Rolland Active Treatment Review

Reporting Period: August 2007 to May 2008

EXECUTIVE SUMMARY

Through May 2008, ninety-seven class members have been reviewed; including sixty-two reviewed since the Court Monitor's December 2007 Report.

Ninety-one of the ninety-seven class members (94%) reviewed through May 2008 were found to not be receiving a continuous active treatment program as described by federal regulations and ordered by Judge Neiman. This percentage is the same as it was for the first thirty-five reviews completed by the end 2007.

An Active Treatment program contains six major related components, each dependent on the others and each of which is probed in the review: Assessment, Team Composition, Planning, Staffing and Training, Implementation of Active Treatment, and Monitoring. Implementation of Active Treatment is addressed in the preceding paragraph. Other major systemic findings include:

- **Assessment** 93% of class members reviewed have not received a comprehensive functional assessment that is accurate, current and includes attention to the required developmental areas.

- **Team Composition** At the majority of Interdisciplinary Team (IDT) meetings, key staff were missing. Without their input there is inadequate knowledge with which to plan.

- **Planning** While all but one class member was found to have a document called a Rolland Integrated Service Plan (RISP) (Q.35), only nine (10%) class members were found to have a RISP that was adequate to meet his/her needs.

- **Staffing and Training** Almost half of class members were not supported by adequate numbers of staffing necessary to provide active treatment. While staff interviewed were identified as those who know the individual best, over half were not specifically trained on the specific class member's complex and unique needs.

Based upon the findings of each individual review, the Court Monitor presented to the Defendants individual findings and recommendations for remediation. The Court Monitor continues her request for reports on the timely response to the individual findings and recommendations. The Court Monitor will be available to work with the Defendants to address/resolve the individual findings and recommendation.

The cumulative findings demonstrate that many of the nursing facilities in which class members reside do not have the capacity to provide continuous active treatment to class members.

Rolland Active Treatment Review Report

Reviews through May 2008

A. REVIEW METHODOLOGY AND DEMOGRAPHICS

The reviews included:

Interviewing approximately 485 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 determine 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 63 **nursing facilities** (located in 58 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. 75% 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	22	54	10	12	18	4	0
Marquardt	6	64	0	6	5	1	0
Metro	19	68	4	15	17	2	0
Northeast	16	63	8	8	10	6	1
Southeast	23	67	9	14	15	8	0
UMass	11	54	9	2	9	2	0
Totals	97	62* *avg of sample, not avg of regions' average	40	57	73	23	1

The age of class members reviewed ranged from 21 to 99 as illustrated below.

Persons Reviewed: Age	
18-25	4
26-35	9
36-45	12
46-55	5
56-65	24
66-75	15
76-85	21
86+	7

B. FINDINGS

FINDING #1: SIX[1] OF THE 97 PEOPLE REVIEWED (6%) WERE FOUND TO BE RECEIVING 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)[2]

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:

1. Assessment ,
2. Team Composition,
3. Planning,
4. Staffing and Training,
5. Implementation of Active Treatment, and
6. Monitoring.

The successful functioning of each component is a required ***link*** in accomplishing Active Treatment overall. The failure to accomplish any of these individual components/links significantly limits the likelihood that the class member will be found to be receiving 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 deserving of emphasis.

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

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[1] One person was being served by each of the following: Radius Pedi Center, Eastwood Care Center, Highgate Manor, Everett Nursing Center & Rehabilitation, Catholic Memorial Skilled Nursing, and Marquardt Nursing Center.

