



STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 8, 2014

Dear Chair Hammen,

This letter is in response to your request for information about units in the Department of Health and Mental Hygiene (DHMH) and the Department of Human Resources (DHR) that have responsibilities for medically fragile children in group homes. Specifically, your request was for an organizational chart showing the units' responsibilities, what funding they control, and how they relate to each other.

DHMH and DHR are working closely together to improve the oversight of group homes for medically fragile children. In November, DHMH convened a task force on the quality of services for individuals with developmental disabilities. DHR has been integrally involved in the discussions related to services for children. The task force has met twice and will have a third meeting on January 7. A list of the task force's membership is attached (attachment 1). To facilitate communication between the task force members as well as to the public, a webpage has been established at <http://dhmh.maryland.gov/ohcq/SitePages/DDTaskForce.aspx>

The task force is assisting DHMH and DHR in clarifying the roles and responsibilities within and between the agencies that have oversight to providers that serve medically fragile children. This objective is closely aligned with your request. The task force recognizes that this step is critical to improving care for this vulnerable population. The input of the task force is essential in this process, as it is only through our combined efforts that we will succeed in enhancing the quality of services for individuals with developmental disabilities. To date, the coordination of services between the various agencies has been built, in part, upon institutional knowledge. Therefore, not all of the related processes and steps have been previously set forth in express written policies. DHMH and DHR are closely collaborating toward this objective.

I have attached two documents that the task force is reviewing as it develops recommendations for improving DHMH's oversight of providers that serve individuals with developmental disabilities:

- OHCQ's Review of Services for Medically Fragile Foster Care Youth, which was completed in October 2014 and includes the recommendations that will inform the task force's work (attachment 2).
- Report of Findings and Recommendations for the Office of Health Care Quality

Regarding the Developmental Disabilities Survey Process, completed by Tony Records and Associates in November 2007 (attachment 3).

As we mentioned in our October 17 letter, DHMH expects to report on the clarification of roles and responsibilities between the agencies by January 2015. We believe that by that time, we will be able to provide a fuller answer to your request.

We hope this information is helpful. We appreciate your commitment to improving care for medically fragile children in foster care. We cordially invite you to attend our January 7 task force meeting to participate in these critical efforts. If you have questions, please contact Allison Taylor, Director of Governmental Affairs, at (410) 767-6481.

Sincerely,

A handwritten signature in cursive script that reads "Patricia Tomsko Nay, MD".

Patricia Tomsko Nay, MD, CMD, CHCQM, FAAFP, FAIHQ, FAAHPM
Executive Director and Acting Medical Director
Office of Health Care Quality
Maryland Department of Health and Mental Hygiene

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

Membership:

- Bernard Simons, DDA (Co-Chair)
- Tricia Tomsko Nay, OHCQ (Co-Chair)
- Patricia Arriaza, Governor's Office on 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

Review of Services for Medically Fragile Foster Care Youth

Office of Health Care Quality
Maryland Department of Health and Mental Hygiene
October 2014

Summary

As part of an on-going quality process, the Office of Health Care Quality (OHCQ) in the Maryland Department of Health and Mental Hygiene (Department) has reviewed the recent regulatory history of four facilities that provide services to medically fragile foster care youth. The purpose of the review was to identify areas for improvement in oversight.

OHCQ has had multiple contacts with all four providers of care for medically fragile foster children since January 2011. Statutory mandates with respect to the renewal survey frequency every two years were met. This review did not find unexpected serious gaps in the oversight of group homes for medically fragile foster care youth; however, several areas for improvement in oversight of these facilities were identified. Recommendations include:

Recommendation 1: OHCQ recommends clarification and documentation of the roles and responsibilities within and between agencies that provide oversight to these providers. Projected date: January 2015

Recommendation 2: Each government agency should maximize data point collection for each oversight activity it carries out. An analysis of that data should be shared with other agencies, as appropriate, through formal processes. Projected date: June 2015

Recommendation 3: The initial licensure process for programs for medically fragile children should be reviewed and revised to ensure that applicants have a sustainable business model. Projected date: February 2015

Recommendation 4: As the lead on investigations of complaints and self-reported incidents, OHCQ should develop formal processes to ensure that coordination with other agencies occurs in a timely and consistent way. Projected date: January 2015

Recommendation 5: The children's unit at OHCQ should receive an additional position to serve as a coordinator to implement these recommendations and ensure oversight over the medically fragile children's homes. Projected date: December 2014

To continue progress in this area, Bernie Simons, the new Deputy Secretary of Disabilities, and Tricia Tomsko Nay, Executive Director and Acting Medical Director of OHCQ, will be convening and co-chairing a task force on the quality of services for individuals with developmental disabilities. 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, legislators, and other stakeholders. The Department of Human Resources (DHR) will be integrally involved in the parts that relate to services for children in the agency's care. The task force will deliver an initial set of recommendations in January 2015.

