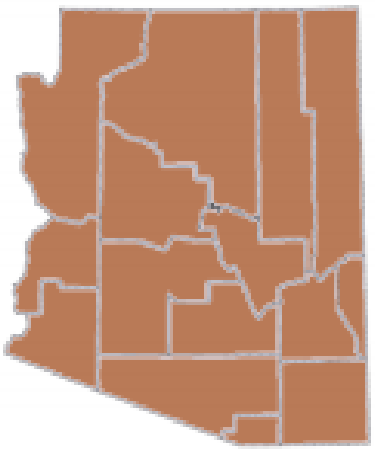
INDEPENDENT OVERSIGHT COMMITTEES 2020 ANNUAL REPORT



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ARIZONA STATE HOSPITAL INDEPENDENT OVERSIGHT COMMITTEE

2020 ANNUAL REPORT

November 6, 2020

The Honorable Douglas A. Ducey
Governor, State of Arizona
1700 West Washington Street
Phoenix, Arizona 85007

The Honorable Karen Fann
President, Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

The Honorable Russell Bowers
Speaker, Arizona House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

On behalf of Arizona State Hospital (A.S.H.) Independent Oversight Committee, it is my pleasure to present the Annual Independent Oversight Committee report for 2020. The preparation of this report as per the requirements of A.R.S. § 41-3804(G).

The Arizona State Hospital (A.S.H.) Independent Oversight Committee (I.O.C.) has had several new members and several former board members' resignations. ADOA has brought the much-needed organization to the I.O.C. committee. The relationship between the Independent Oversight Committee and the A.S.H. administration continues to be a minimally collaborative effort. The A.S.H. administration does not attend the meetings, which would make for a significantly better relationship and more profound development of serving the patients' needs at AZ State Hospital.

Under the new ADOA direction, we now ensure majority approval to request any information and use a formal system for such requests. The A.S.H. administration provided requests for information by combining email and telephonic consultation outside of the formal meeting. We continue to emphasize the need to keep relationships with the patients in a purely professional manner. We do not advocate for any individual patient but advocate for all patients; visits are exclusively committee visits.

We adopted a purpose statement for our Committee.

"To provide independent oversight for patients at A.S.H., promoting and protecting their safety, dignity, quality of life, and human rights; with the goal of reintegration back into society."

ADOA has provided a valuable service as a non-biased facilitator. They continue to provide supportive collateral material:

- Updated brochures
- Operations manual
- Business cards
- Badges with photo identification
- Updated procedural forms

The A.S.H. I.O.C. committee had an educational presentation on:

- Use of tablets. The information has been provided to the A.S.H. administration to follow up. Successful implementation of tablets for incarcerated persons has reported that aggression and violence have significantly been reduced.
- Peer training program

The I.O.C. contributed money to the holiday funds for patients' gifts for the holidays. The use of the money was for permitted personal items.

The COVID pandemic resulted in I.O.C. restrictions on hospital grounds due to COVID protocols. We have therefore held telephonic visits with the patients.

A.S.H. administration has assisted the I.O.C. members with more available connections to the patients when calling into the units. All members are volunteers and find it frustrating when connections are delayed due to a lack of understanding of the patients' rights to have I.O.C. visits. Recently implemented patient visits were using Google Meet for virtual meetings and onsite, using non-contact rooms. We can now visit during the weekend since all committee members are volunteers and work full-time during the week.

We changed the bylaws to permit a person to join the Committee after attending one session instead of three sessions.

Requested Information

During the past year, we have requested and received numerous policy and procedural information.

- Grievance, complaints, and Appeals process- an educational meeting during our January 2020 meeting from AHCCCS to help our committee members and the public understand the process.
- S.M.I. rights of appeal

- Forensic patient information:
    - Forensic levels-
        - Specific off-ground activities-escorted
        - Resolution group and policy- more clarity required
        - Tobacco-free philosophy statement
        - Surveillance system equipment rules/G.P.S. consent
        - Patient weekly schedule
        - Patient sign out /in sheet
        - Off grounds pass protocol
- Treatment plan protocol with adherence to the Joint Commission and State Rules
- Policy regarding violence reduction training of staff (full-time and part-time)
- Assault reduction strategy (system & individual)
- De-escalation training schedule
- Number of code grays by year by campus:

We do not have data on number of Code Grays prior to 2017. Below is data with the total number of Code Grays by year from January 2017 – September 2019, broken down by campus:

	Jan-17 - Dec-17	Jan-18 - Dec-18	Jan-19 -Sep-19
Civil	537	629	385
Forensic	77	35	60

- Top assaulter reports
- Review of the incident on videotape- approved after legislative interpretation and meeting with A.S.H. administration.
- The transition process for patient moves in the unit and between units
- Employee recognition programs
- Policy consistency across the campuses

- Patient request to amend medical records
- Clarity about guardian notification protocol for police after an incident has occurred
- Clarification on patients in jail and re-admittance into A.S.H. process
- Policy and process to get medical records while still being a patient
- Clarity about the absence of deaths in the incident, accident, and death report, never reported
- Clarity regarding restriction on patient's ability to call a supervisor or management
- Clarity about a civil patient(s) on forensic campus
- Medical staff documentation
- Medical necessity protocol for elective procedures or appointments based on risk assessment from Valleywise
- COVID protocol
- COVID visitation guidelines
- Covid P.P.E. usage and availability

- Job posting process at A.S.H.
- Animal therapy policy

Concerns

We have discussed that we have not seen any deaths listed in the Incident, Accident, Death reports for the past few years. We still have not viewed any to date. An explanation is that the declaration of death often occurs at another hospital (Valleywise), where that hospital then reports the death to the appropriate authorities.

A.S.H. administration does not attend the meetings. We have requested that they participate in the discussions, A.S.H. administration has rejected that request. The Chair does call the administration to clarify the Incident and Accident reports with Chief Quality Officer Lisa Wynn of patient advocate Jacqueline B before the monthly meetings. Many of the newer committee members have had no interaction with the administration.

