

From: John M. Cissik
To: Down Syndrome Guild, Dallas Texas
Re: Texas State Schools
Date: December 10, 2008

Chronology:

- December 11, 2006: The Department of Justice (DOJ) Civil Rights Division issued a report on the investigation of the Lubbock State School (LSS)
- April 5, 2007: DADS released a paper highlighting the actions taken as a result of the DOJ report as well as other feedback they received
- July 2008: Texas State Auditor's office issued a 46 page report on "State Mental Retardation Facilities, DADS, and DFPS"
- November 2008: Texas's Legislative Budget Board (LBB) issued a report "Addressing Shifts in Care from State Schools to Community Settings"
- December 1, 2008: DOJ Civil Rights Division issued a report on the investigation of all the Texas State Schools and Texas State Centers.

Each report is highlighted in this memo. Some interpretation of each is also provided. Note that media hype is not included in this memo.

Lubbock State School (LSS), December 11, 2006:

The DOJ's Civil Rights Division issued a report stating that the LSS substantially departs from generally accepted professional standards of care in that the facility fails to (note that everything outlined here is accompanied with very sad cases to support each point):

1. Provide adequate health care
 - a. Nursing services at LSS are inadequate:
 - i. Nursing services are reactive, nursing care plans do not address individual's health status and do not include interventions to treat illnesses or prevent recurrences, and there is a lack of preparation of the staff regarding medical emergencies.
 - ii. Nurses do not obtain vital signs when appropriate.
 - iii. LSS does not have an infection control program.
 - iv. The fundamental cause of these problems is a lack of staffing. At the time this report was written, LSS had 14 nursing vacancies.
 - b. Care and services provided at LSS' infirmary are inadequate and place individuals at risk of harm:
 - i. Staff is unfamiliar with infection control procedures.
 - ii. Emergency equipment is not monitored to ensure that it works. They note that two oxygen tanks were empty.
 - c. Physical and nutritional management is not provided consistent with generally accepted professional standards:
 - i. None of the PNM team members have specialized training to develop programs for residents
 - ii. There is no system to check on the effectiveness of current PNM treatment programs and revise them if ineffective (a lot of problems with residents suffering aspiration pneumonia)
 - iii. Meal plans are not followed, positioning is not implemented on schedule, and adaptive equipment is not available.
 - d. Physical and Occupation Therapy is not being received by LSS residents

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- e. Pharmacy Services are adequate but there is no alerting of the medical staff with regards to drug interactions and laboratory follow-ups
- f. Resident medical charts lack a comprehensive dental assessment
- g. LSS does not provide adequate psychiatric services:
 - i. None of the psychiatric assessments reviewed contained the necessary components of a standard assessment
 - ii. Many residents are diagnosed as having disorders based upon vague diagnosis that do not comport with professional standards and that impact treatment. Much of this is due to lack of staff.
 - iii. There is not adequate oversight of medication use (psychiatric medicines) by the residents
 - iv. LSS overuses sedatives to control the residents. This is not communicated to psychiatrist, which impacts assessment/treatment/ and diagnosis.
 - v. There is no system in place to ensure that residents receive needed group or individual therapy.
 - vi. LSS lacks a formal system for collaboration between neurology and psychiatry.
2. Protect residents from harm
 - a. Residents are being subjected to a pattern of harm due to inadequate supervision, neglect, and possible abuse.
 - b. LSS does not have an incident management system and quality improvement system
3. Provide adequate behavioral services
 - a. LSS' behavior programs for residents are not based on adequate assessment, not implemented as written, are not monitored, are not evaluated, and are not revised adequately.
 - b. There is one trained staff member for 50 residents. The standard is 1:25.
 - c. LSS' use of restraints is excessive
 - i. Several residents are kept in restraints for nearly all of their waking hours
 - ii. Manual restraints by staff are abusive
 - iii. Chemical restraints (mentioned above)
 - iv. LSS continues the use of restraints even when proven ineffective
 - v. Much of the issues causing need for restraint is due to residents' inability to communicate with staff (goes back to behavioral services)
 - d. Many LSS residents receive little meaningful habilitation training and activity programming.
 - e. LSS fails to provide residents with adequate and appropriate communication services.
 - i. Only a part-time speech professional is available, which impedes service delivery.
4. Provide services in the most integrated setting appropriate to their needs
 - a. LSS is failing to place individuals in the community despite the fact that many are very capable.

