Rolland Active Treatment Review
2007 Report
Reporting Period: August 2007 to December 2007
January 24, 2008

EXECUTIVE SUMMARY

From August 2007 to December 2007 supports and services provided to thirty-five class members were reviewed using the Rolland Active Treatment Protocol document. [1] This report identifies eighteen findings resulting from these reviews. Findings in the report are contained within the components necessary to provide active treatment (see page 5).

The findings present a very uncomfortable starting point. They clearly depict the failure to provide, for 94% of the thirty-five class members reviewed, a continuous active treatment program as described by federal regulations, ordered by Judge Neiman, and reviewed by competent, trained reviewers.

These findings not withstanding, there is a sincere commitment to improvement/change present in the parties, many of the providers, and the Court. In recognition of this commitment, recommendations and offers of support follow the findings listed below. The key findings follow.

FINDING: OF THE 35 PEOPLE REVIEWED, 94% WERE FOUND TO NOT BE RECEIVING [2] A CONTINUOUS ACTIVE TREATMENT PROGRAM, WHICH INCLUDES AGGRESSIVE, CONSISTENT IMPLEMENTATION OF A PROGRAM OF SPECIALIZED AND GENERIC TRAINING TREATMENT, HEALTH SERVICES AND RELATED SERVICES. (Q.72[3])

FINDING: MOST CLASS MEMBERS (97%) HAVE NOT RECEIVED A COMPREHENSIVE FUNCTIONAL ASSESSMENT THAT IS ACCURATE, CURRENT AND INCLUDES ATTENTION TO THE REQUIRED DEVELOPMENTAL AREAS. (Q.29)

FINDING: KEY STAFF ARE FREQUENTLY MISSING FROM PLANNING MEETINGS. WITHOUT THEIR PRESENCE THERE IS INADEQUATE KNOWLEDGE WITH WHICH TO PLAN.

FINDING: ALL OF THE TWENTY-FIVE CLASS MEMBERS IN THE NOVEMBER AND DECEMBER REVIEW WERE FOUND TO HAVE A DOCUMENT CALLED A RISP.[4] (Q.35)

The following findings relate to the existing RISP whether found to be adequate (12%) or inadequate (88%) to meet the class member's needs.

---

[1] Ten people were reviewed in August 2007; sixteen people were reviewed in November and nine people were reviewed in December 2007

[2] Of the two people who were receiving a continuous active treatment program, one person was being served by the Radius Pedi Center and one person was being served by Eastwood Care Center.

[3] When referencing question numbers, this refers to the specific question in the Active Treatment Protocol document dated December 4, 2007.

[4] During the Pilot, four people did not have a RISP that met criteria. After the Pilot, this question was split into two. One question asks if the person has a document called a RISP and a separate question addresses the adequacy of the content of the RISP.

FINDING: TWENTY-TWO (88%) CLASS MEMBERS IN THE NOVEMBER AND DECEMBER REVIEWS DID NOT HAVE A RISP THAT WAS ADEQUATE TO MEET HIS/HER NEEDS. (Q.60)

FINDING: TWENTY-ONE OF 25 CLASS MEMBERS (84%) HAD SPECIALIZED SERVICES (DAY) STAFF WHO DEMONSTRATED THE SKILL AND TECHNIQUES NECESSARY TO IMPLEMENT THE RISP. (Q.63)

FINDING: ONLY 10 OF 25 CLASS MEMBERS (40%) HAD NURSING FACILITY STAFF WHO DEMONSTRATED THE SKILL AND TECHNIQUES NECESSARY TO IMPLEMENT THE RISP. (Q.63b)

FINDING: CLASS MEMBER SPECIFIC TRAINING IS LACKING FOR BOTH DAY AND NURSING FACILITY STAFF.

FINDING: TWENTY-SEVEN CLASS MEMBERS (77%) DID NOT HAVE A RISP WHICH WAS IMPLEMENTED BY ALL STAFF WHO WORK WITH HIM/HER. (Q.67)

FINDING: FOR THE MAJORITY OF CLASS MEMBERS, THE RISP WAS NOT REVIEWED/REVISED WHEN AN OBJECTIVE WAS COMPLETED, WHEN THE INDIVIDUAL REGRESSED OR LOST SKILLS, OR WHEN THE INDIVIDUAL FAILED TO MAKE PROGRESS TOWARD IDENTIFIED OBJECTIVES. (Q.77, 78, 79)

Because this is an initial report, the following recommendations are offered as proposed first steps.

1. Based upon the findings of each individual review, the Court Monitor presented to the Defendants individual findings and recommendations for remediation. The Court Monitor requests that DMR follow up to ensure that these recommendations are considered and acted upon. When the class member is reviewed a second time, reviewers will be asked to make judgments regarding the extent to which supports and services provided to the class member have improved and whether or not Active Treatment is being provided.