Background

OHCQ is the agency within the Department of Health and Mental Hygiene charged with monitoring the quality of care in Maryland's 15,043 health care facilities and community-based programs. OHCQ licenses and certifies health care facilities; conducts surveys to determine compliance with state and federal regulations; and educates providers, consumers, and other stakeholders through written materials, websites, and presentations.

In January 2013, the OHCQ implemented a strategic planning process that included an evidence-based review of survey protocols in the context of the statutory and regulatory requirements. One of the broad organizational goals is regulatory efficiency, that is, how to best use OHCQ's limited resources to fulfill its mission.

Interventions for improving regulatory efficiency throughout the agency have included a regulatory and statutory review; revised survey processes, where appropriate; revised initial and on-going employee training; streamlining hiring processes; improving recruitment efforts; streamlining the provider application process; sustaining an internal quality improvement process; interacting proactively with stakeholders and providers; utilization of social marketing; and streamlined and consistent information management processes.

Review of Programs for Medically Fragile Children

In order to provide effective and efficient oversight and ensure the quality of services being delivered, OHCQ completed a focused review of programs for medically fragile children. These programs serve foster care youth who are medically fragile and may require a ventilator and other complex care, as is described in COMAR 14.31.05.03. The providers must meet standards, including consultation by a pediatric medical specialist, special equipment, training for staff in the needs of each child, and emergency medical plans for each child (COMAR 14.31.07.07). Providers in the program for medically fragile children must renew their license every two years (COMAR 14.31.05.06C).

For many years, OHCQ has placed a priority on oversight of providers serving children with developmental disabilities. From 2011 to the present, there have been four providers serving this population: Center for Social Change, Lifeline, Second Family, and Total Quality.

Methodology

OHCQ staff reviewed the survey reports and investigations of complaints and self-reported incidents since January 2011 for all four providers serving medically fragile foster care youth. Staff reviewed processes within OHCQ, including initial licensure, relicensure, triage of self-reported incidents and complaints, survey process, deficiency statements, plans of correction, administrative actions, data management, record keeping, and work flow. Additionally staff reviewed collaboration with other parts of the Department and other agencies, including Department of Human Resources, Governor's Office for Children, Developmental Disabilities Administration, Medicaid, Office of the Attorney General, and Office of the Inspector General. Feedback was solicited from providers, advocacy groups, and other stakeholders.

Findings

OHCQ has had multiple contacts with all four providers of care for medically fragile foster children since January 2011 (Table). Statutory mandates with respect to the renewal survey frequency every two years were met. Reviews identified deficiencies at each of the four programs, which providers addressed through corrective actions. When considering the table, consideration must be given to the fact that not all deficiencies are equivalent in scope and severity. Note that Total Quality recently began services and there has only been one survey. In the case of LifeLine, the facility surrendered its license after serious concerns were identified by OHCQ.

	Center for Social Change	Lifeline	Second Family	Total Quality
First OHCQ survey (completed after the first child is placed)	May 2003	December 2000	July 2002	July 2014
Total licensed capacity at all of the provider's sites	14 beds total at 3 sites	15 beds total at 5 sites	53 beds total at 11 sites	3 beds total at 1 site
Licensure status as of September 2014	Active	No longer licensed	Active	Active
Number of deficiency statements from January 2011 – August 2014	4	4	5	1
Number of deficiencies from January 2011 – August 2014	33	42	113	4
Number of deficiencies from January 2011 - August 2014 per licensed capacity	2.4	2.8	2.1	1.3

The table below summarizes the eleven most frequently cited deficiencies in these children's programs from January 2011 to August 2014. Seven tags involved lack of documentation of required training, two tags involved requirements for emergency drills, one tag involved lack of documentation of the outcome of a children's protective service check, and one tag involved behavior plans that were incomplete or not up to date.

