VOR

Speaking Out for People with Mental Retardation

EMPTY PROMISES:

Lack of Community Oversight Persists, People with Intellectual and Developmental Disabilities Remain at Risk

In this time of great need, don't eliminate good care. Maintain the specialized, life-sustaining supports already available in Habilitation Centers and improve community care through enhanced and effective oversight.

http://vor.net/index.php/abuse-and-neglect

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VOR

Speaking out for people with intellectual and developmental disabilities

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EXECUTIVE SUMMARY

Several bills filed in the Missouri State House this session attempt to close Missouri's habilitation centers and transition the remaining 600 residents into community placement – with or without the consent of resident guardians and family members.

HABILITATION CENTERS PROVIDE SPECIALIZED, LIFE-SUSTAINING SUPPORTS

VOR, a national advocacy organization, and its Missouri affiliates and members, vehemently oppose these bills and any efforts to close habilitation centers. Habilitation centers are licensed as Medicaid Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR). They provide highly specialized care to individuals with severe and profound intellectual and developmental disabilities and who also experience complex physical, medical and behavioral challenges. Blocked admissions, short-term/temporary placements, and proposals to eliminate habilitation center care have risked lives. Families of long-term residents and those whose loved ones were admitted short-term due to a community crisis, recognize that their family members are thriving due to the 24/7 compassionate, skilled center supports. The habilitation centers serve as a life-sustaining care option that is simply not cost effective or available in smaller, unlicensed settings.

COMMUNITY PREPAREDNESS CAUSE FOR CONCERN

Families and legal guardians of habilitation center residents have due cause to be concerned about the preparedness of community providers to serve individuals with very high needs.

In 2009, the Missouri Department of Mental Health (DMH) reported that 8% of clients who *voluntarily* moved from habilitation centers to community settings were ultimately returned to habilitation centers because community placement was found unsuitable; and thirty-two people who live in community settings were admitted to the habilitation center for short term stays.

What's more, a review of recent DMH inspection records of community providers and other quality indicators suggests severe problems with quality and safety in these settings. Information we found revealed the following:

- According to DMH safety reports in 2009 the average age at death of individuals in community placement was 46; for individuals in habilitation centers it was 55
- DMH certification reports reveal that 373 community provider staff did not meet minimum training requirements for medication administration, First Aide, CPR, or training for complex medical needs or behaviors from 2008-2010.
- DMH reported over 5,000 medication errors, 5 of them causing hospitalization, permanent harm, or death in private community settings in 2009.
- Community providers still violate minimum safety standards with impunity – according to DMH only two have had certification revoked in the last five years.
- Only 27 full time employees are responsible for investigating abuse, neglect, and misuse of funds for over 62,000 people receiving services under the Department of Mental Health. Budgetary pressures make it unlikely there will be more resources for investigations, even as the number of people being served continues to grow.

CONCLUSION

Habilitation centers (ICF/MR) are a critically necessary, life sustaining, safety net for Missouri's most fragile citizens. Instead of displacing these individuals from their home and placing them at risk of abuse, neglect or death, lawmakers should (a) support the right of current and future residents (including individuals on the waiting list) to receive and benefit from specialized habilitation center care and (b) focus on providing adequate oversight of community providers and on assessing and improving the quality of service provision in the community. A detailed presentation to support this Executive Summary is available at www.vor.net/index.php/abuse-and-neglect.

In our ongoing effort to provide current information concerning ICF/MR ("habilitation center") homes, VOR has prepared this presentation. VOR is a national advocacy organization for individuals with intellectual and developmental disabilities, and their families. www.vor.net • 877-399-4867 • thopp@vor.net.