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

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	# in Review	# / % “No”	# / % “Yes”	# / % “N/A”	Adjusted % “Yes”
23. Within 90 days after admission, has the IDT had accurate assessments or reassessments completed as needed to supplement the preliminary evaluation conducted prior to admission?	97	1 1%	1 1%	95 98%	50%
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?	97	63 65%	34 35%		
25. Does the comprehensive functional assessment identify ___’s presenting problems and disabilities and where possible, their causes?	97	62 64%	35 36%		
26. Does the comprehensive functional assessment identify ___’s specific developmental strengths?	97	66 68%	31 32%		
27. Does the comprehensive functional assessment identify ___’s specific developmental and behavioral management needs?	97	68 70%	29 30%		
28. Does the comprehensive functional assessment identify ___’s needs for services without regard to the actual availability of the services needed?	97	61 63%	36 37%		
29. Is there a comprehensive functional supports assessment, that is accurate, current, and includes:	87	81 93%	6 7%		
29.i. physical development and health;	97	50 52%	47 48%		
29.ii. nutritional status;	97	23 24%	74 76%		

FINDINGS: Assessments	# in Review	# / % "No"	# / % "Yes"	# / % "N/A"	Adjusted % "Yes"
29.iii. sensorimotor development;	97	41 42%	56 58%		
29.iv. affective development;	97	61 63%	36 37%		
29.v. speech and language development (communication);	97	46 47%	51 53%		
29. vi. auditory functioning;	97	62 64%	35 36%		
29.vii. cognitive development;	97	80 82%	17 18%		
29.viii. social development;	97	60 62%	37 38%		
29. ix. adaptive behaviors or independent living skills necessary for___ to be able to function in the community;	97	66 68%	31 32%		
29. x. and, as applicable, vocational skills.	97	44 45%	21 22%	32 33%	32%
30. Were the Comprehensive Functional Assessment(s) reviewed and revised as needed based on the person's needs.	97	88 91%	9 9%		

FINDING #2: ALMOST ALL CLASS MEMBERS (93%) HAVE NOT RECEIVED A COMPREHENSIVE FUNCTIONAL ASSESSMENT THAT IS ACCURATE, CURRENT AND INCLUDES ATTENTION TO THE REQUIRED DEVELOPMENTAL AREAS. (Q.29)

One class member had assessments in all fourteen areas listed above; two class members had assessments in twelve areas; three class members had assessments in eleven of the fourteen areas. The majority of the class members (73%) were assessed in seven or fewer of the fourteen areas.

By specific types of assessment, areas in which at least a majority of class members received the specific assessments include:

- 76% nutritional status;
- 58% sensorimotor (down from 69% in the January 2008 Report); and
- 53% speech and language development (down from 74% in the January 2008 Report).

Areas in which less than a majority of class members received specific types of assessments include:

- 48% physical development/health;
- 38% social development;
- 37% affective development (down from 51% in the January 2008 Report);
- 36% auditory functioning;
- 36% presenting problems/disabilities/causes and developmental/behavioral management needs;
- 35% age/implications at each stage and adaptive behaviors/independent living skills (down from 46% in the January 2008 Report);
- 32% specific developmental strengths (down from 49% in the January 2008 Report);
- 32% vocational skills for those for whom it was applicable; and
- 18% cognitive development (how the person receives and processes information).

In the listing above there are five areas cited as having a 10% or greater reduction in score since December 2007. This represents a quite significant shift because the data for the 35 people reviewed in the January 2008 Report are included in the data for the total of 97 people reported

here and reviewed to date. Thus for the 62 people reviewed in 2008, the Assessment area scores in these five areas are lower, resulting in the shift in overall scores.

FINDING #3: NINE OF 97 CLASS MEMBERS (9%) HAD A COMPREHENSIVE FUNCTIONAL ASSESSMENT REVIEWED AND REVISED AS NEEDED BASED ON THEIR INDIVIDUAL NEEDS. (Q.30)

FINDING #4: APPROXIMATELY ONE-THIRD (32%, DOWN FROM 49% IN THE JANUARY 2008 REPORT) 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. Generally, deficit based planning is not successful.

