rate and billing limitations for the PASRR Level II MI and IDD Evaluations. Effective May 1, 2013, the approved rate for a PASRR evaluation is $12.73 for each 15-minute increment of service, or $50.92 per hour, and a limitation of 6 hours per day.

Table 5. Actual and Projected Costs of Administering PASRR Level II Evaluations MI Only

Fiscal Year	State Funds (25%)	Federal Funds (75%)	Total
2013*	$11,466	$34,398	**$45,864**
2014	$344,651	$1,033,953	**$1,378,604**
2015	$274,874	$824,623	**$1,099,497**
2016	$150,842	$452,525	**$603,367**

[2] Texas Population Projections, 2010TO2050. (n.d.). Retrieved October 20, 2016, from http://osd.texas.gov/Resources/Publications/2014/2014-11_ProjectionBrief.pdf

Fiscal Year	State Funds (25%)	Federal Funds (75%)	Total
2017±	$256,789	$770,367	**$1,027,156**
2018±	$260,127	$780,382	**$1,040,509**
2019±	$263,509	$790,526	**$1,054,035**
Total	**$1,562,258**	**$4,686,774**	**$6,249,032**

*PASRR evaluation data was not available until fiscal year 2013, quarter 4.
± Dates reflect projected costs.
Source: Legacy DADS Data Warehouse, September 29, 2016.

5.3 ID and DD PASRR Level II Evaluations

The information presented in Table 6 reflects the current and projected expenditures related to the completion of PASRR Level II evaluations for IDD only. The projected figures for fiscal years 2017 through 2019 are based on the mean costs over the previous three fiscal years, incorporating a 0.5 migration scenario.[3]

As noted with the mental illness only, the costs related to complying with PASRR federal requirements are based on a prospective uniform statewide reimbursement rate and billing limitations for the PASRR Level II MI and IDD evaluations. Effective May 1, 2013, the approved rate for a PASRR evaluation is $12.73 for each 15-minute increment of service, or $50.92 per hour, and a limitation of 6 hours per day.

Table 6. Actual and Projected Costs of Administering PASRR Level II Evaluations IDD Only

Fiscal Year	State Funds (25%)	Federal Funds (75%)	Total
2013*	$22,892	$68,676	**$91,568**
2014	$172,873	$518,620	**$691,493**
2015	$104,757	$314,272	**$419,029**
2016	$52,250	$156,750	**$209,000**
2017±	$52,930	$158,788	**$211,718**
2018±	$53,618	$160,852	**$214,470**
2019±	$54,315	$162,943	**$217,258**
Total	**$513,635**	**$1,540,901**	**$2,054,536**

*PASRR evaluation data was not available until fiscal year 2013, quarter 4.
± Dates reflect projected costs.

[3] Texas Population Projections, 2010TO2050. (n.d.). Retrieved October 20, 2016, from http://osd.texas.gov/Resources/Publications/2014/2014-11_ProjectionBrief.pdf

Source: HHSC, Medical and Social Services Division, IDD Services Section, Legacy DADS Data Warehouse, November 10, 2016.

5.4 Mental Illness Specialized Services

Individuals with a positive PASRR Level II evaluation for mental illness are eligible to receive mental health services in the nursing facility from the LMHA. The services an individual receives are based on the Adult Needs and Strengths Assessment (ANSA), a tool designed to identify needs and strengths, support care planning and to allow for the monitoring of outcomes. Individuals are admitted to the appropriate level of care based on their ANSA assessment. Services may include, but are not limited to:

- Psychiatric diagnosis
- Pharmacological management, training and support
- Skills training and education
- Case management
- Supported housing and supported employment
- Peer-delivered services (including family partners)
- Crisis intervention
- Therapy
- Rehabilitative services

LMHAs are reimbursed for these specialized services at the fee-for-service Medicaid rates.

Since 2014, the number of individuals receiving mental health services while in a nursing facility increased by 27 percent.[4] It is anticipated that this number will continue to rise due to the increased rigor around the PASRR process and LMHAs' ability to provide community-based services. Table 7 contains the number of individuals with mental illness only that received specialized services and the associated costs.

