GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

REPORT OF SPECIAL EVALUATION

DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES
DEVELOPMENTAL DISABILITIES
ADMINISTRATION

November 2012

CHARLES J. WILLOUGHBY
INSPECTOR GENERAL

OIG No. 13-I-0053JM **November 2012**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

November 30, 2012

Via Hand Delivery

Laura Nuss
Director
Department on Disability Services
1125 15th Street, N.W., 9th Floor
Washington, D.C. 20005

Dear Ms. Nuss:

Enclosed is our final *Report of Special Evaluation of the Department on Disability Services' Developmental Disabilities Administration* (13-I-0053JM). Written comments from your agency on the special evaluation team's 6 findings and 16 recommendations are included verbatim in the report. This report will be available publicly at http://oig.dc.gov; I encourage you to share it with your employees.

We reviewed your responses to our draft report and noted in this final report that we consider five of our recommendations to be "closed" based on the actions you reported. For the 11 recommendations that remain, we have enclosed *Compliance Forms* on which your staff should record and report to this Office the actions taken on each recommendation. These forms will assist both you and the OIG in tracking compliance with recommendations in the report. Where the form asks for "Agency Action Taken," please report actual completion, in whole or in part, of a recommendation rather than "planned" action. Please ensure that the *Compliance Forms* are returned to the OIG by the response dates noted on the forms.

We appreciate the cooperation shown by you and your employees during the special evaluation and look forward to your continued cooperation during the upcoming follow-up period. If you have questions or comments concerning this report or other matters related to the special evaluation, please contact me or Alvin Wright Jr., Assistant Inspector General for Inspections and Evaluations, at (202)727-2540.

Sincerely,

Charles J. Willoughby
Inspector General

CJW/ebs

Enclosure

cc: See **Distribution List**

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Inspections and Evaluations Division

Mission Statement

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness and economy in operations and programs. I&E's goals are to help ensure compliance with applicable laws, regulations, and policies, identify accountability, recognize excellence, and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

TABLE OF CONTENTS

ACRONYMS

ACRONYMS

CFR	Code of Federal Regulations
COTR	Contracting Officer's Technical Representative
CY	Calendar Year
DHCD	Department of Housing and Community Development
DHCF	Department of Health Care Finance
DDS	Department on Disability Services
DDA	Developmental Disabilities Administration
D/DDA	Director/ Developmental Disabilities Administration
FY	Fiscal Year
GAO	U.S. Government Accountability Office
HCA	Human Care Agreement
HCBS	Home and Community Based Services
I&E	Inspections and Evaluations
ICF	Intermediate Care Facility
IDT	Interdisciplinary Team
ISP	Individual Service Plan
JRC	Judge Rotenberg Educational Center
MCIS	MRDDA Consumer Information System
MIS	Management Information System
MOA/U	Memorandum of Agreement/Understanding
MRDDA	Mental Retardation and Developmental Disabilities Administration
OAG	Office of the Attorney General

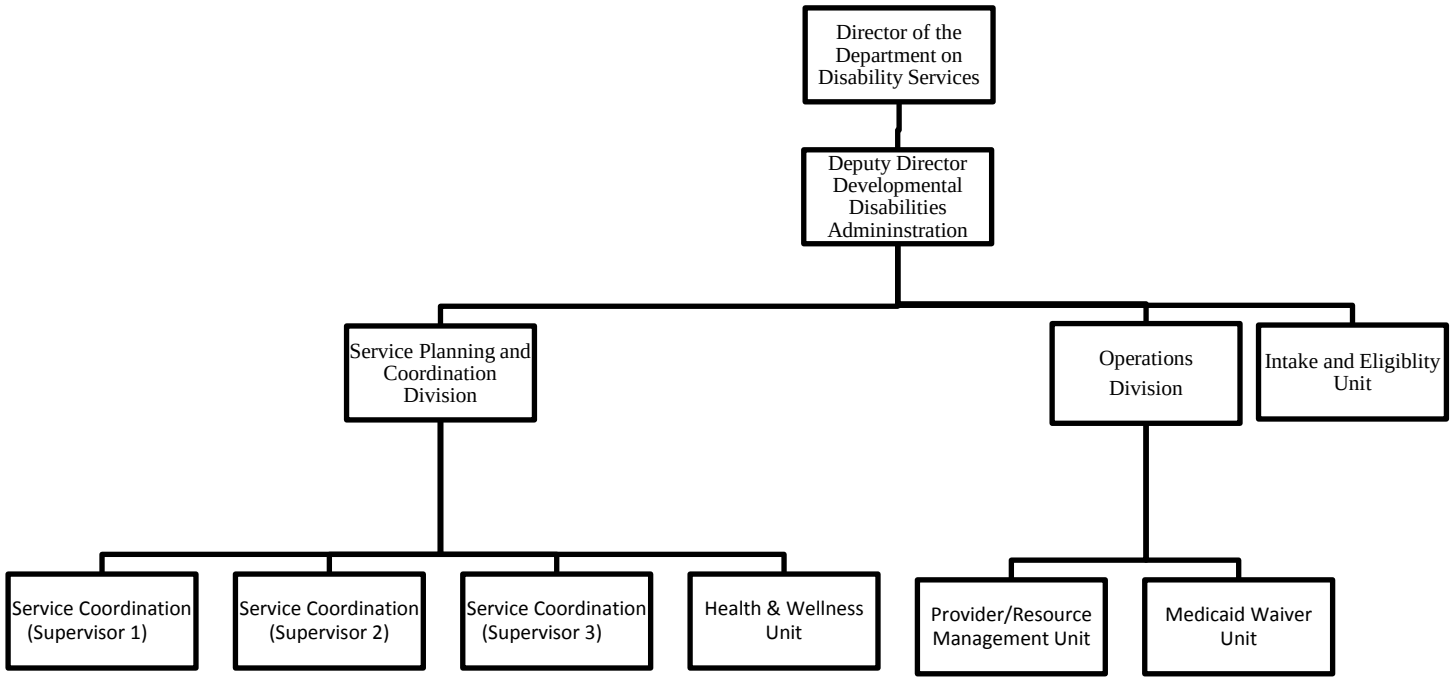
ACRONYMS

OIG Office of the Inspector General

RRC Residential Referral Committee

ORGANIZATION CHART

ORGANIZATION CHART



Based on information received from DDA as of April 19, 2012.

EXECUTIVE SUMMARY

Overview

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General (OIG) conducted a special evaluation of the Department on Disability Services (DDS), Developmental Disabilities Administration (DDA) from September 2010 through July 2011. DDS's mission is to "provide innovative, high quality services that enable people with disabilities to lead meaningful and productive lives as vital members of their families, schools, workplaces and communities in every neighborhood in the District of Columbia."[1] The agency is comprised of two administrations: the Developmental Disabilities Administration (DDA) and the Rehabilitation Services Administration.

Objectives

The special evaluation objective was to assess the quality and efficiency of DDA's monitoring of clients' treatment in out-of-state residential facilities.[2] The team focused

[1] Http://dds.dc.gov/DC/DDS/About+DDS?nav=0&vgnextrefresh=1 (last visited Jan. 13, 2012).

[2] As stated in the OIG's engagement letter to DDA, the team planned to assess whether DDA adequately assesses clients' needs before moving them from out-of-state placements back to the District. However, during its fieldwork, the team learned that there are various individuals in addition to DDA personnel who are involved with deciding the placement location for a client, including the client, the Superior Court of the District of Columbia, the client's appointed attorneys, and guardians. DDA recommends to the Court where a client should be placed, but the Court has to approve these placement decisions.

DDS's October 2012 Response, as Received:

In footnote 2 on page 2, the draft report mentions the involvement of other key players in individual placement decisions. The footnote simultaneously overstates the importance of the Superior Court and understates the significance of the inter-disciplinary team or "IDT" in decision making. D.C. Official Code § 7-761.05(1)(a) requires DDS to "[p]rovide services and supports to consumers" in accordance with Chapter 13 of Title 7, which is the codification of D.C. Law 2-137, the "Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978," effective March 3, 1979, D.C. Official Code § 7-1301.01 et seq. (2008 Repl.), as amended. Under D.C. Law 2-137, DDS may provide services and supports to District residents who are "at least moderately mentally retarded" through the admission and commitment process by petition to the Family Court for residential services and by application to DDS for non-residential services. See D.C. Official Code §§ 7-1301.03(2) and 7-1301.03 through 7-1303.06. The delivery system for care and habilitation services provided to District of Columbia residents with IDD is comprised of hundreds of vendors providing services and supports funded through either the State Plan for Medical Assistance ("Medicaid State Plan") or the Home and Community-Based Services ("HCBS") waiver program, or through local funding for persons who are not Medicaid-eligible or who are in certain out-of-state placements or for those services (i.e. room and board) which are not covered by the HCBS waiver. The specific services and supports (e.g. ICF/MR placement or one or more HCBS waiver services) are based on the person's individual support plan ("ISP"), individual habilitation plan ("IHP") or plan of care developed by the IDT. Through the initial admission and commitment processes for persons receiving residential supports, and the annual review hearing for committed individuals, the Family Court reviews the ISP and the attendant decision making by the individual and the IDT.

OIG Comment: **The OIG team acknowledges the specifics provided in DDS's response about the role of the IDT and the Family Court. In footnote 2, the OIG was providing a brief explanation as to why it did not evaluate whether DDA adequately assesses clients' needs before moving them from out-of-state placements back to the District. DDS's clarification validates the OIG's decision not to assess this area as there are numerous parties involved with admission and commitment processes for DDA clients.**

primarily on DDA's Service Coordination Division, which coordinates services for DDA clients and assesses the quality and delivery of services through periodic monitoring.

OIG inspections comply with standards established by The Council of the Inspectors General on Integrity and Efficiency and pay particular attention to the quality of internal control.[3] The team conducted 22 interviews with DDS/DDA personnel, reviewed 40 randomly selected case records, and observed key work processes at DDA.[4] The team also interviewed provider representatives and relevant stakeholders and observed client residences at six provider locations outside the District. The team attempted to obtain feedback from Family Court judicial officers regarding the quality and efficiency of DDA services rendered to its clients; however, the Chief Judge of the D.C. Superior Court denied our request as our questions related to policy issues being considered by the legislative body.

Compliance Form for Priority Matter

The team issued the following Compliance Form for Priority Matter: *DDS's policy on "Restrictive Procedures" lacks clarity regarding: (1) whether certain aversive procedures are prohibited; and (2) its applicability to DDS clients in District and out-of-state placements*. The team learned that a DDA client was receiving aversive treatment in a Massachusetts facility. However, the D.C. Code prohibits the application of aversive treatments to District residents. The team also found that DDA's policy does not specifically prohibit aversive procedures such as shock therapy, white noise therapy, and bitter-tasting food procedures, and does not indicate whether this policy extends to all DDS clients, in both District and out-of-state facilities.

Summary of Findings

A list of the report's 6 findings and 16 recommendations is included at Appendix #1. The OIG identified findings related to monitoring of and service delivery to DDA clients in out-of-state placements. DDA officials face recruitment challenges regarding Washington, D.C.-area providers who can adequately care for DDA clients. Consequently, DDA must place clients with providers in states such as West Virginia, Texas, and Florida. Additionally, the team found that DDA is not consistently monitoring clients placed in out-of-state facilities. Although some clients received substantial monitoring, others did not. The team also identified concerns with DDA's lack of written policies and procedures for clients placed out-of-state; the amount of resources available to DDA staff to conduct visits with clients in out-of-state facilities; and the lack of training and written procedures for use of DDA's electronic databases to input case management information. Finally, the team found that provider certification reviews conducted

[3] "Internal control" is synonymous with "management control" and is defined by the Government Accountability Office as comprising "the plans, methods, and procedures used to meet missions, goals, and objectives and, in doing so, supports performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud." STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT, Introduction at 4 (Nov. 1999).

[4] After consulting with the D.C. Office of the Attorney General, the team did not interview DDA clients to obtain their perspectives on services received, due to personal privacy concerns and the possibility clients would perceive the interviews as intimidating.

by a contractor for DDA have not been completed for all service providers located outside of the District. All of these concerns impede effective service delivery to DDA clients.

The team learned that DDA did not have a current Memorandum of Agreement (MOA) in place with Maryland's DDA governing District clients' placement in Maryland facilities. The previous MOA expired in September 2007. The team addressed this issue with a DDA legal official and was told that DDS was working with Maryland to draft and execute a current MOA. As the District places many of its clients in residences in Maryland, this MOA allows the District to oversee the licensing requirements of its Maryland providers and conduct oversight of DDA clients in Maryland. In July 2011, DDA provided the OIG team with a copy of the formalized MOA executed with the Maryland DDA, which was fully implemented in May 2011.[5]

Although not a finding in this report, the team believes that DDA managers should consider revising its protocol for service coordinator caseload assignment. The team analyzed DDA data regarding caseloads assigned to its service coordinators and found disparity with case assignments based on geographic location. Some service coordinators were assigned 11 to 15 clients placed in Maryland; others were assigned 5 to 7 clients placed in facilities outside of the District and Maryland; whereas other coordinators were assigned no clients in placements beyond the District. An out-of-state provider stated that multiple DDA service coordinators have been assigned to different clients with this provider. For example, this provider houses approximately 90 DDA clients who are assigned to 40 different DDA service coordinators. The team believes that this assignment protocol is operationally inefficient as it may result in redundancy of work efforts and increased travel expenses resulting from multiple service coordinator visits to the same out-of-state placement. A DDA official stated that while caseloads are manageable, DDA has established a performance improvement team to identify ways to improve the efficiency of workloads. One area being assessed is rebalancing service coordinators' caseloads.[6] Although changes have not yet been implemented, proposed changes

[5] **DDS's October 2012 Response, as Received:**
In the [first] paragraph on page [4], the draft report should be changed to reflect that the memorandum of agreement ("MOA") with Maryland "allows the District to oversee the [certification] requirements of its Maryland providers and conduct oversight of DDA [individuals served] in Maryland." DDA does not possess licensing authority in the District and does not exercise licensing authority in Maryland; rather, the HCBS waiver allows DDA to certify HCBS providers in the District and the MOA allows DDA to certify its Maryland-sited providers.
OIG Comment: **The OIG acknowledges DDS's clarification. The OIG used this terminology based on language in the MOA effective in May 2011 that states "DC DDA's requirement for approval of programs to services individuals with developmental disabilities are substantively equivalent to MD DDA licensure requirements."**

[6] **DDS's October 2012 Response, as Received:**
In the [second] paragraph on page [4], the draft report states that, "[a]lthough not a finding in this report, the team believes that DDA managers should consider revising its protocol for service coordinator caseload assignment." Please note that, several months ago, DDS/DDA undertook a rebalancing of caseloads initiative based on the findings of the performance improvement team or PIT team.
OIG Comment: **The OIG acknowledges DDS's update that DDA has undertaken an initiative to rebalance its caseloads. The OIG team's analysis of caseload assignment was based on data from DDA as of May 2011.**

include assigning one service coordinator, rather than several, to a particular facility.[7]

Summary of Select Recommendations

The OIG made 16 recommendations to DDS/DDA to improve the deficiencies noted and increase operational efficiency. These recommendations include ensuring effective monitoring of out-of-state clients, instituting policies and procedures regarding the delivery of services to those clients, conducting a feasibility study with other District agencies to identify handicapped-accessible housing within the District for DDA clients,[8] and providing training and written guidance to DDA staff on use of its case management system.

During the special evaluation, DDA managers and employees were cooperative and responsive.

DDS reviewed the draft of this report prior to publication, and its comments in their entirety follow each OIG recommendation.

Note: The OIG does not correct grammatical or spelling errors in an agency's comments, but does format its responses in order to maintain readability of OIG reports. Such formatting is limited to font size, type, and color, with the following exception: if an agency bolds or underlines text within its response, the OIG preserves those elements of format.

