



**The Association of Public & Private
Developmental Disabilities Administrators**

THE DIGEST

Summer 2011

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The Digest

Summer 2011

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President’s Message.....	5
2011 APDDA Conference Program Highlights.....	7
CMS Expectations & Focus of State Surveyors.....	7
Peggye Wilkerson.....	7
Kelley Leonette.....	8
Douglas Thomas.....	8
What role Could State Developmental Centers Play in the Future?	
Than Johnson.....	9
MR/DD State Director’s Panel: Delaware- Roy LaFontaine.....	10
MR/DD State Director’s Panel: Arizona—Lisa Foti and Debra	
Peterson.....	11
Department of Justice Activities Throughout the USA	
Thomas York.....	11
The Ethics of Person Centered Planning—Michael Gillette.....	13
Topics on Quality Assurance: Client Aggression Related to Population	
Density—Norris Edwards, Feraz Ferozali, Fozia Ferozali.....	15
2011 APDDA Conference Sponsors.....	17
APDDA Regional Alignment.....	18
News from the Regions.....	19
2012 APDDA Conference Announcement.....	27
2012 APDDA Conference Registration Form.....	29
APDDA Mission and Vision.....	31
Resources.....	33
APDDA Membership Info.....	35
APDDA Membership Form.....	36



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THE PRESIDENT'S MESSAGE

~ John Finn ~



Having the opportunity to be President of the Association of Public and Private Developmental Disabilities Administrators (APDDA) is an honor and privilege. Succeeding our immediate past President, Ted Williams is also a bit daunting. Ted has led APDDA through a period of tremendous growth and progress during some of the most challenging times in recent memory. Under Ted's leadership APDDA has evolved in several important ways, perhaps the most significant being our expanding partnerships with private and public agencies serving people with intellectual and other developmental disabilities. The challenges faced during these difficult times of shrinking resources and increasing demands, cut across public and private facilities and it is through our shared values and our commitment to shared solutions that we can best respond.

This edition of The Digest includes summaries of the excellent presentations and cutting edge information that was provided at our annual conference in Scottsdale, Arizona in February of 2011. I think you will agree that this type of timely, topical, and insightful information, provided by experts from across the country, is uniquely valuable. It is also representative of the type of high quality presentations experienced at our annual conferences each year.

Our upcoming 2012 conference is scheduled for February 19, 2012 through February 22, 2012 in San Antonio, Texas. The 2012 conference will focus on our shared challenges, shared values and shared solutions. I encourage everyone to join us in sunny San Antonio in February and experience firsthand the camaraderie, access to state of the art vendors, national experts and exceptional presentations. I also invite everyone who is not yet a member, to join APDDA and become a part of our exciting future.

As we move ahead, our ongoing efforts promote the best possible opportunities for people with developmental disabilities to live richer, fuller and more satisfying lives. We know now, perhaps more than ever, that our shared mission requires us to find ways to reach across the continuum of services and supports and fashion solutions that put the people we support first, foremost, and always.

Thanks again to Ted Williams for all of his incredible hard work and please enjoy this edition of The Digest.

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2011 APDDA Conference

Program Highlights

The following is a summary of information provided by the speakers during their presentations at the 2011 APDDA Conference in Scottsdale, Arizona, February 20-23, 2011.

CMS Expectations & Focus of State Surveyors

Presenters via teleconference- Peggye Wilkerson, Kelley Leonette, Doug Thomas, Division of Continuing Care Providers, CMS Survey and Certification Group-

Opening comments from Peggye Wilkerson, "It's been a very active year in ICF-MR programs".

"Rosa's Law" signed by President Obama in October 2010, requires changing federal references from "mental retardation" to "intellectual disabilities". CMS Central Office is in the process of changing references from MR to ID. Although this process continues, the CMS Office of Legal Counsel came to a determination that Rosa's Law doesn't specifically apply to the Social Security Law and as a result the references to MR should be changed when the federal regulations change. When the ICF-MR regulations are updated, the change in references to Intellectual Disabilities will be achieved by CMS.

Policy Memoranda letters were circulated for input during the year to Regional CMS offices and Provider Groups (Association of Public and Private Developmental Disabilities Administrators, National Association of State Developmental Disabilities Administrators, ANCOR, and AHCA). These letters are intended to further clarify 5 specific issues that have arisen in ICF surveys in recent years. Those include:

- Reporting Injuries of Unknown Source to the Administrator - This letter is intended to further clarify what is included as an injury of unknown source, to affirm that all injuries of unknown source are reported to the administrator and to address the regulatory language that..."all occurrences are reported to the administrator "or" other officials in accordance with state law".

- Locked Areas - This letter is an attempt to get beyond a listing of what can and cannot be locked, to provide surveyors with direction in investigating the factors justifying the need and authorization for locked items/areas and to reiterate that access restrictions needed by one person in a shared residence cannot be applied to others who share the residence who do not require the access restriction. The letter also addresses the requirement for training to teach skills needed to eliminate the need for such restrictions.
- Self-Administration of Medication (SAM) - This letter is intended to further clarify what SAM is and the regulatory process for determining if a person is a candidate for SAM training.
- Video Surveillance - This letter is intended to address the use of video cameras in residential settings and to establish the circumstances under which video cameras may be used with consideration to protecting peoples' rights (i.e., following a rights restriction process, with consent and Human Rights Committee review). The message is intended to be somewhat rigid about video surveillance never being used in areas where people typically have a reasonable expectation of privacy.
- Immediate Jeopardy (IJ) - This letter is intended to address "automatic IJ's", reiterating the process for determining the presence of harm or risk of harm, immediacy and culpability.

The depth of background in Qualified Mental Retardation Professional (QMRP) staff in the CMS Regional Offices has been reduced with the retirement this year of Joaquin Perez-CMS Region 2, Joe Gaffney-CMS Region 3, Myron Reinke-CMS Region 7 and Paul Greenburg-CMS Region 8. Other CMS staff members are stepping up to take fill the gaps created with their departures.

The ICF Survey Contract- Kelley Leonette
CMS continues the ICF Survey contract employing

six experts in the field of Intellectual Disabilities to participate in three types of surveys across the nation;

Orientation Surveys are used to assist new state agency surveyors completing Basic ICF Training. These surveys provide new State Surveyors with additional mentoring and guidance in applying the regulations.

Team Participation Surveys are used to assist provide a federal contract surveyor to assist a state agency survey Team during a survey process. The federal contract surveyor serves as a team member in assisting the team in completing the survey, in answering questions and in providing guidance.

Comparative Surveys, previously referred to as Look Behind Surveys, are used to compare the findings of a state agency survey team with the findings of a survey completed by CMS surveyors and/or federal contract surveyors.

The majority of CMS surveys implemented in 2010 were Team Participation Surveys. The post survey input from state agency survey staff has been very positive and supportive of this effort.

The surveys for 2010 and 2011, summarized by CMS Regions, were discussed in brief detail (See power point presentation).

Training

CMS implemented a new design for ICF Basic Training for state agency surveyors in 2010. The design included onsite training at partnering provider location. State agency surveyor trainees are paired with a preceptor (either a CMS Regional Office ICF specialist or an ICF Survey Contractor) in groups of 2 to 3. The training is designed to include half day classroom training and half day onsite in work/day programs and residences. This method provides participants with exposure to supports provided while in small groups with close communication with experienced survey staff. Significant focus during this training is placed on helping new surveyors identify what active treatment looks like. Preceptors model sensitivity to surveying people's lives and demonstrations of respect for people with ID and the people who support them. This is a participation process for both CMS and the provider. Participants are frequently reminded these activities are training exercises, not a "mock" survey. A full debriefing is provided to the agency director and staff on the last day of training with full disclosure of

information gathered during the on-site activities. The agencies that have participated in this training have indicated feedback that the experience was helpful.

The next Basic ICF training is scheduled for Anaheim, CA in March of 2011 with 60 new surveyors scheduled. After that the next Basic ICF training will be scheduled for September with 50 to 60 surveyors.

CMS will not conduct a Focused or Advanced ICF Training in 2011. Instead, and in consideration of state budget issues, four Webinars will be offered for continuing training. These will include:

- "Effective Investigations", presented December 3, 2010 by Susan LeBlanc, ICF Specialist from CMS Region 6. This training is available for viewing through archives. If interested contact Doug Thomas electronically at Douglas.Thomas@cms.hhs.gov.
- "A comparison of ICF and NR Process", to be presented in March or April of 2011 by Paul Miller, ICF Specialist from CMS Region 1.
- "Health Assessments in ICF-MR", to be presented in July 2011.
- "Behavior Issues in ICF-MR", to be presented in September 2011.