2. It is clear that some of the nursing facilities in which class members reside, while having the best of intentions, do not have the capacity to provide continuous active treatment to the few residents who are class members. Those nursing facilities are designed to provide supports and services to other populations. Rather than expecting those facilities to transform themselves, it is recommended that they be invited by the Division of Mental Retardation to discuss and implement strategies to find more appropriate placements for their class member residents. While such individual change/movement is uncomfortable, the probability of them developing the capacity to provide Active Treatment is low and the class members would be better served in other more appropriate settings.

The Defendants are responsible for and committed to change. The Court Monitor will look to them to rapidly identify and implement systemic means to accomplish the needed change. The Court Monitor will be available to work with the Defendants to design and implement systems change.

As a result of these reviews the Court Monitor now knows significantly more about the system designed to support persons with mental retardation and developmental disabilities now residing in Massachusetts nursing facilities. To the extent that knowledge is useful to the parties and the Court, the Court Monitor is prepared to make this

information available for use of ensuring that class members have improved lives as quickly as possible.

Review Methodology and Demographics

Supports and services provided to thirty five class members were reviewed in 2007 using the Rolland Active Treatment Protocol (RATP).[5] For clarity, it is important to note that after the Pilot, some questions in the Protocol scoring section were changed or combined. Consequently, for some questions there is a report on the outcomes for 25 people (those reviewed in November and December) in other cases there is a report on 35 people (those reviewed in August, November and December).

The reviews, in part, included:

Interviewing approximately 175 people including, when possible, the class member, the class member's guardian, the service coordinator/case manager; the specialized services day staff that knows the class member best and the nursing facility staff that knows the person best.

Reviewing each Individual's File to document the planning that occurred, the nature and competency of supports and services provided, the impact of those services, and the monitoring that occurred on behalf of the individual.

Visiting a total of 27 **nursing facilities** (located in 24 different communities) in which the reviewed class members reside.

Observing Specialized Service providers in all regions including both "mobile day habilitation" (services provided in the nursing facility of residence) as well as "off site day habilitation" (services located in facilities/programs away from the nursing facility).

The following table provides demographic information, by region, regarding the class members reviewed and, in the three columns to the right, information about whether they receive specialized services at or away from the nursing facility. 85% of the class members receiving specialized services receive it at/in their nursing facility.

Region	# Reviewed	Average Age	# Male	# Female	Nursing Facility Based Day Hab	Site-Based Day Hab	No Day Hab
Central West	8	62	5	3	7	1	0
Marquardt	2	59	0	2	2	0	0
Metro	7	71	2	5	6	1	0
Northeast	8	65	4	4	2	5	1
Southeast	6	55	2	4	5	1	0
UMass	4	64	3	1	3	1	0
Totals	35	63*	16	19	25	9	1

*average of sample, not average of regions' average

[5] Ten class members were reviewed during the August 2007 Pilot; sixteen class members were reviewed during the November 2007 Training Review and nine class members were reviewed in December 2007. The RATP was amended after the August 2007 Pilot, based upon input/information from the Pilot.

The age of class members reviewed ranged from 21 to 97 as illustrated below.

Persons Reviewed: Age	
15-25	1
26-35	1
36-45	5
46-55	3
56-65	9
66-75	6
76-85	8
86+	2

FINDING #1: OF THE 35 PEOPLE REVIEWED, 94% WERE FOUND TO NOT BE RECEIVING [6] A CONTINUOUS ACTIVE TREATMENT PROGRAM, WHICH INCLUDES AGGRESSIVE, CONSISTENT IMPLEMENTATION OF A PROGRAM OF SPECIALIZED AND GENERIC TRAINING TREATMENT, HEALTH SERVICES AND RELATED SERVICES. (Q.72[7])