Compliance and Follow-Up

The OIG inspection process includes follow-up with DDA on findings and recommendations. Compliance forms will be sent to DDA along with this report of special

[7] **DDS's October 2012 Response, as Received:**
Beginning on page [5], and in other places throughout the draft report, the term "facility" is used. While technically accurate for an intermediate care facility for individuals with intellectual disabilities ("ICF/IID"), which is the current name for the federally certified Medicaid State Plan intermediate care facility for persons with mental retardation ("ICF/MR"), we try to use the term residence or home to be respectful that the overwhelming majority of these locations for residential services, and especially those funded under the HCBS waiver program, are individual homes of six or less people in the community and not large, institutional settings.
OIG Comment: **The OIG acknowledges DDS's response. For the purpose of clarity, the OIG used the general term "facility." Footnote 23 provides detailed explanations of the various types of DDA placements, including that of a residential habilitation facility.**

[8] **DDS's October 2012 Response, as Received:**
Throughout the draft report, the persons served by DDS/DDA are in most instances referred to as "client" or "clients" instead of by more appropriate terms such as "individual(s)," "person(s)," or "people." From a programmatic standpoint and based on the People First Respectful Language and Modernization Amendment Act of 2012, which will become D.C. Law at the end of this month, it is preferable to use "individual(s)," "person(s)," or "people."
OIG Comment: **The OIG appreciates DDA's feedback about the OIG's use of the word "client." The OIG team used this word to differentiate these individuals from District employees, provider agency personnel, guardians, and family members. In addition, the team found that DDS uses the term "client." For example, several DDS documents available on the Internet refer to the word "client," including DDS's response to its FY 2011 – FY 2012 Performance Oversight Hearing, dated February 27, 2012, and DDS's Definition Appendix that refers to a "Client Services Liaison."**

evaluation. The I&E Division will coordinate with DDA on verifying compliance with recommendations agreed to in this report over an established period. In some instances, follow-up activities and additional reports may be required.

During their review of the draft report, inspected agencies are given the opportunity to submit any documentation or other evidence to OIG showing that a problem or issue pointed out in a finding and recommendation has been resolved or addressed. When such evidence is accepted, the OIG considers that finding and recommendation closed with no further action planned.

INTRODUCTION

Background and Perspective

In accordance with the Developmental Disabilities Services Management Reform Amendment Act of 2006, the Department on Disability Services (DDS) was established in 2007 as a cabinet-level agency, subordinate to the Mayor within the executive branch, to lead the reform of the District's system of care and habilitation[9] services for citizens with mental retardation and other developmental disabilities. DDS replaced the Mental Retardation and Developmental Disabilities Administration (MRDDA), which was located within the Department of Human Services. [10]

The Developmental Disabilities Administration (DDA) is one administration within DDS. DDA's three main divisions[11] include:

> **Service Coordination:** Service Coordinators help coordinate, link, and connect eligible individuals to resources and services. They meet and talk with clients, their families/significant others, and providers to gather information to help develop each client's Individual Support Plan (ISP).
>
> **Operations:** It is responsible for coordinating provider technical assistance and contract oversight, conducting community outreach and education and eligibility determinations for services, and assisting individuals and service coordinators with benefits planning and management for Medicaid, Medicare, Social Security Disability Insurance, and Social Security.
>
> **Quality Management:** Its responsibilities include overseeing the Incident Management System, Provider Certification Reviews, and Mortality Reviews, as well as collecting performance data and reports, tracking and trending information and recommending corrective actions and improvement initiatives. This Division also

[9] D.C. Code § 7-761.02 (2008) defines "habilitation," in pertinent part, as "the process by which a person is assisted to acquire and maintain those life skills which enable him or her to cope more effectively with the demands of his or her own person and of his or her own environment."

[10] **DDS's October 2012 Response, as Received:**
On page [8], the draft report incorrectly states that "DDS replaced the Mental Retardation and Developmental Disabilities Administration (MRDDA), which was located within the Department of Human Services." While it is accurate that MRDDA formerly "was located within the Department of Human Services," it is more accurate to state that MRDDA became DDA within the newly-created DDS, which also included the Rehabilitation Services Administration. The statutory support for this assertion can be found in D.C. Official Code § 7-761.08 (2008 Repl.).
OIG Comment: **The intent of this report was to report on DDA. The OIG issued a Report of Inspection of DDS's Rehabilitation Services Administration in September 2010.**

[11] Based on information at:
http://dds.dc.gov/DC/DDS/Developmental+Disabilities+Administration/DDA+Divisions?nav=1&vgnextrefresh=1
(last viewed Mar. 16, 2012).

includes the Health and Wellness Unit, which provides technical assistance, oversight, and training in health and clinical services.[12]

Overview of DDA's Client Intake and Eligibility Processes

DDA's Intake and Eligibility Determination Unit (IEDU) is responsible for receiving and processing applications and determining eligibility for individuals who apply for services through DDA. To apply for services, an individual has to submit a completed application and various documents to DDA. According to DDA's website, the following items constitute the supporting documents required for a completed application:

(1) Proof of District residency;
(2) Proof of a diagnosis of intellectual disabilities as described below;
(3) The complete application package includes:
- Copy of the individual's birth certificate
- Social Security card
- Proof of health insurance (DC Medicaid[13] or private coverage), if applicable
- Supporting documentation that the applicant was diagnosed as having an intellectual disability prior to the age of 18, such as school records, medical records, or social history, if available
- Psychological evaluations, based on one or more standardized test, that document significantly sub-average general intellectual functioning Intelligence Quotient ("IQ") scores of 69 or below, was diagnosed and/or manifested before the age of 18 years, and that impairments in cognitive adaptive functioning continue into adulthood;
- Psychological and psychiatric evaluations that document any diagnosed psychiatric condition, should one be present
- Psychological evaluations that include a formal assessment of adaptive behavior or other supporting documentation of

[12] Although DDS's website lists these three divisions as components of DDA, DDA officials provided an organization chart dated April 20, 2012, which reflects that the Quality Assurance Division reports directly to the Director of DDS.

DDS's October 2012 Response, as Received:

In [footnote 12 on page 9], the draft report correctly indicates that the Quality Management (as opposed to Quality Assurance) Division reports to the DDS Director, which has been the case since June 2011. Please note as well that the Health and Wellness Unit, formerly included in the Quality Management Division, currently falls within the Service Planning and Coordination Division as is evidenced by the organizational chart on page ORG-ii.

[13] According to the D.C. Department of Health Care Finance (DHCF) website, "DC Medicaid is a healthcare program that pays for medical services for qualified people. It helps pay for medical services for low-income and disabled people. For those eligible for full Medicaid services, Medicaid pays healthcare providers. Providers are doctors, hospitals and pharmacies who are enrolled with DC Medicaid." *See* http://dhcf.dc.gov/dhcf/cwp/view,A,1412,Q,609122,dhcfNav,%7C34820%7C.asp#2.

adaptive behavior deficits or developmental delays manifested during the developmental period
- Medical evaluation current within the last 12 months[14]

According to a DDA senior official, a client has to at least be diagnosed with mental retardation,[15] otherwise referred to as an intellectual disability, in order to receive DDA services. The client may also have a second diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)[16] or have a second cognitive disability such as autism, along with mental retardation.[17]

A coordinator from IEDU is assigned to assist each applicant. The coordinator conducts initial and subsequent case review meetings with the client, explains DDA intake procedures, reviews the file with the client (and his/her representatives if applicable), and explains what further information is needed, if any, to determine eligibility to receive DDA services. DDA may order additional psychological or social work assessments to assist in determining a client's eligibility. An applicant's case may be closed due to non-cooperation, incarceration, or lack of information.

DDA also provides services to individuals covered under the provisions of the *Evans* and *United States vs. Fenty* lawsuit.[18] This was a class action lawsuit filed in 1976 asking the court

[14] *See* http://dds.dc.gov/DC/DDS/Developmental+Disabilities+Administration/How+To+Apply+For+Services (last visited Mar. 22, 2012)

[15] Intellectual disability, formally known as mental retardation, "is characterized by significant limitation in both intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before the age of 18." See http://www.arcdc.net.

DDS's October 2012 Response, as Received:

In [footnote 15 on page 10], the more appropriate definition of ID (or MR) in this jurisdiction should be to D.C. Official Code § 7-1301.03(19) (2008 Repl.), which governs the provision of supports and services to persons diagnosed with ID.

OIG Comment: **D.C. Code provides slight variation with the definition outlined in footnote 15. According to D.C. Code § 7-1301.03(19), "Mental retardation" or "persons with mental retardation" means a substantial limitation in capacity that manifests before 18 years of age and is characterized by significantly subaverage intellectual functioning, existing concurrently with 2 or more significant limitations in adaptive functioning.**

[16] The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*, otherwise known as the DSM-IV, categorizes psychiatric disorders. It is published by the American Psychiatric Association and covers all mental health disorders for both children and adults.

[17] **DDS's October 2012 Response, as Received:**

Similarly, as discussed more fully below, in lieu of the terms "mental retardation" and "mentally retarded," the more respectful terms "intellectual disability" or "intellectual and developmental disability" and the acronym "IDD" is and should be used to the extent possible.

OIG Comment: **As already noted in the report and in footnote 15, the OIG referred to the more respectful term of "intellectual disability" as it is "preferred by most advocates in most English-speaking countries. Clinically, however, mental retardation is a subtype of intellectual disability….Because of its specificity and lack of confusion with other conditions, *mental retardation* is still the term most widely used and recommended for use in professional medical settings, such as formal scientific research and health insurance paperwork." See http://en.wikipedia.org/wiki/Mental_retardation. The DSM-IV-TR, published in 2000, uses the coding and diagnosis of Mental Retardation. Lastly, D.C. Official Code § 7-1301.03(19) defines "Mental retardation" or "persons with mental retardation."**

[18] In 1978, the Court entered a consent decree pursuant to which defendants agreed that plaintiffs' constitutional rights had been violated and they would have to take certain actions to remedy these violations. A series of consent

to: 1) implement the Home and Community Based Services (HCBS) waiver program,[19] which is a Medicaid program; and 2) place class members in a less restrictive setting. The plaintiffs also alleged that the District was in contempt because it failed to provide timely payment to group home service providers.

After DDA receives an individual's eligibility documentation, the coordinator meets with his/her supervisor to discuss his/her impressions of the client. If there is enough required information present, the supervisor will schedule an eligibility date. On the eligibility date, a "Eligibility Team" meets and reviews the client's application and documentation to determine whether the client is eligible for DDA services. The team applies an "axis method" to assist in determining an individual's overall eligibility, which includes: 1) mental health concerns; 2) developmental disabilities, including mental retardation; and 3) other conditions, such as adaptive concerns, which measure an individual's functionality in real life.

During this meeting, DDA makes one of the following eligibility decisions: "eligible," "not eligible," "closed no determination" (meaning a decision could not be reached as to eligibility), or "deferred" (meaning the application packet was referred to one of DDA's consulting psychologists for further evaluation). The service coordinator mails the applicant a letter with the determination of eligibility. If an individual is deemed "not eligible," the letter describes the reason and includes instructions regarding an appeal. For those applications deemed "closed no determination" the letters state the reasons. An individual is not allowed to appeal a "closed no determination" decision.[20]

If an individual is deemed "eligible," the applicant's packet is prepared for transfer to DDA's Service Coordination unit. A case transfer meeting is held in which representatives from the Intake unit and Service Coordination unit discuss the case and the client's needs.

Overview of Service Coordination and Residential Placements

The key responsibilities of a service coordinator from DDA's Service Coordination unit include coordinating, linking, and connecting clients to resources and services. For each client, the service coordinator must schedule and hold an annual meeting to review the client's Individual Service Plan (ISP) during which the client's goals, needs, and plan-of-care are outlined for the upcoming year, and the service coordinator assesses the client's progress in

orders and remedial plans have followed. *See* http://www.pascenter.org/olmstead/olmstead_cases.php?state=washingtondc (last viewed Oct. 24, 2011).

[19] For further information on the HCBS waiver program, see page 13 of this report.

[20] **DDS's October 2012 Response, as Received:**
The description of the determination of eligibility on page [11] contains a number of mischaracterizations from a programmatic standpoint. "An applicant's case may be closed due to non-cooperation, incarceration, or [failure to provide information]." The Intake and Eligibility Unit does not "schedule an eligibility date," but rather "an eligibility determination review." The discussion of "axis method" does not reflect DDS/DDA official policy, which is the basis for determining eligibility. And finally, even though it is accurate that "[a]n individual is not allowed to appeal a 'closed no determination' decision," an applicant may reapply at any time.
OIG Comment: **The OIG acknowledges DDS's clarifications to the determination of eligibility process. During its fieldwork, the team conducted an interview with a DDA official who provided the team with a general overview of the eligibility determination process.**

meeting his/her goals for the prior year. Also during this meeting, the service coordinator meets with the client and the client's representatives, which may include family members or guardians, legal representatives, medical personnel, and applicable provider staff. This annual ISP meeting provides the client and stakeholders with a forum to discuss any concerns, future plans, and needs. During the ISP meeting, the team discusses treatment options with the client and determines what further services the client seeks. Additionally, the service coordinator may order additional tests and assessments, including psychological and medical assessments.

After the ISP meeting, the service coordinator drafts the formal ISP for the upcoming year, with the client's input, and sends the completed ISP to a supervisor for review and approval. The new ISP must be completed within 1 year of the prior ISP. Once the ISP is approved, the service coordinator initiates or continues services to the client that are outlined in the ISP.[21]

DDA clients may access residential services, which include overnight housing accommodations.[22] Other options available to DDA clients include host homes, supported living (i.e., supervised apartments/homes, residential habilitation (group homes), and Intermediate Care Facilities.[23] DDA clients also have access to day-treatment programs, many of which include

[21] **DDS's October 2012 Response, as Received:**
The "Overview of Service Coordination and Residential Placements" on pages [11-14] requires additional attention. The Service Planning and Coordination Division within DDA includes the Service Coordinators. The Service Coordinator leads the interdisciplinary team or IDT in discussions of available "supports and services options" as opposed to "treatment options" based on "assessments," and not "tests and assessments." The language included in the draft report is based on the medical model where individuals are treated as patients in an institution instead of persons whose individualized needs may include specific supports and services. "After the ISP meeting, the service coordinator finalizes the draft ISP for the upcoming year, with the individual's input, and sends the finalized ISP through MSIS to his or her supervisor for review and approval."
OIG Comment: **The OIG acknowledges DDS's clarification. The OIG's overview was based on information gleaned from DDA policies, information on DDS's website, and an interview with a DDA official.**

[22] **DDS's October 2012 Response, as Received:**
Twenty-four hour residential services should not be referred to as "overnight housing accommodations" as they are available services to meet individualized needs.

[23] A DDA senior official stated that a "host home" refers to homes where three to five individuals reside. According to a document provided by DDA, a "supported living facility" refers to homes and apartments under the HCBS waiver, in which one to three individuals reside and receive support from a DDA provider; a "residential habilitation facility" refers to homes under the HCBS waiver where four to six clients live and receive support from a DDA provider in a group home setting; and Intermediate Care Facilities (ICFs) consist of homes where four to six individuals require an institutional level of care, which typically means individuals with significant medical support needs. ICFs are certified by the D.C. Department of Health's Health Regulation and Licensing Administration to provide habilitative and health services under federal healthcare regulations.

DDS's October 2012 Response, as Received:
The discussion of the available residential services is incorrect in the text on page [12] and with respect to "host home" in the related footnote [23]. Residential services include host home, supported livings services of one to three persons, residential habilitation services of four to six persons, and ICFs/IID. Both residential habilitation services settings and ICFs/IID homes are considered "group homes" because each includes four to six persons. A "host home" is akin to a foster home where an individual resides with a host home family.
OIG Comment: **The OIG acknowledges DDS's clarification of a host home. As stated in footnote 23, the OIG's definitions of supported living facility, residential habilitation facility, and ICFs were based on information in a document provided by a DDA official.**

supported employment.[24]

DDA's Residential Referral Committee (RRC) approves a client for residential services and determines whether the provider is eligible for the Home and Community Based Services (HCBS) waiver program, which is a Medicaid program.[25] It allows the District to provide person-centered community-based programs and supports designed to help individuals leave institutional settings or to prevent their having to move into one. The federal government reimburses the District 70% of the cost of services and supports for people enrolled with a provider who has the HCBS waiver program. This reimbursement helps the District to fund programs that might otherwise not be affordable. This is desirable for DDA to pursue because without this waiver, DDA would pay for a client's placement, room and board, and services by using local dollars, which would be a significant cost to the District.[26] The Medicaid Waiver mandates a quality assurance program, and allows DDA to independently certify providers.