Table 7. Number of Individuals Receiving Specialized Services from LMHAs and Associated Costs by Fiscal Year

Fiscal Year	Numbers Served	Associated Costs
2013	76	$27,121
2014	659	$160,595
2015	764	$329,496
2016	1,422	$561,850
2017±	1,838	$755,382
2018±	2,472	$980,466

[4] HHSC, Medical and Social Services Division, Behavioral Health Services Section, Office of Decision Support, October 20, 2016.

Fiscal Year	Numbers Served	Associated Costs
2019±	2,996	$1,189,037
Total	**10,227**	**$4,003,947**

Note: The associated costs represent the estimated full cost of all services provided to the individual, both Medicaid and state general revenue. The associated estimated costs are based on the Cost Accounting Methodology and number served. The numbers served include clients who received one or more mental health services after receiving an MI positive PASRR evaluation. These service dates are compared to legacy DADS Service Authorization System begin and end dates. For clients who are in this system, only services occurring during the time they were in the nursing facility are included. For clients who could not be identified in the system, all services are included. For all clients, only services provided in a nursing facility or office/clinic are included. In fiscal year 2013, data was not available until the fourth quarter.

± Dates reflect projected costs where data is not yet available or complete.

Source: HHSC, Medical and Social Services Division, Behavioral Health Section, Office of Decision Support, October 20, 2016.

5.5 IDD Specialized Services

The cost of providing specialized services to individuals identified in the PASRR Level II evaluation has increased over the past 10 years due to an increase in the identification of individuals who require these services and an overall increase in the age of the IDD population. The services the individual will need is based on the IDT meeting. During the service planning team meeting conducted by the LIDDA service coordinator, the individual and service providers determine and document, based on a person-centered process, what services are needed and wanted by the individual. The service coordinator conducts a service planning team meeting with the individual on a quarterly basis to evaluate those services and determine if any additional services are required. It is anticipated this number will continue to rise due to the increased rigor around the PASRR process and each LIDDAs ability to provide community based services.

Specialized services provided by the nursing facility may include physical therapy, speech therapy, occupational therapy, customized manual wheelchairs, and DME which includes gait trainers, standing boards, special needs car seat or travel restraint, specialized/treated pressure reducing support surface/mattress, positioning wedges, prosthetic devices, and orthotic devices. Table 8 includes combined cost of these services by fiscal year and 10-year totals.

Table 8. Actual and Projected Costs of Specialized Services from Nursing Facilities by Fiscal Year

Fiscal Year	State Funds	Federal Funds	Total
2010	$33,684	$81,870	**$115,554**
2011	$28,144	$58,001	**$86,145**
2012	$43,452	$61,049	**$104,501**
2013	$41,950	$60,895	**$102,845**
2014	$113,911	$162,170	**$276,081**
2015	$503,456	$698,108	**$1,201,564**

Fiscal Year	State Funds	Federal Funds	Total
2016	$957,709	$1,280,452	**$2,238,161**
2017±	$1,223,716	$1,753,986	**$2,977,702**
2018±	$1,449,657	$1,907,586	**$3,357,243**
2019±	$1,737,172	$2,291,519	**$4,028,691**
Total	**$6,132,851**	**$8,355,636**	**$14,488,487**

Note: The Medicaid match for Nursing Facility specialized services varies by year.
± Dates reflect projected costs.
Source: HHSC Budget Office, November 10, 2016.

Specialized services provided by the LIDDA may include, but are not limited to service coordination, including alternate placement, employment assistance, supported employment, day habilitation, independent living skills, and behavioral supports. Table 9 includes combined cost of these services by fiscal year and 10-year totals.

Table 9. Actual and Projected Costs of Specialized Services from LIDDAs by Fiscal Year

Fiscal Year	State Funds (100%)
2014*	$57,980
2015	$268,183
2016	$1,457,730
2017±	$2,480,616
2018±	$2,480,616
2019±	$2,480,616
Total	**$9,225,741**

Note: The specialized services provided by the LIDDA are funded by state general revenue because these services are not currently in the Medicaid state plan.
*Services did not start until 2014.
± Dates reflect projected costs.
Source: HHSC Budget Office, November 10, 2016.

5.6 Diversion and Transition Slots for IDD Populations

In addition to specialized services, LIDDAs have access to funded transition and diversion slots through the Home and Community-based Services (HCS) 1915(c) federal waiver and general revenue appropriated during the 83rd and 84th Legislatures. Transition slots are reserved for individuals who have been admitted to a nursing facility for services and then later transitioned out of the facility to receive community-based services. Diversion slots are reserved for individuals who meet the level of care for a nursing facility, but are never admitted and instead, are served in the community through other programs.