Top 10 Deficiencies-Douglas Thomas

Mr. Thomas presented information on the most frequently cited regulations during ICF surveys for 2008, 2009 and 2010 (See Power Point presentation). The most frequently cited regulations remain relatively consistent across the years and include, in variable order; W249-(program implementation), W369-(drugs administered without error), W104-(governing body exercises direction over the facility), and W159-(individual's programs integrated, coordinated and monitored by a QMRP).

Interpretive Guidelines Update- Peggye Wilkerson Revising the ICF Interpretive Guidelines has taken a longer period of time than hoped. A great deal of work has been dedicated to this effort. The last revision was implemented in the 1980's. When the revision was started the goal was to provide surveyors with very clear instruction so that even without a background in the field of intellectual disabilities, surveyors could use those instructions to arrive at correct compliance decisions. The revision

effort has included each of the eight Conditions of Participation, significant input from the CMS Regional Offices. Current CMS Central Office staff are incorporating all comments and completing the final version of the document to prepare it for distribution to the provider groups.

Next Steps include distribution to the four provider groups, reassessing new comments, revising the document to incorporate needed changes, obtaining a review from the CMS Office of General Council. The current projected completion time frame is set for Fiscal Year 2011, although this may be a bit optimistic. Perhaps February of 2012 is a more realistic completion date.

Upon reviewing updated version it will be noted that many of the probes included in the Guidance to Surveyors section have been removed but those will be incorporated into the survey process section of the Field Resource Guide and included in training.

Questions

Will there be an opportunity for input from providers to the video surveillance? **Answer-** The proposed letter was circulated to all the states for comment. CMS does not intend to redistribute the letter for comments again, but would send the letter out upon request. The turn around time for any comments to be considered would have to be extremely short (48 hours).

Has CMS come to a revised position on determining people to be not in need of active treatment? **Answer-** ICF surveys do not deal with eligibility. The regulation at W198 remains, but we are very carefully approaching the issue of determining whether or not a person is in need of active treatment. This issue will likely be included in the CMS work plan for 2012.

In preparation for moving from an ICF to a community based residence, a person with ID/DD needs experience with "alone time." Would this be acceptable in an ICF? **Answer-** No.

Peggye Wilkerson is the Deputy Director of the Division of Continuing Care Providers within the Survey and Certification Group in Baltimore. She is a veteran surveyor with 10 years State and 6 years Regional Office survey experience in the areas of long term care, ICF/MR and home health/hospice. Prior to joining the SCG she was a Technical

Advisor in the Division of Medical Review within the Program Integrity Group in CMS.

Kelley Leonette is a Health Insurance Specialist in the Division of Continuing Care Providers within the Survey and Certification Group in Baltimore. She is the project officer for two contracts, the ICF/MR Federal Monitoring and Oversight Contract, and the Psychiatric Hospitals Federal Monitoring and Oversight Contract.

Douglas A. Thomas is a Health Insurance Specialist in DCCP within the Survey and Certification Group in CMS' central office. He was invited to enter Federal service 11 years ago as a Research Psychologist for DOJ's: Bureau of Prisons and has worked in CMS' Survey and Certification Group with several provider types for the last seven years.

What Role Could State Developmental Centers Play in the Future? - Than Johnson

I am afraid that "Closing a Developmental Center isn't always about doing what is right for people". Ohio closed a Developmental Center, and the property was converted into a prison. This change didn't help the consumers or the local community. Obviously, the community providers were happy to get more referrals but was it really what the people who lived at the Center wanted? The perspectives are different depending where you fit into the puzzle: a consumer, a provider, or the State Central Office.

A major difference between State Operated and Private ICF's are daily rates and program costs (especially wages). State Centers have had higher rates and higher expenses. However, community providers have had to operate with lower reimbursement rates. This has forced them to pay lower wages and focus on cost controls. The wage discrepancy is why developmental center staff rarely transfer into positions in the private sector. Even in Ohio, a pilot to have DC staff follow individuals into community placements failed because the community providers couldn't match the State employee wage scale. These differences are seen even more vividly when individuals move from DCs into waiver programs. The difference in reimbursements, really creates a situation where although any service should be available regardless of the setting, in reality things (supports and services) fall through the cracks.

States are keenly aware of the differences in rates and they are decreasing the size of their DCs as a cost saving measure. In addition, states are also keenly aware of the problems that are created when an announcement is made to close a DC. In Ohio, those announcements in 2004, created a “bloodbath”. It pitted the State against the local communities and providers. It pitted the State against, parents and guardians who fought to keep their child or ward in DC services. To them lower reimbursements, translated into lower wages, fewer programs, and worse outcomes. Therefore, I think we will see states reduce their DC populations through gradual census reductions.

If you ask the typical parent or guardian about their level of satisfaction with State Center services, they usually say, “its great and they want their child to stay at the Center.” They realize that the institutional model that was so prevalent in the 60s and 70s has been replaced by good and specialized services. Parents and guardians of individuals in Public Centers are also very concerned about the impact of lower reimbursements. They view the State movement of people into the community as a way for the State to cut costs. The old idea of the money follows the individual is a fallacy, because the money spent per person at a Center is always more than they will receive in a private ICF-MR or waiver bed.

In the not too distant future, the largest ICF-MRs will be privately owned and operated. Unfortunately, these providers will become targets of the DOJ and they will be subject to the same level of scrutiny. And this will result in ICF-MRs getting smaller and it will force people to move into community beds.

One benefit of the Ohio Pilot program was that it forced the staff to interact. And the interaction resulted in better understanding of the similarities and differences between settings. For example: we serve the same customer, we operate under Federal guidelines, we face the same challenges with staff, and we provide similar services. We also share a lot of critics and our model of service provision is devalued. Finally, there are differences between the Public and Private Centers: such as: funding & cost structures (wages, benefits, unions, etc.), impact from elections/ politics, and the ability to say no in providing services to an individual. I think our similarities far outweigh the differences.

APDDA and other organizations, like ANCOR, should be working collaboratively to overcome these

differences and establish a new set of services that are perfectly suited to the ICF model. This might include: Short term admissions, stabilization and treatment (until community services are available); Resource Centers (behavioral, dental, medical, psychiatry, therapy, etc.); Community staff training; Crisis intervention teams, Best Practice development, and Special in-home supports (for people that challenge community services). If the States can embrace this or a similar idea, consumers, families, and providers will see that these “New Centers” have a valid role and offer services that link the provider community.

Than Johnson is CEO of CRSI, the largest non-profit residential provider in Ohio serving citizens in HCBS Waiver and ICF/DD settings. Mr. Johnson is a Past National President of ANCOR and is the current President of the Ohio State Provider Association (OPRA). He currently serves as the co-chair of ANCOR's Government Relations Division. He served, by appointment, on President Bush's CMS/Medicare National Advisory Council. He has also served on the CMS Technical Advisory Committee on ICF/DD Issues.

State Directors Panel: Delaware

Roy LaFontaine, PhD

Dr. Lafontaine spoke to the conference participants as part of the State Directors Panel. Dr. Lafontaine serves as the State Director for the Delaware Division of Developmental Disabilities Services. Dr. Lafontaine has served in the ID/DD field for over 30 years and he gave a very light hearted and interesting introduction to Delaware. Specifically, he interspersed his presentation about ID/DD services in Delaware with facts about the State and famous people from Delaware.

Delaware is the 49th smallest state and it is located between Philadelphia and Baltimore. The size of the state presents some advantages as it is just 80 miles from north to south and approximately 40 miles wide. The State provides services to over 3,100 people including 2,200 people in family services/ natural supports and 900 people in residential supports. Delaware has one Developmental Center, the Stockley Center, that provides ICF-MR services to 62 individuals. DDDS receives about 20-30 service referrals each month and demands for all services are increasing. DDDS' annual budget is \$64 million.

The Vision for services in Delaware is to “ensure that the people we serve live fulfilling lives”. The State is facing budget challenges and at this point DDDS will not have a cut in service funding. A new program by the Governor is looking at ways to eliminate or limit long-term reliance on government for services.