When the RRC has approved a client for residential services, the service coordinator reviews available vacancies with providers. DDA issues a memorandum to providers regarding the new client's application, and the provider must approve the placement. The client visits the provider's site, and is given a choice of up to three residential placements. Once a client and his/her representative agree on a placement, the service coordinator schedules a transition meeting with the client, service coordinator, and provider representatives.

[24] **DDS's October 2012 Response, as Received:**
It is inaccurate to refer to "day-treatment programs," but rather should indicate "day and vocational programs."
[25] DDS defines a "provider" as "the individual, agency or other legal entity with day-to-day responsibility for the operation or delivery of services or supports or facilities regulated by DDS by law or contract as outlined in the [client's] ISP [and also includes] any entity that meets the HCBSW requirements, has signed an agreement with the Department of Health Care Finance to provide services and is enrolled by DHCF and DDS to provide HCBSW services." *See* http://dds.dc.gov/DC/DDS/Developmental+Disabilities+Administration/About+Our+Services/Home+and+Community+Based+Services+Waiver+Program (last viewed Mar. 21, 2012).
DDS's October 2012 Response, as Received:
DDA's Residential Referral Committee or RRC neither approves residential services nor determines HCBS waiver eligibility, but rather looks at resources available to meet the person's individualized needs.
OIG Comment: **The OIG team acknowledges DDS's clarification. During fieldwork, the team conducted an interview with a DDA official who provided the team with an overview of RRC responsibilities.**
[26] **DDS's October 2012 Response, as Received:**
The discussion of the HCBS waiver program on page [14] is inaccurate in that it is a choice program, referrals are made to three providers at a time based on the individual's choice, the Human Care Agreement is a contract issued by DDS which uses local funding to pay the cost of room and board not covered under the HCBS waiver program, the Human Care Agreement, and all HCBS waiver providers also must have a Medicaid provider agreement issued by DHCF for the services provided under the HCBS waiver program. Generally speaking, these contractual agreements already are in place for providers and it is a question of issuing a task order against the Human Care Agreement or initiating services for a particular person under the Medicaid provider agreement. As discussed above, there are no "day-treatment" services available to DDA individuals, but rather day programs.
OIG Comment: **The OIG acknowledges DDS's clarification. The OIG's general description of the HCBS waiver program was based on information gleaned from DDS's website and interviews with a DDS and a DDA official.**

When a client is placed with a provider, DDA and the provider execute a Human Care Agreement (HCA), which is similar to a contract.[27] A DDA manager stated that incoming providers must agree to enter into the Medicaid Waiver enrollment process, meet qualification standards through the Provider Resource Management Unit's (PRMU) certification process, and satisfy technical and fiscal responsibility standards. This DDA manager also stated that if DDA believes that a provider is not providing adequate care to DDA clients, the provider will be referred to DDA's Quality Management Division for enhanced monitoring. DDA's Case Management Monitoring Procedures state that all government contractual providers will provide access to DDA case management staff for client visits and records review, and will comply with the development and implementation of the plan of action.[28]

After DDA and the provider execute the HCA, the service coordinator initiates a funding authorization request, which upon approval, permits the client to move into the facility. The service coordinator monitors the client and completes either a day treatment monitoring tool or a residential monitoring tool[29] and ensures that the provider's staff are adequately trained to care for the client and that the site has been prepared for the client's arrival.

During the ISP meetings, DDA uses an Interdisciplinary Team (IDT) to provide the client with support and guidance and to identify the best placement available for the client. The IDT generally consists of the client, family members, guardians, legal representatives, provider staff, medical personnel, and DDA service coordinators.

According to a DDA senior official, the District is the only jurisdiction that requires court approval for a DDA client's commitment or for the client's receipt of residential services. He/she added that after court approval, the client is committed to the facility. Two DDA service coordinators stated that the court also must approve a client's placement in a specific facility. Another said that if a member of the client's team disagrees with a request by DDA, the member can petition the D.C. Superior Court to address the matter.

[27] According to D.C. Code § 7-761.06(e) (2008), DDA has independent procurement authority and contracting oversight independent of the Office of Contracting and Procurement. According to a DDA official, any contract in an amount that exceeds $1 million needs the approval of the Mayor's Office, D.C. Council, and the D.C. Office of the Attorney General.

[28] *See* http://dds.dc.gov/DC/DDS/Developmental+Disabilities+Administration/Policies/Program+Policies+and+Rules/Management+Monitoring+Procedures (last visited Mar. 23, 2012).

[29] Residential monitoring tools are completed for monitoring activity conducted at a client's placement; whereas, the day monitoring tools are completed for monitoring activity conducted at a client's day treatment or day habilitation program.

SUMMARY OF COMPLIANCE FORM FOR PRIORITY MATTER

Summary of Compliance Form for Priority Matter issued on May 6, 2011

DDS's policy on "Restrictive Procedures" lacks clarity regarding: (1) whether certain aversive procedures are prohibited; and (2) its applicability to DDS clients in District and out-of-state placements.

D.C. Code § 7-1305.06 (2001) reads: "No psychosurgery, convulsive therapy, experimental treatment or behavior modifications program involving aversive stimuli or deprivation of rights … shall be administered to any resident." DDS Policy 6.2, Restrictive Procedures (effective Nov. 30, 2007) states, in part, that the following procedures are "expressly prohibited:"

> Any procedure or action that is degrading, humiliating, harsh, or abusive; [and] … Any aversive conditioning, including the contingent use of unpleasant substances to modify behavior. . . .[30]

In May 2011, the OIG issued a Compliance Form for Priority Matter after learning that a DDA client placed in the Judge Rotenberg Educational Center (JRC) in Massachusetts was receiving aversive stimuli in the form of electric shock therapy. Our review of DDA policies and procedures revealed that DDS Policy 6.2 did not specifically prohibit the following procedures: electric shock therapy, white noise therapy, and bitter tasting food. DDA officials stated that such practices are prohibited, and that it would update its policy to affirmatively state this prohibition. In what seemed to be an apparent contradiction, however, DDA informed the team that it had entered into a Human Care Agreement (Agreement) with the JRC that allowed aversive treatments for the client at JRC. DDA stated that it was working with the client's family to find an alternative placement, and noted that no other DDA clients in District or out-of-state placements are subject to prohibited aversive treatments or stimuli.

Concerned about possible legal issues for the District because of DDA's Agreement with the JRC, the OIG requested a written opinion on the Agreement's legality from the District's Office of the Attorney General. The Attorney General opined that due to unique circumstances surrounding this client, "there is little likelihood that the District would be held liable for this placement . . . particularly given the lack of an alternative available placement and the familial consent involved."

Update

In June 2012, the OIG requested a status update from DDA about its client at JRC, as well as updates on whether any other DDA clients were receiving aversive treatments. In its response, a DDA senior official stated that the client continues to be serviced by JRC, and that DDA had extended is contract with DDA through September 30, 2012. This contract extension appeared to reflect DDA's agreement to maintain the status quo for use of aversive treatments for this client in unique circumstances, despite its policy and District law prohibiting such treatments. The official again stated that there are no other DDA clients receiving aversive

[30] *Id*. at 3.

treatments. A DDS official stated that DDS will send a letter to the JRC client's guardian and other family members stating that it is DDS's intent to cease funding services for this client effective October 1, 2012, if "DDS is unable to secure their full cooperation in seeking alternative placement for [the client] that will meet his personal-centered needs."

The team reviewed DDA Policy 6.3, Positive Behavior Support,[31] issued in August 2011, which in § 6.J states that "[a]ll community provider agencies shall have and implement written policies and procedures for behavior support that utilize individualized positive behavior support techniques and prohibit aversive practices. (Emphasis in original.)" However, this policy does not specify which treatments are considered aversive.

DDS's October 2012 Response, as Received:

At pages [15-17] of the draft report, OIG includes the Summary of Compliance Form for Priority Matter section. By way of brief background, while the special evaluation was framed more broadly, in May 2011, OIG issued its Findings and Recommendations Compliance Form for Priority Matter and recommended based on its findings that DDA amend is Restricted Control Procedure/ Behavioral Support Policy; clarify why DDA has permitted the use of aversive treatments by the Judge Rotenberg Educational Center, Inc. ("JRC") in Massachusetts and what action(s) DDA has taken to rectify the situation; and determine whether any current DDA clients are subjected to prohibited procedures and ensure knowledge of D.C. Official Code and DDA policy prohibitions. DDA responded to these three recommendations by letter in May 2011, along with an executed copy of the OIG Compliance Form for Priority Matter. OIG thereafter followed up with another letter in June 2011, requesting further clarification with respect to DDA's response to the first two recommendations and a copy of JRC's most recent human care agreement. DDA provided OIG with the requested clarification in June 2011, but the OIG sent another letter in August 2011, addressed to both the Attorney General and the DDS Director, expressing concern that the District may be held liable because aversive treatments and that DDS clients in out-of-state placements may not be afforded the same protections from mistreatment as those individuals in District placements. In October 2011, the Attorney General sent a three-page letter responding to the OIG on behalf of both DDS and OAG by declining the invitation to provide a written opinion as recommended, but urging the DDS Director to undertake every reasonable effort to expeditiously seek an appropriate alternative placement for the individual at JRC.

In June 2012, the DDS Deputy Administrator for DDA provided follow-up to OIG by email with respect to the one individual still residing with JRC. By letters dated August 13, 2012, and August 31, 2012, respectively, DDS/DDA notified the co-guardians (1) of the District's intent to cease funding JRC placement beyond September 30, 2012, to seek their cooperation and written consent to permit DDS/DDA to share records with another provider, and to meet with them to fully explore a suitable residential and day habilitation services option to meet the person's individualized needs; and (2) of DDS/DDA's perspective on how to move the process forward. Since that time, DDS/DDA has been encouraged by the efforts to work together with the family and the other provider to identify the outlines of a suitable program and

[31] According to a DDA senior official, this policy replaced Policy 6.2.

to describe an effective transition plan which could take up to six months. The family already has visited the other provider and is working to permit a site visit to JRC to observe the individual.

DDS is aware that DDA Policy 6.3, Behavior Support Policy, dated August 2, 2011, does not specifically state that "shock therapy, white notice, and bitter-tasting food procedures constitute prohibited aversive stimuli." At paragraph 6.J., the Behavior Support Policy states that "[a]ll community provider agencies shall have and implement written policies and procedures for behavior support that utilize individualized positive behavior support techniques and prohibit aversive practices." (Underlining contained in the original.) Underlined words are included in the online Definitions Appendix, which has been changed to include a definition of "aversive practices" as follows: "Unpleasant, painful, uncomfortable or distasteful stimuli used to alter a person's behavior. The use of aversive interventions is strictly prohibited in all programs funded or operated by DDS, including but not limited to shock therapy, white noise and bitter tasting foods procedures." Please note that both the Behavior Support Policy, and the related Human Rights Policy dated February 21, 2012, are currently under review for revisions.

Recommendations:

That the Director of DDS (D/DDS):

(1) Apprise the Inspector General when the client at JRC has been placed with another provider, and affirm that the new provider does not employ aversive practices.

Agree **X** Disagree _____

DDS's October 2012 Response, as Received:

By letters dated August 13, 2012, and August 31, 2012, respectively, DDS/DDA notified the co-guardians (1) of the District's intent to cease funding JRC placement beyond September 30, 2012, to seek their cooperation and written consent to permit DDS/DDA to share records with another provider, and to meet with them to fully explore a suitable residential and day habilitation services option to meet the person's individualized needs; and (2) of DDS/DDA's perspective on how to move the process forward. Since that time, DDS/DDA has been encouraged by the efforts to work together with the family and the other provider to identify the outlines of a suitable program and to describe an effective transition plan which could take up to six months. The family already has visited the other provider and is working to permit a site visit to JRC to observe the individual.

OIG Comment: **DDS's actions appear to meet the intent of this recommendation. DDS should notify the Inspector General when DDA has successfully placed this client with another provider.**

(2) Amend DDA Policy 6.3, Positive Behavior Support, to specify the prohibited practices that DDA considers aversive.

Agree **X** Disagree _____

DDS's October 2012 Response, as Received:

DDS is aware that DDA Policy 6.3, Behavior Support Policy, dated August 2, 2011, does not specifically state that "shock therapy, white notice, and bitter-tasting food procedures constitute prohibited aversive stimuli." At paragraph 6.J., the Behavior Support Policy states that "[a]ll community provider agencies shall have and implement written policies and procedures for behavior support that utilize individualized positive behavior support techniques and prohibit aversive practices." (Underlining contained in the original.) Underlined words are included in the online Definitions Appendix, which has been changed to include a definition of "aversive practices" as follows: "Unpleasant, painful, uncomfortable or distasteful stimuli used to alter a person's behavior. The use of aversive interventions is strictly prohibited in all programs funded or operated by DDS, including but not limited to shock therapy, white noise and bitter tasting foods procedures." Please note that both the Behavior Support Policy, and the related Human Rights Policy dated February 21, 2012, are currently under review for revisions. Technically, DDS continues to consider it a mistake in policy drafting to attempt to list or identify activities or behaviors that are considered aversive, but have acquiesced in agreeing to this recommendation to bring the issue to closure.

CLIENT CASE RECORD REVIEW

Background

As part of the special evaluation, the OIG team conducted a review of DDA's client files. The goals of the review were to determine whether:

1. monitoring and visits occurred at the frequency required; and,
2. ISPs were developed and written at the frequency required by DDA policies and key components of the ISP were completed.

Methodology

The team limited the scope of the review to activities recorded from January 1 to December 31, 2010. On February 23, 2011, at the team's request, DDA provided the OIG with a list of the universe population of all DDA clients residing in a placement outside of the District, including those residing in Maryland.[32] This included such information as each client's name, the type of facility each client resided in, name and address of the client's provider, as well as the DDA service coordinator assigned to the client.

This universe included 265 clients residing with 39 providers.[33] Two hundred twenty-five of those clients resided in Maryland placements, and 40 resided in other states. The OIG selected a random sample of 40 clients from the universe. This sample is not statistically representative and the results cannot be extrapolated to the entire population of DDA clients. However, the team's review of these randomly selected cases found deficiencies in DDA case

[32] DDA considers many of its placements in Maryland to be District placements if the MOA with Maryland authorizes the District to treat the Maryland facility as a District provider.

DDS's October 2012 Response, as Received:

[Footnote 32 on page 21] makes the point that "DDA considers many of its placements in Maryland to be District placements if the MOA with Maryland authorizes the District to treat the Maryland facility as a District provider." The fact of the matter is that DDA considers any Maryland-sited provider which is delivering services to an eligible DDA individual and is certified as part of the HCBS waiver program as being the equivalent of a District placement. Thus, even though the draft report speaks to the "universe" of out-of-state placement in calendar year 2010 being 265 individuals with 39 providers (with 225 of those individuals in Maryland and 40 in other states), DDS/DDA would only consider the 40 "other states" and some considerable smaller subset of Maryland-sited providers as meeting the functional definition of an out-of-state placement. This issue was discussed with the team and DDS/DDA must agree to disagree with the OIG in this regard.

OIG Response: **The OIG does not agree with DDA's characterization of Maryland placements. During its e-mail request of the universe population to DDA officials in February 2011, the OIG clearly articulated that it was seeking a list of all DDA clients who reside in an overnight placement outside of the District, including those placed in Maryland. Additionally, as reported on page 4 of this report, DDA did not have an official MOA with Maryland DDA from October 2007 through April 2011 that allowed the District to oversee the certification requirements of its Maryland providers. Lastly, the MOA executed with Maryland DDA in May 2011 indicates that Maryland DDA may ultimately deny a license by waiver for a DDA placement in Maryland. It states that Maryland DDA reserves the right to deny a license by waiver to any District applicant; it may revoke a license by waiver under certain circumstances; and it may summarily suspend the license by waiver under certain circumstances.**

[33] This list reflected information on clients who were placed in facilities such as host homes, support living, residential habilitiation, and nursing homes.

oversight that DDA managers should evaluate in order to help improve the quality of DDA case management.