OVERVIEW

Today, over 29,000 Missourians with developmental disabilities already receive services from publicly funded, privately operated community providers. As many as 6,300 people receive residential services which provide up to 24 hour care in state-licensed facilities or non-licensed homes or apartments (often referred to as ISLs – Individualized Support Living). Unlike state-operated habilitation centers, which are licensed as Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) and are subject to federal inspections, neither the Centers for Medicare and Medicaid nor the U.S. Department of Justice inspects facilities or providers in the community. Rather, the Missouri Department of Mental Health (DMH) is tasked with providing oversight and assurances of safety and quality to the state and federal governments. [1]

In recent years, DMH has been scrutinized in media reports and state audits for inadequate oversight of community providers. The audits and media coverage also revealed a community provider industry wrought with abuse and neglect. Though some changes have been made, no evidence based assessments have been conducted to confirm actual improvements in quality of care and consumer safety in the community. In fact, as the number of people served in the community continues to grow, resources for oversight efforts are dwindling. In this report, we provide evidence that calls into question the quality of care provided to clients already in the community, and raises serious questions as to the preparedness of these community providers to serve habilitation center residents, who are among the most vulnerable and profoundly disabled citizens in Missouri.

HISTORY OF ABUSE AND NEGLECT

MEDIA SCRUTINY AND STATE AUDITS REVEAL WIDESPREAD ABUSE, NEGLECT AND DEATH

In 2004, the *Post-Dispatch* began a two year investigation of safety conditions in state-run and privately operated facilities for people with developmental disabilities. The result was a 2006 exposé series, *Broken Promises, Broken Lives*, that brought to light thousands of allegations of abuse and neglect and grave and systemic problems with state oversight.[2] Corroborating the findings of the series were two state audits, conducted in 2001 and 2007, that also found the state was not fully protecting clients from injuries and abuse and neglect. [3]

Though the exposé and audits revealed problems in state-operated habilitation centers, they found that most deaths from abuse and neglect occur in private facilities. They also found that extremely lax state oversight allowed private organizations to avoid following quality control and safety rules with impunity. From 2000-2006 they found thousands of allegations of abuse and neglect of residents receiving care in the community. From those cases, 14 resulted in death in private community homes. The statistics they uncovered were no doubt a fraction of incidents that actually

1 MO MRDD Home and Community Based Care Medicaid Waiver application, approved through June 30, 2011

2 Tuft, Carolyn and Joe Mahr. "Broken Promises Broken Lives." *St. Louis Post-Dispatch* 12 June 2006.

3 Audit of Management and Oversight of Contractors Responsible for Care of People with Developmental Disabilities, March 15, 2001, Missouri Auditors Office; Audit of Departments of Social Services, Mental Health, and Health and Senior Services/Protecting Clients from Abuse, November, 2007, Missouri State Auditors Office

occurred, because, as the 2007 state audit revealed, the state was not providing enough oversight to ensure that providers were reporting all incidents. The 2007 audit found numerous examples of incidents not being entered into the state's incident tracking system by private facilities.

In summary, the following represents some major findings of the audits and exposé:

- Community providers did not report suspicious incidents as required.
- State overseers did not investigate all reports that were submitted, and did not complete investigations on time.
- The state failed to revoke licenses of community facilities where workers committed deadly lapses, and failed to ensure that workers who mistreated residents didn't get jobs at other places and abuse again.

DMH RESPONDS – PROMISES IMPROVEMENTS

In response to the public scrutiny, then-Governor Matt Blunt created a Mental Health Task Force comprised of family members, advocates, and state officials, and charged it with making recommendations for change.

Progress towards realizing the new safety agenda was tracked in the newly required DMH Annual Safety Report. In 2009, three years after the recommendations were first publicized, DMH reported that it had "completed the work necessary to operationalize the safety agenda set forth by the Task Force."[4]

Though DMH admits that improvements and ongoing monitoring of safety indicators are always necessary, it reported that 22 of 25 recommendations were fully implemented as written, that 2 were implemented to the extent of DMH authority, and that 1 was integrated into other DMH activities. Of the 25 recommendations, four that were considered fully implemented attempted to ensure that the quality control policies that existed for habilitation centers were also applied to private providers in the community.

NEW SAFETY AGENDA MEANS NEW OPPORTUNITIES TO ASSESS COMMUNITY SAFETY

The 2010 and subsequent Annual Safety Reports allow family advocates and others to review safety indicators such as injuries and neglect investigation processing times relating to quality of care in all care settings and determine whether the state's "safety agenda" truly made meaningful improvements since the 2006 *Post-Dispatch* expose, and the state audits in 2001 and 2007.