The current priorities for services in Delaware are: management of emergency placements, support services for individuals in family supports, establish performance based monitoring standards, get back to the basics to ensure high quality care, establish a new strategic plan and reorganize the DDDS in accord with the plan.

Dr. Lafontaine closed his remarks by inviting people to visit Delaware to see many of the good things that are occurring with regard to ID/DD services.

***Roy A Lafontaine, Ph.D.** is the Director of the Delaware Division of Developmental Disabilities Services. He has held a variety of positions while in State service ranging from Clinical Behavior Analyst to Community Services Director.*

State Directors Panel: Arizona

Lisa Foti and Debra Peterson

Health Care Cost Containment System (AHCCCS) is the single Medicaid agency responsible for the waiver with CMS. It is the only Medicaid program in the country in which all long term and acute care services are bundled under a single system to coordinate and enhance system delivery. The Division of Developmental Disabilities is the program contractor for people with developmental disabilities. The purpose of the Project Waiver is to demonstrate that home and community based services and a managed care approach are most cost effective than institutionalization. Applicants must meet medical and financial eligibility criteria. Services are provided based on assessed individualized needs.

There are 30,995 people served. Approximately 74.8% are long term care members, 10.5% are state only members, 14.7% receive case management and acute care through AHCCCS. For those receiving residential services, 87.5% live at home; 0.9% live in child developmental homes; 2.8% live in adult developmental homes; 8.2% live in group homes ;0.7% live in institutions. Determination of eligibility is based on: 1) A qualifying medical diagnosis; 2) Preadmission Screening score; 3) Limitations in

Activities of Daily Living (ADL's); 4) Limitations in ADL's must be medically related and NOT due to psychiatric diagnosis; 5) DD Diagnosis must be manifested before the age of 18; 6) Condition is likely to continue indefinitely; 7) Client must be at risk for institutionalization.

Arizona's goal is to expand service options for people. The provider network includes an four acute care plans; behavioral health network and a Home and Community based provider network. Arizona uses an open and continuous process to place providers on the “qualified vendor” list. A published rate is used. A provider can drop off the list of available providers at any time. The purpose is to increase choice and to ensure there is a sufficient provider network to meet the individuals' needs. There are about 2650 independent providers.

For people that are determined eligible for “state-only” , services are paid with state appropriated dollars based on the availability of funds. Long term care eligible people are funded through a capitation rate with service approval based on medical needs. For FY 2010, the total of provider services equals \$653.9 million. Of the total, 41.8% used for residential service, 36% for in-home services, 14.2% for Adult Day and Employment Programs, 4.1% for Therapies, 1.7% for Children Early Intervention and Day programs, 0.4% for Other services and 0.5% for Specialized habilitation services.

How is Arizona doing? The Case for Inclusion: 2010 An Analysis of Medicaid for Americans with Intellectual and Developmental Disabilities ranks Arizona #1 (tied with Vermont). The four key outcomes are: 1) 98% of the resources are allocated to the community; 2) 95% of individuals are served in their home or community; 3) families are supported to stay together; 4) supportive of meaningful work. Arizona has ranked #1 in 2007, 2008 and 2010.

***Lisa Foti** is the Deputy Assistant Director, Arizona Division of Developmental Disabilities ,*

***Debra Peterson** is the Business Operations Administrator, Arizona Division of Developmental Disabilities*

Department of Justice Activities Throughout the USA

Thomas York, Esquire

Thomas York is the founder of The York Legal Group located in Harrisburg, Pennsylvania and he is the foremost attorney in the country who assists states to respond to Department of Justice suits against public ICF/MR providers. Mr. York has been practicing law for more than 30 years and has been focused on helping states to respond to the DOJ for the past 20 years. He has been the lead attorney on DOJ cases in many states and most recently completed a six week trial in the DOJ suit against Arkansas. A decision in favor of the State was issued on June 7, 2011. (See page 21.)

Mr. York opened his presentation with a warning about the motives of the DOJ. He believes that the DOJ is trying to close Public Residential Facilities (PRFs) and he gave a series of quotations by Sam Bagnestos, the head of the DOJ's Civil Rights Division to support his claims. These quotations show that Mr. Bagnestos' personal philosophy is anti public residential facilities. Mr. York also presented the arguments that the DOJ is using in CRIPA, ADA, and Olmstead suits.

Mr. York outlined the process steps of a typical DOJ case. The steps include: Investigation Letter; Initial Tour with DOJ experts; Letter of Findings (Results may or may not be shared with state); Settlement discussions; Filing of the complaint; Set the case schedule; Selection of experts & expert tours; Complete discovery & depositions; Trial; Briefs & Pleadings; and Judge's ruling. He suggested that these steps are intended to even the playing field for the parties, and that scheduling and the filing of injunctions are two critical issues for defendants. Setting the schedule for the case is important because it sets time lines for both sides to collect data and prepare the case. Injunctions are actions by the court to stop activities by one of the parties that are allegedly placing people at risk.

Recently, Mr. York has observed that the DOJ has been using injunction filings to gain an advantage in these cases. For example, in a recent case the DOJ filed an injunction just before the defense's experts started their visits at the Center being sued. This prompted a number of actions that effectively put the State at a disadvantage because it reduced the amount of time the defense had to collect information about the Center. Mr. York also related one experience when the DOJ filed a

preliminary injunction seven years after they had conducted their expert visits. Mr. York added that the center had only improved since the first DOJ had visited. He believed this action was undertaken to disrupt the pretrial planning activities of the defense.

Mr. York indicated that he believes that the DOJ will be initiating litigation at community residential facilities in the future. In terms of advice, Mr. York made a number of suggestions for agencies that receive letters of investigation from the DOJ. First, he recommended that from the start, States must realize that the DOJ wants to close PRFs. Second, States should be cautious in entering into a settlement agreement. Third, States should engage experts and complete an independent assessment of the conditions. Finally, that States should not be apologetic regarding center-based services.

Mr. York closed his remarks by challenging the attendees to promote the good services and outcomes that Centers are able to achieve. He also suggested that we need to change the argument from "Institution versus Community" to "Bundled Services versus Unbundled Services". And finally, States and providers need to get the message out that PRFs are just one of the available service options in the continuum of care that is available for providing person centered services to people with Intellectual disabilities.

Thomas York is a Magna Cum Laude graduate of Indiana University of Pennsylvania and a Cum Laude graduate of the University of Pittsburgh School of Law. Mr. York concentrates his practice around Civil Rights of Institutionalized Persons Act (CRIPA) actions, Americans with Disabilities Act (ADA) actions and represents various states in section 1983 class actions. Mr. York served as Deputy Attorney General for the Commonwealth of Pennsylvania and Chief of Litigation with the Department of Public Welfare. Mr. York has 28 years of experience in legal practice which includes litigation involving civil rights, employment discrimination, labor law, constitutional law, environmental law, commercial transactions, health care reimbursement, product liability, personal injury and real estate transactions.

The Ethics of Person Centered Planning

Michael Gillette, PhD

Michael Gillette, PhD spoke to a large group about the Ethics of Person-Centered Planning. Dr. Gillette, serves as a professor at the University of Virginia School of Medicine and he is the president of Bioethical Services of Virginia, Inc. For more than 20 years he has assisted organizations to develop and implement bioethics teams in hospital, ID/ DD, and psychiatric settings.

He opened his talk by defining the Person Centered Plan (PCP) as a formal planning process to meet the needs of the individuals being served. In ID/DD we are often asked to make decisions for individuals that have limited or no communication abilities. This presents a few problems. Often different stakeholders have different opinions of what an individual needs. At times, self determination is interpreted as you get anything you want. Unfortunately, in life no one can have everything they want. Often the biggest issue in person centered planning becomes a matter of our comfort at varying levels of risk.

Dr. Gillette presented a few case studies to support his points. In each case, he asked the group to give their opinions and then he presented the opposing viewpoints. In these discussions, Dr. Gillette presented the idea that the persons who are asking/ demanding something have the burden of proof to support their points. It also became clear that if the arguments are equal, then the discussions need to focus on the person. However, the person's needs should not super-cede the rights and needs of the group. This led to a lively discussion about the ethics of intervention and types of risk.

Dr. Gillette spent a good amount of time discussing the ethics of intervention. He described two arguments that are commonly presented. Paternalism can be summarized with the statement "you might get hurt." Many people interpret this as going against the idea that people should be free to make decisions. Dr. Gillette outlined four questions to form our thinking: Does the individual have diminished capacity? Is there a clear risk? Is the treatment being suggested the least restrictive? And do the potential benefits outweigh the risks?