Tag	# of Times Cited from 1/2011 – 8/2014	Description
Y2335	6	No documentation of the required 40 hours of initial training
Y2380	6	No documentation of training in discipline and behavior management techniques
Y2405	6	No documentation of training in special needs of the population
Y3160	6	No documentation that emergency drills were held monthly
Y2390	5	No documentation of annual infection control training
Y3175	5	No documentation that emergency drills included emergencies other than fires
Y4795	5	Behavior plan was not current or was incomplete
Y2275	4	No documentation of the outcome of a children's protective services check
Y2370	4	No documentation of training in child abuse and neglect
Y2395	4	No documentation of training in parenting issues, collaboration with families, and supporting children and families
Y2400	4	No documentation of training in psychosocial and emotional needs of children, family relationships, and separation

The next sections of this report examines specific areas of oversight, including opportunities for improvement.

General Responsibilities

Oversight of group homes for medically fragile foster care youth involves various methods by multiple agencies. While the system needs some redundancies to avoid missing important issues, unnecessary duplication leads to inefficiency. Historically, the Developmental Disabilities Administration issues the license. OHCQ conducts relicensure surveys and investigates complaints and self-reported incidents. The Department of Human Resources (DHR) provides payment and monitors these providers through quarterly visits from its licensing coordinators. Each month, DHR caseworkers also see the youth assigned to them who are placed with these providers. The agencies share information to coordinate the oversight of the services delivered to this medically fragile population.

In monitoring the quality of care and delivery of services, there are many potential red flags: poor performance on a relicensure survey, financial instability, administrative concerns, increased number and/or severity of complaints, and significant deviation in the number of self-reported incidents. Using information from multiple sources, OHCQ investigates the provider and cites noncompliance with regulations. A deficiency report is issued and the provider must complete and submit an acceptable plan of correction to the agency. If indicated, administrative actions may be imposed for serious noncompliance with the regulations.

Not every red flag is a predictor of current or potential system failures in a provider. For instance, a provider facing bankruptcy may provide high quality care until the last day of service. Conversely, a provider with the largest profit margin in their industry may be providing poor quality care. While financial instability and other concerns may be a red flag, each situation is unique and must be examined in the larger context of available information.

This review has found that while front line staff between agencies communicate frequently, processes for communication and role definition can be better delineated. Greater clarity in the roles, processes, and procedures will ensure that agencies provide coordinated oversight. This is particularly important as the State has an aging workforce. At OHCQ, fifty-one percent of the staff are eligible for retirement now or within five years. As new employees retire and individuals assume new roles, it is crucial that processes, policies, and procedures are well documented to ensure clear transitions. Process description and documentation also provides an opportunity for reassessment to determine how to most efficiently and effectively conduct oversight of these providers.

Recommendation 1: OHCQ recommends clarification and documentation of the roles and responsibilities within and between agencies that provide oversight to these providers. Projected date: January 2015.

Data Management

The Department's ability to collect and analyze data is limited by software, technology, and time. While OHCQ staff have the ability to analyze the data in meaningful ways to enhance the quality of oversight services, the above limitations prevented the agency from doing so routinely in the past. OHCQ oversees the quality of care in 15,043 providers and issues tens of thousands of deficiencies each year. There are multiple systems that track large amounts of data, but unfortunately not all of these systems can communicate with each other. Some tracking is still done manually or on a Microsoft Excel spreadsheet.

Early in 2013, OHCQ began utilizing software licensed to OHCQ by the Centers for Medicare and Medicaid Services for the developmental disabilities unit. Improving record retention, data point collection, and data retrieval will center on maximizing use of the powerful software. Moving forward, this will facilitate data management and survey activities in the unit. Additional benefits of this transition will be seen over the next year as the software is more fully implemented.

Maximizing existing technology to increase staff efficiency and effectiveness and planning for future technology is essential to all agencies involved in oversight. OHCQ is engaged in an ongoing process of making more data points, documents, and agency findings accessible in its comprehensive software for tracking all its licensees. However, this work is developing outside of potential coordination with others.

Recommendation 2: Each government agency should maximize data point collection for each oversight activity it carries out. An analysis of that data should be shared with other agencies, as appropriate, through formal processes. Projected date: June 2015

Initial Licensure Process

There are many steps in the current initial licensure process to ensure that applicants are equipped to provide quality services in a sustainable business model; however, the administrative challenges that were later identified as facing Lifeline, Inc. has identified opportunities to strengthen the licensure process for this and other provider types. OHCQ, DHR, and DDA have many areas of expertise, but their staff are not expert at reviewing business plans, assessing the sustainability of financial models, and identifying fraud and abuse.