The LIDDAs are responsible for enrolling and managing the interest list for individuals to access HCS. HCS waiver slots are designed to assist in the transition from the nursing facility to the community. Nursing facility transition slots are for individuals at least 21 years of age with IDD who currently reside in a nursing facility and would like to transition to the community. Starting in fiscal years 2014 and 2015, 360 transition slots were appropriated to assist individuals transitioning from nursing facilities to the community. In fiscal years 2016 and 2017, an additional 700 transition slots were appropriated for nursing facility transition to the community.

During the same time frame of fiscal years 2014 and 2015, 150 HCS and 125 Texas Home Living diversion slots were appropriated to help individuals avoid nursing facility placement and receive community-based services and support. In fiscal years 2016 and 2017, an additional 600 diversion slots were appropriated to help individuals divert from nursing facility placement.

Nursing facility diversion slots are available for individuals determined to be at imminent risk of a long-term stay in a nursing facility, and who meet nursing facility level of care. Table 10 shows the actual and projected average number served in both diversion and transition slots by fiscal year. It is important to note the number of HCS slots represented in the table below are not cumulative numbers. This is because the HCS slots are dedicated to individuals transitioning out of or avoiding nursing facility placement in the biennium in which they are added. Over time, as individuals leave the waiver program, the slots return to the general HCS program.

Table 10. Actual and Projected Average Number of Transition and Diversion Slots by Fiscal Year

Fiscal Year	Transition Slots	Diversion Slots
2014*	25	11
2015	94	90
2016	86	56
2017±	456	371
2018±	189	163
2019±	539	463
Total	**1,389**	**1,154**

*Funding for transition and diversion slots was not available until 2014.
± Dates reflect projected number of slots.
Source: HHSC Budget Office, November 10, 2016.

Tables 11 and 12 show the projected and actual costs of transition and diversion slots by fiscal year. It is important to note transition and diversion slots were not funded until fiscal year 2014. For fiscal years 2016 and 2017, funding was appropriated for 700 transition slots over the biennium. Fiscal years 2014 through 2016 are based upon actual slots enrolled. The fiscal year 2017 projection assumes the remainder of the slots would be filled by the end of the fiscal year. Projections for fiscal years 2018 and 2019 are based on the assumption that an additional 1300 transitions slots are funded during the 85th Legislative Session through an exceptional item

request. Net expenditures include state and federal amounts. In addition, the percentage of state and federal amounts vary by year.

Table 11. Actual and Projected Costs of Transition Slots by Fiscal Year

Fiscal Year	HCS Expenditures	Nursing Facility Cost Offset	Net Expenditures	State	Federal
2014	$1,605,154	($1,014,156)	$590,998	$243,846	$347,152
2015	$6,035,379	($4,013,334)	$2,022,045	$847,237	$1,174,808
2016	$5,521,730	($3,671,773)	$1,849,957	$791,596	$1,058,361
2017±	$29,278,009	($19,468,938)	$9,809,071	$4,290,488	$5,518,583
2018±	$11,575,730	($8,620,711)	$2,955,019	$1,275,977	$1,679,042
2019±	$32,993,378	($24,570,925)	$8,422,453	$3,631,762	$4,790,691
Total	**$87,009,380**	**($61,359,837)**	**$25,649,543**	**$11,080,906**	**$14,568,637**

*Funding for transition and diversion slots was not available until 2014.
± Dates reflect projected costs.
Source: HHSC Budget Office, November 10, 2016.

Table 12. Actual and Projected Costs of Diversion Slots by Fiscal Year

Fiscal Year	HCS Expenditures	Nursing Facility Cost Offset	Net Expenditures	State	Federal
2014*	$673,126	($446,229)	$226,897	$93,618	$133,279
2015	$5,507,395	($3,842,554)	$1,664,841	$697,568	$967,273
2016	$3,426,824	($2,390,922)	$1,035,902	$443,262	$592,640
2017±	$22,702,707	($15,839,860)	$6,862,847	$3,001,809	$3,861,038
2018±	$9,943,908	($7,405,457)	$2,538,452	$1,096,103	$1,442,349
2019±	$28,301,892	($21,077,069)	$7,224,824	$3,115,344	$4,109,480
Total	**$70,555,852**	**($51,002,091)**	**$19,553,763**	**$8,447,704**	**$11,106,059**

*Funding for transition and diversion slots was not available until 2014.
± Dates reflect projected costs.
Source: HHSC Budget Office, November 10, 2016.