The team developed an instrument for the case record review, using questions based on criteria in DDA policies and forms. The team piloted[34] the instrument and made necessary changes. DDA provided the team with "read only" access to its MRDDA Consumer Information System (MCIS)[35] and the clients' hard copy case folders. In order to accurately analyze each case, the team reviewed both MCIS and the hard copy case record for each client.

Findings of Case Record Review

Strengths

The case record review revealed the following strengths in the client case file information:

1. All clients had an ISP developed during calendar year (CY) 2010.
2. All clients had defined goals and action steps listed in their most recent ISP during CY 2010.
3. All cases reflected at least one contact between the DDA service coordinator and the client during CY 2010.

Areas for Improvement

Out of the 40 client files reviewed, the following key areas of concern or those that need improvement mainly pertain to DDA's monitoring and frequency of visits with clients during CY 2010:

1. DDA did not complete a residential monitoring tool for 5 (13%) of the 40 clients;
2. DDA service coordinators met the monitoring requirement of completing eight residential and/or day placement monitoring tools for only 13 (43%) of the 30 clients who resided in placements located within a 25-mile radius of DDA;
3. DDA service coordinators met the requirement of completing four residential and/or day placement monitoring tools for only 4 (40%) of the 10 clients who resided in placements located more than 25 miles from the District; and
4. the DDA service coordinator met the requirement of conducting a total of 12 face-to-face visits for only 16 (40%) of the 40 clients.

The following discussion provides a more detailed account of our observations from the case record review.

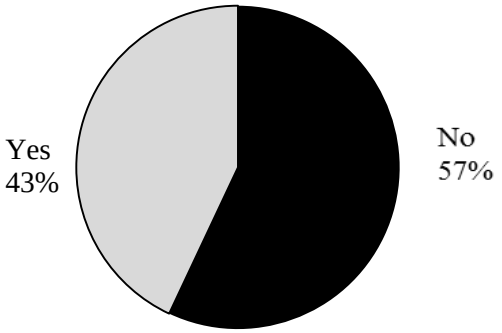
[34] "Piloting" the case review instrument refers to pretesting it to identify whether the proposed methods or instruments are inappropriate or too complicated. *See* http://sru.soc.surrey.ac.uk/sru35.html.
[35] MCIS is an electronic file system used by DDA to organize and record important client information and support key business processes.

1. Client monitoring and on-site visits were inconsistent.

The team assessed the visits to and monitoring of DDA clients during calendar year 2010. As stipulated in its policy, DDA must monitor its clients to ensure compliance and implementation of a client's goals as well as support/services identified in the client's ISP. For clients living within a 25-mile radius of the District, the service coordinator must complete eight monitoring tools. For those clients living more than 25 miles away from the District, the service coordinator must complete four monitoring tools.[36] A DDA manager explained that both the day and residential monitoring tools count towards these standards, and the required number of monitoring activities that must occur at either location (day or residential) may vary on a case-by-case basis (See Finding 1 for further information regarding the lack of clarity in DDA's monitoring policy).

Out of the 40 client files the OIG team selected for review, 30 clients resided within 25 miles of the District. The team first assessed whether DDA completed 8 residential monitoring tools for each client. During CY 2010, DDA completed 8 residential monitoring tools for 4 (13%) of the 30 clients, but did not meet the standard for 26 clients (87%). The team conducted a second analysis and factored in day placement monitoring tools along with residential monitoring tools and found that[37] DDA met the standard for 13 clients (43%), but failed to meet this standard for 17 clients (57%), as shown in Chart 1 below.

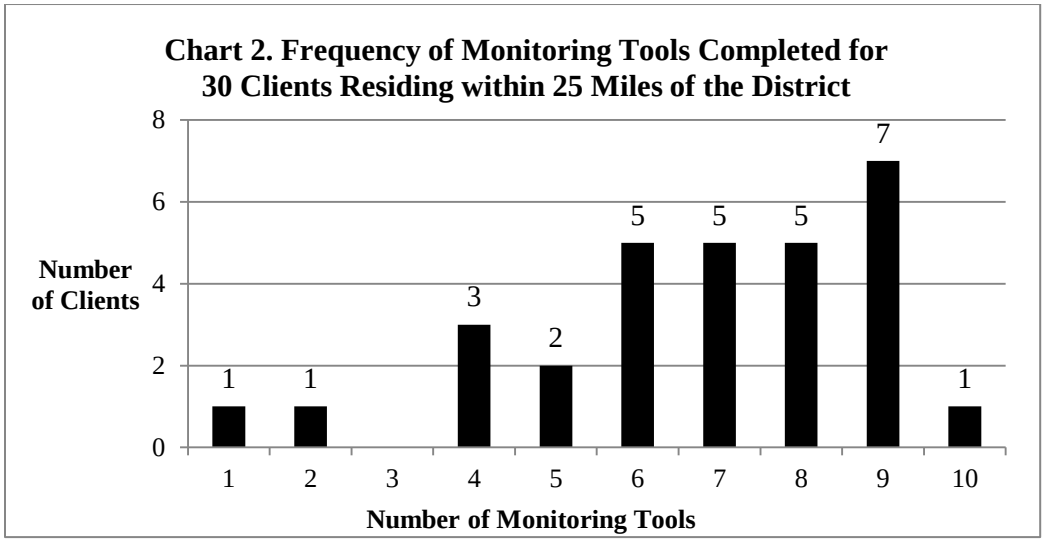
Chart 1. Completion of Eight Monitoring Tools for 30 Clients Within 25 Miles of the District



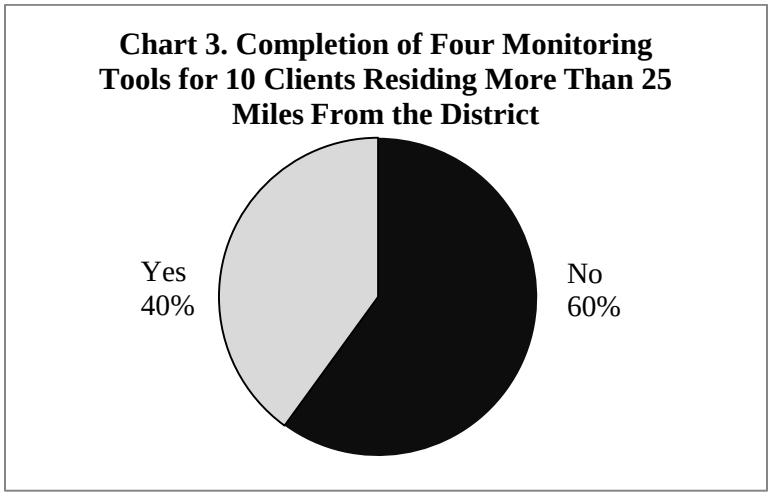
[36] *See* DDA Policy 10.3, Case Management Monitoring Policy, § 7. A DDA manager informed the team that DDA has not specified a point in the District from which to measure the 25-mile radius. DDA Policy No. 6.7.2, Employee Travel – Revised, defines "out-of-town travel" as travel outside a 50-mile radius from the DDA main office at 1125 15th Street, N.W., Washington D.C. For the purposes of the case record review, the team assessed whether clients resided more than 25 miles from DDA's office at 1125 15th Street, N.W., Washington, D.C. In addition, DDA Policy 10.3 does not specify the time frame within which to complete required monitoring. One DDA manager stated that the client monitoring must occur within the ISP year. Due to the lack of clarity in written policy, the OIG's analysis focused on the required client monitoring during CY 2010 for a consistent, 12-month period of testing for all clients.

[37] According to a DDA supervisor, of the eight monitoring tools, four should be residential monitoring tools and four should be day placement tools. However, this numerical breakdown can vary on a case-by-case basis. For example, a client may not want visits to occur at his/her place of employment.

Chart 2 below shows a frequency breakdown of DDA's completion of residential and day placement monitoring tools for 30 clients who resided within 25 miles of the District.



During CY 2010, of the 10 clients residing more than 25 miles outside of the District, DDA completed 4 residential monitoring tools for only 2 clients (20%). By factoring in day placement tools, DDA met this standard for 4 clients (40%) but did not meet the standard for 6 clients (60%), as shown below in Chart 3.

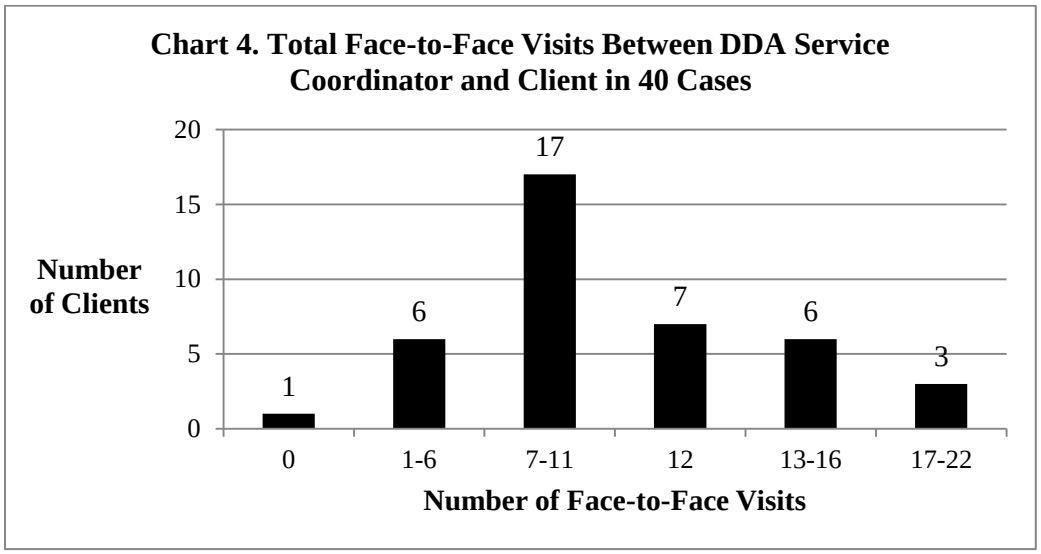


2. Required client contacts were inconsistent.

An internal DDA memorandum (Issuance Number 2005-003) states that DDA service coordinators must conduct one face-to-face contact each month with each client, for a total of no less than 12 visits per year. The team found that during CY 2010, service coordinators met the requirement of 12 visits for only 16 clients (40%).[38] This analysis factored in residential and

[38] The team only analyzed whether DDA conducted 12 visits during CY 2010 but did not assess whether visits

day program monitoring tools, narrative write-ups about a contact between the client and service coordinator, and any other form of documented evidence of a face-to-face contact between the client and service coordinator. A DDA supervisor said that the monitoring tool qualifies as a form of face-to-face contact. Chart 4 below shows a breakdown of visits.



During CY 2010, DDA service coordinators made contact with clients in 35 cases (88%). This included in-person and telephone contacts that were not part of a client visit or monitoring requirement. There was no evidence of such contact in 5 cases (13%).

DDA representatives informed the team that they have the ability to submit and sign monitoring tools electronically in MCIS. However, the team found that even applying this standard, two tools had no service coordinator signature.

3. ISPs were developed and present for all Clients

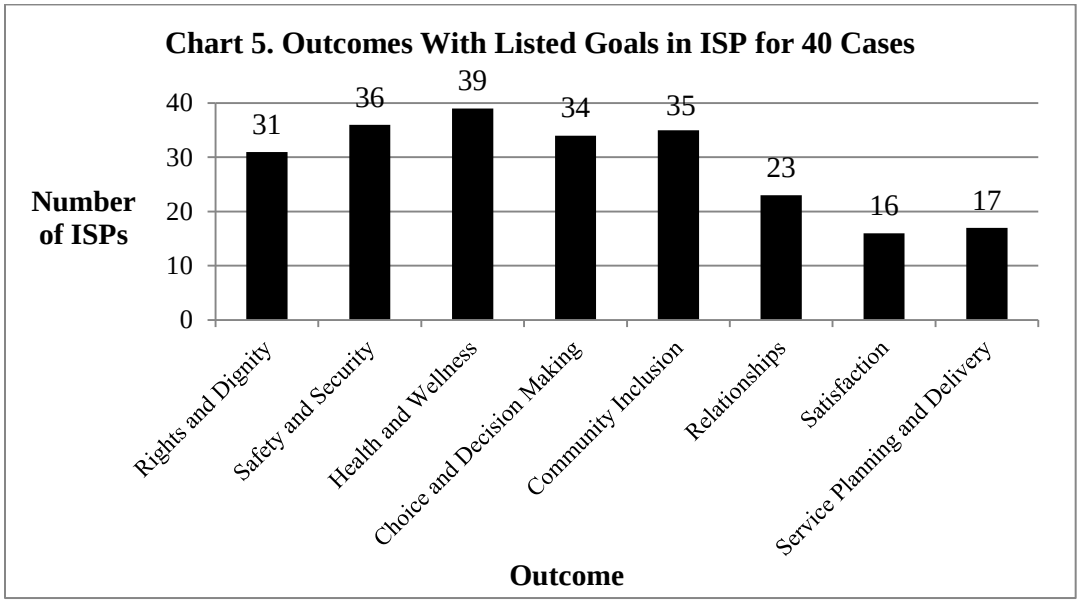
On an annual basis as set forth in DDA policy, DDA officials must develop and update an ISP for each client. The ISP must define the client's needs, preferences, and goals, and outline the services in support of the client.[39] A team approach is used in developing an ISP, and includes input from the client, service coordinator, residential provider representative, and family members. An ISP must include quality outcomes[40] for a client, and within each outcome, a goal must be reflected along with a statement of the planned action steps necessary to achieve the goal and the responsible party for completing them. For example, some DDA quality outcomes include health and wellness as well as safety and security.

occurred each month.

[39] *See* DDA Policy No. 7.1, Individual Support Plans, § 5 (Nov. 2008).

[40] According to DDA Policy 7.1, § 4, an "outcome" means "tangible results of goals that reflect the desired quality of life as defined by the individual."

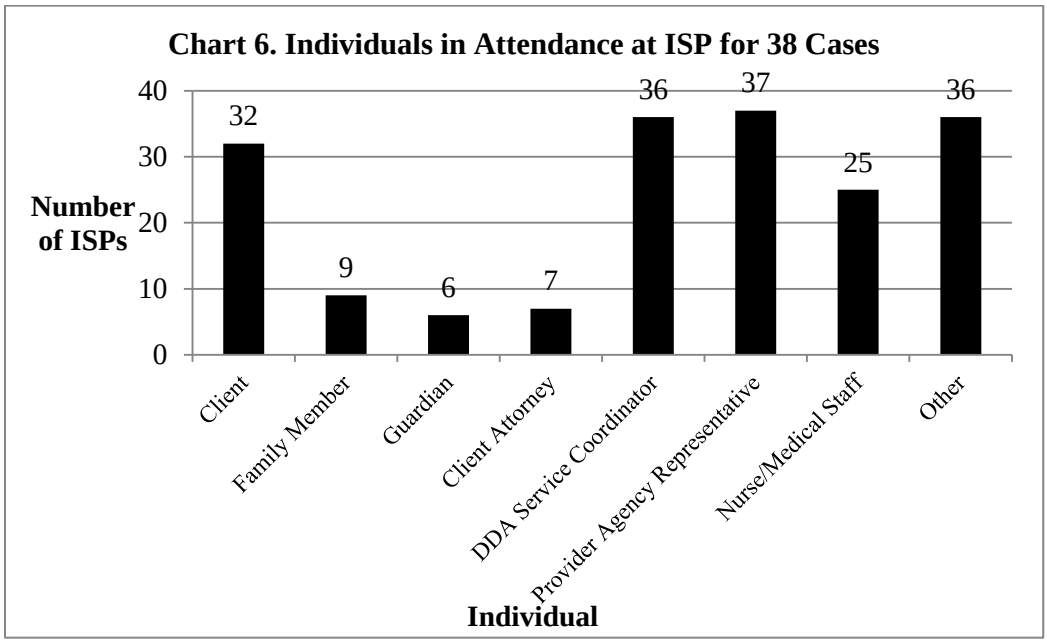
The team reviewed the listed goals in each client's ISP.[41] The team did not test the goals for quality, but only checked to see if they were present. Since January 2010, an ISP had been developed for each of the 40 clients and all 40 ISPs reflected goals and action steps for the clients. While all ISPs had a goal in at least one of the outcomes, Chart 5 below, reflects the frequency of ISPs with at least one goal for the outcomes.