Provider solvency and liquidity can impact continuity of care. Application for a new license should require documentation that demonstrates a sound business plan and capital to provide and sustain the care described in the program service plan. The content of the application that would demonstrate acceptable financial preparedness is best determined by state agencies with expertise in this area.

However, the potential for financial strain to impact continuity of care makes the business plan a critical component to initial licensure.

The importance of tightening up the initial licensure process is paramount in our long-term ability to serve this population. This has countless benefits downstream for all parties involved. Investment of time and effort on the front end helps to ensure quality services are provided in a sustainable model.

Recommendation 3: The initial licensure process for programs for medically fragile children should be reviewed and revised to ensure that the applicant has a sustainable business model. Projected date: February 2015

Investigations of Complaints and Self-Reported Incidents

Complaints and self-reports are potential red flags that a provider may not be adhering to sound processes or may identify faulty processes. It is crucial that these potential problems are promptly triaged and investigated, as indicated, to ensure the quality of the services being delivered. Investigations are done on-site or through administrative reviews, as appropriate.

After review of the provider's incident report, many self-reports do not require any further action. Others may require coordination with other state and local agencies, including DHR, Governor's Office for Children, DDA, Children's Protective Services, and law enforcement. While this happens through communication at a staff level, there is a need for a more formal documentation of this process.

Recommendation 4: As the lead on investigations of complaints and self-reported incidents, OHCQ should develop formal processes to ensure that coordination with other agencies occurs in a timely and consistent way. Projected date: January 2015

OHCQ Staffing

OHCQ employs three full-time staff to oversee quality in 17 group homes that provide services to medically fragile foster care youth. While this staff has been able to conduct required inspections and review complaints and self-reports, it is not sufficient for the full range of planning, policy review and revision, and interagency coordination needed. Additional human resources are needed to review and revise the plans contemplated by the other recommendations and establish an improved oversight process.

Recommendation 5: The children's unit at OHCQ should receive an additional position to serve as a coordinator to implement these recommendations and ensure oversight over the medically fragile children's homes. Projected date: December 2014

Conclusion

This review did not find unexpected serious gaps in the oversight of group homes for medically fragile foster care youth. Relicensure surveys were conducted with the required frequency and complaints and self-reports were triaged and investigated. However, the review did find multiple areas for improvement. Some of these lessons that we learned are applicable to other provider types. System improvement will require the active involvement of stakeholders associations, and advocates and that the agencies be transparent with them about process improvement efforts. By unnecessarily decreasing the administrative burdens of providers; simplifying processes; implementing evidence-based changes to the survey process; enhancing training and technical assistance; and optimizing data analysis; we can better ensure quality for individuals receiving services.

With limited resources, we must focus our skills on the timely investigation and resolution of complaints and self-reported incidents to best protect individuals. There is a need for on-going strategic planning and quality improvement processes that continually examine each agency's efficiency and effectiveness. Through these actions, we can create a system that will better protect the health and safety of individuals with intellectual and developmental disabilities throughout Maryland.

Moving Forward

OHCQ has applied the lessons learned from this and other reviews to other provider types, including those serving adults with developmental disabilities. Lasting system improvement requires an on-going commitment to a quality improvement process based upon a collaborative inter-agency strategic plan including widespread accountability. The Department is committed to such a process rather than quick fixes, unattainable assurances, or uncoordinated actions among multiple agencies.

Bernie Simons, Deputy Secretary of Disabilities, and Tricia Tomsko Nay, Executive Director and Acting Medical Director of OHCQ, will be convening and co-chairing a task force on quality oversight of services for individuals with developmental disabilities. 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, legislators, and other stakeholders. DHR will be integrally involved in the parts that relate to services for children in the agency's care. The task force will deliver an initial set of recommendations in January 2015. Though we look at the issues through different perspectives, it is only through our combined efforts that we will succeed in enhancing the quality of services for individuals with developmental disabilities.