5.7 Costs of PASRR Related IT Projects

5.7.1 Automation of PASRR Level I Screenings and Level II Evaluations

Enhancements to the LTC Portal have been critical to managing the PASRR program in 1,200 nursing facilities in Texas. Between May 2013 and July 2014, the online portal converted

information from the MDS assessment to a PASRR Level I screening form for all individuals residing in nursing facilities. The purpose of this conversion was to ensure compliance with Title 42, Subpart C, of the Code of Federal Regulations, and ensure each individual residing in a nursing facility suspected of having an MI or IDD diagnosis was assessed through a comprehensive PASRR Level II evaluation to confirm PASRR eligibility.

5.7.2 PASRR Individual Review Monitoring System

The PASRR Individual Review Monitoring (PIRM) system is a web-based application used by the HHSC contracted independent reviewers and state staff to record visits to individuals living in the facility and/or individuals who have moved from a facility into the community. PIRM is the tool used to gather Quality Service Review (QSR) data and compile the compliance reports. HHSC created the compliance reports based on the specifications developed by the independent expert reviewer in an effort to better serve the PASRR population.

Table 13 shows the actual and projected PASRR related IT project costs. Note, projected costs are anticipated to end in fiscal year 2019.

Table 13. Actual and Projected Costs of PASRR Related IT Projects by Fiscal Year

Fiscal Year	State Funds	Federal Funds	Total
2012	$101,607	$769,082	**$870,689**
2013	$335,490	$2,129,418	**$2,464,908**
2014	$106,095	$954,853	**$1,060,948**
2015	$0	$0	**$0**
2016	$260,093	$2,340,839	**$2,600,932**
2017±	$191,679	$1,725,108	**$1,916,787**
2018±	$2,068,125	$6,204,375	**$8,272,500**
2019±	$2,068,125	$6,204,375	**$8,272,500**
Total	**$5,131,214**	**$20,328,050**	**$25,459,264**

Note: The Medicaid match for IT projects varies by year.
± Dates reflect projected costs.
Source: HHSC Budget Office, November 10, 2016.

5.8 Full Time Equivalents Supporting PASRR Activities

5.8.1 Quality Assurance Initiatives

The QSR program was established in 2014 to ensure compliance with PASRR state and federal regulations and to ensure individuals with IDD who:

- seek admission to a nursing facility are identified and evaluated and, when appropriate, are offered community placement and the services and supports needed to successfully reside in the community; and

- reside in nursing facilities are identified, evaluated for specialized services, receive recommended specialized services with the frequency and duration necessary to meet their needs, and are offered education about available community placement.

The state retained an independent expert consultant, Crosswinds Consulting, LLC, who developed a process to properly identify individuals with IDD who are living in nursing facilities or who have moved to community settings. This process includes obtaining an appropriate sample of individuals with IDD in nursing facilities, conducting field reviews, entering the data from these reviews into the web-based PASRR individual review monitoring tool, and writing reports using this tool to assess how well the state is meeting its goals related to PASRR.

In addition, the state hired six FTEs in fiscal year 2016 as training staff. These QSR teams provide statewide training to nursing facilities and LIDDAs on PASRR services, and recommend best practices in addition to performing their audit functions for the HHSC PASRR system. The QSR:

- ensures care and services are provided to those individuals who are PASRR positive for IDD; and
- provides the expert reviewer with the data necessary to determine whether the state is meeting its goals related to PASRR (the QSR teams are trained and certified by the independent expert reviewer team).

5.8.2 Additional State Staffing Supports for PASRR

From fiscal years 2010 to 2016, DADS eventually employed 10 FTEs responsible for PASRR activities ensuring nursing facility and LIDDA compliance with state and federal regulations. In addition, DSHS employed one FTE dedicated to PASRR activities ensuring LMHA compliance with federal regulations. These FTEs have since been consolidated into one program unit within HHSC.