OVERSIGHT PROBLEMS ENDURE

Some changes in regulations and laws affecting state oversight of community providers tried to ensure standards were consistent with those in state-operated habilitation centers. However, a closer look at several action steps the Department was supposed to have taken to improve oversight reveals the lack of follow-through necessary for substantive improvements. This includes

4 2009 Department Mental Health Annual Safety Report

some recommendations of the safety task force considered "fully implemented" in the DMH Annual Safety Report.

PROVIDER PENALTIES NOT ENFORCED IN COMMUNITY

DMH reported as fully implemented a recommendation to establish penalties for community providers that failed to implement plans of correction and for those who fail to report abuse and neglect. Their 2009 annual safety report says they have a "plan in place to create this authority."[5] However, a review of current DMH regulations reveals a reluctance to enforce administrative sanctions or penalties on community providers:

> "Rather than taking the traditional approach of penalizing agencies that fail to meet minimum standards, the division shall direct its resources and support towards assisting agencies that demonstrate innovation and initiative in pursuing best practices and realizing outcomes contained in the principles set out in section."[6]

RECOMMENDATION # 5: REDESIGN OF DMH LICENSURE AND CERTIFICATION

Full Recommendation	
The Department of Mental Health shall pursue legislation and amend regulations involving Licensure and Certification to permit administrative actions, up to and including fines, for failure to implement plans of correction.	
2009 Update	**Status**
Plan in place to create the authority through administrative rules for Licensure and Certification to penalize providers who are in violation of this provision	 2009

2009 Department of Mental Health Safety Report, page 8

Information recently disclosed by DMH shows that the department does not revoke certification from providers who fail to meet minimum standards. **Since 2006 – a span of five years – only two community providers have had their certification revoked by the Department because of violations.** There are currently over 700 community providers that are certified and have contracts with DMH to provide services.[7] According to DMH certification records, many community providers are repeatedly found in violation of federal and state laws and DMH policies. Some take months and several plans of corrections to fix problems identified by state inspectors.

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5 2009 Department of Mental Health Safety Report, page 8

6 9 CSR 45-5.010, Rules of Department of Mental Health, Division 45. Division of Mental Retardation and Developmental Disabilities Chapter 5. Standards for Community-Based Services

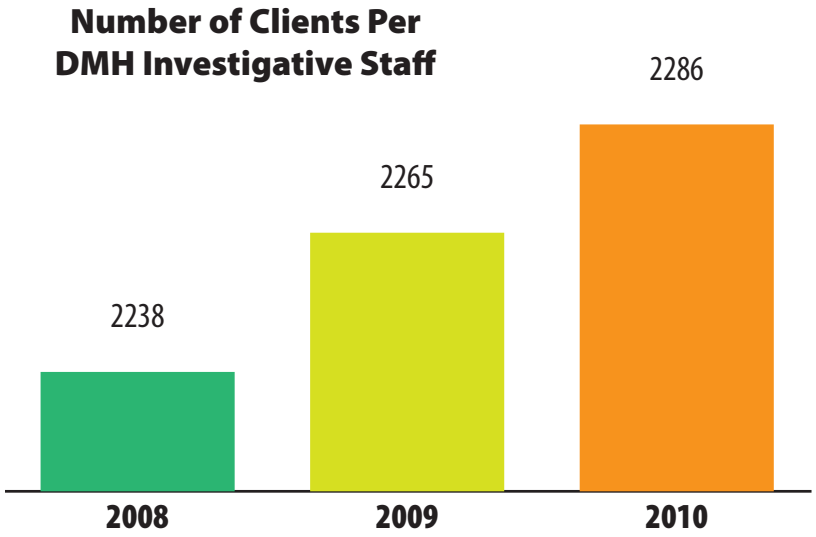
7 Information obtained in January, 2011, through request for information from DMH Licensing and Certification Unit

CERTIFICATION PROCESS REMAINS ANEMIC

When the safety task force was convened in 2006, DMH was only inspecting community-based providers every two years during certification reviews, and providers were made aware of inspection dates in advance. The safety task force recommended that DMH redesign its process for licensure and review of community-based providers. DMH admitted in their annual safety report that annual site visits to facilities should be mandatory.[8] However, citing resource constraints in the Licensure and Certification Unit, DMH made no changes to the certification process to this affect. DMH still only regularly surveys most community providers once every two years during certification reviews and still announces inspection dates beforehand. [9] Even though community providers know when the state is coming to inspect, hundreds of severe violations of clients' rights, staff training requirements, and health and safety standards are reported each year.

