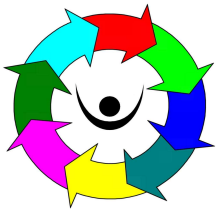

Transition Planning and Services

Reporting Period: May 2010 to February 2011

BACKGROUND

The 2008 Settlement Agreement on Active Treatment, provides in part that:

¶28. Class members who are on the Rolland Community Placement List as of March 1, 2008 will be provided at least the same level of specialized services that they currently receive or as modified by the RISP Team based upon a change in circumstances. In addition, in order to ensure that class members on the List are provided with active treatment transition services relevant to their projected placement, DMR will undertake the following actions for each individual on the List:

a. *DMR will develop a transition plan for each individual, based upon the principles of person-centered planning. DMR will develop a standard format for the transition plan after discussion with the parties and input from the Court Monitor. In order to facilitate a successful transition, the transition plan will identify the needs that must be addressed and the transition services that must be provided to meet those needs while the person is still in the nursing facility. The transition plan will be integrated into the RISP. These transition services, together with enhanced specialized services described in the remaining subsections of the paragraph, constitute active treatment transition services for these individuals.*

b. *DMR will substantially intensify the involvement of the service coordinator or case manager, so that they are actively engaged with the class member and directly responsible for ensuring the implementation of the RISP, including the transition plan.*

c. *DMR will expand opportunities for specialized services that are provided in the community, and make their best efforts to reduce reliance upon mobile day habilitation services offered directly at the nursing facility. Service coordinators and case managers will actively encourage class members to participate in specialized services programs in the community.*

d. *DMR will expand transition services, as a form of specialized services, which offer class members the opportunity to participate in community activities during the evening and weekend hours. These transition services will be consistent with each individual's transition plan. These transition services will be delivered by community residential, individual support, and other community providers, in order to facilitate the person's transition to the community and to allow these services to continue in the community, to the extent appropriate for the individual.*

Subsequent to the appointment of the Court Monitor an instrument was designed to measure compliance with the provisions cited above. The instrument has since been used under the direction of the Court Monitor to review the provision of Individual Transition Planning and related services as they have been provided to 143 class members.

Findings for 80 class members were reported to the Court in the Monitor's previous report. This report provides the results of a second round of ITSP reviews conducted from August 2010 through December 2010. This report also reflects overall scoring for the total of 143 class members.

A. Methodology and Demographics

A "desk audit" review was held for each of the thirty-two (32) class members reviewed from September 2009 to December 2009; for forty-two (42) class members reviewed from January 2010 to March 2010; and for sixty-three additional (63) class members reviewed from August 2010 to December 2010. Reviewers were provided with and completed a review of, at least:

- the current and past RISP,
- the ITSP,
- progress notes provided for Transition and Specialized Services,
- Service Coordinator/Case Manager notes, and
- assessments from the Nursing Facility, Specialized Services and Transition Services

Interviews were conducted by telephone with the Service Coordinator/Case Manager, a member of the Transition Services Staff, and when possible, the guardian of the class member, the Health Care Proxy, or a close family member.

The protocol was then scored, Findings and Recommendations were developed and the reviewer and their quality review judge reconciled the scores.

One hundred and six (106) of the 143 individuals reviewed are supported by a DDS Service Coordinator and 37 are supported by a UMASS Case Manager[1]. Eighty-two (82) different nursing facilities were included in these reviews. The numerical results for each question are listed in Appendix A at the end of this report.

When reviewing scores, it is important to note that class members for whom a question does not apply are scored "N/A". When calculating percentages, people with N/A scores are not calculated into the adjusted percentage. An example follows.

Intensified Service Coordination (2010)	**Sample**	**No**	**Yes**	**N/A**	**Adj %**
26. The SC/CM reports any health or safety concerns to DPH.	143	6	13	124	68%
		10%	10%	81%	

In this case, 124 of the 143 class members reviewed had no health or safety concerns that would need to be reported to DPH. Of the 19 class members who did have health and/or safety concerns that should have been reported to DPH, 13 were reported and 6 were not[2], therefore the adjusted score of 68%. Attachment A includes the adjusted score information for all questions. This enables the reader to determine number as well as percentage of class members and how they scored for each question.

