Task Force on the Quality of Services for Individuals with Developmental Disabilities

The Task Force is charged with continuing to explore improvements to the oversight of DDA licensed services. It is essential that everyone's voice is heard in this process—individuals with intellectual and developmental disabilities, family members, friends, advocates, providers, associations, government agencies, and other stakeholders. The task force will deliver recommendations in January 2015.

Task Force Meetings

November 19, 2014, 10:00 am-Noon

December 3, 2014, 10:00 am-Noon

January 7, 2014, 10:00 am-Noon

All meetings will be held at OHCQ in the conference room:

Office of Health Care Quality
Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue
Catonsville, MD 21228

410-402-8001

Bernard Simons, DDA (Co-Chair)
Tricia Tomsko Nay, OHCQ (Co-Chair)

- Patricia Arriaza, Governor's Office for Children
- Brian Cox, DD Council
- Kathleen Durkin, Arc of Baltimore
- Janet Furman, DDA
- Darlene Ham, DHR
- Margie Heald, OHCQ
- Margaret Holmes, Legal Aid
- Laura Howell, MACS
- Sharon Krevor-Weisbaum, Brown Gold
- Christine Marchand, ARC of Maryland
- Jason Noel, Mortality Committee
- Susan Panek, Medicaid
- Nancy Pineles,MDLC
- Valerie Roddy, DDA
- Dr. Christopher Smith, KKI MCDD
- Shelley Tinney, MARFY

Task Force on the Quality of Services for Individuals with Developmental Disabilities

AGENDA

November 19, 2014

10:00 a.m. – 12:00 noon

Office of Health Care Quality
Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue
Catonsville, MD 21228

- Welcome
- Introductions
- Purpose of Task Force
- Overview of Children's Services
  - DHR
  - OHCQ
  - Children's Legislative Report
- Discussion of Children's Services
  - Licensure/Re-Licensure
  - Oversight
  - Investigation of Complaints/Self-reports
  - Administrative Actions
- Wrap-up

Adjournment

Next Meeting: December 3, 2014
10:00 a.m. – 12:00 noon

Meeting Notes

November 19, 2014

1. Welcome – Bernie Simons, Deputy Secretary of Developmental Disabilities
2. Introductions
    a. Purpose of task force to explore the oversight and improvements of DDA licensed providers
    b. Open and free discussion
    c. Request any documents
3. Overview
    a. DHR – license children's services in Maryland. Annual and re-license every two years
    b. COMAR 14.31.05, 14.31.06, and 14.31.07
    c. Quarterly monitoring visits
    d. Expanded quarterly monitoring visits to non-DHR licensed providers (DDA licensed providers)
    e. Entrance conference; physical plant inspections; review logs, contact notes & records; interview staff and kids in service; and exit conference (address any findings)
    f. Technical Assistance and Corrective Action Plan
    g. Findings of deficiencies relate to health and safety-respond w/in 10 business days
    h. Reports are sent to OHCQ designee w/in 30 days
    i. Joint monitoring with OHCQ DD Unit staff – annually or more frequently as needed

Q & A

How many sites? 133 DHR licensed provider sites (70 providers) and 3 DDA licensed providers for medically fragile children. (DDA licenses 17 children's providers total)

How many children? About 1,000. How many are DD? Have to get that breakdown

How often are the DDA licensed sites visited? OHCQ licenses and does site visits.

How many children are in the 3 DDA licensed providers for medically fragile children? Currently there are three providers for medically fragile children. The largest provider has 35 children.

Are there any joint licensed providers? No.

Are the children in the medically fragile homes funded by DHR, DDA, or combination? Primarily DHR, but Medicaid may provide some nursing services.

Are any of the licensed provider sites just for children or include adults? Exclusively children. Once they turn 21 they must move to an adult licensed home.