**Report of Findings and Recommendations for the Office of Health Care Quality
Regarding the Developmental Disabilities Survey Process**

November 15, 2007

Introduction

Pursuant to Blanket Purchase Order #M00B7200571, this report is provided by Tony Records and Associates, Inc. (TRA, hereinafter referred to as Contractor) to the Director of the Office of Health Care Quality (OHCQ). The Contractor is required to submit a report with recommendations to address the efficiency and effectiveness of the process for surveying licensed community services for people with developmental disabilities. As of the date of this report, all activities in the review of the survey process have been completed.

This review was conducted solely by Tony Records, President of TRA. Mr. Records has more than 33 years of experience in services for people with developmental disabilities. He has reviewed services for people with disabilities in twenty-two different states.

This report includes a description of activities of the Contractor, acknowledgements, findings and recommendations.

The Contractor engaged in the following activities:

1. Participated in initial meetings with OHCQ Director and other key staff to clarify tasks, establish liaisons and develop work schedule.
2. Reviewed survey documents, regulations, manuals and protocols used by OHCQ for surveys.
3. Interviewed five surveyors to determine how surveys and investigations are conducted.
4. Participated in two additional meetings with OHCQ staff to discuss survey process and possible recommendations.
5. Accompanied three OHCQ surveyors to observe survey process and protocol.
6. Conducted research on the feasibility of "deeming" process utilizing national accreditation bodies.
7. Reviewed possible sampling methodologies for provider surveys.

Acknowledgements

Throughout the review process, OHCQ staff have been fully cooperative, forthcoming and accommodating with the Contractor. All information requested by the Contractor has been provided on a timely basis. The Contractor would like to particularly acknowledge the Program Manager of the Developmental Disabilities Unit for her assistance in coordination efforts, scheduling of meetings and provision of necessary documents.

Without exception, the OHCQ surveyors, investigators and management staff that were interviewed and observed by the Contractor demonstrated a high degree of competence, commitment, knowledge and professionalism in performing their respective functions and duties. In almost every instance of the Contractor's observations in the field, OHCQ staff were working extra hours and taking the additional time to ensure thoroughness in their reports and findings. Suggestions and recommendations in this report are designed to enhance OHCQ's productivity and effectiveness. Many of the OHCQ staff also contributed valuable suggestions that are incorporated as part of this report.

Findings and Recommendations

Finding #1: Staffing resources needed to conduct surveys and investigations in accordance with state and federal law and regulations are significantly inadequate.

Although there are numerous findings and recommendations listed below, there is a single overarching concern that affects the survey process more than any of the others. Simply put, there are far too few surveyors. As of the time of this evaluation, there were 11.5 FTE community licensure surveyors (2 unfilled positions), 7 FTE incident investigators and 3 mortality review investigators.

Over the past ten years, from 1996 to 2006, the number of people with developmental disabilities in Maryland receiving Medicaid-funded out-of-home community residential support increased from 3,848 to 6,373 or more than 65%¹. There has also been a continuous growth of state funded non-Medicaid services. The entirety of this growth has occurred in community-based services. The number of small homes serving one, two or three people has been the highest area of growth in residential services.

During this same ten year period of continuous growth of people with developmental disabilities being served, the number of surveyors of community services has hardly increased at all. In addition, during this period of time, the standards for community services as well as the survey processes have become increasingly complex. As a result, there is currently a significant ongoing backlog of licensing surveys, incident investigations and mortality reviews. While there are some recommendations below that may streamline the survey process to some extent, this will not be nearly enough. More resources are needed.

Recommendation #1: *OHCQ should request at least 20 additional survey staff and five (5) additional administrative staff.*

There should be a total of at least 25 FTE licensure surveyors, 10 FTE incident investigators and 5 FTE mortality investigators to ensure that OHCQ complies with current Maryland statutes and regulations. In addition, there are many tasks that surveyors undertake (such as data entry, scheduling and document preparation) that could be performed by administrative staff. Each survey team should have sufficient administrative support to ensure timely report production and dissemination and administrative preparation for upcoming surveys and investigations.

¹ August 2007, Residential Services for Persons with Developmental Disabilities, University of Minnesota

Annual licensing surveys are complex and lengthy processes. For a large community services provider for example, an annual survey can take as many as seventy-five surveyor days. Even for a moderate size community provider serving approximately 50 people in residential and day services, as many as 18 surveyor days are needed from start to finish of the survey process. As stated above, the number of small homes for people with developmental disabilities continues to expand. In some instances, the traditionally larger five and six-person homes are converting to two smaller settings. While this conversion is generally considered a very positive development for the overall quality of individual services, it also translates to additional residential settings that require on-site reviews by surveyors. On a parallel with the workload for licensing surveyors, the growth in community services has a similar impact on the workload of the incident investigators and mortality investigators.