Due to the short time frame between when the Incident, Accident, Death reports are available in the AHCCCS portal and the scheduled meeting, this is not always possible. The A.S.H. administration is working on getting the reports uploaded sooner. At this point, only the chairperson has access to review the reports. The Chair has requested that other members gain access to ensure multiple reviews of the incidents from different perspectives. A.S.H. administration has provided a high-level seclusion dashboard report, which has the dates and times and seclusion type. This report highlights the events that are outliers and may need to be explored in the detailed report. This overview report has been beneficial.

The I.O.C.'s primary concern is that patients have consistently voiced concerns over retaliation from some staff after filing grievances. There is also an ongoing complaint that not all staff act in a therapeutic and supportive manner. We believe it would be beneficial to have a surveillance system with both audio and video capability to investigate better and substantiate some of the grievances and complaints. We requested the ability to review a video surrounding a retaliation allegation. Initially, the A.S.H. administration denied the request, and we followed the appeal process. From A.S.H. administration July 8, 2020, *"Because the I.O.C. does not have the authority to conduct an investigation, there would be no purpose for I.O.C. members to conduct a video review. A.S.H. respectfully denies the request to view the video."* The administration thought we were asking to be the official investigative authority, which was never the I.O.C's intention. We wanted to carry out our advocatory obligation and try to validate the allegation of retaliation and mistreatment. After we received a legislative interpretation and a meeting with the administration, an I.O.C. committee members went into the facility to review the videotape. It was never the intention of the I.O.C. to receive a DVD or thumbnail drive of the videos. We were not able to validate the allegation based on the video views.

Per the A.S.H. administration, the patient has the following official channels to report abuse:

These matters are handled through the Hospital's Office of Complaints, Grievances, and Appeals, and a thorough and objective investigation is conducted. There is an appeal process associated with these matters outlined in Statute and in Article 4 of the A.A.C.

In addition to working with this office, patients have the right to contact the AZ Center for Disability Law, Adult Protective Services through AZDES, the AZ Department of Health Services Licensing Office, the U.S. Center for Medicaid and Medicare Services (C.M.S.), and the Joint Commission. Many of our patients regularly contact these entities with concerns.

We continue to see numerous incidents on the civil campus units. There are fewer incidents on the forensic units. Most of which seem to be self-harm or relatively minor.

Both patients and guardians have complained about the treatment meetings and family or support limitations in these meetings—a notable lack of transparency on treatment goals and treatment progress.

We also have heard allegations of mistakes on the medical records. A.S.H. administration has communicated the process to correct errors.

Several patients have complained about difficulties in getting timely medical attention. Some of the reports list broken bones, infection bites, podiatry issues, and ongoing pain from arthritis. We also have concerns about lengthy seclusion administrative incidents.

The COVID protocol is as follows:

For offsite medical appointments:

- If a medical provider believes an offsite appointment is medically necessary, it is scheduled.
- The medical necessity of the patient is weighed against the risk of exposure to Covid-19.
- Patients being transported to offsite medical appointments are provided an N95 mask and gloves.
- Employees transporting patients offsite are required to wear an N95 mask and gloves.

COVID interrupted the following:

- Patient visits (Governor's executive order interpretation for in-patient hospitals (not specific to level 1)
- In-person I.O.C. visits
- Internet usage
- Group therapy except for music and exercise
- Limited availability of any of music & exercise therapy sessions
- Forensic off site visits, which are required for progression

The I.O.C. received very few civil requests for visits during 2020. We began visiting patients on the forensic side after July 2019. The Chair was able to participate in community forums onsite for both civil and forensic units; the meetings were highly informative and well attended by patients and administration. Community meetings have been suspended in that format for the COVID period. The administration will alert the Chair when the community session recommences.

Initiatives

We are working on the following initiatives:

- We were able to get a commitment to education funding for patients through philanthropic donations. We were able to secure interest from a local charitable fund. We introduced the administration and representative of the philanthropic fund to work out the logistics of receiving the funds and reporting responsibilities. The administration temporarily halted the effort due to COVID.

- We are still evaluating whether a peer-run organization can provide training on campus; this will need to be coordinated through the social services department. Funding is not presently available.

- Trying to assist in getting more staff funding to help reduce the number of current staffing vacancies as we feel it hinders patient treatment. We also think that staff shortages create tension when staff shortages prevent therapeutic activities from happening on time and/or visits to the patios or mall. A hospital switch to 12 hr shifts has alleviated some staffing shortages.

- Prioritize updated training for staff on lowering violence and seclusion and restraint usage.

- We advocate for updated surveillance systems on civil and forensic campuses with better overall site coverage and audio/visual capability.

- We are advocating for tablet implementation and usage on the units. The Edovo tablets could be an asset to the patients. These tablets are completely configurable regarding content or features. Edovo tablets could offer a possible solution to some of the issues referenced in this report:

    - Access to varying levels of educational materials towards G.E.D.'s/Degrees/Certifications
    - Provide a tangible way to track patient progress & reward system
    - Utilizing therapy modules (especially during COVID cutbacks)
    - Reduction of boredom/violence
    - Provide C.B.T. programs
    - Provide mindfulness-based interventions, including:
        - substance abuse
        - stress and anger management techniques
        - job & re-entry programs

Suggestions

- Because we are a volunteer organization, administrative support is critical to our sustainability.
- We think it would be advisable to have a legal department that could help the I.O.C.s whenever a legal opinion is required.
- We think it is incredibly beneficial to maintain a consistent staff I.O.C. liaison and think changes in agency oversight would be disruptive.
- Improved communication with A.S.H. administration. It is challenging to collaborate with an agency that does not attend the meetings.
- Replacing antiquated surveillance systems would help both staff and patients act more professionally and support investigations.
- Bring in professional training on de-escalation techniques from well-known agencies using evidence-based practices.
- Re-evaluate the requirement for the resolution group or present a consistent policy and availability of the group therapy.