While most cases had clearly defined goals for the client, there were instances of either vague or non-specific goals. For example, a client's goal in one section read: "[Client X] will maintain his rights and dignity for the following year." The team assessed whether the current ISP reflected the progress[42] during the last year with his/her outcome statements, and found that 34 (85%) ISPs reflected progress and updates, while 6 (15%) did not.

The individuals most often present at ISP meetings were a representative from the provider agency, the DDA service coordinator, and the client. In two cases, the ISP did not indicate who was present at the ISP meeting.[43] See Chart 6, on the following page, for further details regarding ISP meeting attendees for the remaining 38 ISPs that reflected individuals in attendance.

[41] At the time of its testing, the team reviewed the most recent ISP completed since January 2010.
[42] With regard to progress, the ISP includes a section for the service coordinator to provide an update on the client's progress with achieving his/her outcomes and goals within the last year. The team assessed whether this section was completed for each of the 40 ISPs.
[43] The team did not assess if there was a documented reason for those clients not in attendance at the ISP meeting. In addition to the two cases in which the ISP did not reflect who was present, for six other cases in which the client was not present, neither a guardian, family member, nor an attorney was present at four of the six.



The team assessed whether each ISP was signed, and by whom.[44] A DDA official informed us that a "signature page" should be uploaded into MCIS reflecting the ISP meeting attendees as well as the client's acknowledgement of his/her plan of care for the year. The team observed that the signature pages were located in various tabs within MCIS. Of 40 ISPs, 70% (28) were signed by the DDA service coordinator while the remaining 30% (12) were unsigned.

4. Additional Issues

The team found that 7 clients (18%) had changed placements at least once during CY 2010. A DDA supervisor informed the team that there should be a "provider's choice" form in MCIS attesting to the client's agreement with changing placement to the new provider. The team found that there was evidence for two of the seven clients that reflected their agreement with the placement changes.

According to DDA's "Out of State Placement Policy," § 6(C), dated February 1, 2011,

> DDA will respect the preferences of individuals supported by DDA in regards to his or her choice of location of receiving [ ] supports and services if those services can be secured in a cost equivalent manner in an out-of-state location.

Although the language in the policy reflects that DDA will respect the client's preference, it does not require the client's signature as proof of agreement to change his or her placement.

[44] DDA Policy 7.1, § 8(D)(3)(m), states that the service coordinator shall maintain documentation in the client's ISP "indicating that the [client]l or the [client's] family, guardian, or designated representatives, when applicable, has been involved in development of the ISP, and agree or disagree with the ISP."

The team was unable to determine when 36 of the 40 clients began receiving DDA services from DDA. Of the 36, 18 clients were former Forest Haven residents (*Evans* class members). A DDA official stated that these members would have been DDA clients from the point of the MRDDA's establishment. DDA loses the ability to analyze its clients' historical service record by not consistently maintaining their DDA service initiation dates.

The team looked for evidence of a guardian or legal representative acting on the client's behalf.[45] A DDA official said that a DDA client may act on his/her own behalf; however, there must be an assessment signed by a DDA health professional attesting to the client's ability to do so.[46] The team found that 80% (32) of clients observed had a guardian or representative acting on his/her behalf.[47] For the remaining 8 (20%) clients, the team found evidence that 4 were acting on their own behalf but there was no information for the other four. For the four clients acting on their own behalf, the client file contained an assessment signed by a DDA health professional attesting to the client's ability to act on his/her own behalf.

Recommendations:

For recommendations pertaining to DDA's monitoring, see Finding 1.

For recommendations pertaining to training DDA staff on the use of MCIS, see Finding 4.

DDS's October 2012 Response, as Received:

At pages [20-29], the draft report provides its background, methodology and findings related to its case record review for 40 individuals. DDS/DDA has no factual basis upon which to dispute the strengths, areas for improvements, or recommendations.

OIG Comment: **The OIG stands by its methodology, findings and recommendations in the client case review section of this report. The OIG encourages DDS and DDA leadership to review these findings to identify areas for improvement in serving DDA clients.**

[45] According to a DDA official, there is no statutory requirement for individuals serviced by DDA to have a guardian or legal representative. However, by law, DDA is responsible to ensure that individuals served by DDA who lack capacity to make decisions have identified a substitute decision-maker. DDS assists individuals to execute a power-of-attorney if their psychological assessment indicates they can understand and can execute a power-of-attorney. When an individual does not have anyone to serve as a power-of-attorney or a substitute decision-maker, DDA seeks the appointment of a guardian through the D.C. Superior Court.

[46] **DDS's October 2012 Response, as Received:**
On page [29], please note that an individual is presumed by law as possessing capacity, and that the issue of capacity is addressed in each person's psychological examination, which is completed by a licensed psychologist who is either contracted or an independent psychologist and not a DDS/DDA employee.

[47] For 15 of the 32 clients with a guardian or representative, either the guardian, family member, and/or attorney was in attendance at the ISP meeting.

SELECTED FEEDBACK, PROVIDER OPINIONS, AND OBSERVATIONS OF CLIENT RESIDENCES

Methodology

During the OIG's entrance brief with DDA officials in October 2010, DDA provided the OIG team with a list of 56 providers that render residential services to 285 DDA clients residing outside of Washington D.C. as of September 30, 2010.[48] From this list, the team selected 11 providers and conducted interviews with them in January and February 2011. The team selected providers who housed clients in various states and within different facility types, ranging from host homes, supported living, and residential habilitation. Six of the selected providers had clients placed in Maryland and five had clients placed in other states, such as West Virginia and Florida. The team interviewed the provider's point-of-contact with DDA. Additionally, the team conducted an observation of the residences for 9 DDA clients placed with 6 of the 11 providers. Seven of these clients were placed with five providers in Maryland and two clients were placed with one provider in Pennsylvania.

During the interviews, the team gathered information from the point-of-contact at each provider about such matters as the adequacy of DDA policies and procedures, communication between DDA and the provider, adequacy of DDA monitoring and training, and completion of assessments. The providers render services to a quantity of clients ranging from a minimum of 1 to as many as 85.

The information below summarizes themes and individual opinions providers articulated regarding areas of strength and areas needing improvement in working with DDA. It does not reflect all opinions gathered. While this information was not gathered using a scientific or structured methodology, it provides useful insights and generated recommendations for DDA to consider.

The team's observations of DDA clients' living arrangements consisted of assessing safety and sanitary conditions in each residence, such as the cleanliness of rooms, structural conditions, and functioning plumbing.[49]

Results of Provider Observations

The team visited residences and observed living conditions for nine DDA clients placed with providers in Maryland and Pennsylvania. To facilitate these observations, the team developed and completed a checklist of certain health and safety standards to assess at each residence. Overall, the team found the residences free from any empirical defects. The residences were clean, stocked with adequate food supplies, equipped with doors that secured properly, and electrical, heating, and cooling systems functioned properly. The residences also were equipped with operative smoke detectors and maintained fire evacuation plans. The buildings presented no visible leaks or structural damage, broken windows, exposed wiring, or cracked floor tiles. The client files were organized and properly secured. One residence was

[48] This list had more clients and placements reflected than the list provided in February 2011, which was used to select the case file sample, because the 2010 list also reflected information on clients residing in foster homes.
[49] The team focused its observations on common, observable conditions that a layperson would notice, as they are not licensed housing or safety inspectors.

cluttered with furniture, boxes, and clothes although it was well maintained and common areas were clear. Table 1 presents the team's aggregate results checklist from observations at the nine residences.

Table 1. Results of Residence Observations for Nine DDA Clients

Observation Tested	Yes	No
Kitchen is clean	9	
Bathroom is clean	9	
Hallway/living area is clean	9	
Doors secure properly (e.g., locks and deadbolts)	9	
Exposed electrical wiring		9
Functioning electricity (e.g., lights and sockets)	9	
Presence of exposed plumbing		9
Cracked floor tiles (potential asbestos)		9
Concerns with structural integrity (e.g., cracks in walls, floor, ceiling, and/or roof)		9
Evidence of water leaks		9
Proper running water in sinks, faucets, and toilets	9	
Adequate food supply	9	
Functional heating/cooling system	9	
Broken windows		9
Operable smoke detectors	9	
Presence of fire evacuation plan	9	
Organization and security of client files	9	

Provider Opinions

DDA Strengths

Professional Knowledge. Stakeholders cited various areas in which DDA's performance is strong. One provider stated that DDA has qualified administrators who understand the intricacies of service delivery and the Medicaid system. Another commented that DDA stays updated on client needs, planning, and care. A third provider stated that their DDA service coordinator is supportive and understands their clients' needs.

DDA Policies. Eight providers commented that DDA's policies are adequate, and seven providers stated that no additional DDA policies were needed to improve service delivery to DDA clients. One of those providers stated that DDA's policies were well-written.

Communication. In relation to the level and quality of communication occurring between DDA and the providers, nine providers stated that communication with DDA was frequent and/or DDA was responsive. Seven providers stated that they knew which DDA managers to contact if they disagreed with a request from a DDA staff member. One provider stated that DDA's frequency of client contacts depends on the service coordinator and the client's needs.

Another provider stated that visits usually occur monthly. A third provider stated that DDA visits at least once per month while some DDA service coordinators visit more often.

Training. With regard to the level and quality of DDA-administered provider training, seven commented that the training was adequate. One provider stated that DDA has offered a wealth of training, including training on incident management, healthcare issues, and human rights. This provider added that whenever DDA introduces a new policy, DDA officials also provide training.

DDA Areas for Improvement

Various providers expressed concerns about DDA's client monitoring at their facilities. For example, one provider stated that there has been little DDA client monitoring at their facility. This provider added that there is general dissatisfaction regarding communication with DDA and lamented that DDA personnel are extremely unprofessional to communicate with. Another provider stated that DDA will monitor one client at its facility, but fail to monitor another. A third provider stated that although the service coordinators are required to leave a copy of the completed monitoring tool so that the provider can address any issues, coordinators do not leave this document. This provider added that better communication is needed and DDA is inefficient with provider follow-up.

A fourth provider commented that they submit monthly updates to DDA and DDA visits once a year, while a fifth provider stated that DDA visits the provider location every year for the ISP meeting and contacts the client a couple of times per year, but DDA used to visit more frequently.

Two providers expressed concerns about DDA's failure to compensate them for client services rendered. Another expressed concerns regarding the voluminous nature of the Medicaid billing paperwork. A fourth provider expressed concerns with obtaining a specialized wheelchair for a DDA client and the lack of healthcare providers in their geographic area willing to accept D.C. Medicaid.

In response to the team's question to providers about the adequacy of DDA policies, one provider stated that he/she was unaware of DDA policies and procedures for serving DDA clients. Another provider expressed a desire to receive more information about DDA's online policies. A third provider expressed concern that DDA does not have an emergency discharge policy, which allows a provider to discharge a DDA client when the provider believes it cannot support the client. A fourth provider stated that it would be beneficial if DDA had a streamlined process for submitting paperwork for billing matters. A fifth provider reported a need for further guidance in the DDA Incident Management Reporting requirements.

Three providers stated that they did not know which DDA manager to contact in the event they disagreed with a DDA staff member's request. These three providers added that they have not received DDA training. One provider stated that ISP training is needed because the ISP's format has radically changed. Another provider stated that DDA should provide Medicaid

training. Yet another provider stated that DDA should provide training with respect to its structure, lines of communication, and billing processes.

DDS's October 2012 Response, as Received:

DDS/DDA has no factual basis upon which to dispute the OIG's reported findings in this five-page section of the draft report. Nevertheless, DDS/DDA appreciates receipt of this information and will review and consider it as appropriate.

FINDINGS AND RECOMMENDATIONS

1. DDA lacks consistent monitoring of its clients in out-of-state placements.

Criteria:[50] The Government Accountability Office (GAO) states: "[M]anagement is responsible for developing the detailed policies, procedures, and practices to fit their agency's operations and to ensure that they are built into and an integral part of operations."[51] Additionally, GAO states that agencies should "appropriately assign[ ] authority and delegate[ ] responsibility to the proper personnel … and … [consider that] management has effective procedures to monitor results."[52]

DDA's Case Management Monitoring Policy states in relevant part:

> **2.** Each Case Management Coordinator shall complete at least 8 monitoring tool [sic] on each individual in his/her caseload who resides within a 25 mile radius of the District.
> **3.** Each Case Management Coordinator shall complete a minimum of 4 monitoring tools for each individual on his/her caseload who resides more than 25 miles outside of a 26 mile radius of the District of Columbia.[53]

In addition, as of January 1, 2006, DDA's Case Management Policy states:

> Effective immediately, all [DDA] Case Management Coordinators are required to conduct at least one (1) face to face visit with each client in their assigned caseload every month for a total of no less than (12) face to face client visits per year.[54]

Condition:[55] The OIG team found inconsistencies in the Service Coordination Unit's quality and frequency of DDA client monitoring. The case record review revealed that only 13 (43%) of 30 clients living within 25 miles of the District had 8 monitoring tools (residential and/or day placement tools) completed in calendar year 2010. For the 10 clients residing further away from the District, only 4 (40%) clients had the required 4 monitoring tools completed. (*See* Client's Case Record Review Section for further detail.)

The team found that DDA's Case Management Monitoring Policy lacks clarity. The policy does not specify completion time frames for monitoring tools (e.g., annually, semi-annually, quarterly, etc.). It does not address monitoring protocols that apply when a client transfers to another provider and residence during the year. In addition, the monitoring policy is

[50] "Criteria" are the rules that govern the activity being evaluated. Examples of criteria include internal policies and procedures, District and/or federal regulations and laws, and best practices.
[51] GENERAL ACCOUNTING OFFICE, STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT 7, GAO/AIMD-00-21.3.1 (Nov. 1999).
[52] GENERAL ACCOUNTING OFFICE, INTERNAL CONTROL MANAGEMENT AND EVALUATION TOOL 17, GAO-01-1008G (Aug. 2001).
[53] DDA, Case Management Monitoring Policy, MRDDA 10.3, § 7 (Oct. 10, 2006).
[54] DDA, MRDDA Case Management Policy, 2005-003, (Jan. 1, 2006).
[55] The "condition" is the problem, issue, or status of the activity being evaluated.

unclear how many monitoring activities are to occur for clients who reside within 26 to 51 miles of the District. The policy references expectations for those clients within 25 miles as well as those "more than 25 miles outside of a 26 miles radius" (i.e., 51 miles). Additionally, this policy does not establish the address of the central point of reference for calculating this radius.[56]

The monitoring policy does not clarify where client monitoring activity should occur. For instance, the policy does not specify the number of monitoring activities that should occur at the client's residence versus DDA headquarters or the client's place of employment/day treatment location. The case review revealed that DDA service coordinators conduct monitoring activity at both day treatment programs and residential placements. A DDA manager clarified that monitoring activity conducted in both locations counts towards the monitoring requirements.

After the team conducted its case review, DDA issued a Service Coordination Monitoring policy in July 2011 that supersedes Case Management Monitoring Policy 10.3.[57] The new policy clarifies the required frequency for completing client monitoring activity as well as the permissible locations for fulfilling the requirement. It also delineates the frequency of monitoring activity for those clients residing in placements with HCBS Waivers versus clients from the *Evans* lawsuit, ICFs, and natural homes.[58] This policy discusses the client monitoring expectation for those residing within and beyond a 25-mile radius. However, it does not state the central point for measuring this radius. The team noticed that DDA has decreased the monitoring activity requirement for certain clients. For example, clients living outside a 25-mile radius of the District must undergo two monitoring sessions rather than four. Clients in a HCBS Waiver program within 25-miles of the District must undergo four monitoring sessions rather than eight. The clients from the *Evans* lawsuit within 25 miles of the District must undergo eight monitoring sessions, but the policy does not clarify the expectation for *Evans* clients living beyond 25 miles of the District.

The team observed that the monitoring tool completed by DDA service coordinators is lengthy. It is five pages long and is used to review both residential placements and day treatment programs. The monitoring tool requires service coordinators to assess nine outcomes, including whether clients are: 1) free from abuse, neglect, and injury; 2) supported with the best possible healthcare services; and 3) receiving services outlined in their ISP. One of these 9 outcomes contains 10 questions that the service coordinators must answer.