II. INTERDISCIPLINARY 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 of Mental Retardation (DMR) 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	# Review	# / % "No"	# / % "Yes"	# / % "N/A"	Adjusted % "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?	97	58 60%	39 40%		
32. Have appropriate nursing facility and specialized services staff participated in the IDT meetings?	97	49 51%	48 49%		
33. Was participation by other agencies serving _________ encouraged?	97	31 32%	36 37%	30 31%	54%
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)?	97	54 56%	43 44%		

FINDING #5: THE ROLLAND INTEGRATED SERVICE PLANS (RISP) FOR THIRTY-NINE CLASS MEMBERS (40%) WERE 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: AT THE MAJORITY OF IDT MEETINGS, KEY STAFF ARE MISSING FROM PLANNING MEETINGS. WITHOUT THEIR PRESENCE/INPUT 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 or have input to 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. Lack of compliance in Sections I and II demonstrates its consequence in planning.

FINDINGS: Adequacy of Planning	# Review	# / % "No"	# / % "Yes"	# / % "N/A"	Adjusted % "Yes"
35. Did the Team convene a meeting and develop a document called a RISP?	87[3]	1 1%	86 99%		
36. Does ________ have a RISP?	97	63 65%	34 35%		
37. Was the RISP developed within the first 90 days after admission?	87	1 1%	1 1%	85 98%	50%
38. Is ____'s RISP based on assessed needs and strengths and does it address major life areas essential to increasing independence and ensuring rights?	97	72 74%	25 26%		
39. Does the RISP contain objectives necessary to meet _________'s needs as identified by the comprehensive assessment?	97	70 72%	27 28%		
40. Are objectives organized in a planned sequence?	97	87 90%	10 10%		
41. Are objectives stated separately, in terms of a single behavioral outcome?	97	50 52%	47 48%		
42. Is each objective assigned projected completion dates?	97	79	18		

[3] Because of the change in the protocol since the Pilot, this question reflects scores of 87 people reviewed, not the total of 97 which includes the Pilot.

FINDINGS: Adequacy of Planning	# Review	# / % "No"	# / % "Yes"	# / % "N/A"	Adjusted % "Yes"
		81%	19%		
43. Are objectives expressed in behavioral terms that provide measurable indices of performance?	97	58 60%	39 40%		
44. Are the outcomes organized to reflect a developmental progression appropriate to ________?	97	76 78%	21 22%		
45. Are the outcomes assigned priorities?	97	87 90%	10 10%		
46. Does each written training program designed to implement the objectives in the RISP specify the methods to be used?	97	45 46%	52 54%		
47. Does each written training program designed to implement the objectives in the RISP specify the schedule to be used?	97	66 68%	31 32%		
48. Does each written training program designed to implement the objectives in the RISP specify the person responsible for the program	97	49 51%	48 49%		
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?	97	74 76%	23 24%		
50. Does each written training program designed to implement the objectives in the RISP specify the inappropriate behaviors, if applicable?	97	37 38%	7 7%	53 55%	16%
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?	97	38 39%	7 7%	52 54%	16%
52. Does the RISP describe relevant interventions to support ________ toward independence?	97	65 67%	32 33%		
53. Does the RISP identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found?	97	43 44%	54 56%		
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.	97	56 58%	27 28%	14 14%	33%
55. Does the RISP identify mechanical supports, if needed, to achieve proper body position, balance, or alignment?	97	57 59%	30 31%	10 10%	34%
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?	97	64 66%	17 18%	16 16%	21%
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?	97	41 42%	56 58%		
58. The RISP includes opportunities for ________ to have choice and self-management.	97	44 45%	53 55%		
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?	97	33 34%	64 66%		
60. Overall, is the RISP adequate to meet ________'s needs?	87	78 90%	9 10%		

FINDING #7: WHILE 99% OF THE CLASS MEMBERS WERE FOUND TO HAVE A DOCUMENT CALLED A RISP (Q.35), **ONLY 10% OF THOSE RISPS WERE FOUND TO BE ADEQUATE TO MEET THE CLASS MEMBER'S NEEDS.** (Q.60) [4]

Even though only 10% of the RISPs were found to be adequate overall, as demonstrated in the bullets which follow, some contained one or more of the components which are a part of development of an adequate RISP.