The second argument was Distributive Justice. This can be summarized with the statement "it wouldn't be fair to others". He pointed out a number of examples and posed a few questions to consider in

these situations. Will this place others at risk? Have the other people at risk given their consent to be placed at risk? Does the issue transgress clearly defined social expectations?

Dr. Gillette then spoke about the ethics of treatment refusal and the limits of provider intervention. He suggested that using the concept of a continuum of care options that range from optimal care (do everything available) to sub-optimal care/ super standard care (do some things), to sub optimal care (do the wrong things). Dr. Gillette used this model to demonstrate that reasonable limits exist and that they can be defined by standards of care. He also reminded the group that although providing sub-optimal and super-optimal care and standard care could be acceptable, providers must never agree to provide sub-standard care. He outlined a process for dispute resolution and gave more examples to support his reasoning.

Finally, Dr. Gillette outlined the policy considerations that should be considered when designing a PCP. The PCP should be individualized and embrace utilization of the least restrictive environment. Organizations should avoid making blanket limitations of rights. He urged the attendees to remember that the PCP process should try to become comfortable with a certain amount of risk. People have the right to make decisions and take responsibility for some risk. In the PCP process, the burden of proof should not be upon the individual or organization it should be the responsibility of the staff who will be making the intervention(s) to justify their points. And finally, the PCP should never be punitive to the individual making the decision or the staff who are having trouble with accepting the decision or issue.

Dr. Michael Gillette attended Brandeis University as an undergraduate and graduated magna-cum-laude with majors in philosophy and classical Greek and was elected Phi Beta Kappa. He went to Brown University for his Masters and Ph.D. in Philosophy where he wrote a doctoral dissertation entitled "Paternalism in Psychiatric Medicine: A Philosophical Perspective". Dr. Gillette has taught philosophy at several colleges and universities, received tenure at Randolph-Macon Woman's College, published several articles in the field of clinical ethics and has received numerous teaching awards. He is presently a Clinical Assistant Professor of Family Medicine at the University of Virginia School of Medicine and works full time as President of Bioethical Services of Virginia, Inc., a

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TOPICS ON QUALITY ASSURANCE

Client Aggression Related to Population Density

Norris Edwards, MA in Psychology, Feraz Ferozali, BA in Psychology, and Fozia Ferozali, Ed.D, RN

The relationship between over-crowding and aggression has been an area of concentrated study stemming back to Calhoun (1962) who demonstrated that crowding could be associated with severe pathology among rats and mice. With the exception of few studies (e.g. Freedman, 1975), research findings have indicated that crowding can have negative effects on humans and animals (cf. Baum & Epstein, 1978; Cox et al., 1982; Paulus, 1980; Sunstrom, 1978). Therefore, the opening of new low population density residences at Porterville Developmental Center (PDC) offered a unique research opportunity to examine the behavioral impact of low population density units in comparison to a more traditional living residence.

Prior to examining the phenomena at PDC, it is important to examine past studies among prison populations as this will offer important insights into the relationship between crowding and aggression for psychiatric populations. Cox et al., 1982 examined the impact of crowding within a Texas Department of Corrections and found a number of detrimental effects. These effects included increased psychiatric commitments, illness complaints, disciplinary infractions, and suicide attempts. Further evidence of the impact of crowding on prison populations can be found in the experiences of Mississippi State Prison at Parchman. Subject to federal order (Gates et.al. v. Collier et.al. 1974) Mississippi reduced their population by 30%. Following the population

reduction, inmate-to-inmate assaults dropped by approximately 60%, suicide attempts and self-mutilation decreased by a factor of 1.97 times. When the order was later modified to allow specific units to increase their population by 19%, assaults increased by 36%. These findings support the notion that overcrowding results in increased aggression, depression, suicide attempts and even alterations in perceptions which cause patients to interpret the actions of others as overtly aggressive and provocative (Lawrence and Andrews, 2004). These research findings correlate with the findings at PDC.

Hypotheses

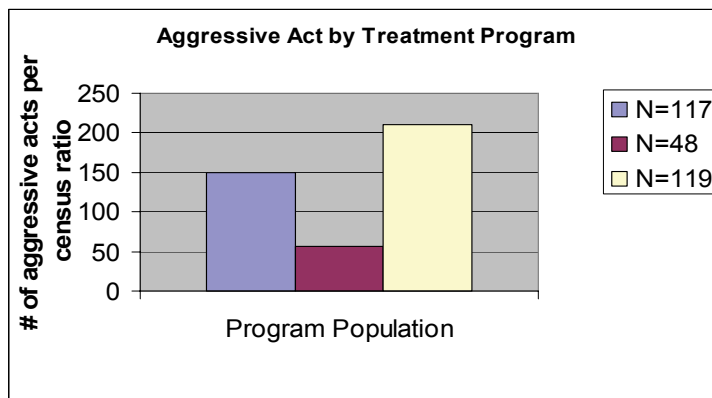
The null hypothesis tested was units with lower population density will have the same rate of assaultive crisis when compared to units with high population density. The alternative hypothesis tested was that units with lower population density will be associated with less frequent assaultive crisis when compared to units with high population density.

Methodology

An eighteen month sample of all occurrences related to the application of highly restrictive interventions was drawn from all secured treatment units (n=502). Then, units were compared across the following dimensions:

- Number of assaultive crises by unit
- Client by client analysis of rate of assaultive crisis
- Analysis of aggressor to victim
- Analysis of day of week to assaultive crisis
- Analysis of time of day to assaultive crisis

Frequency of assaultive crisis situation was correlated against the population density of each unit. Population



density was operationally defined as the licensed capacity of the residence minus any beds currently in suspense. An assaultive crisis was operationally defined as any event identified as an aggressive act against property or another client rising to the level of an incident report. Data was normalized by dividing the total number of assaultive acts by the unit's population density to generate a comparable loading as an index of violent on the individual units.

Findings

A cursory review of the frequency of assaultive crises revealed the following, but yielded little usable information relative to the impact of crowding. (See chart.)

An examination of assaultive crises revealed that a concentration of incidents within the STP and in particular on units with high population. These units' rates of assaultive crisis were more than double than that of any other units in the facility.

An examination of the rates of assaults prior to the move of clients to the new population revealed the following:

The rate of assaultive crisis decreased once the clients were transferred to the low-population units. Additionally, fewer repeat assaults were noted follow the transfer to the low-density units. It should also be noted that the data revealed a much greater rate of repeated assaults between victims and aggressors on high population units; but no apparent pattern of repeated aggression against a particular client

This would suggest that targets of the aggression were not selected but rather were simply in the wrong place at the wrong time or target of convenience. Another interesting observation was that while an examination of repeated violent acts by aggressors revealed no duplication of targets; while there were several repeats noted among the victims. This finding might suggest that victims may either not be attentive to signs of escalation among their peers and remained in the area rather than withdraw to a safer location as suggested by Wendy Regoeczi (2008).

In conclusion, this examination suggests that indeed there is a correlation between populations of living

residences. Further analysis should be encouraged to assist interdisciplinary teams in designing more effective preventative measures to reduce the risk of assaults.

References

Calhoun, J.B. (1962). Population density and social pathology. *Scientific American*, 206, 139-148.

Cox, V. C., Paulus, P. B., & McCain, G. (1984). Prison crowding research: The relevance for prison housing standards and a general approach regarding crowding phenomena. *American Psychologist*, 39(10), 1148-1160. doi:10.1037/0003-066X.39.10.1148

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Norris G. Edwards is the Director of the Office of Performance Excellence at Porterville Developmental Center, California Department of Developmental Services. He pioneered in the application of six sigma technology as applied to compliance with federally mandated conditions of participation, organizational behavior, motivation, process improvement, and development of benchmarking techniques for health care facilities and enhances client services through the CQI process. He can be reached at: pvperson@ocsnet.net

Feraz (Tim) Ferozali is a research assistant who obtained his Bachelor of Arts degree in psychology. Feraz possess' a strong body of knowledge in both quantitative and qualitative studies. He has assisted in various academic research studies for various researchers and serves a strong proponent of adult learning theory. Currently, he is working on obtaining his Masters degree in dietetics and become a dietitian.