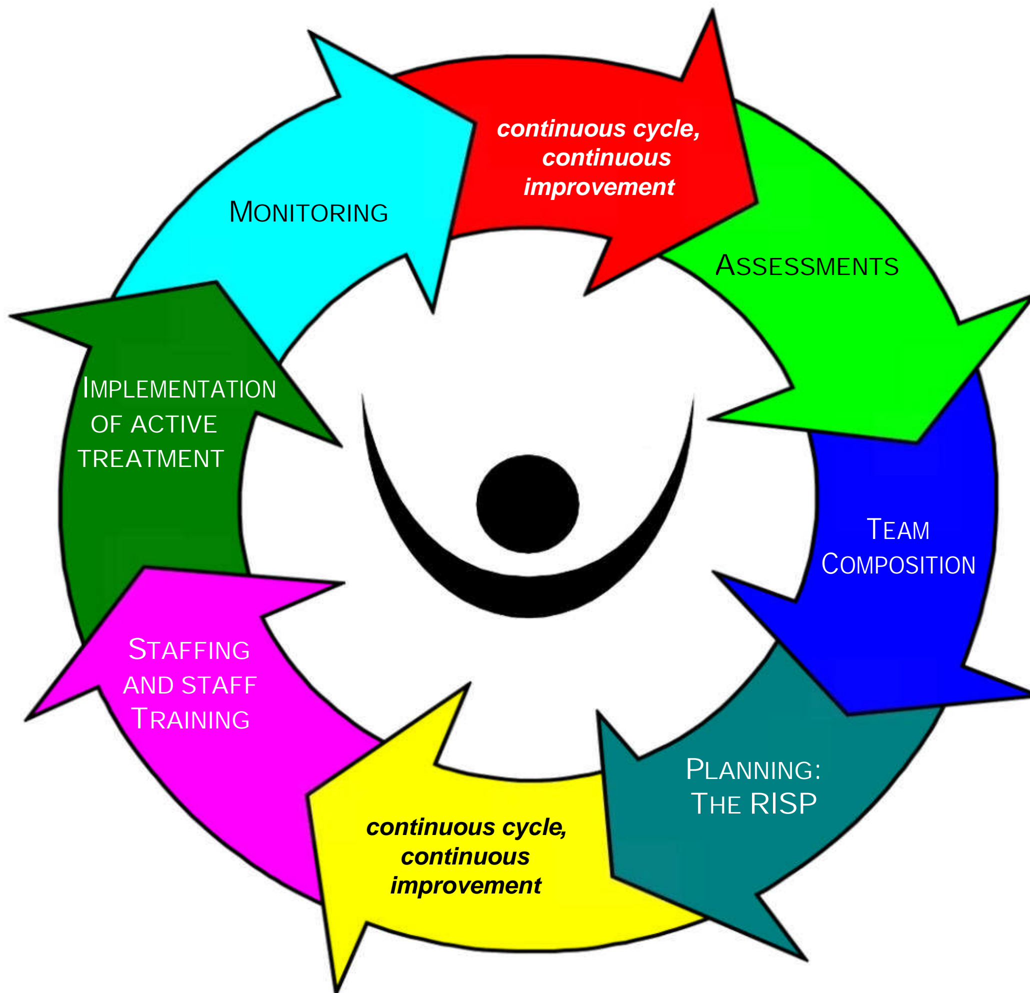
In order to better understand this finding, it is important to identify what impacts this determination. All components of the active treatment process are individually examined as a part of the Rolland Active Treatment Protocol and review process. Those components are: Assessment, Team Composition, Planning, Staffing and Training, Implementation of Active Treatment, and Monitoring. The successful functioning of each component is a required link in accomplishing Active Treatment overall. The failure to accomplish any or all components significantly limits the likelihood that the class member will be found to be receiving a continuous active treat program.

The flow chart on the following page depicts the components and the flow of the process of providing active treatment.

[6] Of the two people who were receiving a continuous active treatment program, one person was being served by the Radius Pedi Center and one person was being served by Eastwood Care Center.

[7] When referencing question numbers, this refers to the specific question in the Active Treatment Protocol document dated December 4, 2007.

The Components of a Continuous Active Treatment Program



The six components of Active Treatment are addressed in the following sections. There are three parts to each section:

a. A description of the component;
b. The Active Treatment Protocol questions addressing the component with the cumulative results of scoring for each question; and
c. By section, some findings that were found to be deserving of emphasis.

It is important to understand that **the primary findings are ALL of the scores.** The identification of some findings for emphasis does not minimize the value of any of the other scores or suggest that remediation should only be undertaken to address the emphasized findings.

I. ASSESSMENTS

"Assessment", generally, refers to the processes of identifying an individual's specific strengths, developmental needs and need for services. The purpose of assessments and individual consultations are to obtain information that will assist team members to plan, establish goals, identify the individual's capabilities and areas of need relative to those goals, and to identify the strategies and supports that are the least restrictive and likely to be effective in assisting the individual to attain his or her goals.

Assessments are foundational. If the foundation is not well done, the entire plan is in jeopardy of being weak and poorly constructed.

Each class member should have a current comprehensive functional supports assessment/s, which should address, at least, the following fourteen areas:

1. the person's chronological age and the implications for active treatment at each stage of life (Q.24);
2. presenting problems and disabilities and where possible, their causes (Q.25);
3. developmental strengths of the person (Q.26);
4. specific developmental and behavioral management needs (Q.27);
5. physical development and health (Q.29.i.);
6. nutritional status (Q.29.ii);
7. sensorimotor development (Q.29.iii);
8. affective development (Q.29.iv);
9. speech and language development (communication) (Q.29.v.);
10. auditory functioning (Q.29.vi);
11. cognitive development (Q.29.vii);
12. social development (Q.29.viii);
13. adaptive behavioral or independent living skills necessary to be able to function in the community (29.ix);
14. as applicable, vocational skills (29.x).