Over the past year, the communication between OHCQ management and the provider community has been greatly enhanced. One function that should be expanded by OHCQ, however, is provider technical assistance. Interviews with providers revealed that there is much clarification needed on the interpretation of licensing and investigation requirements. This lack of clarity often leads to unnecessary deficiencies in licensing reviews and investigation protocols that result in developing and reviewing plans of corrections. Plans of corrections require a significant amount of time and energy for service providers and surveyors alike. Ongoing technical assistance sessions between OHCQ surveyors, DDA and community services providers could alleviate many unnecessary deficiencies and, consequently, improve the overall quality of the service delivery system. Currently, the workload of surveyors is far too burdensome to allow for ongoing technical assistance communication between OHCQ surveyors and community service providers. The addition of more surveyors as recommended above would allow for the technical assistance function of OHCQ to be further developed.

Finding #2: - The data and information systems used by surveyors are cumbersome, inefficient and often not operational.

Currently, there is no single system of collecting, sharing and utilizing data for people with developmental disabilities in Maryland. As a result, there are multiple systems in place that have severe limitations and are minimally effective. There is a consistent theme communicated by surveyors – a new data system is needed. Anecdotally, when one surveyor was asked about the data system, she responded by asking “What data system?” It was reported to the Contractor repeatedly by surveyors that the current ASPEN system is often not operational and/or slow. The current system also requires the re-entry of much demographic data already in other systems. In many instances, surveyors needed to contact DDA or community service providers directly to verify the site locations or the names of the individuals who live there. It is clear that real-time, accurate information is necessary to support the various survey functions of OHCQ. Also, the current system is not amenable to electronically downloading or transferring information in order to be incorporated into survey reports. There are also other less significant deficiencies in the current system, such as a lack of spell-check, requiring surveyors to take additional time in editing reported information.

Recommendation #2: The current data and information system should be replaced with a real-time, server-based system that has interface capabilities with the DDA system.

Of all of the needs expressed by the surveyors and investigators, the need most repeated was a single data system that can be used in conjunction with DDA data. Although the Contractor did not have the ability to conduct a surveyor time/effort evaluation, it was quite clear that accessing current information and re-entering demographic information is a major time-waster in their typical workday. A comprehensive information system that

interfaces with DDA could also assist DDA in maintaining information from OHCQ that could be used to support program related decisions. For example, if DDA was negotiating with a community services provider to expand or provide a new service, they would have current information immediately available related to the quality and performance of that particular provider.

An additional but related recommendation is for surveyors and investigators to be provided with available technology assistance to increase efficiency and productivity. For example, global positioning system (GPS) devices and PC wireless internet cards are now available at a reasonable cost. These devices would assist surveyors a great deal as they are constantly traveling statewide and the benefit of being able to locate new sites as well as the capability to connect to the internet while on site location far outweighs the relatively small cost.

Finding #3 – The operational components of the licensure survey processes and instruments are cumbersome and require redundant steps by surveyors.

While the Consultant fully appreciates the thoroughness in which licensure surveys are conducted, too much time and effort is devoted to excess document review and re-review. Surveys of even moderate size community providers often take weeks of time by survey teams and more than a month for large providers. Much of this time is spent verifying documentation, reviewing staff training and personnel records and entering and re-entering the same demographic and identifier information. Notes are often hand-written and transcribed at a later date. In some instances, documents are reviewed merely for their existence with no review of content or quality. As stated earlier, surveys of a single provider can consume up to seventy surveyor days. This task can be shortened with some reasonable changes in methodologies and sampling techniques.

Recommendation #3: *The licensure survey process should be significantly revised and streamlined to allow for preliminary self-evaluation, revised sampling techniques and document certification.*

Most of the on-site time by surveyors should be spent interviewing individuals with disabilities and staff, observing services and supports and reviewing relevant program documents. Currently, much of the time is spent reviewing documents and verifying the existence of provider records. For example, a large amount of time is spent reviewing staff training records. This process alone could be greatly reduced by the implementation a provider certification process confirming that specific training requirements have been completed. In some instances, OHCQ may choose to verify the certification through a sampling methodology, but would not need to conduct a comprehensive review of every training record.