Dr. Fozia Ferozali is the Educational Program Coordinator for the Medical, Surgical and Rehabilitation services at Cedars- Sinai Medical Center. She is a Registered Nurse by profession and holds a Doctorate Degree in Education. Dr. Ferozali has over ten years of experience in the field of nursing with various job titles including but not limited to: a professor, nurse consultant, and Hospital Administrator. She can be reached at: foziaferozali@yahoo.com

The opinion or conclusions stated in this paper are those of the authors and are not to be construed as official or as necessarily reflecting the policy of the Department of Developmental Services for the State of California.

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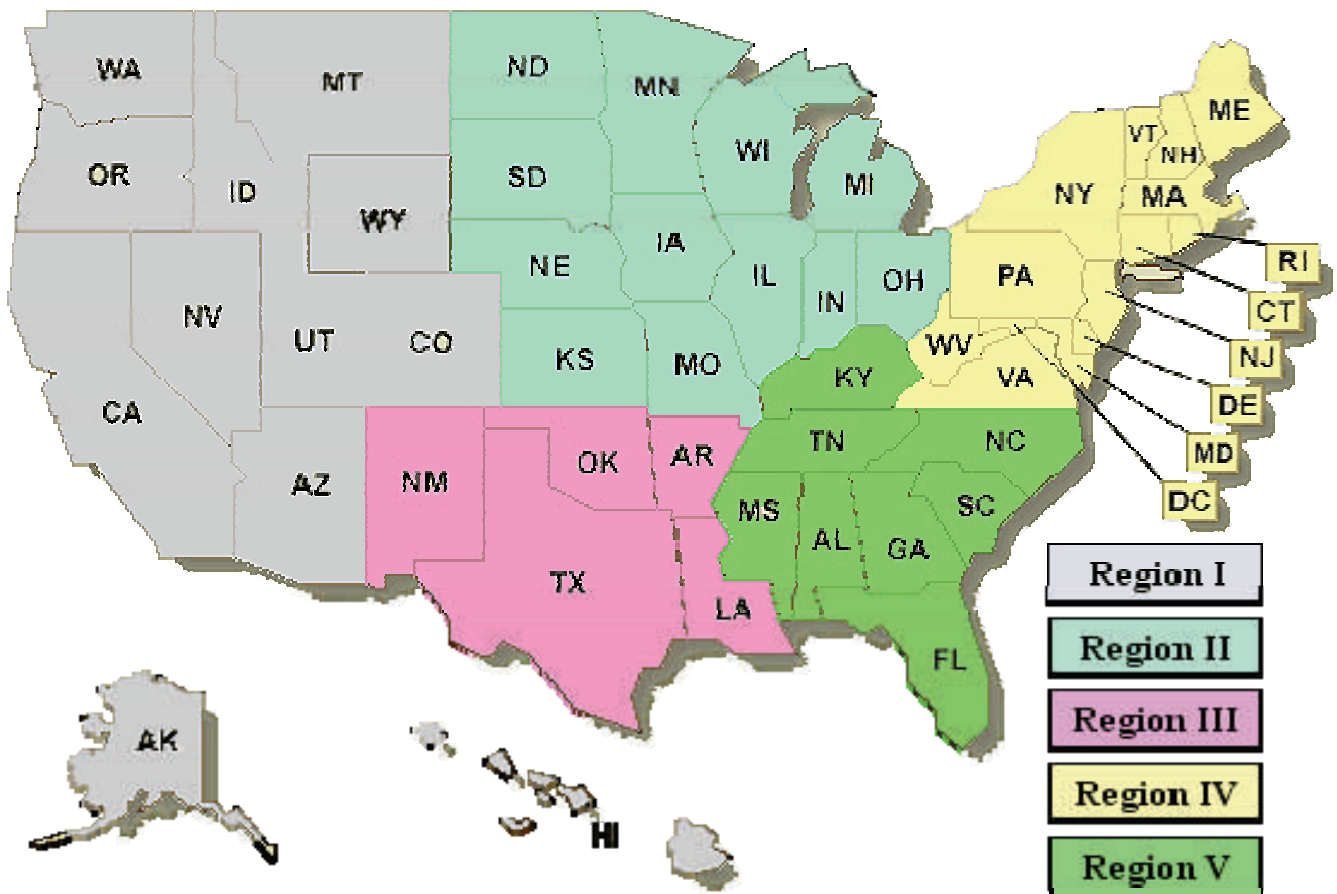
Whisperglide (wheelchair accessible glider swings)

APDDA Regional Alignment

The regional configuration of states is designed to help address common regional issues, obtain the best match for Centers for Medicaid and Medicare (CMS) regional offices, balance the number of state facilities within each region, and reduce on-going administrative costs.

The map below indicates the regional state memberships.

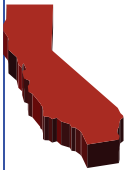
APDDA Regions



NEWS FROM THE REGIONS

NEWS FROM REGION I

CALIFORNIA



Prisons in California still have not complied with a December 2001 order to protect inmates with developmental disabilities. U.S. District Judge Charles R. Breyer issued an Order September 16 in the case, *Clark v. California*. There was no dispute about the utility of the Settlement Agreement and Remedial Plan ordered by the court. Prison officials testified that the Remedial Plan has been valuable to the California Department of Corrections and Rehabilitation (CDCR). What was in dispute is whether the Order requiring compliance with the Plan, including monitoring by plaintiffs' counsel and Court experts, is necessary. To help answer that question one of the Court's experts, Dr. Peter Leone, conducted a systemic review of the treatment of developmentally disabled prisoners in the CDCR. Based on over 150 prisoner interviews, a review of extensive prison documents and interviews with 29 prison staff at the seven prisons that house a majority of class members, he concluded that "while some dedicated CDCR staff were providing appropriate services and support to inmates with DD, the system as a whole appeared indifferent to the needs of these inmates" and that "the breadth and severity of problems described in this report suggest that with some exceptions, inmates with DD do not receive the protections and supports as described in the Clark Remedial Plan."

The weight of the evidence supported and amplified Dr. Leone's conclusions. "In total the evidence demonstrates that mentally retarded prisoners and those with autism spectrum disorders are verbally, physically, and sexually assaulted, exploited, and discriminated against in California prisons. Illiterate prisoners are not given the help they need to understand or fill out important prison documents, leaving them with no way to use sick call slips or grievance forms, unless they can pay other prisoners or beg them for help. Developmentally disabled

prisoners are punished for violating prison rules that they do not understand, and are punished at hearings which they do not comprehend. These conditions violate those prisoners' rights to be free of unlawful discrimination based on their disabilities."

The judge ordered the state of California to prepare a plan to address deficiencies in staff training, identification and classification of prisoners with developmental disabilities and their needs, and self-monitoring, and submit the plan to court experts and to the Prison Law Office.

FINDINGS OF FACT AND
CONCLUSIONS OF LAW
Clark vs. California
September 2010

NEWS FROM REGION II

KANSAS



The Kansas legislature passed a budget bill that includes full funding for the Kansas Neurological Institute (KNI), and that rejected Governor Brownback's proposal to begin a process to close KNI over a 2 year period starting in July 2011. A House Social Services Budget Committee had previously voted to concur with the governor's recommendation, and ultimately the full House Appropriations Committee concurred. After hearing testimony the Senate State Hospitals Sub-committee voted to restore funding, and the full Senate Ways and Means Committee concurred. The Senate Public Health & Welfare Committee also took a strong stand in favor of keeping KNI open. The differing positions in the House and Senate appeared likely to lead to the issue being resolved in a conference committee, but late in the session a conservative Republican House member introduced a budget amendment that called for eliminating state expenditures for bottled water in state offices and a modest reduction in budgets for office supplies that was sufficient to restore the budget cut. Framed in

this way, the House voted 104-15 to restore funding. The restoration of funding held through a conference committee, and Governor Brownback has indicated he plans to honor the legislature's decision on this matter.

Before the next session the full legislative delegation from this area, all of whom favor keeping KNI in operation, obtained approval for a Legislative Post Audit to answer a few questions about KNI. They believe this audit will show that the state won't save money by providing equivalent services in community settings, and they also want to know if there are services provided free of charge that should be charged for, if there are potential alternate uses for some of our land and for a building we don't use, etc. It's difficult to predict what the results of this audit will show or whether the issue will resurface again next year, but it's clear that the people who requested it feel it will provide evidence that KNI should remain in operation.