FINDINGS: Assessments	#Asses	# "No"	#"Yes"
24. Does the comprehensive functional assessment take into consideration___'s age (e.g., child, young adult, elderly person) and the implications for active treatment at each stage?	35	19 54%	16 46%
25. Does the comprehensive functional assessment identify ___'s presenting problems and disabilities and where possible, their causes?	35	25 71%	10 29%
26. Does the comprehensive functional assessment identify ___'s specific developmental strengths?	35	18 51%	17 49%
27. Does the comprehensive functional assessment identify ___'s specific developmental and behavioral management needs?	35	25 71%	10 29%
28. Does the comprehensive functional assessment identify ___'s needs for services without regard to the actual availability of the services needed?	35	19 54%	16 46%
29. Is there a comprehensive functional supports assessment, that is accurate, current, and includes:	25	24 96%	1 4%
29.i. physical development and health;	35	15 43%	20 57%
29.ii. nutritional status;	35	9 26%	26 74%
29.iii. sensorimotor development;	35	11 31%	24 69%
29.iv. affective development;	35	17 49%	18 51%

FINDINGS: Assessments	#Asses	# “No”	#“Yes”
29.v. speech and language development (communication);	35	9 26%	26 74%
29. vi. auditory functioning;	35	22 63%	13 37%
29.vii. cognitive development;	35	26 74%	9 26%
29.viii. social development;	35	15 43%	20 57%
29. ix. adaptive behaviors or independent living skills necessary for___ to be able to function in the community;	35	19 54%	16 46%
29. x. and, as applicable, vocational skills.	35	26 74%	9 26%
30. Were the Comprehensive Functional Assessment(s) reviewed and revised as needed based on the person’s needs.	35	32 91%	3 9%

FINDING #2: MOST CLASS MEMBERS (97%) HAVE NOT RECEIVED A COMPREHENSIVE FUNCTIONAL ASSESSMENT THAT IS ACCURATE, CURRENT AND INCLUDES ATTENTION TO THE REQUIRED DEVELOPMENTAL AREAS. (Q.29)

One class member (2.8%) had assessments in all fourteen areas listed above; One class member had assessments in twelve areas; two class member have assessments in eleven of the fourteen areas. The majority of the class members (69%) were assessed in seven or fewer of the fourteen areas.

Areas in which more class members received assessments include:

- 74% nutritional status and speech and language development;
- 69% sensorimotor;
- 57% physical development/health and social development; and
- 51% affective development.

Areas in which few class members received assessments include:

- 49% specific developmental strengths;
- 46% age/implications at each stage and adaptive behaviors/independent living skills;
- 37% auditory functioning;
- 29% presenting problems/disabilities/causes and developmental/behavioral management needs;
- 26% cognitive development and vocational skills;

FINDING #3: THIRTY-TWO CLASS MEMBERS (91%) DID NOT HAVE A COMPREHENSIVE FUNCTIONAL ASSESSMENT REVIEWED AND REVISED AS NEEDED BASED ON THEIR INDIVIDUAL NEEDS. (Q.30)

FINDING #4: LESS THAN ONE HALF (49%) OF THE CLASS MEMBERS REVIEWED HAD ASSESSMENTS IDENTIFYING THEIR DEVELOPMENTAL STRENGTHS. (Q.26) This is the single category in the Active Treatment assessment section which identifies what the individual is good at and, usually, really likes to do. All other assessments essentially measure deviation from the norm or “differentness”. The identification and utilization of individual strengths is the most positive and successful basis for individual planning.

II. TEAM COMPOSITION

Successful support planning requires the greatest possible involvement of the individual, his or her family, guardian, and designated representative, if any, the Department and providers of supports to the individual. Each participant - individual, family, professionals, paraprofessionals and non-professionals - is expected to work together and to demonstrate a continuing commitment to learn about the individual and his or her current goals and circumstances, and to support the individual in particular ways to realize those goals.

The responsibilities of providers include, in part, to ensure completion of assessments and professional consultations; to work collaboratively with the individual and other team members to identify the individual's goals; and to develop a RISP which is likely to be effective in assisting the individual to achieve his/her goals.

People who know the individual best must participate in the interdisciplinary team meetings and process. Those staff persons who work with the person most often should be present. They have the best knowledge of the individual, his or her strengths and capacities, what works and what doesn't.