Table 14 shows the actual and projected costs of state support staff by fiscal year. Cost fluctuations are partially represented by increased ramp up in staff training, thus reducing the need for more costly contracted services. All staff are projected to be fully trained by June 2017, resulting in a greatly reduced contractor role.

Table 14. Actual and Projected Costs of State Support Staff by Fiscal Year

Fiscal Year	State Funds	Federal Funds	Total
2010	$17,752	$17,752	**$35,504**
2011	$17,752	$17,752	**$35,504**
2012	$17,752	$17,752	**$35,504**
2013	$43,416	$27,472	**$70,888**
2014	$270,842	$355,200	**$626,042**
2015	$828,263	$812,725	**$1,640,988**

Fiscal Year	State Funds	Federal Funds	Total
2016	$1,073,356	$1,176,326	**$2,249,682**
2017±	$868,963	$1,440,982	**$2,309,945**
2018±	$861,982	$1,434,001	**$2,295,983**
2019±	$861,982	$1,434,001	**$2,295,983**
Total	**$4,862,060**	**$6,733,963**	**$11,596,023**

Note: The Medicaid match for FTEs varies by year.
± Dates reflect projected costs.
Source: HHSC Budget Office, November 10, 2016.

6. Summary of PASRR Expenditures

Table 15 provides a summary of the actual IDD PASRR costs and estimated MI PASRR costs in all funds for fiscal years 2010-2012. It includes MI and IDD costs.

Table 15. Actual Costs (All Funds) for MI and IDD PASRR, Fiscal Years 2010 - 2012

Expenditures	FY 2010	FY 2011	FY 2012	Total
Nursing Facility Specialized Services	$115,554	$86,145	$104,501	**$306,200**
IT Projects	N/A	N/A	$870,689	**$870,689**
Support staff	$35,504	$35,504	$35,504	**$106,512**
Total	**$151,058**	**$121,649**	**$1,010,694**	**$1,283,401**

Source: HHSC Budget Office, February 10, 2017.

Table 16 provides a summary of the actual IDD and estimated MI PASRR costs in all funds for fiscal years 2013-2016.

Table 16. Costs (All Funds) for MI and IDD PASRR, Fiscal Years 2013 - 2016

Expenditures	FY 2013	FY 2014	FY 2015	FY 2016	Total
PASRR Evaluations	$137,432	$2,070,097	$1,518,526	$812,366	**$4,538,421**
MI Specialized Services	$27,121	$160,595	$329,496	$561,850	**$1,079,062**
Nursing Facility Specialized Services	$102,845	$276,081	$1,201,564	$2,238,161	**$3,818,651**
IDD Specialized Services	$0	$57,980	$268,183	$1,457,730	**$1,783,893**
IDD Diversion and Transition Slots	$0	$817,895	$3,686,886	$2,885,859	**$7,390,640**
IT Projects	$2,464,908	$1,060,948	$0	$2,600,932	**$6,126,788**
FTEs	$70,888	$626,042	$1,640,988	$2,249,682	**$4,587,600**
Total	**$2,803,194**	**$5,069,638**	**$8,645,643**	**$12,806,580**	**$29,325,055**

Source: HHSC Budget Office, November 10, 2016.

For fiscal years 2017 through 2019, the state projects the costs for staff support will be roughly consistent with current levels. In addition, the state anticipates the cost of specialized services for individuals with IDD will remain constant through 2019 with annual amounts totaling approximately $2,480,616 all funds. During this same time period, the state anticipates funds for PASRR evaluations, specialized services for MI, nursing facility, and diversion and transition slots will increase over time. See Table 17.

Table 17. Projected Costs (All Funds) for MI, IDD PASRR
Fiscal Years 2017 – 2019

Expenditures	FY 2017	FY 2018	FY 2019	Total
PASRR Evaluations	$1,238,874	$1,254,979	$1,271,293	**$3,765,146**
MI Specialized Services	$755,382	$980,466	$1,189,037	**$2,924,885**
Nursing Facility Specialized Services	$2,977,702	$3,357,243	$4,028,691	**$10,363,636**
IDD Specialized Services	$2,480,616	$2,480,616	$2,480,616	**$7,441,848**
IDD Diversion and Transition Slots	$16,671,918	$5,493,471	$15,647,277	**$37,812,666**
IT Projects	$1,916,787	$8,272,500	$8,272,500	**$18,461,787**
FTEs	$2,309,945	$2,295,983	$2,295,983	**$6,901,911**

Expenditures	FY 2017	FY 2018	FY 2019	Total
Total	**$28,351,224**	**$24,135,258**	**$35,185,397**	**$87,671,879**

Source: HHSC Budget Office, November 10, 2016.