B. Findings and Recommendations

When reviewing the information in the following charts, the following numbers apply:

2009	summarizes the information for 32[3] people who had ITSP Reviews
2010 Part I	summarizes the information for 42 people who had ITSP Reviews
2010 Part II	summarizes the information for 63 people received ITSP Reviews
Avg	the average of all scores

[1] DDS supports people with a primary diagnosis of mental retardation. UMASS supports people whose primary diagnosis is developmental disabilities.
[2] Examples of what was not reported included hospitalizations/falls/aspiration pneumonia.
[3] An additional 6 people were reviewed as a part of the ITSP Pilot.

Transition Plans:

During previous reviews, there were concerns regarding the completeness, accuracy and overall adequacy of all ITSPs reviewed. In every instance, scores in the 2010 Part II review are slightly lower than they were in prior reviews. Three areas are highlighted for particular attention.

Individual Transition Services Plan (ITSP)	2009	2010 Part I	2010 Part II	Avg
2. The person has a current ITSP.	100%	98%	89%	**94%**
2.a. The person has an ITSP that is updated annually.	NA	91%	88%	**89%**
3. Does the ITSP identify the person's needs that must be addressed as they relate to a transition to the community?	50%	76%	67%	**66%**
5. If the individual/guardian is refusing community placement, is this noted in the ITSP?	89%	94%	86%	**90%**
5.a. If the individual/guardian is refusing community placement, is there a plan for the service coordinator or case manager to work toward the acceptance of transition[4]?	74%	79%	69%	**74%**
7. The ITSP is integrated into the RISP process.	52%	74%	68%	**64%**

It is important to recognize that the three questions with lower scores (each including about one third of the class members sampled) address more substantive issues for class members: 1. ITSP based upon the person's needs (Question #3); 2. Planning and working toward acceptance of transition (Question 5.a.); and 3. ITSP integrated into the individual's primary Rolland plan (Question #7). The other three questions are more focused on paper compliance.

Individual Transition Services Plan (ITSP)	2009	2010 Part I	2010 Part II	Avg
1. The person has an ITSP based upon the principles of person-centered planning.	31%	43%	37%	**36%**
4. The person's ITSP has goals and objectives that address challenges to community placement.	59%	60%	60%	**59%**
6. The person's ITSP has goals and objectives that address increased opportunities for purposeful and functional community integration.	50%	60%	56%	**56%**
6.a. If not, the ITSP explains why.	31%	41%	32%	**35%**
8. The ITSP is modified by the team as necessary to address changes in circumstances and the achievement, or obstacles to the achievement, of an individual's goals.	44%	62%	57%	**55%**

Again it is notable that all scoring in late 2010 was lower than in those reviews conducted in the earlier part of 2010. These lower scores may reflect the fact that class members reviewed in late 2010 were more resistant to community placement and/or may present more or different programmatic/health care challenges.

[4] Part of the March 25, 2011 response from the Defendants to this report noted that, "required documentation for the individuals and guardians refusing transition services and planning would be contained in the class member's (Community) outreach work plan and not the ITSP". … Once your office confirms that the required information is in the outreach work plans, we ask that the scores be re-calculated and the draft report revised accordingly. Based on a sample review, it is clear that reviewers did take this "plan" into account. Of the 143 people reviewed, 90% of those refusing transition were found to have this noted in the ITSP (Question 5). Twenty-eight people didn't have a "plan" (Question 5.a.). Six of those 28 had ITSPs that did explain why there was no plan (Question 5.b.). Of the 22 who were not credited with a Plan, a sample was review again. Examples of why this rating remains unchanged include: the Plan provided continues to say the exact same thing for months so there is no evidence that the plan has been acted on. In another case, the class member does not have a guardian, but a Health Care Proxy. The Plan addresses work with the Health Care Proxy but no efforts to work directly with the class member.