FINDINGS: Team Composition and Function	#Asses	# "No"	#"Yes"
31. Does ____ have a RISP developed by an IDT that represents the professions, disciplines or service areas that are relevant to: identifying ____'s needs as described by the comprehensive functional assessment; and designing programs that meet ____'s needs?	35	26 66%	12 34%
32. Have appropriate nursing facility and specialized services staff participated in the IDT meetings?	35	20 57%	15 43%
33. Was participation by other agencies serving _________ encouraged?	35	15 43%	20 57%
34. Did _____ and his/her parent (if the person is a minor), or ____'s legal guardian participate in the development of the RISP (this is required unless the legal guardian/parent is unobtainable or it is found to be inappropriate)?	35	17 49%	18 51%

FINDING #5: TWENTY-SIX CLASS MEMBERS (66%) DID NOT HAVE A RISP DEVELOPED BY AN IDT THAT REPRESENTS THE PROFESSIONS, DISCIPLINES OR SERVICE AREAS THAT ARE RELEVANT TO IDENTIFYING THE PERSONS NEEDS AS DESCRIBED BY THE COMPREHENSIVE FUNCTIONAL ASSESSMENT; AND DESIGNING PROGRAMS THAT MEET THE PERSON'S NEEDS. (Q.31)

FINDING #6: KEY STAFF ARE FREQUENTLY MISSING FROM PLANNING MEETINGS. WITHOUT THEIR PRESENCE THERE IS INADEQUATE KNOWLEDGE WITH WHICH TO PLAN. Examples include class member teams where the individual has recently experienced fractures but RN's and Physical Therapists with primary knowledge about after care did not attend the meeting immediately following the fracture. Often guardians and/or the class member are not in attendance; the day habilitation person that works with the class member day-to-day is frequently not part of or consulted about planning meetings; and behavior support consultants/therapists are notably absent before, during or after meetings in spite of the presence of Axis I diagnosis and complex menus of medications.

III. ADEQUACY OF PLANNING

The Rolland Integrated Services Plan (RISP) Team is charged, in part, with the responsibility to prepare a plan based on the assessed needs and strengths of the class member. This plan should provide opportunities for individual choice and self management and should identify:

- the relevant interventions to support the individual toward independence;
- the discrete, measurable criteria based objectives the individual is to achieve; and
- the specific individualized program of specialized and generic strategies, supports and techniques to be employed.

The RISP should address the acquisition of behaviors necessary for the individual to function with as much self-determination and independence as possible and should prevent or decelerate regression or loss of current optimal functional status.

As needed, the person must be furnished with, have maintained in good repair, and be assisted to use and make informed choices about the use of aids and adaptive equipment such as dentures, eyeglasses, hearing and other communication aids, braces and other devices identified by the team or clinical consultants.

As stated previously, the precursors to effective planning are an appropriate Team working with fully informative assessments. The lack of compliance in Sections I and II will demonstrate its consequence in planning.

FINDINGS: Adequacy of Planning	#Asses	# "No"	#"Yes"
35. Did the Team convene a meeting and develop a document called a RISP?	25	0 0%	25 71%
36. Does ________ have a RISP?	35	22 63%	13 37T
38. Is ____'s RISP based on assessed needs and strengths and does it address major life areas essential to increasing independence and ensuring rights?	35	27 77%	8 23%
39. Does the RISP contain objectives necessary to meet _________'s needs as identified by the comprehensive assessment?	35	22 63%	13 37%
40. Are objectives organized in a planned sequence?	35	29 83%	6 17%
41. Are objectives stated separately, in terms of a single behavioral outcome?	35	19 54%	16 46%
42. Is each objective assigned projected completion dates?	35	27 77%	8 23%
43. Are objectives expressed in behavioral terms that provide measurable indices of performance?	35	19 54%	16 46%
44. Are the outcomes organized to reflect a developmental progression appropriate to ________?	35	27 77%	8 23%
45. Are the outcomes assigned priorities?	35	30 83%	5 14%
46. Does each written training program designed to implement the objectives in the RISP specify the methods to be used?	35	18 51%	17 49%
47. Does each written training program designed to implement the objectives in the RISP specify the schedule to be used?	35	19 54%	16 46%
48. Does each written training program designed to implement the objectives in the RISP specify the person responsible for the program	35	20 57%	15 43%
49. Does each written training program designed to implement the objectives in the RISP specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives?	35	25 71%	10 29%
50. Does each written training program designed to implement the objectives in the RISP specify the inappropriate behaviors, if applicable? (*For 17 of 35 this question was not applicable.)	35*	12 34%	6 17%