CRITICAL NEED FOR MORE INVESTIGATORS

The state's Centralized Investigations Unit is responsible for investigating abuse, neglect, and misuse of funds in all state operated mental health facilities and on behalf of clients who receive community services. [10] From 2007-2009 DMH employed 28 FTE (full time employees) in the Investigations Unit. Since 2010 they have employed 27 FTE - a 3% decrease.[11] From 2008-2010, the number of people with developmental disabilities receiving residential services in the community increased by over 13%, totaling 6,738 in 2010. The total number of community clients, including those receiving non-residential services, rose 14% over the same time period and totaled 29,500 people in 2010.



Source: 2010 Department of Mental Health Safety Report

8 2009 Department of Mental Health Safety Report

9 9 CSR 45-5.010 Certification of Medicaid Agencies Service Persons with Developmental Disabilities

10 According to DMH, while the state's Regional Offices do have staff conducting initial inquiries into allegations, they are only investigated by the central office unit.

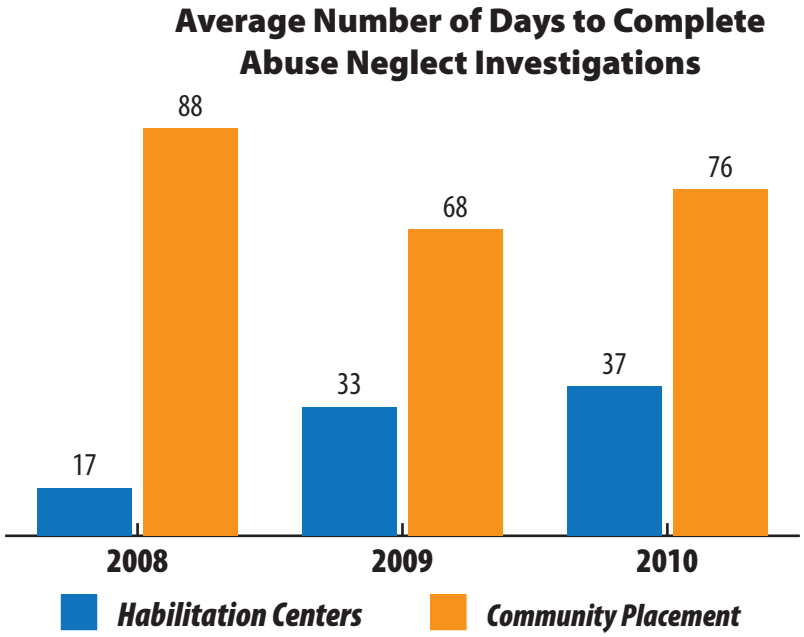
11 Information obtained in January, 2011, through request for information from DMH Licensing and Certification Unit

What's more, the Investigations Unit is also responsible for investigating abuse, neglect, and misuse of funds for over 5,000 individuals who stay in state operate psychiatric centers and over 27,000 clients who receive community psychiatric services.[12]

That means, a team of just 27 FTE is responsible for investigating abuse, neglect, and misuse of funds for over 62,000 people. Without a focused effort by lawmakers budgetary pressures are unlikely to allow more resources for investigations, even though the number of people receiving services will certainly continue to grow.

INVESTIGATING SCATTERED COMMUNITY SETTINGS TAKES TWICE AS LONG AS HAB CENTERS

It is important to note that it is especially difficult for an under-resourced team to conduct investigations into thousands of individual community settings, as compared with centralized habilitation centers where staff supervision is more ample. In fact, on average it takes investigators more than double the amount of time to complete an investigation in community placement, than it does in state-operated habilitation centers.[13]