7. Conclusion

Since the re-design of the PASRR program, significant progress has been made in ensuring federal compliance, maintaining continuous quality monitoring and oversight of federal and state PASRR program requirements, and implementing best practices to identify and serve individuals eligible for PASRR specialized services. Overall, the re-design of the program has had significant positive impacts on the PASRR population.

As the population in Texas grows, it is anticipated the costs of maintaining compliance with federal PASRR requirements will also increase.

List of Acronyms

Acronym	Full Name
ANSA	Adult Needs and Strengths Assessment
CMS	Centers for Medicare and Medicaid Services
DADS	Department of Aging and Disabilities
DME	Durable Medical Equipment
DSHS	Department of State Health Services
FTE	Full-Time Equivalent
FY	Fiscal Year
HCS	Home and Community-based Services Waiver
HHSC	Health and Human Services Commission
IDD	Intellectual or Developmental Disabilities
IDT	Interdisciplinary Treatment Team
IT	Information Technology
LAR	Legally Authorized Representative
LIDDA	Local Intellectual and Developmental Disability Authority
LMHA	Local Mental Health Authority
LTC Portal	Long-Term Care Portal
MI	Mental Illness
PASRR	Preadmission Screening and Resident Review
PIRM	PASRR Independent Review Monitoring
QSR	Quality Service Review
SPT	Service Planning Team
TMHP	Texas Medicaid & Healthcare Partnership

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

LORETTA ROLLAND, et al., Plaintiffs	)	
v.	)	Civil Action No. 98-30208-KPN
DEVAL PATRICK, et al., Defendants	)	

ORDER APPROVING REVISED ACTIVE TREATMENT STANDARDS

The Court hereby orders that:

1. The Court hereby approves and adopts the Revised Active Treatment Standards that are attached to this Order, as modified by paragraphs 3 and 4 below, as the criteria for compliance with the requirements specified in the Court's Orders dated April 10, 2007 and May 16, 2007. The Court Monitor shall use the Revised Active Treatment Standards, as modified by paragraphs 3 and 4 below, to develop her protocol for conducting active treatment reviews. The Revised Active Treatment Standards consist of certain regulatory references and federal standards, called "Tags," that were developed by the federal Centers for Medicaid and Medicare Services ("CMS") to evaluate compliance with the federal active treatment regulations.

2. The Court Monitor may incorporate or otherwise use any of CMS's Guidelines, Probes, and Facility Practices for the specified Tags listed in the Revised Active Treatment Standards in her review protocol, or new Active Treatment Measurement Device (ATMD), that she will use to evaluate compliance with the

standards set forth in those Tags. Where language in a particular Tag has been modified by paragraphs 3 or 4 of this Order, any of CMS's Guidelines, Probes, or Facility Practices for that Tag shall be deemed modified so as to be consistent with the Revised Active Treatment Standards and this Order.

3. The Court has previously ordered Defendants to comply with the active treatment requirements set forth in 42 C.F.R. §§ 483.440(a)-(f). In order to ensure consistency between the regulations governing nursing facilities in 42 C.F.R. § 483.1 *et seq.* and § 483.100 *et seq.* and the federal ICF/MR regulations on active treatment: (1) references in relevant CMS Guidelines, Probes, or Facility Practices to "the facility" or "the ICF/MR" shall be construed to mean either "Defendants or their designees" (when the reference concerns a standard or obligation) or "Defendants, the nursing facility, day habilitation providers, or other service providers" (when the reference concerns where or by whom services to class members are provided) as appropriate; (2) the thirty day time limits for convening an interdisciplinary treatment team, performing assessments, and preparing an individual program plan set forth in 42 C.F.R. § 483.440(c) shall be deemed satisfied by (a) the convening of a specialized services interdisciplinary team by the specialized service provider, the development of an interim specialized services plan by that team based on all assessments available at that time, and the provision of interim specialized services pursuant to that interim plan within 30 days after admission, and (b) the completion of all relevant assessments, the development of an individualized services plan, and the provision of specialized services pursuant to that plan within 90 days after admission; (3) the comprehensive functional assessment required by 42 C.F.R. § 483.440(c)(3) may consist of a

combination of assessments , including the PASARR assessment, all specialized services assessments, any relevant nursing facility assessments, and any other assessments done for the person; and (4) Defendants may provide active treatment to class members through a combination of services identified by Defendants and provided by Defendants, the nursing facility, day habilitation providers, or other service providers.