FINDINGS: Adequacy of Planning	#Asses	# "No"	#"Yes"
51. Does each written training program designed to implement the objectives in the RISP provide for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate?	35	13 37%	6 17%
52. Does the RISP describe relevant interventions to support ________ toward independence?	35	25 71%	10 29%
53. Does the RISP identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found?	35	19 54%	16 46%
54. Does the RISP include, if ________ lacks 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 _________ is developmentally incapable of acquiring them.	35	23 66%	8 23%
55. Does the RISP identify mechanical supports, if needed, to achieve proper body position, balance, or alignment?	35	16 46%	13 37%
56. Does the RISP identify the reason for each support, the situations in which each is to be applied, and the schedule for use of each support?	35	17 49%	9 26%
57. Does the RISP provide that ________ (if he/she has multiple disabilities) 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?	35	12 34%	23 66%
58. The RISP includes opportunities for ________ to have choice and self-management.	35	11 31%	24 69%
59. Is a copy of ________'s RISP made available to all relevant staff including staff of other agencies who work with _________ and to _________'s parents (if the person is a minor) or legal guardian?	35	15 43%	20 57%
60. Overall, is the RISP adequate to meet ________'s needs?	25	22 88%	3 12%

FINDING #7: ALL OF THE TWENTY-FIVE CLASS MEMBERS IN THE NOVEMBER AND DECEMBER REVIEWS WERE FOUND TO HAVE A DOCUMENT CALLED A RISP.[8] (Q.35) This question solely addresses the presence of a document called a RISP.

FINDING #8: TWENTY-TWO (88%) CLASS MEMBERS IN THE NOVEMBER AND DECEMBER REVIEWS DID NOT HAVE A RISP THAT WAS ADEQUATE TO MEET HIS/HER NEEDS. (Q.60)

- 8 (23%) people had RISPs based on assessed needs and strengths that addressed major life areas essential to increasing independence and ensuring rights. (Q.38)
- 13 (37%) people had a RISP which contained objectives necessary to meet the class member's needs as identified by the comprehensive assessment. (Q.39)
- 17 (49%) people had a written training program designed to implement the objectives in the RISP which specified the methods to be used. (Q 46)
- 10 (29%) people had a written training program designed to implement the objectives in the RISP which specified the type of data and the frequency of data collection necessary to be able t assess progress toward the desired objective. (Q.49)
- 24 (69%) RISPs included opportunities for choice and self-management. (Q.58)

[8] During the Pilot, four people did not have a RISP that met criteria. After the Pilot, this question was split into two. One question asks if the person has a document called a RISP and a separate question addresses the adequacy of the content of the RISP.

- 20 (57%) people and/or their Guardian and relevant staff had copies of their RISP. (Q.59)

It is important to note that the majority of the class members have many Axis I, Axis II and other diagnoses, reflecting challenging needs. However, the number of Goals identified in each RISP, even for the people with the greatest challenges, is typically no more than three. This results in significant questions as to whether the planned goals comprehensively address the assessed needs. Further, the few Goals identified are frequently repeated year-to-year with little or no change regardless of the class member's response to them. One would expect that, based upon the success of (or lack thereof) implementation of the individual's goals and objectives, there would be significant change in or adjustment of goals and/or objectives during the year, and change definitely would occur from one annual RISP meeting to the next.

IV. STAFFING AND TRAINING

Sufficient, competent, and informed staff must be present in order to successfully implement a program of continuous active treatment which includes aggressive, consistent implementation of a program of specialized and generic training treatment, health services and related services. Staff must know the individual, the individual's RISP, and the activities they must carry out to implement it.

FINDINGS: Staffing and Training	#Asses	# "No"	#"Yes"	# "N/A"[9]	Adj. "Yes"
61. Have staff received training focused on skills and competencies directed towards ________'s	(not a scored question)				
61a. Developmental needs?	25	19 76%	6 24%		
61b. Behavioral needs?	25	11 44%	8 32%	6 24%	42%
61c. and health needs?	25	17 68%	8 32%		
62. Have staff demonstrated the skills and techniques necessary to administer interventions to manage the inappropriate behavior of ________	25	7 28%	5 20%	13 52%	42%
62. a. Did DAY/Specialized Services staff demonstrate the knowledge, skills and techniques necessary to administer interventions to manage the inappropriate behavior of ________?	25	4 16%	8 32%	13 52%	67%
62. b. Did Nursing Facility staff demonstrate the knowledge, skills and techniques necessary to administer interventions to manage the inappropriate behavior of ________?	25	5 20%	5 20%	15 60%	50%
62. c. Did the Case Manager/Service Coordinator demonstrate the knowledge, skills and techniques necessary to understand and monitor interventions to manage the inappropriate behavior of ________?	25	3 12%	5 32%	14 56%	73%
63. Staff demonstrated the skills and techniques necessary to implement the RISP for ________.	25	18 72%	7 28%		
63.a. Did the Day/Specialized Services staff demonstrate the skills and techniques necessary to implement the RISP for _____?	25	4 16%	21 84%		
63.b. Did the Nursing Facility staff demonstrate the skills and techniques	25	15 60%	10 40%		

[9] The column #NA refers to the number of persons reviewed for whom this question was Not Applicable. In those instances the percentage scores for "Yes" answers were recalculated and the recalculated percentage is found in the last column to the right. For instance, with question 61b, 6 of the 25 reviewed were identified to NOT have specific behavioral needs. Nineteen did have identified behavioral needs. So for the eight class members scored "Yes" for question 61b., the percentage was adjusted from 32% (8 of 25) to 42% (8 of 19).