Source: 2010 Department of Mental Health Safety Report

NEW EVIDENCE OF AN ONGOING PROBLEM

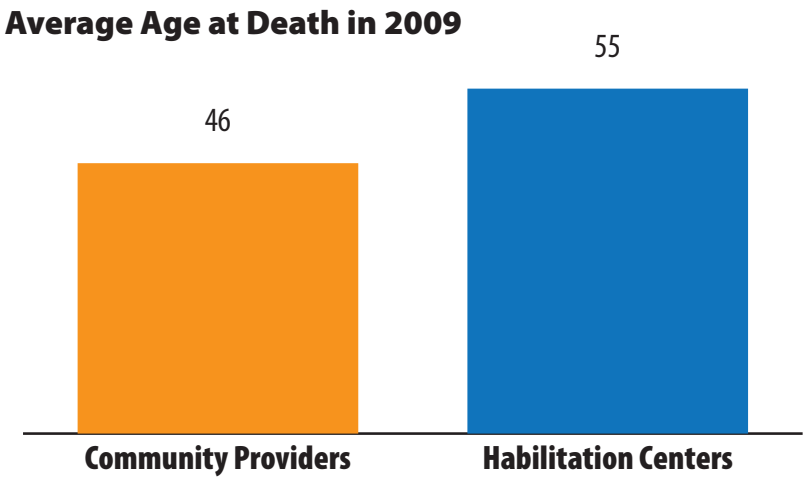
A recent assessment of certain safety indicators suggest a severe quality of care discrepancy between community providers and habilitation centers remains:

According to DMH safety reports, in 2009 the average age at death of individuals in community

12 2010 Department of Mental Health Safety Report

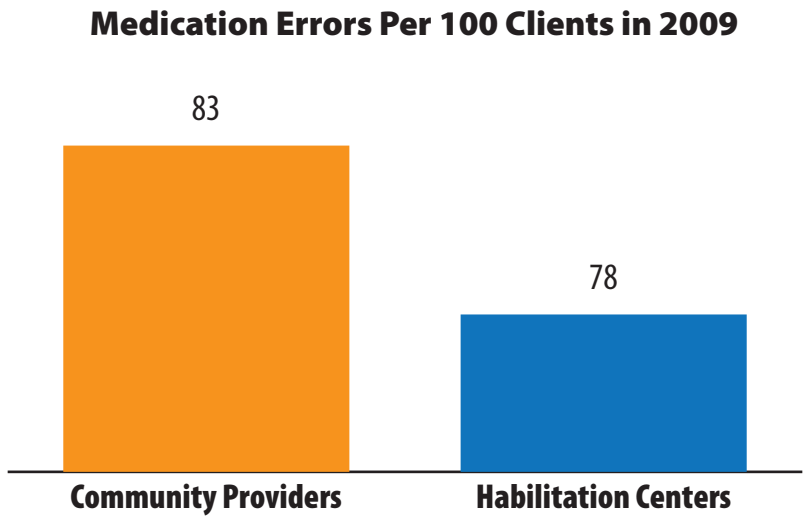
13 2010 Department of Mental Health Safety Report, page 56

placement was 46. In habilitation centers, the average age at death is nearly a decade older at 55.



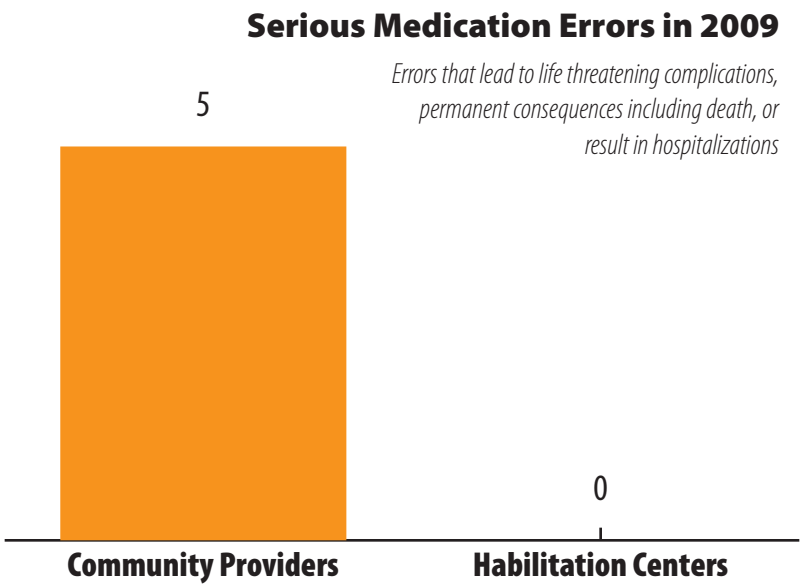
Source: 2010 Department of Mental Health Safety Report