A.S.H. I.O.C. 2020 Committee Membership

	ASH IOC Names	Position	Membership Status	Comments
1	Sharon Ashcroft	Chair	Not Active	Resigned on 9/18/2018
2	Ashley Oddo	Lawyer	Active	
3	Jim Gillcoatt	Psychiatric Nurse	Not Active	Resigned on 4/18/2019
4	Ross Davids	Psychology student	Not Active	Resigned on 10/14/2019
5	Leon Canty	Peer, Former Forensic Patient	Active	
6	Laurie Goldstein	Engineer, Parent of An Adult Behavioral Health	Active- Chair	
7	Kathy Bashor	Peer	Not Active	Resigned on 5/21/2020
8	Kim Schereck	Family Member of Behavioral Health	Active	
9	Lynn Gibson	Law and advocate	Not Active	Resigned on 11/21/1019
10	Alyce Klein	Psychiatric Nurse	Active	
11	Natalie Trainor	Education	Active	
12	Rebecca Kasper	Psychologist	Not Active	Resigned on 2/17/2020
13	Dee Putty	Medical Nurse	Active	
14	Joe O'Cain	Forensic Patient member	Not Active	Was told he could no longer participate
15	Barbara Honiberg	Public Health, Parent of An Adult Behavioral Health	Active	Effective 9/17/2020
16	Melissa Farling	Architect, Family of An Adult Behavioral Health	Active	Effective 9/17/2020

Please contact me at 480-363-4887, Laurie Goldstein, Chair, if you wish to discuss this report's contents.

Sincerely,

Laurie Goldstein
A.S.H. I.O.C. Chair

cc:

Carolyn Allen, Senate Health and Human Services Committee Chair
House of Representatives Health Committee
Matt Gress, Director, OSPB
Richard Stavneak, Director, JLBC Staff

AHCCCS SOUTH INDEPENDENT OVERSIGHT COMMITTEE

2020 ANNUAL REPORT

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

February 2, 2021

The Honorable Karen Fann
President, Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

The Honorable Russell Bowers
Speaker, Arizona House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

Dear President Fann and Speaker Bowers:

On behalf of the Arizona Department of Administration (ADOA) Southern Arizona Independent Oversight Committee, it is my pleasure to present to you the Annual Independent Oversight Report for Southern Arizona. The report has been prepared in accordance with the requirements of A.R.S. § 41-3804(G).

Please contact me at 520.730.8763 or Barbara Carling, Vice Chair at 206.909.9093 if you wish to discuss the contents of this report. Thank you for your support of our work.

Sincerely,

Ken Karrels, Ph.D.
Chairperson
Southern Arizona Independent Oversight Committee

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

Responsibilities

As outlined in A. R. S. 41-3804 E:

Each Committee shall provide independent oversight to:

1. Ensure that the rights of clients are protected.
2. Review incidents of possible abuse, neglect or denial of a client's rights
3. Make recommendations to the appropriate department director and the legislature regarding laws, rules, policies, procedures and practices to ensure the protection of the rights of clients receiving behavioral health and developmental disability services.

2020 was a challenging year due to Covid 19 reaching Arizona in late February-March. The virus greatly hampered the Committees ability to perform many of the duties required, in particular the ability to conduct site visits, conduct in person meetings, and, in many cases, recruitment efforts.

With the assistance of ADOA, the Committee was able to move quickly from in-person means to an on-line platform. Consequently the Committee was able to meet 10 times during 2020. Eight of those meetings were held virtually. The on-line platform has been successful and will remain in place after the dangers of the virus are lifted. This will be essential in recruiting new members from outlying areas.

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

Membership

The Southern Arizona IOC currently has 9 all volunteer voting members. The members are diverse, extremely committed and dedicated an average of 3-4 hours monthly to their IOC work. We are fortunate to have representatives from ADOA and AHCCCS serve in the role of liaisons and support. Regular representatives from numerous Behavioral Health organizations attend our monthly meetings which has proved invaluable.

Ken Karrels, Ph D. Chair/Medical
Barbara Carling, MSW Vice-Chair/Professional
Joe Mucenski Family Member
Joanna Keyl Coyote Task Force/ Cafe 54
Sharon Faulkner-Gillespie Foster Care Licensing Coordinator
Phyllis Grant Children and Young Adults Foster Parents
Susan Hyder Family Member/Advocate
Sergeant Jason Winsky Mental Health Support Team, Tucson Police Dept.
Susan Moreno LOA/Family Member
Tyson K. Gillespie, MSC, LA Executive Director, Desert Rose & ACT Teams
Community Partners

In addition we are grateful for the continued support from guests representing numerous organizations

AHCCCS Division of Community Advocacy and Intergovernmental Relations
Arizona Complete Health
Mercy Care
Banner University Health Plan
United Healthcare
Various Provider Agencies
Larry Allen ADOA liaison
Fredreaka Graham AHCCCS liaison

Site Visits

Due to the virus only one site visit was conducted during 2020. Members were understandably concerned about visiting facilities both for their own and client safety.

Dempsey House
Unlicensed facility housing clients referred by La Frontera.
Areas of concern were communicated to facility management and the IOC:

1. No heating in bedrooms.
2. One client reported feeling unsafe.

Special Populations

COVID has impacted the children significantly. Children have not received behavioral health services in person. In addition foster care families receiving virtual visits have caused barriers in the reunification process. There are also concerns that DCS is prolonging supervised visits with Bio parents even after the Bio parents have progressed well into their case plan. In addition this creates a problem with a shortage of staff to supervise them.

Crisis Intervention Team

The Crisis Intervention on Team (CIT) is a community partnership of law enforcement, mental health professionals, individuals who live with mental illness, their families and other advocates. It is a police-based crisis intervention training program provided to Tucson Police and Sheriff Departments.