What is in it (positives):

1. Health Care:
 - a. LSS provides adequate services to address the needs of individuals with neurological disorders.
2. DOJ feels that LSS is staffed "...predominantly by dedicated individuals who are generally concerned with the well-being of the persons in their care."

DOJ goes on to make 8 pages of specific recommendations to improve this facility and its services (address each of the above issues).

DADS Initiatives, LSS, April 5, 2007:

DADS, in an eleven page response, addressed a number of the DOJ's concerns. After being notified of the impending DOJ investigation in 2005, DADS conducted their own review of the LSS and also contracted The Columbus Organization to conduct an external review of the LSS.

As a result of all the above, DADS reports that it did the following (I'm just presenting the highlights here):

- Replaced key management staff at the LSS
- Created 16 key positions to address the recommendations from the DOJ report:
 - Nursing care
 - Program compliance
 - Prevention care nurse
 - Infection control nurse
 - Nursing case managers
 - Physician assistant
 - Occupational therapists
 - PNMP coordinators
 - Dentist
 - Program auditor (psychiatry)
 - Pharmacist
 - Behavior analyst
 - QMRP coordinator
 - Master trainers
 - Direct support staff
 - Additional night shift supervisors
- In addition, DADS contracted for the following services:
 - In-home hospice
 - Medical transcription
 - Neurologists
- Their reported results include:
 - Pressure sores dropped from 28 in 12/05 to 6 in 12/06
 - Respiratory infections dropped from 83 in 5/06 to 24 1/07
 - Patients receiving outside counseling went from 6 in 12/06 to 12 in 1/07
 - Reduced patients with 3 medications from 46 in 6/05 to 36 in 1/07
 - Reduced patients with 4+ medications from 25 in 6/05 to 6 in 1/07
 - 28% total reduction in psychoactive medications from 6/05 to 12/06
 - Injuries per month declined from 500 in 6/05 to 200 in 1/07
 - Allegations of abuse/neglect reduced from 27/month in FY05 to 17/month in FY07
 - Contingent/emergency restraint use declined from ~160/month in 2005 to ~40 in 1/07
 - Emergency medication (i.e. sedatives) declined from 20/month in 2005 to <5 in 1/07

In other words, according to DADS documents they took the DOJ's findings seriously and made/are making a serious efforts to address the deficiencies at the LSS which largely sprung from a lack of qualified staff and a lack of staff training.

State Auditor's Report, July 2008:

The SAO audited DADS' operations of the Texas State Schools in 2008, probably as a result of the DOJ investigation which was rapidly expanding from the Denton State School (it was conducted in parallel with the DOJ investigations). The audit covered operations from Sep 1, 2005 to Dec 31, 2007.

Basically this audit when combined with the LBB report provide ammunition for Legislative actions whether they are personnel or institutional (fire people, close schools, change funding patterns).

First, I'll present the SAO's major findings. Second, I'll show SAO's major recommendations and DADS' response.

Major findings:

1. DADS should strengthen certain processes associated with consumers' community living options (i.e. DADS is not ensuring that consumers are aware of the range of living options outside of state schools).
 - a. Documentation of this needs to be improved. Among other things the auditors found that discussion records have been copied from prior years, identical discussion records appear for different consumers, and discussion records are filled out in advance of the discussions.
 - b. DADS central office needs to do a better job of monitoring community living option discussions and living arrangement decisions
2. DADS and DFPS should strengthen their investigations processes
 - a. DADS should strengthen its processes for investigation complaints and incidents. For example, while DADS responded to priority I incidents in a timely manner, it only responded to 59% of priority 2 incidents in a timely manner.
 - i. DADS should ensure that quality assurance reviewers don't review their own work.
 - ii. Facilities that are not in compliance with state rules should be penalized by DADS.
 - iii. DADS should ensure that facilities don't hire individuals with a history of abuse, neglect, or exploitation. 10 employees at state schools were listed as unemployable in the Nurse Aid and Employee Misconduct Registries due to acts of abuse, neglect, or exploitation.
 - iv. 61% of complaints and incidents come from 3 state schools in FY07, these three schools service 79% of consumers committed by a court in the course of a criminal proceeding.
 - v. 22% of substantiated complaints and incidents were in state schools, 31% were in community facilities.
 - vi. "...the total number of substantiated complaints and incidents for verbal abuse and exploitation is significantly higher at community ICF/MR facilities than at state schools."
 - b. DFPS should strengthen its processes for investigating allegations of abuse, neglect, and exploitation.
 - i. DFPS should investigate in a timely manner.
 - ii. DFPS should make accurate initial assessments of allegation priorities. 17% of initial priority assessments were incorrect.
 - iii. 52% of DFPS' investigations were from the San Angelo, Mexia, and Corpus Christi state schools.
3. State schools cost \$335.63/day to serve a consumer. Community ICF/MR facilities cost \$165.17/day to serve a consumer.
 - a. Direct care staffing costs are higher in state schools (they pidge double the staffing ratios and almost twice as many hours of direct care staffing/day than community facilities).
 - b. Employee benefit costs are greater for state schools (\$23/consumer/day compared to \$5/consumer/day).
 - c. Administrative costs are higher in state schools than community facilities (\$102.59/day/consumer compared to \$37.59/day/consumer).
 - d. DADS central office administration costs allocated to state schools have increased 156% from FY04 to FY07, but this is largely thanks to the Legislature changing how the state allocates central office costs.
 - e. Comprehensive medical care costs were more than 3x as much per consumer in state schools as in community facilities. The auditors note, however, that they are comparing apples to oranges here.