In 2009, DMH reported 5,281 medication errors committed by community providers. That's a rate of about 83 errors, per year, per 100 people in placement. Five of these errors were classified as "serious," meaning they lead to life threatening complications, permanent consequences including death, or resulted in hospitalizations. To compare, the habilitation center reported a rate of about 78 errors, per year, per 100 residents. None of the errors were classified as serious. [14]



Source: 2010 Department of Mental Health Safety Report

14 2010 Department of Mental Health Safety Report, pages 58-59



Source: 2010 Department of Mental Health Safety Report

DMH INSPECTIONS OF COMMUNITY PROVIDERS

DMH tracks critical incident reports from community providers and state habilitation centers in an electronic database. However, most of those records are not made available to the public. Aggregate statistics and state certification surveys of community providers are made public.[15] As mentioned above, most private providers are only inspected by DMH once every two years to grant recertification. Survey visits are scheduled and providers are made aware of survey protocol in advance of the inspection. Even so, these reports reveal blatant health and safety violations, and other unmet requirements that beg the question: ***What happens when the state's not looking?*** It can take several follow up inspections that occur over the course of several months for providers to fix problems. We found several providers who are repeat offenders, continuously found in violation of certification standards year after year.

From 2008-2010 DMH documented over 300 deficiencies – including health and safety violations – in their scheduled inspections of community providers. DMH surveys each provider every 2 years in order to maintain provider certification, and schedules the inspections with providers. Even when plans of correction were submitted by providers, 8% of the deficiencies were not resolved by community providers until investigators had conducted 2 follow up visits.

HEALTH AND SAFETY DEFICIENCIES

Many deficiencies revealed violations of health and safety certification standards. For example, a recent survey of a group home and ISL provider in Perryville, described untrained staff trying to supplement for a lack of available medication:

> "Medications are not being administered as prescribed… It had been documented that the home had been out of Valprioc Acid for the consumer with the G-tube for 12 dosages. In an attempt to maintain the ordered dosage, staff was puncturing Valprioc Acid gel caps with a thumb tack and adding liquid

15 DMH does make available to the public, reports of substantiated abuse and neglect reports. We were not able to obtain the information in time for this publication, however.

> Valprioc Acid trying to get the correct dosage. They attempted this for eight of the 12 missing dosages. Staff did not recognize this as a medication error."[16]

The same provider was cited for not providing a clean and safe environment:

> "Wet sheets were left on the bed of one individual. Used Attends are left in open trash containers. Toxic chemicals are stored in the laundry room on shelves in an open closet." [17]

A provider of services for 40 individuals in apartments around Independence, MO was cited for not keeping up with resident dental exams and even immediate medical needs:

> "One woman's file contained an order for tests because she was suspected of having Chlamydia and Gonorrhea. The tests were not conducted until three months after they were ordered."[18]

A survey of another community provider in Independence, found that staff was not prepared to care for the complex medical needs of their residents:

> "One individual with a history of recent seizures did not have physician – driven protocols of what to do in case of a seizure…One woman had a physician's order to call the doctor if her blood sugar level fell below 80 or went above 150. On four occasions in June-July 2008 her blood sugar exceeded these levels but there was no documentation that the physician had been notified."[19]

In many reports, like this one from a provider in Kansas City, providers simply don't take clients to the doctor when they are supposed to:

> "One individual requiring psychiatric services for mental health diagnoses and psychiatric medication management did not receive regular and consistent apps with his psychiatrist every three months as ordered by Dr."[20]

STAFF TRAINING DEFICIENCIES

One of the most common deficiencies reported in certification surveys was a lack of required staff training. Over and over again surveys documented hundreds of staff who care for thousands of clients, without proper medication training, abuse and neglect training, client rights training, etc. **From 2008 -2010, DMH cited 373 direct care staff in community settings as deficient in training requirements.** Below are some examples of deficiencies in staff training found in the reports:

Four providers in the Kansas City area, Raymore, and Harrison serve a total of 74 clients in