Barney Hubert
Kansas Neurological Institute

MINNESOTA



Since 1997, about 200 of the 300 people living at a state facility for the developmentally disabled in Cambridge were restrained by staff, sometimes for nothing more than touching a pizza box. Now, they will share in a \$3 million settlement of a federal class action lawsuit. The settlement...finalizes a tentative agreement reached last fall and bars the state from using handcuffs or other restraints, except in emergencies, at the Minnesota Extended Treatment Options (METO) facility.

"It's fairly obvious to me that there was just a widespread misuse of restraints and seclusion, and it needed to be discontinued," said Shamus O'Meara, a Minneapolis lawyer who sued the state on behalf of three former residents. Under the agreement, each of the three original plaintiffs will receive \$75,000. Other former residents may get from \$200 to \$300,000, depending on how often they were restrained. Most will receive less than \$3,000 apiece,

according to court documents.

The METO facility is scheduled to close next week as part of a statewide reorganization. But the agreement will apply to its "successor facility," the Minnesota Specialty Health System in Cambridge, which will house up to 16 residents. The METO program, which opened in 1997, housed up to 60 developmentally disabled people, many committed by courts for aggressive behavior. Some say the settlement will help close a dark chapter in Minnesota history. "I think the significance is, there won't be people in leg shackles and handcuffs anymore," said Scott Schifsky, program director for The Arc Minnesota, an advocacy group for people with disabilities. He said there are more effective and humane ways of controlling behavior, such as psychological approaches and crisis teams.

The Minnesota Department of Human Services which ran METO, admitted that staff members overused restraints during a two-year period. "We were clearly using restraints for more than just emergency purposes," said Anne Barry, deputy commissioner. The practices were halted in 2008, after an investigation by the Minnesota Department of Health uncovered the abuses and cited the facility for 15 violations.

In 2009, families of three former residents sued, accusing the facility of "abusive, inhumane, cruel and improper" treatment. They said residents were restrained for such minor infractions as disobeying staff. The state denied the allegations. But Barry said the settlement should help improve care, in part by encouraging a shift to smaller, more intimate settings. "When people are in smaller more homelike environments in the community, you see some pretty remarkable changes in people's behavior," she said. The state also agreed to spend nearly \$1 million on additional staff and training for community programs for the developmentally disabled, using funds now budgeted for METO. It also will set up committees to help ensure that people with disabilities can live in the least-restrictive settings possible.

Maura Lerner
Star Tribune

NEWS FROM REGION III

ARKANSAS



DOJ suit filed over five centers is dismissed

On January 25, a federal judge dismissed a U.S. Department of Justice lawsuit against five of Arkansas' human development centers that alleged Americans with Disabilities Act violations because DOJ failed to inform the state of its allegations and determine that "compliance cannot be secured by voluntary means," before filing a lawsuit.

The VOR Voice
Spring 2011

Arkansas Closes Human Development Center

The Alexander Human Development Center closed June 6, 2011. Many of the men who lived at the center have moved closer to their families or into their own apartments. A total of 104 men moved out of the center between July 2, 2010, and June 6. Of those, 61 chose community programs, 42 chose to move to another human development center and one moved into a nursing home.

The state has begun the process of finding other uses for the 80,000-square-foot building and adjoining property. The building opened in 1931 as a sanatorium for African American tuberculosis patients, was converted for use as a Human Development Center in 1967, and at the height of its operations in the 1970s, the center served over 200 clients.

U.S. v. Arkansas: Victory for Choice

In an 85-page ruling, Chief U.S. District Judge J. Leon Holmes dismissed a U.S. Department of Justice (DOJ) case finding that the DOJ failed to prove its claims that the Conway Human Development Center violated its residents' rights under the U.S. Constitution by providing substandard care, as well as under the Americans with Disabilities Act (ADA) (community integration). Judge Holmes questioned the authority, expertise and methods of several expert witnesses used to

support the federal government's arguments. He extensively cited testimony of residents' parents and guardians who he noted were "overwhelmingly satisfied" with the treatment the residents receive at Conway and "believe that the Center is the least restrictive, most integrated placement appropriate for their children and wards." (*U.S. v. Arkansas*, p. 8)

"Most lawsuits are brought by persons who believe their rights have been violated. Not this one . . . All or nearly all of those residents have parents or guardians who have the power to assert the legal rights of their children or wards. Those parents and guardians, so far as the record shows, oppose the claims of the United States. Thus, the United States [Department of Justice] is in the odd position of asserting that certain persons' rights have been and are being violated while those persons – through their parents and guardians disagree." (*Id.*, p. 1).

"Community placement' is a term that implies a more integrated, less restrictive setting than does the term "institution," but it does not follow from the use of these terms that a resident automatically will have a greater degree of interaction in community placement, i.e., with a waiver provider, than in an institution such as Conway Human Development Center. The evidence establishes that residents of Conway Human Development Center do interact with nondisabled persons – the Center is not a prison with inmates barred from interaction with the outside world; and conversely, the evidence establishes that placement with a waiver provider does not guarantee any amount of interaction with nondisabled persons." (*Id.*, p. 61; *see also*, p. 81, citing *Olmstead*, "[DOJ] Failed to prove that Conway Human Development Center is not the most integrated setting appropriate to the needs of any specific resident.")

"It is another oddity of this case that the institution at issue is funded and regulated by one department of the executive branch of the federal government while another department of the executive branch contends that its conditions are so deplorable as to violate rights guaranteed to the institution's residents by the United States Constitution. More pointedly, the

United States simultaneously funds Conway Developmental Center, certifies it as eligible for those federal funds, and contends that the conditions there are so deplorable as to be unconstitutional." [*Id.*, p. 4 (fn 2)].

Just as the federal judge in the Conway case recognized, families and guardians are a necessary and important voice in matters impacting their family members with significant intellectual and developmental disabilities, including where they receive services and the quality of those services (see also, DD Act and *Olmstead*).

H.R. 2032 aims to restore individual and family decision-making in federally funded class action lawsuits and DOJ actions. Specifically, H.R. 2032 provides that residents of ICFs/MR, or where appointed, their legal guardians, receive notice of a federally-funded class action lawsuit involving the ICF/MR before it is filed, and be given a time limited opportunity to opt out. H.R. 2032 also requires that DOJ consult with families as part of any action, and if a lawsuit is filed provides residents of the affected ICF/MR or where appointed, their legal guardians, a right of intervention. The Conway case helps demonstrate both the value of family/guardian input and DOJ's history of excluding their input. Similar examples include cases in Virginia, Georgia, Illinois and Tennessee.

NEWS FROM REGION IV

VIRGINIA



CVTC director expects facility to remain open

Central Virginia Training Center's director told parents that he expects the facility to remain open after negotiations between Virginia and the U.S. Department of Justice are finished. About 50 family members also were assured by a top state official that their relatives can't be moved out of the training center unless families approve their transfer to a smaller, community-based home. The federal agency, after investigating CVTC for three years, issued a report about the training center in February and

told Gov. Bob McDonnell it was prepared to sue Virginia unless it moves faster in transferring residents of all five training centers to community-based homes. The DOJ report put new urgency into the concerns the family group has held for several years about state government's efforts to downsize the training centers, which care for people with intellectual disabilities. CVTC Director Dale Woods said he expects CVTC to continue to have fewer and fewer residents. It has 387 of them now, and in the past 3 ½ years, 66 people have successfully transitioned into community housing. He told the parents, that trend gives the state a better opportunity to upgrade CVTC's existing buildings to meet fire-safety code requirements and other needs. However, Woods said that family members would be able to choose whether their loved one stayed in a training center or moved to a community home.

VOR Weekly E-Mail Update
April 22, 2011

CONNECTICUT




Connecticut Training School Lawsuit Settled

A U.S. District Court Judge signed an order approving the settlement agreement in the 1994 class action lawsuit, *Messier v. Southbury Training School* (STS). All issues pertaining to conditions, care, treatment, medical care, and protection from harm were either ruled moot or decided in favor of the Department of Developmental Services (DDS). The settlement agreement states that DDS will ensure that all interdisciplinary teams will assess a resident's needs and make a professional judgment and recommendation for that person regarding the most integrated setting appropriate to the individual's needs. Each STS resident and their guardian will be given sufficient information to then make an informed decision about these recommendations. Neither the settlement nor the judge's original ruling in 2008 directs the closure of Southbury Training School. STS will remain open for those individuals who wish to continue to live there and will receive comprehensive supports to meet their needs. The department will also continue to make resources available to all STS residents who

choose to move.