It is important to reflect on the two thirds of class members sampled whose ITSPs are not based upon the principles of person-centered planning. Frequently, it is the person and/or the guardian who are not present at team meetings. The other most commonly missing key team members are those direct support staff who know the person best and work most closely with the individual day to day. DDS's, as well as nationally recognized, person-centered expectations include having the guardian and the person present during Team planning/meetings. When that does not occur, the most basic of 'person-centered' principles isn't met. In some cases individuals and/or their guardians are unable or unwilling to attend. In some cases the time meetings are scheduled present challenges due to work, transportation or other access issues.

Of these eight questions, scores are at approximately 50% compliance or lower. In many instances, these scores reflect continued resistance to work through the issues of community placement by the class member and/or guardian as well as service coordinator/case manager and other team members.

> Defendants noted in their comments regarding person centered planning that, "we believe that the low score in this category fails to acknowledge and credit the Department with its on-going efforts in encouraging individuals and guardians resistant to community placements to participate in the Team planning/meetings and further, does not give proper weight to the person-centered planning/meetings and further, does not give proper weight to the person-centered information written in the ITSP about the class member and the identification of the team members who may not have attended the meeting but had nevertheless contributed to the plan. More specifically, Section A of the ITSP includes detailed and individualized information about the class member's personal characteristics, personal routines, social life, relationships, and communications, as well as a "Person Centered Profile" section where the service coordinator/case manager writes an overall summary that ties the key issues (personal, family, medical) and factors affecting transition and placement. We believe that inclusion of this information in your report will provide the Court with a better understanding of the other important principles of person-centered planning that are being satisfied by the ITSPs and the Department's continuing commitment to encourage individuals and guardians to attend the Team meetings." By adding this information in the report I too want to acknowledge and thank the Department for these efforts.

Teams are again encouraged to continue to work with families/guardians so their feelings and fears regarding transition to the community can be specifically addressed in a way that is effective and meaningful. As a result of interviews with various members of the team, almost half of those reviewed indicated direct opposition or reluctance to move to the community and/or had team members who indicated direct opposition/reluctance. Specific steps need to be taken to address these issues and write them into the plan as objectives, with target dates and responsible parties. Likewise, if there are other barriers to community placement (transportation, medical services, equipment needs, etc.) these should be identified, addressed, and objectives to overcome these barriers implemented and tracked. In addition, if DDS determines that the person and/or his/her Team is not likely to agree to move to the community, the referral for the "not recommended for community placement" list should be made as soon as possible.

Overall fifty-six percent (56%) of those reviewed were found to have objectives for increased opportunities for community integration which are purposeful and functional. Obviously, continuing to expand the number of class members who have and are participating in such objectives is essential.

Finally, as with the RISP, the ITSP should be a fluid and flexible plan, and should be revised when the personal circumstances of the class member change, outcomes are attained or progress has not occurred and to address guardian preferences and concerns.

Transition Services:

Transition services should be provided in the amount required by the ITSP and should be utilized to implement the ITSP goals and objectives. Preferably, they should be provided in the evenings and on weekends when specialized services are not available. Finally, they should be designed to help, when needed, to increase the individual's comfort in the community and to allow the person to develop their interests and skills.

All of these areas were matters of concern during the first eighty reviews[5]. The same challenges remain.