In 2020 as part of the program over 50 additional Police and Community Service Officers were trained in mental health first aid and deescala on.

In coordination with the Pima County Sheriffs' Department, CIT was converted to an on-line format and will be delivered in 2021.

Crisis Response Center

The Crisis Response Network provides crisis call center services to help individuals and families get connected to the help they need. They run a 24-hour peer-run Warm Line, Serious Mental Illness (SMI) determinations, mobile team dispatches, crisis transportation services, emergency room-based assessments, Department of Child Services (DCS) rapid response and crisis stabilization services in Pima County.

In 2020 there was a notable increase in Crisis Calls due to the pandemic, however the network expanded their hours and were able to stay open throughout the year, thus enabling them to manage the increase in patients brought to them by the Tucson Police Department.

There are numerous planned changes to Title 36 including expanding the language to allow for clients with substance use disorders to receive more services. This should be a deliverable in 2021.

Training

1. Trauma Informed Care Training -- *Training given providers to aid in understanding the impact of trauma on clients. Condensed version given to IOC.*
2. QM Portal training provided by AHCCCS
3. Mental Health 1st Aid

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

Top Objectives for 2021

1. Increase site visits once health restrictions are removed.
2. Increase review of IAD reports. Assign committee members a sub-category to review i.e., SMI, SMI-Special Assistance, Child/Adolescent, Death, Accidents, etc.
3. Re-institute monthly meetings of the 3 IOC's chairs. These meetings will be coordinated by ADOA.
4. Actively recruit from outlying areas. Develop sub-committees to focus on two of those areas.
5. Develop Annual Report sub-committees under the lead of an Annual Report "manager".

AHCCCS NORTH INDEPENDENT OVERSIGHT COMMITTEE

2020 ANNUAL REPORT

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

December 14, 2020

The Honorable Karen Fann
President, Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

The Honorable Russell Bowers
Speaker, Arizona House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

Dear President Fann and Speaker Bowers:

On behalf of the Arizona Department of Administration (ADOA) – Northern Arizona Independent Oversight Committee (NAIOC), it is my pleasure to present to you the Second Annual Independent Oversight Report for Northern Arizona. The report has been prepared in accordance with the requirements of A.R.S. § 41-3804(G).

Please contact me at 1-928-300-8360 or Ann Gunty, Vice Chair at 1-928-380-4758 if you wish to discuss the contents of this report. Thank you for your support of our work.

Sincerely,

Dorothy O'Brien
NAIOC Chair

ARIZONA
INDEPENDENT OVERSIGHT COMMITTEE

NAIOC Committee Membership

	IOC Member Names:	Position:	Membership Status:	Vong:	Non-vong:
1.	Dorothy O'Brien	Chair	Family Member, Parent of adult	X	
2.	Ann Gunty	Vice Chair	Parent of a child, Behavioral Health	X	
3.	Sue Hernandez	Secretary	Parent of a Child, Behavioral Health, Family Support	X	
4.	Christopher Gonzalez	Chair – Site Visit Subcommittee	Educationon, Family Members – Vive la Esperanzaer, Behavioral Health, CEO Hope L	X	
5.	Keran O'Brien	Member	Family Member, Parent of adult	X	
6.	Katy Welty	Member	Parent of a Child, Family Member, Behavioral Health	X	
7.	Trish Riner	Member	Regional Director-N AZ Family Involvement Center	X	
8.	Dr. Cory Krueger	Member	physician- Geriatric Specialist, Vulnerable Adult Population	X	
9.	Alpha Muluh	Member	Mental Health. Operations Director at Cadens Health and Wellness.	X	
10.	Dr. Katherine Leonardi	Member	Member, Retired Chemical Dependency and Mental Health	X	

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

NAIOC
2020 Annual Report

2020 has been a year of transition and evolution, as we have learned to navigate the pandemic. The Northern Arizona Independent Oversight Committee began the year by making plans for site visits; however the committee quickly pivoted to explore other options due to Covid-19. There were two important changes this year that we will cover in this report.

The first major improvement since last year's report was in the support we received from ADOA and AHCCCS. Adding Larry Allen, Fredreaka Graham and CJ Loiselle to our team helped us to overcome many of the challenges in accessing information that we had previously encountered. We were able to review deliverables and receive the information needed to accomplish our goals. We were able to grow our membership with the aid of their responsiveness and professionalism from 7 to 10 members.

With the addition of new members, the committee was able to allocate and coordinate the responsibility for review of the various vulnerable population categories by our fields of expertise. Doing so allowed committee members to review reports in greater depth, helping to identify patterns and persistent issues. This increased our efficiency and ability to accomplish our oversight goals.

Secondly, in response to the Covid-19 pandemic, the site visit subcommittee, now led by Christopher Gonzalez, reevaluated site visit policies and procedures to determine how to move forward within the limitation of in-person site visits. The re-evaluation also allowed the committee to increase our reach to other underserved or isolated communities as well as increasing the efficiency within both provider and NAIOC coordination of care. A new draft plan was created and approved by the NAIOC and is attached here for review. The plan is awaiting approval from the Director of the ADOA. The plan has been enthusiastically received by the other IOC Chairs around the state and the Committee Chair will be presenting to the other Chairpersons in the near future. In addition, we requested pandemic response guidelines from the providers across our region and appreciate the prompt response we received.

ARIZONA
INDEPENDENT OVERSIGHT COMMITTEE

It is our hope that we will implement our new site visit procedures in 2021, following approval by the Director of the ADOA. We will be able to take the next step in fulfilling the mission of the committee. The committee continues to require support and training on deliverables and portal access. We can't overstate the difference strong professional support has made to the progress and success of the NAIOC.