Four providers stated that most DDA service coordinators visit their clients each month. Another provider stated that DDA visited the facility only twice in 4 years, did not attend an ISP meeting, and that monitoring is not sufficient. A third provider stated that for one client, a DDA service coordinator makes regular visits. However, for another client, the DDA service coordinator has made no in-person visits. Yet another provider stated that DDA makes only yearly visits. A provider stated that better communication with DDA was needed and that DDA conducts inefficient follow-up with them.

[56] In contrast, DDS Policy Number 6.7.2, Employee Travel – Revised, effective April 8, 2010, defines the mileage requirement for out-of-town travel as "travel outside a fifty (50) mile radius of the DDS main office at 1125 15th Street, N.W., Washington D.C. 20005."
[57] The OIG notes that as of November 2011, the former policy was still accessible on DDA's website.
[58] A "natural" home refers to the home of a parent or relative of the DDS client.

Cause:[59] The OIG team is concerned that unclear monitoring tools are impacting effective monitoring. In addition, a DDA service coordinator stated that funding is not always available for travel to client placement locations for monitoring, and in those circumstances, monitoring is conducted by telephone or email. (For additional information regarding DDA service coordinator travel issues, see Finding 5.)

Effect:[60] Inconsistent monitoring may dilute the relationship between the service coordinator and the client as well as the provider, culminating in a lack of service delivery to the DDA client. Regular monitoring of DDA clients allows DDA to work with providers to correct issues that DDA service coordinators identify, provides a forum for regular dialogue, and promotes a safe and responsive environment for DDA clients.

A DDA service coordinator stated that monitoring facilitates rapid response to clients' needs, issues, and concerns that have not been previously communicated and ensures that appropriate follow-up actions are taken. This coordinator added that through monitoring, he/she is able to take immediate action to resolve issues that pose health and safety risks, and provide effective care to clients. For example, a provider had not notified him/her that a client's dentures were broken. During a monitoring visit, this service coordinator learned about the client's dentures problem and ensured that the matter was corrected. In another case, a client reported that his/her air conditioner was broken and his/her room was warm. The provider informed the service coordinator that the client had a portable air conditioner. Through an unannounced monitoring visit, the service coordinator confirmed that although there was a portable air conditioner, the room was still too warm as the thermostat was registering at 87 degrees. Through monitoring, this service coordinator ensured that the client's air conditioning problem was corrected.

Accountability:[61] DDA supervisors and managers are responsible for ensuring that service coordinators conduct required monitoring. DDA service coordinators are responsible for ensuring that they perform monitoring activities as set forth in their job requirements.

Recommendations:

That the D/DDS:

(1) Ensure that DDA service coordinators conduct monitoring at the frequency required by DDA policy.

Agree **X** Disagree _____

[59] The "cause" is the action or inaction that brought about the condition being evaluated.
[60] The "effect" is the impact of the condition being evaluated.
[61] "Accountability" is a description of who is responsible for the condition being evaluated.

DDS's October 2012 Response, as Received:

DDA's Supervisory Service Coordinators currently monitor and measures the frequency of monitoring visits by the Service Coordinators in their charge.

OIG Comment: **Based on DDS's response, the OIG considers the status of this recommendation to be closed.**

(2) Assess the current monitoring tool to determine whether it can be shortened or streamlined.

Agree **X** Disagree _____

DDS's October 2012 Response, as Received:

The Service Coordination Monitoring Tool for residential services, effective October 1, 2012, has been modified and can be efficiently used by Service Coordinators using technology (e.g., smart phones, iPads and laptop computers). The tool was streamlined and uses 47 standard questions or "trigger" questions. The trigger question will generate additional applicable questions needed to monitor the individual services for that person.

OIG Comment: **Based on DDS's response, the OIG considers the status of this recommendation to be closed.**

(3) Periodically evaluate and adjust service coordinator assignments to maintain efficiency with respect to monitoring, with particular attention on clients located at great distances from the District. (For further information, see the Executive Summary.)

Agree **X** Disagree _____

DDS's October 2012 Response, as Received:

DDA recently completed an evaluation and adjustment of Service Coordinator assignments in October 2011. Please note that, while DDS/DDA agrees that there should be periodic evaluations and adjustments to assignments, continuity is an important factor to consider.

OIG Comment: **Based on DDS's response, the OIG considers the status of this recommendation to be closed.**

2. DDA lacks written policies and procedures specific to serving clients in out-of-state placements.

Criteria: The GAO states: "Appropriate policies, procedures, techniques, and mechanisms [should] exist with respect to each of the agency's activities."[62] GAO also states that "[w]ritten documentation [should] exist[ ] covering the agency's internal control structure and for all significant transactions and events.'[63]

Condition: Various DDA officials told the team that DDA has no written policies or procedures specific to serving clients in out-of-state placements. In October 2010, a DDA senior official corroborated this condition. In December 2010, the team reviewed DDA policies and found no current policies and procedures specific to out-of-state clients.[64] Certain policies refer to monitoring activity and other actions to be taken on behalf of clients living beyond the District. For example, the Case Management Monitoring Policy outlines the number of monitoring visits for those clients living in placements located more than 26 miles from the District.[65] In addition, the Individual Support Plans Policy notes that the provider will develop the ISP for clients living beyond the District, Maryland, or Virginia.[66]

A DDA senior official stated that service coordinators use monitoring tools and follow guidelines in the ISP to ensure quality of care for clients in out-of-state placements. Another DDA official stated that while there are no policies, service coordinators use a DDA guide, titled the *Service Coordination Role and Waiver Processes Desk Guide*. The team reviewed this guide, and found that it gives service coordinators detailed instructions on the handling of DDA clients, such as ISP development guidelines, but it does not include procedures specific to clients placed beyond the District.

During OIG interviews with DDA personnel, the team heard varying opinions on which policies and procedures DDA follows and heard variation on how DDA processes are executed for DDA clients in out-of-state facilities.

> ***Policies and Procedures:*** Three DDA service coordinators gave conflicting statements when questioned about DDA's policies and procedures that guide out-of-state client placement processes. One coordinator stated that the ISP, the Service Quality Review (SQR),[67] and consent forms are used. Another stated that court orders are used and that the client, family, and interdisciplinary team guide

[62] GENERAL ACCOUNTING OFFICE, INTERNAL CONTROL MANAGEMENT AND EVALUATION TOOL 34, GAO-01-1008G (Aug. 2001).
[63] *Id.* at 43.
[64] The team reviewed the DDS, Out of State Placement Policy, which became effective February 1, 2011. This two-page policy focuses on placing DDA clients in least restrictive residential settings and making reasonable efforts to return them to the District for supports and services to meet their needs. This policy also outlines DDA's commitment to respecting a client's preference in "choice of location [for] receiving [ ] supports and services if those services can be secured in a cost equivalent manner in an out-of-state location."
[65] DDA, Case Management Monitoring Policy, MRDDA 10.3, § 7 (Oct. 10, 2006).
[66] DDS, Individual Support Plans, Policy No. 7.1, § 5 (Nov. 2008).
[67] The SQR is an annual review of each DDA service provider's qualifications and performance to ensure that DDA clients are well served and free from harm (see Finding #6 for further information on SQRs).

the placement decisions. The third coordinator stated that DDA follows the procedures outlined in the Medicare/Medicaid Waiver requirements. These three service coordinators stated that DDA's policies are adequate.

Monitoring: A DDA official stated that for clients placed outside of the District and Maryland, DDA requires one annual monitoring activity at the facility and four client ISP monitoring activities. These monitoring activities can occur through on-site visits, or contacts via telephone or email. Another official stated that DDA requires service coordinators to conduct annual on-site visits at the provider location and conduct quarterly contacts with clients either in-person or on the telephone. A service coordinator stated that client contacts occur quarterly. Another service coordinator stated that DDA performs quarterly monitoring for clients residing more than 45 miles from the District and monthly monitoring for the other clients. Although DDA has a travel policy, it does not outline travel options for service coordinators to visit clients placed outside of the District and at distances that exceed the allowable use of District-owned or -leased vehicles or personal vehicles (*See* Finding 5). However, a DDA official informed the team that service coordinators can rent cars or fly a commercial airline to see clients who are placed at great distances from the District.

Individual Service Plans: The team heard inconsistencies regarding the development of ISPs, particularly for clients residing in out-of-state placements. A DDA senior official stated that the ISP is developed by the client's ISP team, and the client plays a large role in its development. A provider for a client in Maryland stated that a DDA service coordinator asked that provider to independently develop a client's entire ISP.[68] That provider added that when the DDA service coordinator appeared for the ISP meeting, he/she made changes to the ISP at that time, and it was found to be full of errors, and needed revision. Another provider opined that ISPs were a "joke" and rushed, and that large portions of the ISP text contain vague information. The team asked a DDA official whether providers are developing ISPs for clients in out-of-state facilities and was told that they are not.

Cause: A senior DDA official stated that DDA did not believe that specific policies for clients in out-of-state placements were necessary because these clients are treated the same as DDA clients placed in the District. This official also stated that providers must adhere to Medicaid Waiver regulations,[69] regulations within their own jurisdictions, and District laws. This official did not believe additional policies specific to out-of-state clients were necessary.

[68] DDS, Individual Support Plans, Policy 7.1, § 5 requires the service provider to develop the ISP for clients who live in settings outside of the District, Maryland, or Virginia, and the DDA service coordinator to approve the ISP. However, this policy also states that the DDA service coordinator will develop the ISP for clients who are funded through the HCBS waiver. *Id*.

[69] According to a DDA official, the Medicaid Waiver provides a funding source designed to support persons with disabilities. States and providers must meet requirements in order to qualify for funding. The federal government reimburses states for Medicaid costs and the localities pay for a client's room and board.

Another senior official opined that policies specific to monitoring clients placed in out-of-state facilities are not necessary because the requirements are covered in documents such as the ISP form. He added that the few service coordinators who handle clients in out-of-state placements are familiar with the service delivery process. The team disagrees with the description that only a "few" service coordinators handle such clients because as of May 2011, 79 service coordinators serviced 265 clients in states outside the District.

***Effect**:* During fieldwork, the team heard inconsistent views on how to monitor and develop ISPs for DDA clients in out-of-state placements. The team believes that when written policies and procedures do not exist, are incomplete, or not organized, inconsistent practices and errors that may be harmful to clients may occur. In addition, employees may not carry out their duties as expected or required by District laws and regulations, and such inconsistencies may lead to inaccurate and unreliable care records and affect treatment and other important decisions.

Accountability: DDA senior officials are responsible for ensuring that proper policies and guidelines are developed and implemented.

Recommendation:

(1) That the D/DDS write and issue policies and procedures to DDA employees and providers concerning treatment, placement, monitoring and service delivery to DDA clients in placements outside of the District.

Agree _____ Disagree **X**

DDS's October 2012 Response, as Received:

DDS's Out of State Placement Policy dated February 1, 2011, specifically states the policy that "[e]ligible individuals may receive the same services and supports irrespective of the location of residential placement." Even though the draft report speaks to the "universe" of out-of-state placement in calendar year 2010 as being 265 individuals with 39 providers (with 225 of those individuals in Maryland and 40 in other states), DDS/DDA only considers the 40 "other states" and some considerable smaller subset of Maryland-sited providers as meeting the functional definition of an out-of-state placement. This issue was discussed with the team and DDS/DDA must agree to disagree with the OIG in this regard. Although OIG's position is understood, from a programmatic standpoint, DDS disagrees and takes the policy position that it is ill-advised to bi-furcate or create another set of policies to govern out-of-state placements of District residents.

OIG Comment: **The OIG stands by its finding and recommendation. While the OIG team was aware of DDA's characterization of Maryland placements, the OIG team did not agree with it. In February 2011, the OIG asked DDA officials for a list of out-of-state placements. The OIG made clear that it was seeking a list of all DDA clients who reside outside of the District, including those placed in Maryland. Additionally, as reported on page 4 of this report, DDA did not have an official MOA with Maryland DDA from**

October 2007 through April 2011 that allowed the District to oversee the certification requirements of its Maryland providers. According to the MOA executed with Maryland DDA in May 2011, Maryland DDA may ultimately deny a license by waiver for a DDA placement in Maryland. It states that DDA reserves the right to deny a license by waiver to any District applicant; it may revoke a license by waiver under certain circumstances; and it may summarily suspend the license by waiver under certain circumstances.

3. The District faces various challenges when trying to place clients within its geographical boundaries.

Criteria: During the course of the team's fieldwork, the team did not find or receive DDA policies requiring clients' placement in the District.[70] In February 2011, DDA issued an Out of State Placement Policy that states:

> When individuals are placed in a residential setting outside of the District, DDA will make every reasonable effort to return them to the District for receipt of supports and services that meet their individual needs.
>
> *** * ***
>
> DDA will respect the preferences of individuals supported by DDA in regards to his or her choice of location of receiving of supports and services if those services can be secured in a cost equivalent manner in an out-of-state location.

Id. §§ 6(B)-(C).

In July 2011, a DDA senior official informed the team that DDA was drafting a policy that would outline new protocols for a District-first policy for residential and day services. This includes assessing various factors about a provider, such as whether it provides a safe, affordable, accessible building, as well as accessibility to public transportation, and community resources. The process to determine where a client will be based begins with a determination of the client's assessed needs and the provider's ability to meet those needs. This official added that DDA attempts to honor a client's preference for a provider, such as proximity to his/her

[70] Although the team found no requirement that all DDA clients must be placed in the District, DDA has received formal legal opinions advising that the agency transition its clients back to the District. In May 2008, University Legal Services, Inc. issued a report, *Segregated & Secluded: An investigation of D.C. Residents at the Florida Institute for Neurologic Rehabilitation* [FINR]. It concluded that D.C. residents placed at FINR are subjected to violations of numerous DC human rights policies. In June 2008, The District's Office of Contracts and Procurement issued a Request for Task Order Proposals (RFTOP) for the development of residential settings for individuals returning from out-of-state institutions. The RFTOP stated that "[t]he majority of the individuals are currently placed outside of the District and required to transition from these out-of-state residential programs back into their community and familiar ties in the Washington, DC area."

home or to an area where he/she has ties. In May 2012, the team requested an update from this official on whether the new District-first policy was issued, but did not receive a response.

Condition: Although DDA policy requires DDA officials to make reasonable efforts to return clients to the District for support and services, many clients are not placed within the borders of the District. According to DDA data provided to the team and used to select our case sample, as of February 23, 2011, DDA had 265 clients residing in placements outside of the District. Of these 265 clients, 225 were placed in Maryland. The remaining 40 clients were housed in states as far away as Texas, Florida, and Massachusetts.

According to a DDA official, a reason for a provider's selection as a placement source is its ability to meet the DDA client's needs. However, the OIG team identified various issues that impede DDA's ability to place all of its clients in the District.

Cause: Interviewees stated that court orders, judges' discretion, and the wishes of family members and guardians influence placement decisions. The team found other issues that contribute to DDA's inability to place all of its clients in the District. Some of these include:

> ***District housing costs*** – Various interviewees raised concerns about the prohibitive cost of housing in the District. A provider stated that finding safe, affordable housing in the District is extremely difficult, and housing is more affordable in Maryland. A DDA senior official stated that the cost of room and board in the District is an issue and real estate is less expensive outside of the District. This official added that DDA's use of placements in Maryland is generally attributed to housing costs in the District. Furthermore, unlike other metropolitan areas that can build a facility in a rural area on cheaper land or in another part of its state, the District is only an urban area that does not have land in other parts of its jurisdiction to exercise this option.
>
> ***Community push-back*** – A DDA senior official stated that although DDA clients may reside anywhere, DDA tries not to have many clients residing or clustered in certain geographic areas due to "not in my back yard" complaints. There can be push-back from councilmembers, communities, proactive citizens, and private entities that oppose providers' efforts to place developmentally disabled clients in their community.
>
> ***Lack of providers to serve medically or behaviorally challenged clients*** – A DDA senior official stated that its most medically and behaviorally challenged clients are difficult to place in the District because there are no providers able to care for them. Clients with a mental illness or a second diagnosis, such as psychosis, are also difficult to place. For example, DDA had to find an out-of-state placement for a client who starts fires and another with a history of abscondence and robberies. This official added that there are limited providers even in other jurisdictions equipped and willing to provide services to these types of clients. Another DDA official stated that clients who commit crimes are challenging to place in the District. A DDA service coordinator stated that a

client who disapproved of a placement in a local facility, set fire to the facility. The client was put on probation and placed with a provider in another state because other providers refused to accept this client. Another DDA official said that DDA should improve its recruitment and development of providers who can meet the needs of its population who are diagnosed with mental illness, as this group often has complex behaviors requiring acute inpatient hospitalization.