Transition Services	2009	2010 Part I	2010 Part II	Avg
9. The person receives the transition services provided for in his/her ITSP.	68%	61%	64%	**63%**
9.a. If not, the ITSP explains why.	30%	13%	45%	**29%**
10. The person receives transition services that provide greater exposure to new experiences in the community.	35%	50%	53%	**48%**
10.a. If not, the ITSP explains why.	55%	57%	48%	**51%**
11. The person receives transition services that allow the person to explore and develop their interests and skills.	53%	66%	56%	**56%**
11.a. If not, the ITSP explains why.	47%	36%	39%	**39%**
12. The person receives transition services that allow the person to gain increased comfort with being in the community.	38%	56%	54%	**50%**
12.a. If not, the ITSP explains why.	53%	42%	50%	**47%**
13. There is evidence that the person received community opportunities/ activities in the evening and on the weekends the year before.	NA	50%	40%	**42%**
14. The person receives additional community opportunities and community activities during the evening and on the weekend.	31%	45%	32%	**36%**
14.a. If not, the ITSP/RISP addressed why not.	36%	30%	42%	**38%**

DDS needs to assure that the Service Coordinator/Case Manager and Transition Providers, in particular, understand that Transition Services are meant to supplement - not replace - Specialized Services, and that the emphasis of Transition Services should be on gaining skills and comfort in the community. Transition Services should take place largely in the community. Furthermore, they should be used to enrich the time during evenings and weekends when Specialized Services are not provided.

If for some reason the class member is unwilling or unable to spend time in the community, the ITSP should explain the precise reasons why. A plan should be developed to overcome those barriers.

The scores presented above reflect major transition issues yet to be addressed in the manner anticipated by the Settlement Agreement.

Specialized Services

Specialized Services have been provided to Rolland class members for a long time. While some class members have received those away from the nursing facility, the vast majority have received services at the nursing facilities. "Mobile day habilitation agencies" send staff to the nursing facilities. As people prepare to transition to the community, it was hoped that they would become accustomed to community-based day programs. The Settlement Agreement requires that class members have at least the same amount of Specialized Services as they had in June 2008 and that they be provided opportunities and encouragement to participate in community-based day services. This area has not shown much change over time.

[5] 80 includes the 6 people in the Pilot.

Specialized Services	2009	2010 Part I	2010 Part II	Avg
15. The person receives at least the same type, level, and frequency of specialized services as the person received in the RISP that was in effect June 16, 2008.	90%	83%	86%	**86%**
15.a. If not, there was a change in the person's circumstances that affected this answer.	33%	33%	25%	**33%**
16. Prior to July 1, 2008, this person received day habilitation services at the nursing facility.	79%	72%	54%	**66%**
17. The individual has been offered the opportunity to receive at least some services in a community day habilitation program that offers opportunities for community integration.	50%	52%	76%	**62%**
18. There is evidence that the CM/SCs have encouraged class members to participate in specialized services which are provided in day habilitation programs (off site from the NF).	50%	51%	63%	**56%**

Class members who are preparing for a move to the community need as many experiences as possible to prepare them for the upcoming changes to their lives. Community-based services are already available and should be utilized to help make the transition easier for those who are moving. Service Coordinators/Case Managers must take the lead in encouraging individuals and their families/guardians to consider this service. They should be arranging visits, working out part-time schedules if need be, and aggressively working to assure that this new experience is a success. They should be documenting their efforts in case notes.

Intensified Service Coordination[6]

In recognition of the increased demands of assisting class members in transition, the Settlement Agreement requires smaller case loads for those Service Coordinators/Case Managers (SC/CM) who hold that responsibility. DDS reports on the size of case loads, so those numbers will not be included in this report. Rather, the responsibilities of the SC/CM are discussed.

As the following chart illustrates, scores have remained high in the following areas.

Intensified Service Coordination	2009	2010 Part I	2010 Part II	Avg
19. The SC/CM knows the person well.	91%	98%	93%	**94%**
24. The SC/CM ensures that the Specialized Services set forth in the RISP are implemented in line with the person's needs.	91%	92%	87%	**89%**
25. The SC/CM monitors services to ensure that the person is safe, in line with the person's needs.	81%	79%	75%	**77%**
26. The SC/CM reports any health or safety concerns to DPH.	0%	50%	100%	

Areas which have shown decreases and still require focus include:

Intensified Service Coordination	2009	2010 Part I	2010 Part II	Avg
20. The SC/CM meets with this person at least monthly.	31%	65%	45%	**46%**

[6] Service Coordinators provide services through DDS, Case Managers provide services through UMASS.