Major recommendations and DADS' response (grouped into each finding category above, 1-3):

1.
 - a. DADS should improve all documentation associated with discussions with consumers about community living options, the communication of information, reasons for not providing this as

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an option to consumers, and information on how to appeal decisions. DADS essentially responded that much of this has already been addressed or is in the process of being addressed.

- b. DADS central office staff should better monitor the decisions that state schools make about living arrangements. DADS central office should also begin monitoring community facilities. DADS agreed to implement these recommendations.
2.
 - a. DADS should initiate investigations in a timely manner. Work on the policies and procedures associated with investigating complaints. Impose penalties on community facilities. Consistently perform registry checks on employees. DADS essentially argues that its current procedures are accurate for investigating complaints. They point out that they have legislative restrictions on imposing penalties on community facilities. DADS is working on the registry checks.
 - b. DFPS should do a better job with documentation and conduct preliminary investigations in a timely manner. DFPS essentially responds that they will try to do these things.
 3. SAO had no recommendations about the costs of state vs. community facilities.

LBB Report, November 2008:

Essentially, this report reads to me like the LBB was instructed to build the financial case for closing the state schools should that decision be made. A few things to note:

- *Nowhere in the report is the case made that this should be done for the good of the residents. In fact, the report notes that residents that have profound medical/development/behavioral issues will have challenges finding community facilities, medical providers, and will not be reimbursed by Medicaid.*
- Essentially the LBB tries to make the case that the facilities could be closed for several reasons:
 - Other states have done this
 - Community facilities cost less to operate. After reciting the statistics from the SAO report (see above) the LBB notes that a lot of this has to do with the fact that residents of community facilities have less severe medical and behavioral problems and less overhead. Moving state residents to community facilities would increase the cost of providing care for them, which would increase community facility costs.
 - State schools have \$158 million in deferred maintenance that needs to be done. Closing the facilities means this maintenance won't have to be done, in theory. The LBB then goes on to report that a lot of this would have to be done anyway, all the facilities have so much debt associated with them and deed restrictions that the state probably would not be able to sell them.

Texas State Schools, December 1, 2008:

The DOJ began an investigation of the Denton State School in March, 2008. It noticed problems so similar to the LSS that it notified the state in August that it was going to investigate all of the state schools in Texas. At that point, the state of Texas basically agreed that the findings from LSS and Denton State School (DSS) would apply to all state schools.

Note that each finding is accompanied with lots of heart wrenching examples.

The DOJ's major findings on the Texas state schools fail to:

1. Protect residents from harm
 - a. Since FY04 more than 800 employees have been fired for abusing residents.
 - b. As in LSS, facilities fail to identify risks (such as PICA) and fail to implement preventative strategies to keep residents free from harm. This is attributed to staffing shortages and turnover.
 - c. As at LSS, abuse of restraints is pervasive.
2. Health care is inadequate
 - a. The DOJ notes the same issues here as in the LSS report.

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3. Behavior programs and habilitation are inadequate
 - a. The DOJ notes the same issues here as in the LSS report.
4. Integrated support services and planning: there is no communication between disciplines, which impacts treatment and therapy
5. Residents are not being served in an integrated setting:
 - a. Lack of an adequate admission process that includes information on alternatives
 - b. Facility employees do not know about community placement options
 - c. Ineffective discharge and transition planning

The DOJ goes on to make 11 pages of recommendations.

Something interesting to note. The DOJ in the beginning mentions that there was an investigation of the LSS. Nowhere in the document does the DOJ report one way or the other about LSS' progress.