[4] Because of the change in the protocol since the Pilot, this and several questions which follow reflects scores of 87 people reviewed, not the total of 97 which includes the Pilot.

- 25 (26%) people had RISPs based on assessed needs and strengths that addressed major life areas essential to increasing independence and ensuring rights. (Q.38)
- 27 (28%) people had a RISP which contained objectives necessary to meet the class member's needs as identified by the comprehensive assessment. (Q.39)
- 52 (54%) people had a written training program designed to implement the objectives in the RISP which specified the methods to be used. (Q 46)
- 23 (24%) 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 to assess progress toward the desired objective. (Q.49)
- 53 (55%) people had RISPs which included opportunities for choice and self-management. (Q.58) This is down from 69% in the January 2008 Report.
- 64 (66%) 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 individuals 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 perform to implement it.

FINDINGS: Staffing and Training	# Review	# / % "No"	# / % "Yes"	# / % "N/A"	Adjusted % "Yes"
61. Have staff received training focused on skills and competencies directed towards ________'s	(scoring of this question is in the subparts which follow)				
61a. Developmental needs?	87	54 62%	33 38%	0 0%	38%
61b. Behavioral needs?	87	34 39%	23 26%	30 34%	40%
61c. and health needs?	87	56 64%	30 34%	1 1%	35%
62. Have staff demonstrated the skills and techniques necessary to administer interventions to manage the inappropriate behavior of ________	87	26 30%	15 17%	46 53%	37%
62. a. Did DAY/Specialized Services staff demonstrate the knowledge, skills and techniques necessary to administer interventions to manage the inappropriate behavior of ________?	87	16 18%	22 25%	49 56%	58%

FINDINGS: Staffing and Training	# Review	# / % "No"	# / % "Yes"	# / % "N/A"	Adjusted % "Yes"
62. b. Did Nursing Facility staff demonstrate the knowledge, skills and techniques necessary to administer interventions to manage the inappropriate behavior of ________?	87	23 26%	16 18%	48 55%	41%
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 ________?	87	19 22%	20 23%	48 55%	51%
63. Staff demonstrated the skills and techniques necessary to implement the RISP for ________.	87	49 56%	38 44%		
63.a. Did the Day/Specialized Services staff demonstrate the skills and techniques necessary to implement the RISP for _____?	87	15 17%	72 83%		
63.b. Did the Nursing Facility staff demonstrate the skills and techniques necessary to implement the RISP for _____?	87	46 53%	41 47%		
64. Staff reported that they have had and could describe what they had received as training to work with	87	61 70%	26 30%		
64.a. Did the Day/Specialized Services staff receive and describe training necessary to work with ______?	87	40 46%	47 54%		
64.b. Did the Nursing Facility staff receive and describe training necessary to work with _____?	87	58 67%	29 33%		
65. Is staffing sufficient to carry out ________'s RISP.	87	40 46%	47 54%		
65.a. Is Day/Specialized Services staffing sufficient?	87	27 31%	60 69%		
65.b. Is Nursing Facility staffing sufficient?	87	36 41%	51 59%		

FINDING #8: 41 OF 87 CLASS MEMBERS (47%) HAD NURSING FACILITY STAFF WHO DEMONSTRATED THE SKILL AND TECHNIQUES NECESSARY TO IMPLEMENT THE RISP. (Q.63b)

FINDING #9: 46% OF CLASS MEMBERS HAD DAY STAFF WHO WERE NOT TRAINED ON OR WHO COULD NOT DESCIBE HOW TO WORK WITH THE PARTICULAR NEEDS OF THE CLASS MEMBER; 67% OF NURSING FACILITY STAFF WERE EITHER NOT TRAINED OR CANNOT DESCRIBE THEIR TRAINING. (Q.64A and 64B)

FINDING #10: FOR 41% OF CLASS MEMBERS, NURSING FACILITY STAFFING WAS INSUFFICIENT TO CARRY OUT THE PERSON'S CURRENT RISP. (Q.65B) **(68% WERE INSUFFICIENT IN THE JANUARY 2008 REPORT)**

These findings depict enormous challenges. Over half of the existing staff members are not trained to work with the complex and unique needs of each class member. Many of the existing staff members do not demonstrate the skill to implement even the current RISPs.