Intensified Service Coordination	2009	2010 Part I	2010 Part II	Avg
21. The SC/CM ensures that the Transition Services in the ITSP are implemented.	56%	74%	67%	**66%**
22. The SC/CM ensures that the Transition Services Plan is modified as needed.	46%	62%	58%	**56%**
23. The SC/CM coordinates Transition Services and Specialized Services in line with the person's needs.	50%	74%	70%	**66%**

The Service Coordinator (SC) or Case Manager (CM) is, or should be, one of the key driving forces behind a safe and successful transition for a class member. In order to fulfill this role, s/he must know the class member well, assure that the plan is developed and implemented in line with the person's needs and monitor to assure that all members of the team are fulfilling their individual responsibilities to the class member.

In order to know the class member well, the SC/CM needs to spend time with the person. In this case, the expectation is that SC/CM meets with the class member at least monthly.

Individual Findings and Recommendations

As part of the Individual Transition Services/Plan review, reviewers issue individual findings and recommendations for each class member they review. These findings and recommendations go to the class member, his/her team, the nursing facility and DDS/UMASS. These findings and recommendations are intended to highlight important issues found as well as those that are out of compliance with expectations in one of the four areas reviewed: Transition Services, Transition Planning, Specialized Services and Intensified Service Coordination.

DDS, UMASS and Individual Class Member Team Follow Up

Once the Findings and Recommendations are received, DDS in conjunction with UMASS and each person's team, coordinate needed follow up on all of the findings/recommendations. This needed follow up is memorialized in a plan which includes information regarding action taken for each of the findings and recommendations identified. This plan is provided by DDS to the Court Monitor. If Teams determine that they are not going to take recommended action for a given finding/recommendation, that information, along with the reason(s), is also provided to the Court Monitor in the person's plan.

Status

The ITSP Reviews required by the Settlement Agreement have concluded. No further ITSP reviews will be conducted or reports issued from the Court Monitor.

On March 25, 2011 the Defendants provided a summary of the steps they have taken to address some of the ITSP documentation issues identified. Those actions include:

1. Keeping signature sheets for all meetings including both annual and quarterly meetings;
2. Documenting team meeting participation and contribution by the service coordinators;
3. Improving documentation of individuals being invited and encouraged to attend and participate in their team meetings;
4. Assuring that progress notes are entered on a monthly basis and will describe observations and communications with the individual, and what progress was made. This information will be provided to the Court Monitor and incorporated into future planning.
5. Documenting the schedule and the actual hours of transition services received with written explanation when scheduled hours are missed. This information will be provided to the Court Monitor and incorporated into future planning.
6. Summarizing the actual number of hours delivered and any deviations in the ITSP Reviews and in the transition service provider notes.