4. In carrying out her responsibilities and evaluating compliance with the Revised Action Treatment Standards, the Court Monitor shall consider whether there are sufficient trained professional and non-professional staff who are competent to provide active treatment and any behavioral interventions to the class members that they serve, as set forth in the individuals' treatment plans.

5. Compliance with the standards set forth in the Revised Active Treatment Standards, as clarified above, shall constitute compliance with the federal active treatment requirements specified in the Court's orders.

6. The Court Monitor shall, within the next sixty days, develop a review protocol, or new ATMD, and a process for conducting active treatment reviews.

IT IS SO ORDERED.

DATED: August 2, 2007

/s/ Kenneth P. Neiman
KENNETH P. NEIMAN
Chief Magistrate Judge

REVISED ACTIVE TREATMENT STANDARD

CFR	TAG	STANDARD
§483.440	W195	Condition of participation: Active treatment services.
§483.440(a) §483.440(a)(1) §483.440(a)(1)(i) §483.440(a)(1)(ii)	W196	Standard: Active treatment Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward -- The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and The prevention or deceleration of regression or loss of current optimal functional status.
§483.440(c) §483.440(c)(1) §483.440(c)(i) §483.440(c)(1)(ii)	W206	Standard: Individual program plan Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to - Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and Designing programs that meet the client's needs.
§483.440(c)(2)	W207	Appropriate facility staff must participate in interdisciplinary team meetings.
§483.440(c)(2)	W208	Participation by other agencies serving the client is encouraged.
§483.440(c)(2)	W209	Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.
§483.440(c)(3)	W210	Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.
§483.440(c)(3) §483.440(c)(3)(i)	W211 W212	The comprehensive functional assessment must Take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must – Identify the presenting problems and disabilities and where possible, their causes;

§483.440(c)(3)(ii) §483.440(c)(3)(iii) §483.440(c)(3)(iv) §483.440(c)(3)(v)	W213 W214 W215 W216 W217 W218 W219 W220 W221 W222 W223 W224 W225	Identify the client's specific developmental strengths; Identify the client's specific developmental and behavioral management needs; Identify the client's needs for services without regard to the actual availability of the services needed; and include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and as applicable, vocational skills.
§483.440(c)(4)	W226 W227 W228	Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, and the planned sequence for dealing with those objectives.
§483.440(c)(4) §483,440(c)(4)(i) §483.440 (c)(4)(ii) §483.440 (c)(4)(iii) §483.440 (c)(4)(iv) §483.440 (c)(4)(v)	W229 W230 W231 W232 W233	These objectives must - Be stated separately, in terms of a single behavioral outcome; Be assigned projected completion dates; Be expressed in behavioral terms that provide measurable indices of performance; Be organized to reflect a developmental progression appropriate to the individual; and Be assigned priorities.
§483.440(c)(5) §483.440(c) (5)(i) §483.440(c) (5)(ii) §483.440(c) (5)(iii) §483.440(c) (5)(iv) §483.440(c) (5)(v) §483.440(c) (5)(vi)	W234 W235 W236 W237 W238 W239	Each written training program designed to implement the objectives in the individual program plan must specify: The method to be used; The schedule for use of the method; The person responsible for the program; The type of data and frequency of data collection necessary to be able to assess progress toward the desired objective; The inappropriate client behavior(s), if applicable; and Provisions for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

§483.440(c)(6) §483.440(c)(6)(i)	W240	The individual program plan must also: Describe relevant interventions to support the individual toward independence.