Suggestions

We are a volunteer organization and administrative support is critical to our sustainability. The NAIOC is grateful for the support and suggests the following to continue to be successful:

- Consistent staff liaisons and communication have proved to be fundamental to our success.
- Continued understanding of the committee's mission and scope of work.
- As we transition to on-line site visits and electronic records review, we will look forward to prompt action when issues are reported.

The NAIOC thanks you for your attention!

AHCCCS CENTRAL INDEPENDENT OVERSIGHT COMMITTEE

2020 ANNUAL REPORT

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

February 18, 2021

The Honorable Karen Fann
President, Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

The Honorable Russell Bowers
Speaker, Arizona House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

Dear President Fann and Speaker Bowers:

As provided in A.R.S. §41-3804(h), the Central Arizona Independent Oversight Committee (the "Committee") is pleased to present its 2020 Annual Report for your review and consideration. The Report summarizes the Committee's work during calendar year 2020. For a more detailed accounting of our acvies and the issues that we addressed, please see the Arizona Department of Administration's web-site: hps://ioc.az.gov/committees/ahcccs . You will find copies of our meeting agendas and, also, a recording of each of our meengs. These recordings serve as our meeting minutes and the record of the committee's acvies as required under Arizona's Open Meeting Law, ARS §§ 38-431.01(B), (C), (D) and 431.03(B)).

IOC Committee Work in the Time of CoVID-19

To review the mandates outlined in A.R.S. § 41-3804 E:

E. Each Commitee shall provide independent oversight to:
1. Ensure the rights of clients are protected.
2. Review incidents of possible abuse, neglect or denial of a client's rights.
3. Make recommendations to the appropriate department director and the legislature regarding laws, rules, policies, procedures and practices to ensure the protection of the rights of clients receiving behavioral health and developmental disability services.

The CoVID-19 global pandemic significantly disrupted the Committee's activities. We were able to hold five meengs in 2020, most via telephone and video conferencing. However, since March of 2020 the Committee was unable to carry out its priority activity: site visits to housing where individuals living with serious mental illness reside. The Committee looks forward to resuming site visits when it is safe to do so, hopefully later in 2021.

Purposeful Re-Focused Efforts During CoVID

Pending resumption of site visits, the Committee focused on reviewing hundreds of IAD (Incident, Accident, and Death) reports and also turned its aenon to improving its internal operang competencies, including:

- Adoption of the *Independent Oversight Committees Statewide Operations Manual & Standard Work* prepared by ADOA. hps://ioc.az.gov/sites/default/files/media/IOC_Statewide_Operaons_Manual%26Standard_Work%28publicv1%29.pdf
- Revising methods for assignment of reviews of Incident, Accident and Death ("IAD") reports;
- Training in use of the AHCCCS portal for online access to IADs and techniques to efficiently sort and analyze IAD reports;
- Enhancing communication with other organizations, including reports at each meeng from:
    - o Community organizations (e.g., Mental Health America, NAMI, and ACMI) o Provider agencies, including the RBHA (Mercy) and RBHA-contracted contracted health plans.
    - o Other Arizona IOCs
- Participation in and Reviewing of the Final Report of the Governor's Task Force on Abuse and Neglect, published November 1, 2019, including the 30 recommendations for organizations to approach abuse and neglect issues; and
- Participation in and Reviewing of the 2020 AHCCCS Incident Review Flowchart, which provides a consistent approach for analysis of incident reports across agencies and sets out the IOCs roles in the incident review process.

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

Targeted Areas of Focus for 2021

The Committee identified targeted areas of focus for its work in 2021 assumption of site visits, which remain the Committee's priority. These additional areas of focus for 2021 include:

- Understanding members' access to telephone at all housing placements and residential treatment facilities;
- Reviewing members' experiences at psychiatric screening agencies;
- Continuing review of IAD reports;
- Investigation and evaluation of involvement of Title 14 Guardians in the treatment of their SMI wards;
- strategic planning process with a consultation by the Arizona State Hospital IOC Chair (and parent of a child living with SMI), Laurie Goldstein.

The Committee hopes that there will be an annual meeting of all IOCs in 2021, even if virtually. In 2020, the Committee's Chair, Dr. Jack Potts, reached out to strengthen relationships among the IOCs operating in Arizona. Committee members began regular meetings with all of the IOC chairs, and reported to the Committee about the other IOC's activities, challenges, and areas of focus. An annual meeting of Arizona's IOCs (As happened yearly for several years) would facilitate all IOC committee members' sharing experiences and developing more informed and efficient methods to discharge their statutory dues in A.R.S. §§ 41-3803 and -3804 and the Arizona Administrative Code in R9-21-105.

Current Members

Jack Potts, MD (Medicine, Psychology)- Chair
Marie Raymond (Family Member – Parent, Educaon) – Vice Chair
Jim Ward (Mental Health) - Secretary
Jim Dunn, MEd (Mental Health)
Mahew Moody (Mental Health, Social Work)
Holly Gieszl, Esq. (Law, Mental Health)
Joy Green, (Family Member-Parent)
Josh Mozell, Esq. (Law, Mental Health)
Kathie Roe (Family Member – Parent, Special Education)

ARIZONA
INDEPENDENT OVERSIGHT
COMMITTEE

EXPRESSION OF GRATITUDE

We are all navigang this new normal together. As we lock arms virtually and try to help one another in the ways we can, our vast world suddenly feels a little smaller and a lot more connected. And for that, we are grateful. Michael Dell, CEO, Dell Technologies

The Committee expresses its deep appreciation and respect for the diligent, extremely competent work by Larry Allen and the Arizona Department of Administration. From technical support for virtual communications to meeting logistics to compliance advice to facilitating outreach with other IOCs, Mr. Allen has supported the Committee in many ways. The Committee has also seen a vast improvement in the relationship between AHCCCS and this Independent Oversight Committee; in part because of the efforts of the Arizona Department of Administration and the AHCCCS liaison Ms. Fredreaka Graham. We are grateful.