What is the difference between the DHR homes and DDA homes? DDA homes are for medically fragile children with DD

4. OHCQ

a. Agent of DDA in regulating DDA licensed providers under COMAR 10.22
b. Unit of 35 employees
c. Two main units: Licensing and investigations
d. 17 children's providers, including 3 medically fragile children
e. Incidents review, investigations and administrative actions
f. Process is the same for children and adult providers
g. Self-reports and complaints
h. Administrative reviews were not tracked in the past
i. 4,222 complaints and self-reports last year
j. 304 on-site investigations
k. Trying to establish a system to track all the reports
l. Recognize the need to track differently
m. Can take referrals from other state entities
n. Can initiate an investigation if necessary
o. Investigation can be a desk review or on-site
p. Report from investigation or survey includes findings of substantiated or unsubstantiated and any deficiencies
q. Deficiencies require a plan of correction
r. Technical assistance can be requested and provided
s. Recommendations
t. Sanctions can be imposed
u. Can be appealed to OAH and to the Circuit Court

Q & A

What is considered "serious"? Seriousness is defined in regulations.

Timeline of investigation? Varies. Death investigations take the longest, maybe months due to ME report. Can send a letter to the provider to make them aware of the investigation and issue. DDA clinical team, regional nurses and QE regional staff can provide TA.

Timeline of accepting or rejecting PoC? Depends on completion or comprehensiveness of plan. Timeframe for earlier stages-Complaints and self-reports are triaged. Is this outlined somewhere? In the PORII

Is each incident triaged on the day it is received? No. Usually triaged within a few days. Also depends on the type of incident and how the provider categorized the incident. Multiple agencies receive the report. Sometimes hear about an incident before a report is filed.

Who is in charge? OHCQ serves as the agent of DDA

5. General Discussion

a. How do the children's programs fall under PORII? DDA licensed provider is required to follow PORII. The children's programs licensed by DHR follow DHR guidelines.
b. Three medically fragile – frequency of site visits? DHR monitor quarterly.
c. In four years, OHCQ was made site visits to the 4 providers to medically fragile children over 24 times. Minimum requirements is 24 months.
d. Are you finding that the providers have gotten good at reporting and knowing what they can do internally? The medically fragile providers ask continually about PORII. More recently, DDA is seeing over-reporting. Adult programs seem to have a better understanding.
e. PoC – what follow up takes place to ensure that PoC's are implemented? Depending on the scope and severity of the issue, DDA or OHCQ can go out to do a check on compliance with a plan of correction.
f. 3 children's staff and 2 mortality staff – plus coordinator
g. Over 3,100 DDA sites – 220 licensed providers

6. Review of licensure process
    a. Immediate notification – can demand that provider takes immediate action
    b. Summary suspension – reassignment of people being served
    c. Can temporarily remove and relocate from a specific site
    d. Checked for licensure, capacity and services – license is issued and sites are registered to the license. Each site has to be inspected to confirm service offered and capacity.
    e. Doesn't the state check the tax status? Yes
    f. DHR has recently instituted voluntary self-report on financial stability every six months
    g. Identify a specific list
    h. OHCQ is using a sampling of sites and providers. Make a decision about which ones to visit. Can't get to every site every year
    i. In order to meet the letter of the law need more than double the number of existing staff in the DD unit

7. On-site visits
    a. Can inspect a site or a provider at any time. If a site or provider is new, an inspection occurs before receiving any individuals or placements
    b. Existing providers and sites – any changes
    c. Regular survey – using a targeted survey
    d. Follow up to Plans of Correction or settlement agreements
    e. Compliance of intermediate sanction
    f. All are unannounced now
    g. Exit conferences – do them but they are different. In DD, do one exit conference in person. Will have an idea of what the issues are. Not enough staff to do a detailed second conference.

Q & A

Provider shared that they were surveyed but did not have an exit conference. Received report in the summer and were surprised by some of the findings.

OHCQ sometimes has to decide between doing an investigation or conduct an exit conference. Focus on core functions. They have recently moved from a paper driven process to reporting on survey and investigations in a database called ASPEN.

What is the interaction with DHR reporting system? Recently initiated discussions on how to share information.

What is the overview focus of the task force? What about the broader issues and the good stuff such as accreditation. The focus is to fix the deficiencies in the system but also think about the broader issues.

In closing, minutes will be sent out prior to the next meeting. A Webpage will be set up to share info.

Next meeting scheduled for December 3, 2014 at 10:00 AM at OHCQ.