Another consideration would be to reduce the sampling size of individuals who receive a comprehensive review. Using staff training documentation as an example once again, it is perfectly reasonable to conduct a much smaller portion of the individuals already in the survey sample to confirm whether the provider complies with staff training requirements.

A third consideration is requiring providers to conduct their own self evaluation just prior to the anniversary of their last annual survey. The self evaluation protocol could be similar to the process used by OHCQ. When OHCQ conducts its annual survey, the documentation from the self-evaluation would be reviewed. Based on the review of the self evaluation, the OHCQ surveyor would determine whether further evaluation is necessary for each specific survey area. For example, if the provider provides comprehensive documentation that is in compliance with medication administration certification, OHCQ may decide not to conduct a comprehensive review of the same material.

Finding #4: *OHCQ conducts numerous on-site death investigations that are not necessary, thus utilizing staff and resources that can be used elsewhere.*

Except for the timeline requirements of the investigation, the protocol for death investigations is the same, regardless of the circumstances surrounding the death. For example, all deaths of individuals funded through DDA require on-site investigations, with no exceptions. This includes expected deaths of people who had long-term or terminal illnesses as well as those who were receiving in-home hospice services and/or palliative care.

A single death investigation takes, on average, three surveyor days and can take as many as five surveyor days. As the average age of individuals served in the community by DDA continues to rise, the number of deaths by natural causes or long-term illness is expected to rise accordingly. Although some recommendations emanating from investigations of long-term illnesses may be useful, the Contractor believes that this time could be better spent reviewing unexpected deaths, evaluating trends and systemic issues associated with unexpected deaths² and making recommendations for systemic change.

Recommendation #4: - *OHCQ should revise its protocol for expected, natural deaths due to documented illnesses and medical conditions.*

On-site investigations should not be necessary for all death investigations. In many instances, there is sufficient documentation to verify the relevant information necessary to reach conclusions surrounding a death. In addition, there is always an investigation conducted by the residential provider upon an individual's death. In these circumstances, the OHCQ investigator spends valuable time simply verifying that the information incorporated in the residential provider's report is accurate and complete. It would be

² In some instances of deaths, such as those that are suspected homicide, suicide or abuse and neglect, an investigation is also conducted by the police or other law enforcement agencies.

prudent and wise, therefore, for OHCQ to establish a modified protocol for deaths of documented natural causes.

Finding #5 – All providers, regardless of their track record of previous reviews, spend an inordinate amount of time and resources during the survey process.

The most amount of time spent conducting quality reviews should be devoted to provider agencies that continue to struggle meeting or maintaining licensing standards. Currently, many acknowledged high quality providers, those whose previous reviews by OHCQ revealed minimal or no deficiencies, spent weeks or months with OHCQ demonstrating that which has already been demonstrated. There is no reward for high performance. Conversely, it is critical for OHCQ to have the ability to conduct more comprehensive reviews, repeated unannounced visits and plan of correction follow-up for providers that had multiple or serious deficiencies in previous surveys.

An important ingredient of any quality enhancement system is its ability to recognize where quality is compromised and devoting proportionate resources to that particular area. In the current structure, all licensees are treated the same. While this approach on the surface may appear to be equitable, it fails to place all too limited resources where they are needed.

Below is a list of options for consideration by OHCQ that can be applied in circumstances where community service providers have an established track record. If one or more of these options are implemented, important resources can be used where they are needed and the overall credibility of the survey process can be enhanced.

The contractor is fully aware that some of these options may require regulatory or statutory changes.

Recommendation #5 – OHCQ should consider actions to provide relief to providers with minimal or no deficiencies to include:

- ✓ *Multiple-year licensing for licensees that consistently receive minimal or no deficiencies on licensing review;*

Due to the current backlog of annual licensing surveys, multiple year surveys are, in effect, happening already. Some annual licensing surveys have been more than a year late. For those community service providers that have consistently demonstrated high quality marks through either no deficiencies or minimal deficiencies that do not affect the health and safety of those they serve, two or three year surveys should be considered. Multiple year surveys would allow OHCQ to place their efforts where it is needed – for those providers who are unable to achieve substantial compliance with licensing standards.