Respectfully submitted this 18th day of February 2021.

Jack L. Potts, M.D. Chair,

Central Arizona Independent Oversight Committee

DDD DISTRICT EAST INDEPENDENT OVERSIGHT COMMITTEE

Division of Developmental Disabilities

2020 ANNUAL REPORT

Arizona Department of Economic Security

Independent Oversight Committee DISTRICT EAST July 1, 2019-June 30, 2020 ANNUAL REPORT

Division of Developmental Disabilities

Prepared by Suzanne Hessman Chairperson
on behalf of the Independent Oversight Committee District East

Independent Oversight Committee Function

Independent Oversight Committees (IOCs) are required by ARS 41-3801 and 41-3804 and function as an independent advisory and oversight committee for members being served by the Arizona Division of Developmental Disabilities. District East serves the southeastern portion of Maricopa County, southern portion of Gila County and all of Pinal County, including the Arizona Training Program at Coolidge.

Each committee shall provide independent oversight to:

- Ensure that the rights of clients are protected.
- Review incidents of possible abuse, neglect, or denial of a client's rights. • Make recommendations to the appropriate department director and the legislature regarding laws, rules, policies, procedures, and practices to ensure the protection of the rights of clients receiving behavioral health and developmental disability services. • Each committee shall issue an annual report of its activities and recommendations for changes to the ADOA Director, the Director of the Department of Economic Security, the President of the Senate, the Speaker of the House of Representatives, the Chairpersons of the Senate health and human services committee and the House of Representatives health committee, or their successor committees.

- Approve the use of sedation for medical and dental procedures for members living at ATPC on an annual basis.

Our primary efforts have been focused on reviewing Incident Reports given to us by DDD Quality Management and Behavior Treatment Plans submitted to DDD, that have been approved by Program Review Committee for DDD, for individuals who live in a DDD residential setting and are taking any medication(s) that assist in behavior modification.

We look at data trends regarding providers and the number of incidents they report in a month, we also look at individual members and the number of incidents they have in a month to see what resources need to be extended to them or action taken by the team to improve the quality of life.

Membership

Suzanne Hessman – Chairperson – Parent/Advocate, Realtor
Jennifer Horton – Vice Chairperson – Special Education Teacher
Sheri Reed – Parent/Special Education Teacher, PhD
Sarah McGovern – Parent
Cathy Walen – Guardian, Attorney – Public Defender in Mental Health Court
Susan Kingsbury – Counselor
Elizabeth Bird – Parent
Kin Counts – parent
Amanda Godek – Article 9 trainer
Tonia Schultz – ATPC representative (non-voting)

Per ARS 41-3801 our committee is to be composed of at least seven and no more than fifteen members with members having expertise in the following areas: psychology, law, medicine, education, special education, social work, criminal justice and at least two parents of children who receive services from DDD.

Membership of the committee was 12 members starting in July 2019. Membership of the committee at the end of June 2020 was 9 voting and 1 non-voting member. Training for IOC Committees is an ongoing issue as there is no set curriculum or standard for training new members or refresher training for existing members. We request that there be standardized training for this across the state. We suggest that this could be accomplished with recorded webinars on each topic area that members can watch at their own pace. Jeffrey Yamamoto was trained to be Article 9 trainer, which will be extremely helpful in keeping our committee members Article 9 Certified.

Our committee is made up of volunteers who mostly are employed full time, primarily parents who have children receiving a variety of services from DDD and Behavioral Health. We all bring insight from our experiences with the Division and the agencies providing services. Our diverse insight allows our committee to openly discuss differing points of view to come to a collective decision on matters before us. Dedicating the time necessary to participate on the committee has been a strain at times on our members as they also have had to handle issues experienced by their own children served by the Division; however, they chose to serve regardless because they want to make a difference.

We have lost many members over the years due to the feeling that we are not accomplishing anything that improves the lives of our members but are merely pushing paper around. We believe that the statutory intention of this committee is to protect our members and improve the quality of their lives as it pertains to DDD services. To be able to affect real change we need a change in the role that we currently are playing in this committee. We believe that we need more influence in DDD Policy changes and Legislative changes to accomplish the goals of what the statute intended.

We have had a shift in attitude and cooperation with the Division's leadership. Real changes to our administrative processes have made our jobs easier to complete. Jeffrey Yamamoto, our DDD Liaison provides those administrative processes for us, allowing us to concentrate on our mission. However, more change is needed to make a real difference. We appreciate Assistant Director Zane Garcia Ramadan attendance to our quarterly statewide meetings. He has provided great insight into changes in the division affecting our members as well as listening and addressing our concerns during those meetings.

No site visits were conducted, as DDD does not allow the committee access to any residential sites.

COVID-19

March of 2020 brought a lot of chaos with the COVID-19 pandemic. Residential settings, in particular, were unprepared to handle the pandemic. Although they were required to have a Pandemic Plan, many did not and when they did put one together it was merely a piece of paper and not a plan that was followed. They were unprepared in lack of food supply, cleaning supply, and basic essentials. Many plans were not followed to ensure that the virus was not being spread by staff to our members. The plans did not address the issues of isolation, behaviors, needed socialization and family contact.

Meetings

11 meetings were conducted. Starting March 2020 those meetings were no longer held in person, but via Google Meets. Holding virtual meetings increased participation due in part to decreased time requirements and no travel. We invited many different stakeholders to participate; United Health Care, Mercy Care, National Core Indicator liaison, PRC Chair, OIFA leadership, Behavioral support, and District Program Manager. Many of these stakeholders have been regulars in attendance for those meetings.

Governor's Task Force – Abuse/Neglect Prevention Task Force

Our Chairperson was invited to be a part of the Governor's Abuse/Neglect Prevention Task Force. This group is to address the issues that happened at Hacienda. The Incident Report workflow was created from these meetings.