16 DMH Certification Survey report, Shannon's Neighborhood, December 18, 2010

17 Ibid.

18 DMH Certification Survey report, Heartland Residential Care, August 2, 2006

19 DMH Certification Survey report, S & S Development, September, 26, 2010

20 DMH Certification Survey report, Greater KC Foundation for Citizens w/Disabilities, June, 13 2010

shared apartments and group homes and were among the many that reported staff training deficiencies:

> "One staff did not have training on body substance precautions. Five employee records are missing the original medication administration training verification and two employees are missing the required two year update. Nine staff did not have documentation of first aid training. Eleven staff did not have documentation of CPR training……An individual with cancer receiving outpatient chemotherapy has no specific guidelines in his physician orders regarding what support staff should look for or when and what interventions might be necessary. Support staff files did not contain documentation that any staff had received special task training and delegation from the nurse consultant. There are individuals receiving services that are diabetic, have seizures disorders requiring a vagal nerve stimulator, and a man with cancer receiving chemotherapy."[21]

> "Twenty staff did not have documentation of current abuse/neglect training, and eight staff did not have emergency procedure training." [22]

> "There was no documentation of training in abuse and neglect in 4 personnel files."[23]

> "Two staff giving medications did not have approved training in medication administration."[24]

HIGH RATES OF STAFF TURNOVER

In addition to blatant deficiencies in training requirements, many surveys documented high turnover and inadequate levels of staffing in community placement. The following examples are excerpts from certification reports of providers that serve 20 clients in share apartments and group homes in Perryville, Blue Springs, and Kirksville:

> "Approximately 75% of the agency workforce is new to the agency since the last certification survey two years ago."[25]

> "Direct care staff stated there was a lack of supervisory staff in the home unless the regional office staff was present. They reported that the Community RN is in the home once a month and that the office manager, one supervisor, and the administrator spent most of their time at the agency's ISL."[26]

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21 DMH Certification Survey, Cass County Community Living ISL II, March 3, 2010

22 DMH Certification Survey, Preferred Alternatives of Missouri, September 16, 2010

23 DMH Certification Survey, Greater KC Foundation for Citizens with Disabilities, July 13, 2010

24 DMH Certification Survey, Caring Hands of Kansas City, December 27, 2010

25 DMH Certification Survey, S&S Development, September, 27, 2010

26 DMH Certification Survey, Shannon's Neighborhood, December, 18, 2010

> "Two consumers were not receiving the amount of staff supervision as identified by the plans... The agency has had three administrators in the last three years."[27]

Experts agree that high staff turnover rates adversely affect the quality of care clients receive. In 2008 staff retention was listed as a high priority in a DMH working group on safety, made up of family members, advocates, and state and community stakeholders.[28] Though turnover and vacancy rates and staff overtime in state habilitation centers is tracked and monitored by DMH, the state does not collect this information for community providers. Though no information is formally collected on staff salaries for direct care workers in community placement, anecdotal evidence from family members and advocates suggests that they are paid lower wages and receive fewer benefits than direct care and nursing staff in habilitation centers.

BACKGROUND CHECK VIOLATIONS

In past years community providers were not required to obtain background checks for employees. Now, private providers are required to submit background checks for all employees who interact with clients, and check their names against the Family Care Safety Registry for past convictions of abuse and neglect.[29] However, DMH found that many community providers, even when they know the state is watching, fail to comply with the law. **From 2008-2010 DMH found at least 54 community provider staff were deficient in complying with the background requirement law.** The following examples are from surveys of providers in Independence, Blue Springs, and Kirksville, and who serve a total of 27 clients:

> "16 staff records did not have documentation available of Family Care Safety registry checks."[30]

> "Six staff files did not document results of a Family Care Safety Registry employee background check."[31]

> "Documentation was unavailable for 2 employees regarding the results of the Family Care Safety Registry."[32]

PROBLEM PROVIDERS

When provider agencies are found in violation of certification standards, the state requires them to submit a plan of correction and usually conducts a follow up inspection to ensure compliance. **Certification surveys revealed that from 2008-2010, seven provider agencies required more than one follow up inspection to correct problems.** Still, some providers are found deficient every year and sometimes for the same violations. Below are some examples of providers with a record of repeated violations:

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27 Ibid.