No Intermediate Care Facility (ICF) – A DDA official said that the District has no ICF to handle clients who engage in criminal activities. An ICF would assist DDA's service-delivery to dually-diagnosed clients. DDS's Director has been communicating with Saint Elizabeths Hospital to develop an ICF on its grounds. However, there are complications with establishing this ICF due to Medicaid Waiver regulations, which prohibit client placement in a hospital setting, as the client placement must occur in the least restrictive setting. This official added that the goal would be to establish an ICF in a cottage on the grounds of Saint Elizabeths Hospital[71], which would allow for the Medicaid assistance.

"Age-Outs" or Legacy Clients – According to DDA officials, some clients placed in out-of-state facilities are "age-outs" or legacy clients who began receiving service delivery from either D.C. Public Schools (DCPS) or the Child and Family Services Agency (CFSA) prior to becoming clients of DDA. If such a client who later aged into DDA's system wishes to remain at the out-of-state placement, DDA tries to keep the client there. Another official added that clients who have been in a placement for a long time may have separation issues if moved and DDA has to consider whether it is reasonable to move them back to the District.

***Effect*:** DDA decisions that place clients with out-of-state providers present challenges in regard to regular monitoring and treatment oversight. A West Virginia provider stated that because he/she is required to use D.C. Medicaid, it is difficult to find in-state service providers[72] that accept this payment method. For example, one of his/her clients requires quarterly visits with a psychologist. Because there are no psychologists in the state who accept D.C. Medicaid, the provider has to transport the client to the District. However, the client, who was dually diagnosed with mental retardation and autism, cannot tolerate these trips and misbehaves. A provider in Pennsylvania also stated that there is a lack of local providers who accept D.C. Medicaid. This circumstance requires the provider to transport DDA clients who are sometimes unstable and violent to the District for medical and psychiatric care.

A senior DDA official stated that it would be easier to monitor clients and providers locally, due to increased accessibility, timeliness, and delivery of services.

[71] "Saint Elizabeths Hospital is the District's public psychiatric facility for individuals with serious and persistent mental illness who need intensive inpatient care to support their recovery." *See* http://dmh.dc.gov/page/saint-elizabeths-hospital (last visited Nov. 13, 2012).

[72] A service provider refers to an individual or organization that provides residential or day/vocational, therapeutic, clinical supports, and services to the consumers served by DDA.

***Accountability*:** DDA senior managers are responsible for the recruitment and training of adequate District providers to service the DDA community.

Recommendations:

That the D/DDS:

(1) Conduct a feasibility study and collaborate with the Department of Housing and Community Development (DHCD) to identify, and set aside handicapped-accessible housing within the District for DDA clients.[73]

Agree _____ Disagree **X**

DDS's October 2012 Response, as Received:

Rather than attempt to conduct its own feasibility study and collaboration with the Department of housing and Community Development as recommended, DDS instead will rely on the work of the Mayor's task force identifying safe and affordable housing in the District of Columbia.

OIG Comment: **The OIG stands by its recommendation. In addition to working with the Mayor's task force, DDA should collaborate with DHCD.**

(2) Collaborate with the Department of Mental Health to identify and recruit providers in the District who can service medically and behaviorally challenged clients, including dually-diagnosed clients.

Agree **X** Disagree _____

DDS's October 2012 Response, as Received:

Through the Mayor's Inter-Agency Task Force on Coordination and Management of the Supports and Services Delivery System for Persons with Intellectual and Developmental Disabilities re-established by Mayor's Order 2011-93 dated May 9, 2011, DDDS/DDA is working with DMH to develop an Request for Proposals ("RFP") to recruit one to three core service agencies in the District who will provide mental health services to people with ID. The RFP will provide funding to the core service agencies to provide specialized training to their current staff and to hire people who have expertise in supporting people with ID to provide

[73] The mission of DHCD is to "create and preserve opportunities for affordable housing and economic development and to revitalize underserved communities in the District of Columbia." *See* http://www.dhcd.dc.gov/dhcd/cwp/view,a,3,q,555677,dhcdNav_GID,1575,dhcdNav,%7C32184%7C,.asp (last visited July 7, 2011).

behavior support. In addition, DDS and DMH are working to improve behavioral health care and services by establishing a Certified Behavior Analyst certification in the District of Columbia to increase access to this service for individuals qualified for HCBS waiver services. This work is in process and should be culminated by September 30, 2013.

(3) Continue efforts to establish an ICF that meets Medicaid Waiver regulations.

Agree _____ Disagree **X**

DDS's October 2012 Response, as Received:

It is incongruous "to establish an ICF that meets Medicaid Waiver regulations" as the HCBS waiver program approved by the federal government is literally a "waiver" from the requirements of the Medicaid State Plan and the ICF/IID.

OIG Comment: **During fieldwork, a senior DDS official informed the OIG team that DDS's Director was communicating with officials from Saint Elizabeths Hospital to establish an ICF. DDS should continue to explore ways to establish an ICF in the District so that DDA clients needing this level of care have an alternative to being placed in ICFs beyond the District.**

4. Inadequate training and policies on DDA's MCIS result in case management inefficiencies.

Background: DDA uses the MRDDA Consumer Information System (MCIS) as its electronic central information system to manage DDA client information. Its key purpose is to capture client information and support key business processes. DDA is the primary user of MCIS. Representatives of other District agencies who share responsibility with DDA for customer support as well as DDA providers in the community may use MCIS for limited purposes. DDA staff use MCIS to complete such tasks as data entry (e.g., a client's demographics), ISP creation/amendment; service authorization; and report generation. A DDA service coordinator stated that in addition to DDA staff, several entities have access to MCIS, including the *Evans* court monitor, D.C. Quality Trust,[74] and various service providers, who can upload documentation to a client's profile.

***Criteria*:** The GAO recommends that agencies manage, develop, and revise information systems "to continually improve the usefulness and reliability of [their] communication of information."[75]

[74] According to one of its senior officials, D.C. Quality Trust is an organization charged with improving the advocacy, monitoring, and access to legal services for persons with disabilities. It was created from the provisions of the *Evans* lawsuit.

[75] GENERAL ACCOUNTING OFFICE, INTERNAL CONTROL MANAGEMENT AND EVALUATION TOOL 55, GAO-01-1008G (Aug. 2001).

The GAO also recommends that agencies "provide[] training and counseling in order to help employees maintain and improve their competence for their jobs."[76]

***Condition*:** During the case record review, the OIG had read-only access to client information in MCIS. Generally, the team found MCIS user-friendly to navigate. Client information is recorded under certain tabs related to distinct topics. For example, contacts are stored under the consumer tab, and client monitoring information is stored under the monitoring tab. However, the team found that DDA service coordinators entered case information in various ways, and there appeared to be no standards for data entry. For example, ISP signature pages often were not found, client eligibility dates were not listed, and "choice of provider" documentation (i.e., a document verifying the DDA client's approval of a new residential placement) was not present.

A DDA official informed the team that MCIS is antiquated, "semi-dysfunctional" and overburdened, and the DDS Director was exploring acquisition of a new system for DDA. This official added that DDA staff performance management information is not accurate in MCIS.

A DDA information technology (IT) official stated that approximately 90% of MCIS-generated management reports are accurate. However, this official added that a handful of management reports are completely inaccurate.

Cause: According to interviewees**,** DDA does not offer formalized training on the MCIS system. In addition, according to a DDA official, as of February 2012, DDA does not have a MCIS user manual for service coordinators as a reference guide for data entry. Both DDA management and non-management personnel stated that training and a desk guide are needed. One official stated that he/she was informed that a MCIS tutorial was under development, but this has not come to fruition. Another official said that while he/she was aware of concerns with the system, many issues result from user error.

A DDA supervisor stated that the IT division and supervisors provide informal on-the-job training to employees and the IT division provides MCIS training. However, formal MCIS training and a desk guide are needed. A DDA IT official called the system "complex." He/she added that employees start working at DDS with varying degrees of computer knowledge. Training on basic computer skills and MCIS would strengthen employees' ability to provide more efficient service delivery. A DDA service coordinator stated that MCIS training is informal and the IT division provides inadequate training. This official often assists other DDA employees with the MCIS system who are not as computer literate and opined that it is difficult to locate information in MCIS because it has many tabs and menus.

***Effect*:** Without formalized training and policies on the MCIS system, the team is concerned that employee/user errors may result in inaccurate management reports and information about case specific matters. This condition could present a particularly serious problem in circumstances where a DDA official requires accurate updates about a client when an assigned service coordinator is absent.

[76] *Id*. at 12.

A DDA official stated that the MCIS has been changed in an effort to assist address user-errors issues by service coordinators. He/she added that service coordinators struggle with completing ISPs and incident resolutions. This official stated that Liberty Healthcare Corporation, which is an organization DDA contracted to assess its performance with service delivery, identified these issues during a service coordinators' performance assessment. (See Finding 7 for further information.)

***Accountability*:** DDA management and the DDS IT division are responsible for coordinating to provide DDA employees with adequate MCIS training and policies to ensure that client data are accurately and timely entered into the system.

Recommendations:

That the D/DDS:

(1) Implement a comprehensive and periodic MCIS training program for DDA service coordinators.

Agree **X** Disagree _____

DDS's October 2012 Response, as Received:

DDS acknowledges the general observations and recommendations of the OIG regarding the DDA MCIS system, but is limited in agreement with the recommendations that were proposed. DDS believes that the approaches already underway by DDA are superior to the proposed actions of the OIG as follows:

- *DDS maintains that the MCIS system is NOT antiquated and "semi-dysfunctional." The MCIS date system serves many purposes for DDS and, while it has been continually expanded across the years, we are aware of the system's limitations and work within those limitations. The MCIS does support DDS needs as on ongoing performance and information data system.*

- *DDS implement in September 2012 a major data-integrity initiative that is identifying all areas where inconsistency in data exists including the MCIS and other related data systems and is implementing the necessary changes in programing and procedures to eliminate the inconsistency. The data integrity initiative is eliminating areas where users may experience confusion or difficulty in data entry, eliminating duplications, clarifying data points and conducting regular audits of data accuracy.*

- *DDS acknowledges that the DDA staff needs additional training in the use of MCIS. A previous service coordination training program that included instruction in MCIS had been replaced several years ago in favor of more direct instruction by the DDA supervisors on the operations of MCIS. However, it became evident that the*

approach was not adequate and a MCIS training program is currently in production with an expected roll-out in the next 30 days.

OIG Comment: **The OIG stands by its finding and recommendation. DDS's actions with its data-integrity initiative and planned roll-out of MCIS training appear to meet the intent of this recommendation. The OIG encourages DDA to periodically provide MCIS training to new employees and refresher training.**

(2) Issue a comprehensive MCIS desk guide to serve as a reference for DDA personnel.

Agree _____ Disagree **X**

DDS's October 2012 Response, as Received:

DDA will continue to work on the provision of clear directives to stqff in the data entry and use of MCIS but does not believe that a MCIS desk guide as a stand- alone document has the necessary value for the resources required to produce such a document. Instead, DDA is involved in the production of a broader and more comprehensive DDA desk guide that incorporates MCIS information and instruction along with other related details of DDA operations and has greater value to the staff.

(3) Ensure that DDA managers review the accuracy of service coordinators' MCIS data entry information to facilitate accurate real-time performance report generation.

Agree **X** Disagree _____

DDS's October 2012 Response, as Received:

DDA procedures currently do require all DDA managers to review the accuracy of service coordinators MCIS data entry information.

OIG Comment: **The OIG encourages DDA leadership to confirm that DDA managers are consistently reviewing the accuracy of service coordinators' data entry into MCIS. During its fieldwork, the OIG team heard concerns from DDA personnel about the accuracy of information in MCIS. During its direct observations, the OIG team noted various fields in MCIS that were not populated with information.**

5. DDA lacks clear policy and procedures for conducting visits to clients in out-of-state placements.

***Criteria*:** GAO states that management should ensure that "[e]mployees are provided … tools to perform their duties and responsibilities, improve performance, enhance their capabilities, and meet the demands of changing organizational needs."[77]

DDS Vehicle Operations Policy, § 5 states:

> a. No employee shall use a government, leased vehicle (Zipcars)[78] or a personal vehicle for District government business without advanced written authorization from the employee's supervisor or manager.
>
> **…**
>
> c. Employees, who are requesting to use their personal vehicle, must notify their insurance company of the change to their personal automobile liability and advise them of the use of their vehicle for business purposes. The employee must provide the DDS Human Capital Administration (HCA) with a copy of the insurance policy cover statement reflecting the coverage of the vehicle/driver for business purposes.[79]

In addition, DDS's Employee Travel – Revised Policy states:

> In order to ensure compliance with this policy in regards to using the most efficient and cost effective allowable mode of travel, the destination, availability of public transportation, materials, and equipment to be transported, the time of day, and any established ADA accommodations for the traveling employee will be considered.
>
> **…**
>
> Personal Vehicles will only be used at the request of the employee and when no other travel method (public transportation, taxi, zip cars) is available [emphasis in original] or when the supervisor determines that a special circumstance warrants the use of the personal vehicle.[80]

***Condition*:** Although DDA has issued a travel policy that outlines transportation options and details instructions for travel reimbursement, the team found the policy mainly focused on travel options in the District. For example, the policy discusses travel options in order of priority

[77] GENERAL ACCOUNTING OFFICE, INTERNAL CONTROL MANAGEMENT AND EVALUATION TOOL 36, GAO-01-1008G (Aug. 2001).
[78] According to DDS Vehicle Operations Policy, ZipCars are considered to be leased vehicles.
[79] Department on Disability Services Vehicle Operations Policy, §§ 5(a) & (c).
[80] DDS Policy 6.7.2, Employee Travel – Revised, § 8 (Apr. 8, 2010).

as: 1) public transportation that includes the use of Metro passes and SmarTrip Cards; 2) taxi service, which lists the name and phone number of a taxicab company with a D.C. area code; 3) District-owned or -leased vehicles; and, 4) personal vehicles. The policy is not clear, however, regarding the service coordinators' travel options to conduct visits with clients in out-of-state placements if a service coordinator does not have a personal vehicle or DDA's Zipcar account is suspended. A DDA senior official added that DDA does not have a separate travel policy specific to visiting DDA clients in out-of-state placements.

The team received conflicting information on whether DDA maintains vehicles for use by its service coordinators. In August 2011, a DDA senior official stated that DDA service coordinators may have access to three of six vehicles maintained by DDS if the coordinators complete all parts of the vehicle-use requirements. In May 2012, the team asked this official whether he/she believed DDA had enough vehicles for its service coordinators. This official responded that "DDS/DDA does not have a fleet of vehicles for service coordination staff to use." He/she added that DDA offers options such as Zipcars, Metro or city bus tokens, or taxi vouchers in place of these vehicles.

DDA service coordinators reported difficulties conducting visits with clients due to a lack of access to Zipcars or funds. One service coordinator stated that he/she typically has to use his/her personal credit card to reserve rental cars for visiting DDA clients, and then get reimbursed for the rental. On one occasion, this coordinator submitted a request to visit DDA clients in out-of-state placements, but no funds were available. Managers directed this service coordinator to use personal funds and seek reimbursement later. Another DDA service coordinator stated that he/she often uses his/her own transportation, such as a personal account with Zipcar, to visit clients. This coordinator added that at one point in time, DDA's Zipcar account had been suspended because DDA had not paid its bills. The team reviewed an internal DDA email sent by a DDA supervisory service coordinator, in March 2011, which stated that DDA's Zipcar account was "closed until further notice."