- ✓ *Less intensive licensure reviews for providers that consistently receive minimal or no deficiencies on licensing reviews;*

Another consideration for those providers who consistently demonstrate minimal or no deficiencies would be a modified annual review that does not include the detailed comprehensive approach currently applied for all licensing reviews. A less intensive review may include, for example, a smaller sampling size, provider documentation compliance certifications (see Recommendation #3), provider self evaluations and streamlined review of individual records. In the process of a less intensive licensure review, OHCQ, of course, would determine that there is a need for a fully comprehensive review and exercise that option. Another alternative would be that OHCQ limit its comprehensive review to the area(s) where the provider had documented deficiencies in the past.

- ✓ *Modified investigation process for providers that demonstrate a proven track record in consistently in conducting internal investigations;*

OHCQ also struggles continuously with conducting timely investigations of allegations of neglect and abuse. Although the triage process for investigations has helped focus investigations in the areas where they are needed the most, there remains to be a significant backlog in the timely investigations of allegations of abuse, neglect and exploitation.

Maryland regulations require licensed providers to conduct their own internal investigations of specific reportable incidents. In many instances, providers conduct comprehensive investigations, taking steps and actions even further than are required by regulations. OHCQ reviews these internal investigations and part of their protocol for independent investigations. In numerous instances, OHCQ interviews the same individuals who are connected to the incident, invariably with the same results. For those providers that have a proven track record of conducting comprehensive investigations, OHCQ should have the discretion to reasonably modify its investigatory approach accordingly. Once again, this places the emphasis where it needs to be – on those providers who do not conduct quality investigations of allegations of possible abuse or neglect.

- ✓ *Recommendations to the legislature allowing for “deeming” of licensure if the provider achieves full accreditation by the Council on Quality and Leadership.*

Given the limited amount of resources and the need for emphasis on continuous quality, it is important to consider alternatives that can assist Maryland community services in maintaining quality services and supports that are demonstrating current best practices. The *Personal Outcome Measures* (2002) developed by *The Council on Quality and Leadership in Supports for People with Disabilities* (Council) are nationally considered

to be a high standard of quality for people with developmental disabilities, incorporating best practices in the field. These outcome measures focus on primary themes of Leadership, Systems and Quality Management and Planning. These outcome measures also include strict accountability in the areas of health and safety as well as fiscal and legal accountability. The Council's outcome measures are also are wholly consistent with the recently enacted Home and Community Based Quality Framework developed by the Centers for Medicare and Medicaid Services (CMS).

There are at least six other states that permit community service providers to meet licensure standards if they achieve full accreditation by the Council. The Council is located in Towson, Maryland. Maryland should consider legislation that enables providers to utilize accreditation by the Council in lieu of annual licensing reviews. There are other nationally recognized accreditation organizations that have developed standards for services for people with developmental disabilities. At this time however, until further research is conducted, the Contractor is only recommending the Council accreditation to be considered for deeming status.

Finding #6 – DDA does not play a major active role in ensuring quality of community services.

DDA is the state's program expert regarding community services and supports for people with developmental disabilities. Regulations require DDA, through Service Coordination, to "Monitor and act as third party advocate for implementation of the Individual Plan (IP)."³ It is important for OHCQ to clarify how Service Coordination Monitors implementation of the IP, how this monitoring information is documented and how it can be used in the survey process.

³ COMAR, 1022.09.04, (E.) Functions of the resource Coordination Licensee

It is important to clarify that DDA does have a small office of quality assurance that does review and approve provider quality assurance plans, among other general quality assurance activities. This office does not have the resources, however, to evaluate the implementation or effectiveness of the quality assurance plans. In addition, DDA does not directly review program services through ongoing monitoring efforts.

Recommendation #6 – DDA, through Service Coordination and its office on quality assurance should assume an increased collaborative role in evaluating the quality of development and implementation of individual plans and implementation of quality assurance plans.

Part of the licensure survey process is, through interviews, observation and record reviews to evaluate implementation of the IP. Similarly, DDA, through Service Coordination is required by regulation to monitor implementation of the IP. OHCQ also reviews the Quality Assurance Plans require by regulations.⁴ DDA, through its office of Quality Assurance, reviews and approves these plans. Collaboration of these efforts should result in a more meaningful approach to quality review. This is also an area where OHCQ and DDA could provide increased technical assistance as described in Recommendation #1 above.

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⁴ COMAR. 1022. 02.14. (A). Quality Assurance
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