28 2008 Department of Mental Health Safety Report

29 Title 9 Code of State Regulations 10.5.190 and Department Operating Regulation 6.510

30 DMH Certification Survey, Jackson's Group Home/Personal Touch, April 23, 2009

31 DMH Certification Survey, Unique Quality Care, LLC, August 10, 2010

32 DMH Certification Survey, Preferred Alternatives of Missouri, September 16, 2010

SHANNON'S NEIGHBORHOOD

Shannon's Neighborhood operated an 8 bed group home in Perryville and two ISLs. In 2005, a resident at Bellefontaine Habilitation Center was moved to Shannon's Neighborhood. According to newspaper reports, within a month he was returned to Bellefontaine, with a black eye, cuts on his nose, and a swollen stomach and feet. After an investigation DMH said Shannon's neighborhood didn't do anything wrong. The resident had seizures and an eating disorder and it was apparent the agency could not handle caring for him.[33]

In 2010 three former Bellefontaine residents were living in the home. Several severe deficiencies were cited in the DMH certification survey report, dated November 18, 2010:

- Staff, who had not received required training, were administering medication incorrectly
- Staff were not monitoring consumers according to required staffing levels - RN and other supervisors spent most of their time at the ISL
- The home was dirty and unsafe: wet sheets were left on the bed, toxic household cleaners were not secured from clients' reach

Shannon's Neighborhood had an abuse and neglect rate that was more than 10 times the rate at habilitation centers. From 2008-2009 DMH substantiated 6 cases of abuse and neglect at Shannon's Neighborhood. The organization cared for a total of 11 consumers -that's 54 substantiations per 100 residents in placement.[34] From 2008-2009 in all habilitation centers there were 39 substantiated cases of abuse and neglect, for an average of 811 consumers. That's a rate of 4.8 substantiations per 100 residents in placement.[35]

A follow up certification survey in 2011 reported that the group home voluntarily closed this January. The residents of the group home and ISL were forced to move from their homes again and find other placement.

S & S DEVELOPMENT

During routine certification reviews in 2008 and 2010 DMH surveyors found S&S Development in violation of certification standards including hiring an employee who had not passed a criminal background check; and not conducting a background check for another who was working with residents. In both 2008 and 2010, the agency was cited for not having functioning smoke detectors in the same ISL in Blue Springs. In 2010, the second time it was cited, it took two follow up inspections and two plans of correction before the agency fixed the broken smoke detector.[36] In 2010, the provider reported committing 24 medication errors, though none were serious enough to be life threatening or result in hospitalization.[37] According to certification reports, the agency only cares for 15 clients. That's a rate of 106 errors, per year, per 100 clients.

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33 Parents of mentally retarded fear private home placement. St. Louis Post Dispatch. October 17, 2005.

34 Abuse and neglect report generated from DMH CIMOR Database

35 2010 Department of Mental Health Safety Report, pages 52, 54

36 DMH Certification Survey, S&S Development, September 27, 2010

37 DMH Report of Medication Error by Provider and Severity, obtained in February, 2011 through request for information

CONCLUSION

VOR and its Missouri affiliates and members vehemently oppose any proposal to close habilitation centers. As licensed ICFs/MR, habilitation centers provide highly specialized care to individuals with severe and profound intellectual and developmental disabilities. Most center residents also experience complex physical, medical and behavioral challenges. The habilitation centers serve as a life-sustaining care option that is simply not cost effective or available in smaller, unlicensed settings, as shown by state audits and media scrutiny in past years.

These reports have revealed severe, systemic dangers in community placement. As we've detailed above, many attempts at improving oversight and quality of care fall short of concrete changes. Our review of recent information disclosed by the department and results of certification inspections give reason to believe that systemic dangers in the community are still very much alive. As budgetary pressures stress the state's capacity to provide oversight, the ranks of people receiving services will continue to grow - and so will the lists of people waiting for care. Lawmakers should solicit third-party assessments of DMH's progress towards improving safety, and establish meaningful policy changes that increase the state's direct oversight over service provision in community settings.

As advocates and family members of people with disabilities we implore lawmakers to focus their limited time and resources on improving community care ***and*** maintaining the specialized, life-sustaining supports already available in licensed Habilitation Centers - for current residents and for desperate families whose loved ones needs could be immediately met in the caring and skilled habilitation center setting.