FINDINGS: Staffing and Training	#Asses	# "No"	#"Yes"	# "N/A"[9]	Adj. "Yes"
necessary to implement the RISP for _____?					
64. Staff reported that they have had and could describe what they had received as training to work with ______.	25	20 80%	5 20%		
64.a. Did the Day/Specialized Services staff receive and describe training necessary to work with ______?	25	12 48%	13 52%		
64.b. Did the Nursing Facility staff receive and describe training necessary to work with _____?	25	18 72%	7 28%		
65. Is staffing sufficient to carry out ________'s RISP.	25	15 60%	10 40%		
65.a. Is Day/Specialized Services staffing sufficient?	25	10 40%	15 60%		
65.b. Is Nursing Facility staffing sufficient?	25	17 68%	8 32%		

FINDING # 9: TWENTY-ONE OF 25 CLASS MEMBERS (84%) HAD SPECIALIZED SERVICES (DAY) STAFF WHO DEMONSTRATED THE SKILL AND TECHNIQUES NECESSARY TO IMPLEMENT THE RISP. (Q.63)

FINDING #10: ONLY 10 OF 25 CLASS MEMBERS (40%) HAD NURSING FACILITY STAFF WHO DEMONSTRATED THE SKILL AND TECHNIQUES NECESSARY TO IMPLEMENT THE RISP. (Q.63b)

FINDING #11: CLASS MEMBER SPECIFIC TRAINING IS LACKING FOR BOTH DAY AND NURSING FACILITY STAFF.

FINDING #12: FOR 68% OF CLASS MEMBERS REVIEWED IN NOVEMBER AND DECEMBER NURSING FACILITY STAFFING WAS INSUFFICIENT TO ACCOMPLISH ACTIVE TREATMENT. (Q.65b) **THE SAME WAS TRUE FOR 40% OF CLASS MEMBERS IN THEIR SPECIALIZED SERVICES (DAY) PROGRAM.** (Q.65A)

Generally reviewers found, through observation and interviews, that day services staff, overall, were better trained and more informed regarding their responsibilities as it relates to the RISP. Further, nursing facility staff who were identified as knowing the class member best frequently indicated that they had not had training specific to the class member nor mental retardation/developmental disabilities.

V. IMPLEMENTATION/RECEIPT OF ACTIVE TREATMENT

While separately scored, this section reflects the combination of all previous results. If previous criteria have not been met, it is effectively impossible to provide a continuous active treatment program.

FINDINGS: Implementation/Receipt of Active Treatment	#Asses	# "No"	#"Yes"
66. Does ________ 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 RISP.	35	31 89%	4 11%
67. _____'s RISP is implemented by all staff who work with him/her including professional, paraprofessional and non-professional staff except for those facets of the RISP that must be implemented only by licensed personnel.	35	27 77%	8 23%
68. Does ________ have an active treatment schedule that outlines the current active treatment program and that is readily available for review by staff?	35	33 94%	2 6%

FINDINGS: Implementation/Receipt of Active Treatment	#Asses	# "No"	#"Yes"
69. Is data relative to accomplishment of the criteria specified in _________'s RISP objectives documented in measurable terms?	35	27 77%	8 23%
70. Is there documentation of significant events that are related to _________'s RISP and assessments?	35	11 31%	24 69%
71. There is documentation that is related to _________'s RISP and assessments, and that contributes to an overall understanding of _________'s ongoing level and quality of functioning.	35	18 51%	17 49%
72. Does ______ 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?	35	33 94%	2 6%
73. Does _____ receive a continuous active treatment program which is directed toward the acquisition of the behaviors necessary for _____ to function with as much self determination and independence as possible?	35	29 83%	6 17%
74. Does ___ receive a continuous active treatment program which is directed toward the prevention or deceleration of regression or loss of current optimal functional status?	35	29 83%	6 17%
75. Did the activities and interactions you observed support the accomplishment of the RISP Objectives in _____'s active treatment program?	35	22 63%	13 37%

FINDING #13: THIRTY-ONE CLASS MEMBERS (89%) DID NOT RECEIVE A CONTINUOUS ACTIVE TREATMENT PROGRAM CONSISTING OF NEEDED INTERVENTIONS AND SERVICES IN SUFFICIENT NUMBERS AND FREQUENCY TO SUPPORT THE ACHIEVEMENT OF THE OBJECTIVES IDENTIFIED IN THE RISP. (Q.66)[10] This finding addresses the implementation of the objectives in the existing RISP. Two of these four RISPs were found not to be adequate to meet the individual's needs. Thus these two persons were found to be receiving a continuous active treatment program consistent with the objectives identified in their inadequate RISPs.