A DDA senior official confirmed that DDA's Zipcar account was suspended for approximately 30-45 days while DDA researched to determine why DDA exceeded its Zipcar budget. This official added that DDA found that employees were not following the DDA travel policy. During the account suspension, service coordinators were given the option to use public transportation or personal vehicles with reimbursement for mileage after supervisory approval. He/she added that service coordinators are supposed to file weekly itineraries with their supervisors, and choose their method of transportation, while management factors in safety considerations.

***Cause*:** DDA's travel policy does not articulate options for travel to visit clients in out-of-state placements. DDA does not maintain a fleet of vehicles for service coordinators' to use when traveling out-of-state, including travel to clients residing in Maryland, Virginia or West Virginia.

***Effect*:** Because many DDA clients reside in facilities located outside of the District, service coordinator visits to these clients may be negatively impacted by an unclear travel-arrangement policy.

***Accountability*:** DDA management is accountable for providing adequate resources to facilitate its employees' job-related out-of-state travel.

Recommendations:

That the D/DDS:

(1) Amend DDA's travel policy to include travel provisions specific to the resources available for service coordinator visits to out-of-state placements.

Agree _____ Disagree **X**

DDS's October 12, 2012 Response, as Received:

The Agency disagrees and believes that the current DDS travel policy provides clear direction to the DDA Service Coordination staff on the appropriate transportation methods to be used in visiting out of state consumers. DDS is committed to providing the employees the tools necessary to conduct their job duties including the provision of transportation to employees who must travel to offsite locations to conduct monitoring or other visits with DDA consumers.

The DDS travel policy does focus primarily on travel within the major metropolitan areas (District and Maryland/ VA suburbs) because the overwhelming majority of travel by service coordinators is in the major metropolitan area. Of a total of 10,663 monitoring visits that were conducted by service coordinators in FY 12, 96% or 10,221 visits were in the major metropolitan area including suburban Maryland. A total of 442 or 4% of the visits were outside of the major metropolitan area and considered "out of state". Of these out of state visits, the agency authorizes air travel for visits to Florida, Illinois and Indiana and train travel to Massachusetts. Zip cars were authorized for travel to Pennsylvania, West Virginia and Maryland sites outside of the metropolitan area. The monitoring visits are counted based on the service coordinator's monitoring of the services provided to an individual by a service provider and several monitoring visits may be incorporated into one transportation event as the agency has worked to coordinate the location of the individuals receiving services to minimize the amount of travel that is required. Therefore one travel event may incorporate several monitoring visits.

The agency currently maintains two separate Zip car contracts, one for RSA staff and one for DDA staff. At no time has the DDA contract been suspended, although the RSA Zip car account was suspended for a time in FY2012 however this suspension had no impact on the DDA staff. The DDA Zip car program had an annual expense of $54,000 in FY 12 and a record of 970 times that the Zip cars were used by DDA staff during the 2012 Fiscal year. The agency has not received any requests in FY 2012 from any Service Coordination staff for reimbursement of any funds related to the personal expense of leasing of a Zip car for business use.

DDS is committed to providing options to employees who must travel to conduct their job duties. The agency is also committed to maintaining a "green" transportation program and

encourages the use of metro whenever possible. The addition of the taxi cab voucher was in response to employee requests but is rarely used by the staff. The Zip car program is effectively the DDS "vehicle fleet" and provides a larger number of newer, more efficient and available vehicles for employee use than the use of the current DDS government owned vehicles. However, the employees are not restricted from the use of the government owned vehicles.

OIG Comment: **The OIG stands by its finding and recommendation at stated.**

(2) Explore the option of maintaining some vehicles dedicated for official use by DDA service coordinators.

Agree _____ Disagree **X**

DDS's October 2012 Response, as Received:

DDS utilizes the Zip car program as the agency "fleet" of vehicles. The Zip car program is 100% paid for by the agency and employees are not required to provide any personal funds or credit cards for using a zip car for business purposes. The agency does maintain a small (5 car) fleet of government owned vehicles. Two of those vehicles are allocated to federally funded programs including the Rehabilitation Services Administration (RSA) and the Disability Determination Division (DDD). These vehicles are paid for with federal grant funds and therefore limited in use to RSA and DDD program services. The other three (3) vehicles are made available for employee use as requested and as available. Our records indicate that DDA staff signed out a government vehicle for a site visit 48 times during the 2012 fiscal year. The DDS fleet is aging and management believes that the available fleet of Zip cars is newer and more dependable. Agency records show that there were 970 Zip car rentals by DDA staff in FY 2012.

The DDS policy on Vehicle Operations is in compliance with Mayor's Order 2009-160 "Government and Personal Vehicle Operations Accountability Policy," effective September 23, 2009, which requires that the agency provide advance written authorization for employee use of a government or privately owned vehicle for work activities. The Mayor's Order states that the agency shall require an employee who operates a privately owned vehicle while conducting government business to provide proof of automobile insurance coverage (declaration page) and proof of compliance with all registration inspection and other requirements such as a copy of their driver's license and driving record. The Mayor's Order further states that the "agency shall require employees to report business use of privately owned vehicles to their insurance carrier, if not previously reported." The DDS policy and procedures are intended to comply with the requirements of Mayor's Order 2009-160.

OIG Comment: **DDS's actions appear to meet the intent of this recommendation. The information presented in this finding about use of Zipcars and agency vehicles was based on feedback from DDA personnel. A DDA senior official provided the team with inconsistent information about access to agency vehicles. The OIG encourages DDA to**

clarify to all its service coordinators the process for requesting Zipcars. Based on DDS's response, the OIG considers the status of this recommendation to be closed.

6. Service Quality Reviews have not been completed for all out-of-state placement providers.

***Background*:** In January 2010, DDS entered into a $1.6 million 1-year contract with Liberty Healthcare Corporation (Liberty) with four option years. The total estimated value, including the option years, is $8.1 million. According to the contract terms, Liberty's key responsibilities are to conduct:

- *Three hundred (300) Service Quality Reviews (SQRs)*[81] – The SQR is an annual review of each DDA service provider's[82] performance to ensure DDA clients' safety and receipt of quality services. The contract estimates that during each year, Liberty will conduct 300 reviews, to thereby scrutinize each contracted provider. A DDA official explained that SQRs are organizational reviews that examine client outcomes. According to a DDA official, SQRs are a component of a Medicaid Waiver Application, and Mayor's Order 2009-120 requires provider certification and grants DDA authority to perform this function. DDA found it necessary to enter into a significant contract with Liberty to conduct independent SQRs in order to ensure quality service delivery to DDA clients.

- *An Annual SQR Comprehensive Report* – the analysis of the past year's results from the SQRs, which includes comparison and trend results from the prior year(s) as well as identifying indicators that point to system successes and problem areas with suggestions for improvement.

- *An Annual Individual ISP Utilization Review* – This determines if the services in the clients ISPs are provided in the amount and frequency indicated.

- *A Service Coordinator Performance Audit* – An annual review to assess if services provided by the service coordinator meet best practices and result in customer satisfaction.

In an SQR, Liberty uses an assessment tool to evaluate each service provider annually by conducting interviews with clients, staff, guardians, and patients; documentation reviews, and on-site observations. It assesses such client outcomes as: Rights and Dignity; Safety and Security; Health; Choice and Decision Making; Community Inclusion; Relationships; Service Planning and Delivery; and, Satisfaction. A Liberty official added that Liberty conducts a

[81] According to a Liberty official, the SQRs are currently referred to as Provider Certification Reviews (PCRs). The team used the terminology found in the contract.
[82] The SQR is conducted of contracted agencies of the Home and Community Based (HCBS) waiver that provides such services as supported living, residential habilitation and host homes. Multiple SQRs can be conducted at the same provider if it offers different services.

general overview of the provider's organizational goals. After each outcome is examined, the scores are tabulated and a rating is issued to the provider. A score of 80% is a satisfactory rating.

***Criteria*:** According to the contract between DDA and Liberty:

> The Contractor shall conduct a Service Quality Review (SQR) with each contracted provider annually using an existing tool and process as prescribed by DDA.

***Condition*:** Although required by the contract, Liberty has not conducted SQRs of all out-of-state providers. However, Liberty conducted 311 SQRs from March 2010 through May 2011. Both a DDA and a Liberty Healthcare official confirmed that not all SQRs were completed for providers beyond the District and Maryland. A DDA official stated that 2010 was the first year of Liberty's contract, and Liberty focused on getting in compliance with the current system. This official added that as out-of-state providers are required to follow the rules of their state, DDA was comfortable that there was existing oversight of these providers. The team questions the rationale of this opinion as DDA felt it necessary to enter into a contract worth approximately $8 million with Liberty so that all DDA providers are independently evaluated.

As of June 2011, Liberty had not conducted SQRs of four providers located in Florida, West Virginia, Massachusetts, and Virginia, although Liberty has been contracted since January 2010 to conduct these annual reviews.

A DDA official stated that DDA staff had originally conducted the annual reviews but these reviews were not efficient or effective. The official stated that using outside experts was more efficient than training District staff. The team wonders why the staff in DDA's Quality Management Division cannot conduct some of the reviews outlined in the contract with Liberty to reduce the significant cost of this contract. A DDA official stated that he/she has conducted a cursory review of Liberty's reviews and that he/she has confidence in its performance.

***Cause*:** A DDA official stated that reviews beyond the District and Maryland were not conducted in 2010 as this was the initial year of the contract, and Liberty focused primarily on providers near the District. The team reviewed the contract between Liberty and DDA, and found no language stipulating that Liberty did not need to review providers out-of-state or that Liberty was to prioritize its reviews in Maryland and the District first.

***Effect*:** Without annual reviews of provider performance, DDA is not receiving the formal results of SQRs that are designed to inform DDA whether each provider is meeting the safety and quality standards expected by DDA. The SQR is particularly important for assessing out-of-state providers, as they may be using treatments that are not in accordance with DDA policy or District law.

***Accountability*:** DDA management and Liberty are responsible for ensuring that the conditions of its contract are met.

Recommendations:

That the D/DDS:

(1) Ensure that Liberty completes any outstanding SQRs for out-of-state service providers expeditiously, and that it adheres to all conditions of its contract.

Agree _____ Disagree **X**

DDS's October 2012 Response, as Received:

While DDS agrees that Liberty, similar to all contractors, should be required to adhere to contractual requirements, DDS must disagree that Liberty has failed to do so for out-of-state providers as suggested by the OIG draft report. Liberty is not required to conduct reviews of all out-of-state providers under its scope of work at Section C.8.2., but only for providers funded under the HCBS waiver program.

OIG Response: **In the contract provided to the OIG team, the scope of work is not outlined in Section C.8.2; rather, it is articulated in Section C.3.1. The OIG encourages DDA to follow up on the status of Liberty's review of all providers under the HCBS waiver program. During fieldwork, according to feedback from a DDA official with oversight responsibilities for quality management reviews as well as a Liberty official, Liberty had not completed its reviews of all-of-state facilities although they were scheduled.**

(2) Explore whether its Quality Assurance staff can carry out some or all of the elements in Liberty's contract in order to reduce DDA's cost for this requirement.

Agree _____ Disagree **X**

DDS's October 2012 Response, as Received:

As part of the comprehensive process used to approve and award the Quality Improvement Reviews contract to Liberty, DDS conducted the statutorily required review comparing the fully allocated cost of providing the services using District government employees to the fully allocated costs associated with contracting the services. That review concluded with a finding of total savings of 31% over the duration of the contract if privatization were to occur.

OIG Comment: **Based on DDS's response, the OIG considers the status of this recommendation to be closed.**

APPENDICES

APPENDICES

Appendix 1: List of Findings and Recommendations

Appendix 2: Excerpts of Response from Director of Department on Disability Services

APPENDIX 1

Summary of Compliance Form for Priority Matter issued on May 6, 2011

DDS's policy on "Restrictive Procedures" lacks clarity regarding: (1) whether certain aversive procedures are prohibited; and (2) its applicability to DDS clients in District and out-of-state placements.

That the Director of DDS (D/DDS):

(1) Apprise the Inspector General when the client at JRC has been placed with another provider, and affirm that the new provider does not employ aversive practices.

(2) Amend DDA Policy 6.3, Positive Behavior Support, to specify the prohibited practices that DDA considers aversive.

Findings and Recommendations

1. DDA lacks consistent monitoring of its clients in out-of-state placements.

That the D/DDS:

(1) Ensure that DDA service coordinators conduct monitoring at the frequency required by DDA policy.

(2) Assess the current monitoring tool to determine whether it can be shortened or streamlined.

(3) Periodically evaluate and adjust service coordinator assignments to maintain efficiency with respect to monitoring, with particular attention on clients located at great distances from the District. (For further information, see the Executive Summary.)

2. DDA lacks written policies and procedures specific to serving clients in out-of-state placements.

(1) That the D/ DDS write and issue policies and procedures to DDA employees and providers concerning treatment, placement, monitoring and service delivery to DDA clients in placements outside of the District.

3. The District faces various challenges when trying to place clients within its geographical boundaries.

That the D/DDS:

(1) Conduct a feasibility study and collaborate with the Department of Housing and Community Development (DHCD) to identify, and set aside handicapped-accessible housing within the District for DDA clients.

(2) Collaborate with the Department of Mental Health to identify and recruit providers in the District who can service medically and behaviorally challenged clients, including dually-diagnosed clients.

(3) Continue efforts to establish an ICF that meets Medicaid Waiver regulations.

4. Inadequate training and policies on DDA's MCIS result in case management inefficiencies.

That the D/DDS:

(1) Implement a comprehensive and periodic MCIS training program for DDA service coordinators.

(2) Issue a comprehensive MCIS desk guide to serve as a reference for DDA personnel.

(3) Ensure that DDA managers review the accuracy of service coordinators' MCIS data entry information to facilitate accurate real-time performance report generation.

5. DDA lacks clear policy and procedures for conducting visits to clients in out-of-state placements.

That the D/DDS:

(1) Amend DDA's travel policy to include travel provisions specific to the resources available for service coordinator visits to out-of-state placements.

(2) Explore the option of maintaining some vehicles dedicated for official use by DDA service coordinators.

6. <u>Service Quality Reviews have not been completed for all out-of-state placement providers.</u>

That the D/DDS:

(1) Ensure that Liberty completes any outstanding SQRs for out-of-state service providers expeditiously, and that it adheres to all conditions of its contract.

(2) Explore whether its Quality Assurance staff can carry out some or all of the elements in Liberty's contract in order to reduce DDA's cost for this requirement.

APPENDIX 2

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department on Disability Services
Office of the Director

October 12, 2012

By Email Transmission Only

Mr. Charles J. Willoughby
Inspector General
D.C. Office of the Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

SUBJECT: *Responsive Comments to Draft Report of Special Evaluation of the Department on Disability Services' Developmental Disabilities Administration (August 2012)*

Dear Mr. Willoughby:

The Department on Disability Services ("DDS"), and its Developmental Disabilities Administration ("DDA"), is in receipt of your two-page letter and 52-page draft "Report of Special Evaluation of the Department on Disability Services' Developmental Disabilities Administration," both of which were hand delivered to my office on August 30, 2012. In your letter to me, you asked that DDS "review the findings and recommendations carefully and provide [our] comments by September 14, 2012," which is ten business days from receipt of the report. DDS/DDA was also asked to return the accompanying computer disk which includes a Word copy of the document to the Office of the Inspector General ("OIG") with its comments inserted where appropriate. By letter dated September 13, 2012, "DDS respectfully request[ed] an additional three weeks, or until October 5, 2012, within which to provide our comments." Subsequently, by email on October 5, 2012, DDS requested and was granted one additional week to September 12, 2012. Thank you for your kind consideration of our extension requests. These written comments to the draft report are timely provided within the requested time period as extended. The diskette will be hand delivered to OIG on Monday, October 15, 2012.

DDS/DDA appreciates the considerable time and attention of the team from OIG's Inspections and Evaluations Division in reviewing DDA out-of-state placements since this special evaluation began in September 2010. Such external program evaluations provide an opportunity for agency leadership, mid-level management and staff to undertake a more focused review of particular operations and to determine whether the agency is meeting its mission objectives. In this instance, while DDS/DDA disagrees with several of OIG's findings and recommendations as set forth more fully below and included on the computer disk, the evaluation process has proven both useful and valuable.

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