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 or mental retardation/ developmental disabilities.

V. IMPLEMENTATION/RECEIPT OF ACTIVE TREATMENT

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	# Review	# "No"	#"Yes"	# "N/A"	Adj. "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.	97	83 86%	14 14%		
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.	97	74 76%	23 24%		
68. Does ________ have an active treatment schedule that outlines the current active treatment program and that is readily available for review by staff?	97	85 88%	12 12%		
69. Is data relative to accomplishment of the criteria specified in _________'s RISP objectives documented in measurable terms?	97	77 79%	20 21%		
70. Is there documentation of significant events that are related to _________'s RISP and assessments?	97	37 38%	59 61%	1 1%	1%
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.	97	49 51%	48 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?	97	91 94%	6 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?	97	83 86%	14 14%		
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?	97	75 77%	22 23%		
75. Did the activities and interactions you observed support the accomplishment of the RISP Objectives in _____'s active treatment program?	97	59 61%	38 39%		

FINDING #11: FOURTEEN CLASS MEMBERS (14%) RECEIVED 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 CURRENT RISP. (Q.66) It is important to note that this finding is different from FINDING #1 which identified only six persons who were found to be receiving a continuous active treatment program *in accordance with requirements of federal regulations* (Q.72). Findings #11 and #12 (which follows immediately) do not depend upon the adequacy (or lack thereof) of the RISPs. They simply address the extent to which the existing RISPs were being implemented.

FINDING #12: TWENTY-THREE CLASS MEMBERS (24%) HAD A RISP WHICH WAS IMPLEMENTED BY ALL STAFF WHO WORK WITH HIM/HER. (Q.67)

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. 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" is not met.

FINDING #13: TWENTY-TWO CLASS MEMBERS (23%) HAVE A PROGRAM "DIRECTED TOWARD THE PREVENTON OR DECELERATION OF REGRESSION OR LOSS OF CURRENT OPTIMAL FUNCTIONAL STATUS." (Q.74) For the remaining 77%, the finding is quite significant in that the majority of class members

present aging, physical disabilities and/or other challenging behaviors which, without proactive intervention, result in physical and/or mental regression.

VI. MONITORING AND FOLLOW UP

Even with the best of RISPs effectively implemented, if monitoring and follow up does not occur the RISP may 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	# Review	# "No"	#"Yes"	# "N/A"	Adj. "Yes"
76. Was the RISP reviewed, at least, by the Case Manager/Service Coordinator?	97	20 21%	77 79%		
77. Was the RISP reviewed/revised when _________ successfully completed an objective or objectives identified in the RISP?	87	39 45%	46 53%	2 2%	54%
78. Was the RISP reviewed/revised when _________ regressed or lost skills already gained?	97	28 29%	28 29%	41 42%	50%
79. Was the RISP reviewed/revised if ________ was failing to progress toward identified objectives after reasonable efforts were made?	97	26 27%	31 32%	40 41%	54%
80. Was the RISP reviewed/revised when _________ was being considered for training towards new objectives?	97	16 16%	45 46%	36 37%	74%
81. Was the RISP reviewed at least annually?	97	17 18%	80 82%		

FINDING #14: 79% OF CASE MANAGERS/SERVICE COORDINATORS DID FULFILL THEIR RESPONSIBILITY TO REVIEW THE RISP. (Q.76) 21% did not. 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 # 15: FOR APPROXIMATELY HALF 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 #16: IT APPEARS THAT THE RISP WAS ALMOST ALWAYS (82%) 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 18% OF THE CLASS MEMBERS, CHANGES WERE NOT EVEN MADE ANNUALLY AS NEEDED. (Q.81)