ADOA Administration

Larry Allen took over handling the administration for ADOA with all of the different IOC Committees across the state. He has been very professional, supportive and readily available for our committee. The committee wishes to thank him for all of his work on behalf of the committee. ADOA produced a manual for all of the IOC committees, which was approved. ADOA created a website for the IOCs and agendas and meeting minutes are posted there. ADOA also started a newsletter to go out to all IOC Committee members. New badges were issued with ADOA instead of DDD information on them.

DDD Staff

Three HRC Liaisons were hired for the entire state however, due to circumstances we only have had Jeffrey Yamamoto as the liaison for the entire state. He is a true professional and has provided excellent support for our committee and never oversteps the boundaries thus allowing us our needed autonomy. Since working with Jeffrey, we have had consistency and follow through. We are incredibly pleased with the Office of Individual and Family Affairs (OIFA) TEAM – Leah Gibbs, Barbara Picone, Richard Kautz and Jeffrey Yamamoto.

There has been extreme turnover and unfilled positions for support coordination in District East. There is only a 12% retention rate. In speaking with support coordinators, we found that there is not the up-to-date structured training needed to help them to best perform their job. In addition, support coordinators are not made aware of the resources available to families to provide those families the best support. Low wages, too many cases, lack of behavioral health resources all contribute to the low retention rate. In addition, many support coordinators are promoted to other positions due to the high turnover throughout the division. The frequent turnover leaves our members without the continuity of care that is especially important due to their needs.

Program Review Committees

280 Behavior Treatment plans were reviewed. PRCs are not meeting the mandated number and makeup of members. Many times, BTPs are approved by the PRC Chair and one or two other members. This does not provide the adequate oversight to ensure that these plans are addressing our members behaviors. Many of these plans approved are being written by an outside agency with little to no information on the member they are writing these plans for. We find plans that are cut and pasted and sometimes do not even have the right member's name on the plan. Behavior Treatment Plans are important in protecting our member's rights, otherwise we are essentially just medicating them and not teaching a replacement behavior. We have also become aware that legal guardians are not being notified of when the PRC will be reviewing their member's BTP. Plans are being created without input from legal guardians and other team members.

We have had an ongoing issue with the DE PRC not working with our committee. In essence our dispositions are completely ignored. With the makeup of our committee comprising mostly of members who are employed full time, we are unable to attend the 1-2 days per week PRC meetings to provide our recommendations. We have implored the PRC chair to provide those BTPs to us so that we can make our recommendations prior to the meeting, however these requests have not been addressed.

Incident Reporting Format

10, 398 Incident Reports were reviewed. It takes so long for reports to be investigated that by the time we review them the point is moot. The redaction of the reports creates unnecessary work for DDD administrative staff and removes important information. For example: redacting the names of staff members involved, doesn't allow us to track and make sure those staff members are not just getting a job with another agency.

The committee found that the current IRs do not provide enough information to form an opinion on what occurred. We need to have statistical and expanded information about these agencies, their staff, and clients to get the bigger picture. What was the antecedent? What was the precursor? Is there a guardian? Where do they reside? Is there a BTP in place? Is it working? Number of incidences regarding this client in the last 90 days? Specific information into what exactly happened instead of "member had a behavior". The word "behavior" should not even be allowed. What is the staff: member ratio? What type/s of professional and /or medical help does the members have? How much input or choice does the member have into their situation?

We are receiving poorly written IR's because staff submitting them are not properly trained on the importance of the IR itself. They choose to summarize the IR down to a few sentences leaving out important details. This information would allow us to make more informed recommendations to improve the quality of life. We also would like more information on specific actions that were taken regarding the IRs to protect our members and prevent further problems. Changing the format of what is required of the providers in making their report would then allow us to have that information. Many pages of the reports that we receive have redundant information.

APS has a very high threshold for "substantiation". This creates a problem in that there are many times that it is clear that an individual should not be working with our members and nothing is done because it wasn't substantiated.

Direct Care Staff

Our committee found that the quality of life of our individuals is severely impacted by the lack of quality direct care staff, poor training of that staff and low wages. We read wonderfully written ISPs and BTPs only to find that they are not being read by agency providers and therefore not being followed. There is substantial failure on the part of many providers to professionally train direct care staff. Providers complain that there is a shortage of quality workers.

Standardized mandatory behavioral training for direct care staff who care for clients with extensive behavioral needs require ongoing mandatory continuing education to be provided by Behavioral Health Specialists. This would help to minimize use of emergency measures, decrease escalation of behaviors resulting in verbal and physical aggression, property damage, self-abuse, Crisis and police involvement. Workers having specialized training will be able to better implement behavioral treatment plans and therefore experience fewer behavioral issues from the members. This would create better employee retention and reduce training costs for agencies.

There is an overall theme seen both in BTPs and IRs regarding members wanting to be respected by not being rushed, not being spoken to like a child, not having power struggles with staff, saying no and not giving reasons behind the no, not being sincere, staff not being aware of tone of voice and body language, members not being aware of who is working with them in advance, and members not being aware and informed of their schedule in advance.

Behavior Treatment Plans

Behavior Treatment Plans should be in a consistent format like Individual Service Plans created by Support Coordinators. This would allow ease of reading for Support Coordinators, Providers, Direct Care Staff, PRC and HRC. It would ensure that all necessary information is in the plan. It would provide consistency from member to member, agency to agency and district to district. This would prevent agencies from seeking out presenting their plan to the district they feel is easiest to get approval from, as well as help those agencies struggling with creating appropriate plans.

Our committee requests that it be provided with a behavioral consultant to provide expertise into the effectiveness of the plans that are presented.

Currently when an AIMS report shows that a member is having negative side effects from the behavior modifying medication there is no follow up or action taken by the Division to protect the rights of the members.

Article 9 Changes

We have been told that changes are being made to Article 9. We have not been informed or consulted on what those changes will be and how it will affect our members.