Appendix A
ITSP Review Data - All Reviews through 2010

Individual Transition Services Plan (ITSP)	Sample	No	Yes	N/A	Adj %
1. The person has a ITSP based upon the principles of person-centered planning.	143	92	51		36%
		64%	36%		
2. The person has a current ITSP.	143	8	135	0	94%
		6%	94%	0%	
2.a. The person has a ITSP that is updated annually.	143	9	71	63	89%
		6%	50%	44%	
3. Does the ITSP identify the person's needs that must be addressed as they relate to a transition to the community	143	49	94		66%
		34%	66%		
4. The person's ITSP has goals and objectives that address challenges to community placement.	143	59	84		59%
		41%	59%		
5. If the individual/guardian is refusing community placement, is this noted in the ITSP?	143	11	95	37	90%
		8%	66%	26%	
5.a. If the individual/guardian is refusing community placement, is there a plan for the service coordinator or case manager to work toward the acceptance of transition?	143	28	78	37	74%
		20%	55%	26%	
5.b. If not, the ITSP explains why.	143	22	6	115	21%
		15%	4%	80%	
6. The person's ITSP has goals and objectives that address increased opportunities for purposeful and functional community integration.	143	63	80		56%
		44%	56%	57	
6.a. If not, the ITSP explains why.	143	41	22	80	35%
		29%	15%	56%	
7. The ITSP is integrated into the RISP process.	143	49	86	8	64%
		34%	60%	6%	
8. The ITSP is modified by the team as necessary to address changes in circumstances and the achievement, or obstacles to the achievement, of an individual's goals.	143	59	72	12	55%
		41%	50%	8%	
Transition Services	**Sample**	**No**	**Yes**	**N/A**	**Adj %**
9. The person receives the transition services provided for in his/her ITSP.	143	51	88	4	63%
		36%	62%	3%	
9.a. If not, the ITSP explains why.	143	36	15	92	29%
		25%	10%	64%	
10. The person receives transition services that provide greater exposure to new experiences in the community.	143	74	67	2	48%
		52%	47%	1%	
10.a. If not, the ITSP explains why.	143	36	38	69	51%
		25%	27%	48%	
11. The person receives transition services that allow the person to explore and develop their interests and skills.	143	61	79	3	56%
		43%	55%	2%	
11.a. If not, the ITSP explains why.	143	38	24	81	39%

		27%	17%	57%	
12. The person receives transition services that allow the person to gain increased comfort with being in the community.	143	70 49%	70 49%	3 2%	50%
12.a. If not, the ITSP explains why.	143	37 26%	33 23%	73 51%	47%
13. There is evidence that the person received community opportunities/ activities in the evening and on the weekends the year before.	143	42 29%	31 22%	70 49%	42%
14. The person receives additional community opportunities and community activities during the evening and on the weekend.	143	92 64%	51 36%	[redacted]	36%
14.a. If not, the ITSP/RISP addressed why not.	143	57 40%	35 24%	51 36%	38%
Specialized and Transition Services	**Sample**	**No**	**Yes**	**N/A**	**Adj %**
15. The person receives at least the same type, level, and frequency of specialized services as the person received in the RISP that was in effect June 16, 2008.	143	18 13%	108 76%	17 12%	86%
15.a. If not, there was a change in the person's circumstances that affected this answer.	143	12 8%	6 4%	125 87%	33%
16. Prior to July 1, 2008, this person received day habilitation services at the nursing facility.	143	44 31%	86 60%	13 9%	66%
17. The individual has been offered the opportunity to receive at least some services in a community day habilitation program that offers opportunities for community integration.	143	55 38%	88 62%	[redacted]	62%
18. There is evidence that the CM/SCs have encouraged class members to participate in specialized services which are provided in day habilitation programs (off site from the NF).	143	62 43%	80 56%	1 1%	56%
Intensified Service Coordination	**Sample**	**No**	**Yes**	**N/A**	**Adj %**
19. The SC/CM knows the person well.	143	8 6%	133 93%	2 1%	94%
20. The SC/CM meets with this person at least monthly.	143	75 52%	66 46%	1 1%	46%
21. The SC/CM ensures that the Transition Services in the ITSP are implemented.	143	49 34%	94 66%	[redacted]	66%
22. The SC/CM ensures that the Transition Services Plan is modified as needed.	143	58 41%	75 52%	10 7%	56%
23. The SC/CM coordinates Transition Services and Specialized Services in line with the person's needs.	143	49 34%	94 66%	[redacted]	66%
24. The SC/CM ensures that the Specialized Services set forth in the RISP are implemented in line with the person's needs.	143	15 10%	123 86%	5 3%	89%
25. The SC/CM monitors services to ensure that the person is safe, in line with the person's needs.	143	33 23%	110 77%	[redacted]	77%
26. The SC/CM reports any health or safety concerns to DPH.	143	6 4%	13 9%	124 87%	68%