FINDING #14: TWENTY-SEVEN CLASS MEMBERS (77%) DID NOT HAVE A RISP WHICH WAS IMPLEMENTED BY ALL STAFF WHO WORK WITH HIM/HER. (Q.67)

This finding does not depend upon the adequacy (or lack thereof) of the RISP. It simply addresses the extent to which the existing RISPs were being implemented.

With respect to finding #14, there appear to be two significant issues:

1. lack of documentation of the implementation of goals and objectives by, primarily, the nursing facilities; and
2. the lack of implementation of goals and objectives by the nursing facility.

Often the goals and objectives are implemented by the specialized services (day) provider. When day services are not present, the class member is typically not engaged in RISP goals/objectives. Nights and weekends are particularly void of engagement for the class member. Thus the criteria that the provision of active treatment be "continuous" cannot be met.

FINDING #15: TWENTY-NINE CLASS MEMBERS (83%) DID NOT HAVE A PROGRAM "DIRECTED TOWARD THE PREVENTON OR DECELERATION OF REGRESSION OR LOSS OF CURRENT OPTIMAL FUNCTIONAL STATUS." (Q.74) For the remaining 83%, this finding is quite significant in that the majority of class members present aging, physical disabilities and/or other challenging behaviors which, without proactive intervention, can readily result in physical and/or mental regression.

[10] It is important to note that this finding is different from FINDING #1 on page 2 where two persons were found to be receiving a continuous active treatment program in accordance with requirements of federal regulations (Q.72).

VI. Monitoring and Follow Up

Even with the best of RISPs effectively implemented, if monitoring and follow up does not occur the RISP will quickly become stale, dated and useless. Monitoring and follow up must be carried out:

- to ensure that implementation is occurring and, if not, to cause implementation to occur;
- to evaluate the efficacy of the identified Goals and activities so that, as necessary, they can be adjusted to fit the individual's development and/or changing capacity;
- to catch regression as it may begin to occur so that adjustments may be quickly made to address the regression; and
- to inform the team as they revise and improve the RISP in the ongoing process of assessment > planning > implementation > monitoring.

FINDINGS: Monitoring and Follow up	#Asses	# "No"	#"Yes"	# "N/A"	Adj. "Yes"
76. Was the RISP reviewed, at least, by the Case Manager/Service Coordinator?	35	12 34%	23 66%		
77. Was the RISP reviewed/revised when _________ successfully completed an objective or objectives identified in the RISP?	25	14 56%	9 36%	2 8%	39%
78. Was the RISP reviewed/revised when _________ regressed or lost skills already gained?	35	14 40%	11 31%	10 29%	44%
79. Was the RISP reviewed/ revised if ________ was failing to progress toward identified objectives after reasonable efforts were made?	35	13 37%	11 31%	11 31%	46%
80. Was the RISP reviewed/revised when _________ was being considered for training towards new objectives?	35	11 31%	14 40%	10 29%	56%
81. Was the RISP reviewed at least annually?	35	7 20%	28 80%		

FINDING #16: 34% OF CASE MANAGERS/SERVICE COORDINATORS DID NOT FULFILL THEIR RESPONSIBILITY TO REVIEW THE RISP. (Q.76) Review of the RISP is one of the primary safeguards of the system and one of the basic and most essential functions of the case manager/service coordinator.

FINDING # 17: FOR THE MAJORITY OF CLASS MEMBERS, THE RISP WAS NOT REVIEWED/REVISED WHEN AN OBJECTIVE WAS COMPLETED, WHEN THE INDIVIDUAL REGRESSED OR LOST SKILLS, OR WHEN THE INDIVIDUAL FAILED TO MAKE PROGRESS TOWARD IDENTIFIED OBJECTIVES. (Q.77, 78, 79)

FINDING #18: IT APPEARS THAT THE RISP WAS ALMOST ALWAYS (80%) LEFT FOR REVIEW AT THE NEXT ANNUAL MEETING EVEN IF CONDITIONS EXISTED WHICH SHOULD HAVE RESULTED IN INTERIM ACTION TO ADJUST THE RISP; AND, FOR 20% OF THE CLASS MEMBERS, CHANGES WERE NOT EVEN MADE ANNUALLY AS NEEDED. (Q.81)