PENNSYLVANIA:



The Pennsylvania Department of Public Welfare has agreed to settle a lawsuit filed by Disability Rights Network of Pennsylvania on behalf of over 60 Pennsylvanians with intellectual disabilities who were being inappropriately housed in state psychiatric hospitals. The original complaint, filed in the U.S. District Court for the Middle District of Pennsylvania, alleged that the Department of Public Welfare violated the Americans with Disabilities Act and the Rehabilitation Act by unnecessarily segregating the plaintiffs in state psychiatric hospitals. The complaint also alleged violations of the Fourteenth Amendment of the Constitution by failing to provide constitutionally adequate treatment for these residents.


The announced settlement, subject to the approval of the court, provides for the following:

- Defendants will request funding to provide community mental retardation services to all class members over the next three years;
- Staff at the state psychiatric hospitals will receive comprehensive training in the appropriate treatment of individuals with dual diagnoses of mental illness and intellectual disabilities; and
- Staff at the state psychiatric hospitals will be required to adhere to a comprehensive protocol with respect to the treatment of individuals with dual diagnoses (from assessments to treatment plan development and evaluation, to behavioral approaches) and with respect to discharge planning.

Disability Rights Network of Pennsylvania
August 2010

NEWS FROM REGION V

GEORGIA.



The U.S. Department of Justice announced that it has entered into a settlement agreement that will resolve a lawsuit the United States brought

against the state. The lawsuit alleged unlawful segregation of individuals with mental illness and developmental disabilities in the state's psychiatric hospitals in violation of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.* As part of the terms of the agreement, the following was agreed upon:

- Georgia will cease all admissions of individuals with developmental disabilities to their State Hospitals by July 1, 2011.
- Georgia will transition all individuals with developmental disabilities in the State Hospitals from the Hospitals to community settings by July 1, 2015.
- Georgia will create 1150 home and community based waivers for individuals with developmental disabilities by July 1, 2015: 750 waivers to help transition individuals from the State Hospitals to community settings, and 400 waivers to help prevent the institutionalization of those individuals currently living in the community.
- Georgia will serve those individuals receiving home and community based waivers under the Agreement in their own home or their family's home consistent with each individual's informed choice.
- Georgia will provide those individuals receiving home and community based waivers under the Agreement with support coordination to assist them in gaining access to medical, social, education, transportation, housing, nutritional, and other needed services.
- Georgia will provide family supports to 2350 families of individuals with developmental disabilities by July 1, 2015, to help those families continue to care for a family member with developmental disabilities at home.
- Georgia will have six mobile crisis teams by July 1, 2012, to respond to individuals with developmental disabilities experiencing a crisis anywhere in the community.
- Georgia will establish 12 crisis respite homes by July 1, 2014, to provide respite services to individuals with developmental disabilities and their families.
- Georgia will begin performing by July 1, 2012, an annual network analysis to assess the availability in the community of supports and services for individuals with

developmental disabilities and serious and persistent mental illness

- Georgia will institute a quality management system by July 1, 2012, to perform annual quality service reviews of the community services provided under the Agreement.

• The Parties selected an Independent Reviewer to assess the State's compliance with the terms of the Agreement.

United States v. Georgia
Civil No. 1:10-CV-249-CAP
Settlement Agreement fact sheet

ALABAMA:



Lawmakers hint at legal action over Partlow; Tuscaloosa-area legislators concerned facility will close without adequate preparation

Legislators from the Tuscaloosa area hinted at legal action to keep W.D. Partlow Developmental Center open, at least beyond the initially announced closing date. The Department of Mental Health announced earlier this year that it would close Partlow by Sept. 30, the end of the fiscal year. Gov. Robert Bentley later suspended that date, but still supports eventually closing the facility.

VOR Weekly E-Mail Update
April 15, 2011

NATIONAL NEWS



H.R. 2032 Rep. Barney Frank (D-MA), Rep. Bob Goodlatte (R-VA) and Rep. Debbie Wasserman Schultz (D-FL), with nine original cosponsors, have introduced H.R. 2032, a bill to allow residents and their legal guardians to be notified in advance of a class action lawsuit involving their ICF/MR home, and given a time limited opportunity to opt out, before the lawsuit is filed.

H.R. 2032 will also include a section on the Department of Justice (DOJ). This new section seeks to protect the right to residential choice for people with profound intellectual disabilities in DOJ actions. Since 2009, the Department has

issued investigative reports, filed suit, or presented briefs in cases alleging violations of the Americans with Disabilities Act (ADA), seeking or agreeing to settlements that would reduce significantly the population of or close all ICFs/MR in several states. The new section would require DOJ to consult with the residents and guardians before taking any action and guarantee them the right to intervene in any court proceeding.

VOR Action Alert
May 31, 2011

University of Minnesota's Status and Trends Database Released

The National Residential Information Systems (RISP) Project at the University of Minnesota's Research and Training Center on Community Living released a new database on national and state statistics on public and private residential services, Medicaid program utilization, expenditures, and other information. The National Residential Information Systems Project has been collecting and disseminating this data annually for over 20 years. To access the latest database, *Status and Trends through 2009*, see <http://rtc.umn.edu/risp/main/>

Removing the R Word from State Statutes

On October 5, President Barack Obama signed "[Rosa's Law](#)" to replace the term "mental retardation" with "intellectual disability" in many federal laws. Rosa's Law is named for Rosa Marcellino, a Maryland girl with Down syndrome. However, Rosa's Law does not change Title XIX of the Social Security Act at this time. CMS has proposed draft language that would eventually also impact the Social Security Act. Several states have already passed legislation similar to Rosa's Law will others are working to pass similar legislation.

Following are states that have already passed legislation: Alabama, Arkansas, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Montana, New Jersey, New York, North Dakota, Tennessee, Virginia, Washington.

Following are states that have or are considering legislation: District of Columbia,

Hawaii, Missouri, South Dakota.

Proposal to eliminate “provider tax” cause for concern

Thirty-seven states and the District of Columbia have a federally approved provider tax program to generate additional funds to more adequately fund long term care services for seniors and people with disabilities. The tax is imposed on health care providers, including ICFs/MR, based on a percentage of the providers’ gross revenue. The percentage taxed, up to 5.5% (6% after October) differs by state. The tax collected by the state is matched by federal funds. States use this additional revenue in varying ways, including support for community-based programs, skilled nursing services, or higher Medicaid rates to nursing homes.

The President’s Fiscal Year 2012 budget proposal includes a provision to reduce the provider tax threshold in phases over a 3-year period beginning in 2015. From 6% in 2015, the percentage would be phased down to 4.15% with reductions to 3.5% by 2017.

The VOR Voice
Spring 2011

Disability Convention Receives 100th Ratification

The Convention on the Rights of Persons with Disabilities is the first international human rights treaty of the twenty-first century. On 10 May, Colombia became the 100th country to ratify this Convention. In doing so, it joins the ranks of those countries that now support greater access, backed by their legal systems, for citizens with disabilities to fully participate in the lives of their communities, including the political process and health and education services.

“This is an important milestone for Colombia and for the global community. The Convention on the Rights of Persons with Disabilities is a powerful tool for inclusion and development. Let us use it to make concrete improvements in the lives of persons with disabilities,” said United Nations Secretary-General Ban Ki-moon, commenting on the 100th ratification.

Around 10 per cent of the world’s population, or 650 million people, live with a disability. They

comprise the world’s largest minority who are excluded from fully participating in the economic, social, political, legal and cultural life of their communities. To address this inequality, in 2006, the United Nations General Assembly adopted the Convention on the Rights of Persons with Disabilities, which was drafted along with the participation of persons with disabilities and their organizations. At its core, the Convention ensures that persons with disabilities enjoy the same human rights as everyone else. A record number of 82 countries — the highest in the history of a United Nations treaty — signed it on the opening day.

The Convention marks a shift away from the old “medical” view of disability towards a more “social” view that “disability” is a result of the interaction between a person and his/her environment, and not something that resides in the individual as the result of an impairment.

An estimated 386 million of the world’s working-age population are disabled, but unemployment among the persons with disabilities is as high as 80 per cent in some countries.