§483.440(c)(6)(ii)	W241	Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.
§483.440(c)(6)(iii)	W242	Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.
§483.440(c)(6)(iv)	W243 W244 W245	Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.
§343.440(c)(6)(v)	W246	Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.
§343.440(c)(6)(vi)	W247	Include opportunities for client choice and self-management.
§343.440(c)(7)	W248	A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.
§483.440(d) §483.440(d)(1)	W249	Standard: Program implementation As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.
§483.440(d)(2)	W250	The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

§483.440(d)(3)	W251	Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.
§483.440(e) §483.440(e)(1)	W252	Standard: Program documentation. Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

§483.440(e)(2)	W253 W254	The facility must document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.
§483.440(f) §483.440(f)(1) §483.440(f)(1)(i) §483.440(f)(1)(ii) §483.440(f)(1)(iii) §483.440(f)(1)(iv)	W255 W256 W257 W258	Standard: Program monitoring and change. The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client – Has successfully completed an objective or objectives identified in the individual program plan; Is regressing or losing skills already gained; Is failing to progress toward identified objectives after reasonable efforts have been made or; Is being considered for training towards new objectives.
§483.440(f)(2)	W259 W260	At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed; and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lillian Minor, *et al*.,

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

Case No. SA-5:10-CV-1025-OG

[PROPOSED] ORDER GRANTING PLAINTIFFS' OPPOSED MOTION FOR PRELIMINARY INJUNCTION

Before the Court is Plaintiffs' Motion for Preliminary Injunction. In the Motion, Plaintiffs seek to enjoin Defendants from continuing to fail to fulfill their obligations under the Nursing Home Reform Amendments Act (NHRA) of 1987 to the Medicaid Act, 42 U.S.C. § 1396r(e) and 42 C.F.R. § 483.100, *et seq.*, and in so doing, seeks specific injunctive relief. Having carefully reviewed the Motion, all responses thereto, and after considering the evidence, the Court finds:

1. Plaintiffs are likely to succeed on the merits of their claim that the Defendants have violated the rights of the Plaintiff Class under the NHRA to the Medicaid Act, 42 U.S.C. § 1396r(e) and 42 C.F.R. § 483.100 *et seq*.

2. The Plaintiff Class will suffer irreparable harm if preliminary injunctive relief is not granted.

3. The harm that the Plaintiff Class will suffer if injunctive relief is denied substantially outweighs any harm that Defendants will suffer if the injunction is granted.

4. The public interest supports the issuance of injunctive relief.

Accordingly, it is ORDERED that Plaintiffs' Motion for Preliminary Injunction is GRANTED. It is further ORDERED that Defendants, their agents, servants, and employees as well as all persons acting in concert with them, are enjoined from continuing to violate the rights of the Plaintiff Class under the NHRA to the Medicaid Act, 42 U.S.C. § 1396r(e) and 42 C.F.R. § 483.100 *et seq*. and 42 C.F.R. § 483.440(a)-(f), and are ordered to:

> 1. Conduct PASRR Evaluation reviews by a qualified Intellectual and Developmental Disabilities (IDD) professional who makes a professional judgment, based upon all available information, whether the individual has a need for habilitative services in each of the fifteen areas listed in 42 CFR § 483.136;
>
> 2. Conduct a Comprehensive Functional Assessment of each member of the Plaintiff Class who is admitted to a nursing facility with 15 days of admission;
>
> 3. Provide or ensure provision of all necessary specialized services to members of the Plaintiff Class in nursing facilities in the amount, duration and scope necessary to address all identified habilitative need areas;
>
> 4. Ensure that individuals with IDD in nursing facilities receive a program of active treatment that is planned, delivered, and supervised by qualified IDD professionals, consistent with the requirements of 42 CFR § 483.440(a)-(f);
>
> 5. Provide, or ensure the provision of, service coordination that monitors specialized services provided by the nursing facility and/or the Local Intellectual and Developmental Disability Authorities and ensures that these services are

delivered in a consistent, coordinated, and continuous manner that constitutes a program of active treatment, as required by 42 CFR § 483.440(a)-(f);

6. Ensure that nursing facilities fully comply with all PASRR requirements, and provide nursing facility and specialized services in a consistent, continuous, coordinated manner that constitutes a program of active treatment, as required by 42 CFR § 483.440(a)-(f); and

7. Provide training to all entities and staff responsible for implementing its PASRR program and the above remedial provisions.

Because the Plaintiff Class Members are indigent, it is further ORDERED that the security requirement of Federal Rule Civil Procedure 65(c) is waived. This Order shall be effective immediately.

SIGNED on this _____ day of _____, 2017.

_____
ORLANDO L. GARCIA
UNITED STATES DISTRICT JUDGE