Sha Zukang, the United Nations Under-Secretary-General of the Department of Economic and Social Affairs, which serves as the secretariat for the Convention on the Rights of Persons with Disabilities, said: “We are greatly encouraged by this 100th ratification of the Convention. This is a great achievement by the international community in working towards a just and equitable society, based on equality and equal opportunity for all, including persons with disabilities.”

Press Release
May 2011

Obituary: Dr. Wolf Wolfensberger

Wolf Wolfensberger, Ph.D., 76, of Syracuse, New York, died on February 27, 2011, at St. Joseph's Hospital. Since 1973, Dr. Wolfensberger was a professor in the School of Education at Syracuse University and the director of the Training Institute for Human Service Planning, Leadership and Change Agency at Syracuse University. He was an internationally renowned and often controversial scholar, activist and prolific author in the field of

developmental disabilities. A major early promoter and organizer of community services for the mentally retarded, he worked tirelessly to liberate societally devalued people from oppressions and improve their social position. He popularized the principle of normalization in North America, formulated the concept of Social Role Valorization, and founded Citizen Advocacy, which recruits ordinary citizens to act as unpaid voluntary individual advocates for vulnerable persons. His books, which have been translated into 11 languages, include *Changing Patterns in Residential Services for the Mentally Retarded*, *PASS* and *PASSING*, as well as *The Principle of Normalization* which in 1991 was ranked #1 in the "Education and Training in Mental Retardation" list of 25 classic works in the field. Dr. Wolfensberger was born in Mannheim, Germany, in 1934, the son of Friedrich and Helene Wolfensberger. He immigrated to the United States in 1950. He earned a BS in Philosophy at Siena College in Memphis, Tennessee, an MS in Psychology at St. Louis University and a Ph.D. in Psychology and Mental Retardation from Peabody College (now part of Vanderbilt University). He was on the faculty at the Nebraska Psychiatric Institute of the University of Nebraska Medical School in Omaha from 1964-71. From 1971 - 1973 he was a visiting scholar at the National Institute on Mental Retardation in Toronto, Canada. Dr. Wolfensberger held the title of US chess expert, was active in documenting the history of his family and loved cats and song. He was a member of the Unity Kitchen Community of the Catholic Worker and a founder of the l'Arche community in Syracuse.

His professional positions included postings at Muscatatuck State School (Indiana), E.R. Johnstone Training Center (New Jersey), Maudsley Hospital (London, England), Plymouth State Home and Training School (Michigan), Nebraska Psychiatric Institute of the University of Nebraska Medical School, National Institute on Mental Retardation in Toronto, Canada, and the Institute for Human Service Planning, Leadership and Change Agency at Syracuse University in Syracuse, New York.

Obituary: Robin Sims

Robin Kay Sims, 57 died on Thursday June 23, 2011 at Beth Israel Hospice in Newark. Born in New York City, she lived the last 25 years in Bloomfield. After graduating from Manhattan School of Music, she was a concert soloist and member of the NYC Opera Co.

Along with her husband she served on the Bloomfield Democratic County Committee. Following the birth of her children, she became an advocate for people with special needs and their families. She served on the Bloomfield Recreation Commission, was past president of VOR, the National Advocacy of Families, and also held a seat on the N.J. Council of Developmental Disabilities.

Robin was the beloved wife of William (Jack) Sims, devoted mother of Heather and Benjamin, dear daughter of Edward and Sally Sofer Dubrowsky of Melville, L.I., N.Y., loving sister of Geoffrey Dubrowsky and his wife Rosemarie of Brick, NJ.

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Administrative Officer, APDDA
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Fax: (757) 424-8502

Or E—Mail to: robert.shrewsberry@sevtc.dmhmrzas.virginia.com

Registrants must make their own hotel reservations. The conference rate is \$120 which is also good before and after the conference dates. REGISTER EARLY—there is no penalty for reservation changes/cancellations made within 72 hours of your scheduled arrival.

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APDDA

Mission and Vision

Our Mission. . .

The Association of Public and Private Developmental Disabilities Administrators (APDDA) is a not-for-profit professional organization founded in 1970. We represent facilities across the United States. APDDA is the only national organization that focuses on the unique issues of administrators of public and private ICF/MR programs. APDDA also provides support for other individuals with interests in the field of intellectual and other developmental disabilities. The Association supports the continuous improvement of a comprehensive array of individual and accessible services designed to enhance the quality of life for persons with intellectual disabilities and other developmental disabilities.

What we do. . .

The primary purpose of the Association is to address the needs of people with intellectual disabilities and other developmental disabilities. Our focus and efforts include:

- Member education and information services
- Promotion and recognition of excellence in service management and delivery
- Development of member networks and other supports
- Representation of members' views through advocacy efforts
- Promotion and recognition of research in intellectual and other developmental disabilities
- Public education and awareness

Vision for the Future. . .

APDDA envisions a future in which it is known as an important professional association, making significant contributions to the field of intellectual disabilities and developmental disabilities in the following specific areas:

- **Advocacy:** Involvement and participation in the development of standards and regulations.
- **Collaboration:** Involvement with other developmental disability organizations.
- **Education:** Professional development of members and others in the field.
- **Management:** Continuous examination of the organization, structure and management of the Association to ensure responsiveness to its mission.
- **Marketing:** Recognition and marketing of the role of public and private ICF/MR residential programs within a comprehensive array of service delivery systems.

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Resources



Direct Support Professional National Credential Program

The National Alliance for Direct Support Professionals (NADSP) has three levels in its national credentialing program for direct support professionals (DSPs) who serve individuals with developmental disabilities in community-based settings. They are DSP-Registered, DSP-Certified, and DSP-Specialist. A common component in the requirements for all three credentials is knowing and understanding the NADSP Code of Ethics, and being willing to sign a commitment to adhere to the NADSP Code of Ethics.

To learn more about the NADSP Credential Program, go to:

<http://www.nadsp.org/credentialing/>

To read NADSP's Code of Ethics, click on:

<http://www.nadsp.org/library/code.asp>



The National Association of QMRPs was formed in 1996 by Trinity Services staff as the result of a recognized need by QMRPs - Qualified Mental Retardation Professionals (also known as Case Managers) to establish a strong resource for research, networking, and addressing issues that concern QMRPs today. Although there were a few states that had formed groups by and for QMRPs, the need to form an organization that would address the historical, conceptual, methodological and ethical issues confronting the QMRP today on a national level was evident. The National Conference of QMRPs provides a forum to share information pertinent to the diverse interests of QMRPs.

To learn more about The National Association of QMRPs, please visit:

<http://www.qmrp.org>

The QMRP Online...

This site is dedicated to all who care for and work with the developmentally disabled—to those who provide direct personal care as well as family members, educators, and those in law enforcement.

QMRP Online hopes to promote a greater understanding of the developmentally disabled by providing accurate information, a place for to learn, exchange ideas, and find some support. The QMRP Online offers you a wide range of support services from consulting to educational seminars to QMRP training. For more information, go to:

www.theqmrp.com



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APDDA Membership Info

Membership Information . . .

Full Membership includes individuals employed at executive levels of either:

- A public or private residential program that has an organization element of providing care and treatment for persons with intellectual disabilities or other developmental disabilities, or
- Individuals who have administrative direction involving those programs by way of central governmental administrative capacity.

Associate Membership includes (a) individuals who have been former members, or (b) who have a professional or personal commitment to the purposes of the Association and who wish to have an affiliation with the Association in a non-voting, non-office holding relationship.

Agency Memberships are available for more than one full or associate member from an organization.

Life Membership includes all privileges and responsibilities afforded Full members and are awarded to individuals who have been full members for twenty (20) years/or to Past Presidents.

Honorary Life Membership is awarded to an applicant who meets the following criteria:

- The individual is nominated by a full member and accepted by the Board.
- The individual has made a major contribution to the field of intellectual disabilities and other developmental disabilities.

Activities and Benefits of APDDA Membership . . .

- Conferences on administrative trends in service provision
- The Digest, APDDA news magazine
- Special monographs on current historical trend, e.g., Annual Trends on Public Services for People With Mental Retardation
- Occasional papers on timely administrative topics, e.g., Demographics of APDDA: A National Survey
- Access to the annual directory of public residential facilities, their administrators and APPDA members
- Updates on current trends, Medicaid compliance, behavior programming and management strategies through its publications and convention

APDDA

Association of Public & Private Developmental Disabilities Administrators

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