Police Involvement

Many times when agencies call “crisis” they are told to call the police. The police do not have the appropriate training to deal with our members. The police, as well as the jails and courts are not the appropriate place for our members. Involving the police can result in tragedy such as death.

The jails treat them as a typical criminal and do not understand their unique specialized needs. Members have been denied their medications while in jail resulting in further behavioral and medical issues. The experience with the police, jail and the judicial system causes an escalation of behaviors and/or PTSD. Policy changes need to be instituted to prevent these things from happening. These issues are directly in opposition to laws and policies in place to ensure our members' human rights.

Provider Accountability and Provider Report Cards

Lack of quality providers willing to take on highly behavioral members. DDD needs to provide more transparency with members, their families and guardians. When incident reports are made regarding their members, families deserve to know the outcome of the investigation and any course of action taken by DDD or the agency.

Families should be provided a copy of the contract that an agency has with DDD when caring for their member. This provides clarity of what is being expected for their compensation. There should also be transparency as to the amount of compensation received for services rendered.

Families have the right to know who is working with the member, what their background results are, agency policy for drug tests, and violation consequences/follow up when incidents occur.

Many members and their families are afraid to report agencies and direct care staff for the very real fear of retaliation against the member in their care.

Cameras should be allowed in day programs and residential settings if requested by a guardian. We have seen all too often DCS and APS come back from their investigations with "unsubstantiated" because it is a "he said, she said situation". Cameras would eliminate these ambiguities and provide protection against false allegations for providers. We find that more often than not, our members are not believed and are blamed for circumstances that could very easily be abuse. In addition, many times direct care workers are removed from working with vulnerable members for long periods of time while awaiting the results of the investigation.

A report card system needs to be in place so that families can make educated and informed decisions as to the providers that they want to work with. The report card system should utilize feedback from QA, SC and families/guardians and be available on DDD's website for public access. This has become a common practice for professionals like attorneys, doctors, realtors, general contractors etc. and should be no different for providers. Questions such as: How long have they been in business? Number and category of incidents? Were they corrected? Systems in place? How many homes? Total number of clients? Staff ratio? Staff turnover? How often are clients leaving or the provider is releasing them? Would be beneficial information.

Agencies experiencing issues should not be given more members to service when they are failing to provide quality of care to the members that they are servicing. There seems to be a lack of accountability of enforcing provider's contracts to the detriment of our members.

Health Issues

Diabetes, obesity, digestive and other health issues are oftentimes a direct result of group homes not providing nutritional meals for our members. Direct care staff eat fast food and drink sodas in front of the members which not only provides a poor example but also results in behaviors due to members wanting the fast food and sodas as well. This year we have addressed issues where group homes are refusing to provide nutritionally required healthy meals to members in the homes.

We read a few incident reports regarding a group home or DTA van arriving at their destination, only to later discover a member was left in the van by themselves. Incidents such as this can lead to neglect, medical issues or death. It is extremely important that group homes and DTAs have systems in place to ensure that this never happens.

Adequate Residential Settings

There is a lack of qualified provider agencies able and willing to service members with high behavioral needs. This results in members living for long periods of time in unstable and/or potentially harmful situations where they are not happy. This results in decomposition of the member and a worsening of behaviors. Members have the right to be in a happy stable home. Without enough providers willing to take on these members, they are then subjected to

neglect, abuse and a diminished quality of life without the ability to move to another setting. They are subjected to retaliation from providers if they report abuse, neglect and quality of care issues to DDD, APS or AHCCCS.

There is a need for residential settings that are customized for the members and not just ADH/CDH, Group Homes and IDLA settings. There needs to be freedom to create hybrid models to address these needs. In addition, this year we learned that IDLA settings do not provide reimbursement for transportation to providers. This creates a real hardship for these members. A true person centered residential plan needs to be implemented.

More section 8 housing settings need to be provided for those members who are able to function outside of a group home, but cannot afford to move to another setting due to lack of personal or family funds.

Behavioral Health Hospitals

There are no behavioral health hospitals in Arizona prepared to appropriately meet the needs of our members when psychiatric hospitalization is required due to medication changes that need to take place in an inpatient setting. They are thrown in with mentally ill, criminals and drug addicts. This is true in outpatient facilities such as UPC and SMI clinics as well. There needs to be specialization for our members that are set apart as their needs are extremely different due to the developmental issues and would be more effectively managed with specialization. Furthermore, the division between DDD and Regional Behavioral Health causes the dually diagnosed members to navigate an extremely confusing system which has either side pointing fingers at who is supposed to be providing services. Behavioral health needs to be under one umbrella for our members. This collaboration of cooperative care should be a high priority.

These issues and recommendations have been previously discussed with DDD management via phone, email, District East meetings, statewide meetings, and individual meetings.
This report is a compilation of District East meetings, statewide meetings, review of Behavior Treatment Plans for DE, review of Incident Reports for DE, meetings with families, providers and DDD employees and personal experiences of our committee members during July 2019 to June 30, 2020.

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Suzanne Hessman, Chairperson

DDD DISTRICT CENTRAL INDEPENDENT OVERSIGHT COMMITTEE

Division of Developmental Disabilities

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DISTRICT CENTRAL

INDEPENDENT OVERSIGHT COMMITTEE

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DISTRICT CENTRAL
Independent Oversight Committee
Membership 2020

Karen Van Epps, Chairperson, Family Member/Advocate

Carol McNulty, Vice-Chair, Family Member/Advocate

Eve Hamant, Parent/Advocate

Mandy Harman, Member

Linda Mecham Parent/Educator/Advocate

Andrea Potosky, Parent

Debbie Stapley, Parent

Lisa Witt, School Psychologist/Family Member

Eduarta Yates, Parent

Heidi-Reid-Champigny, Family Member

Sherry Howard Wilhelmi, Family Member

Marlene Riggs, DDD Non-voting Member

The District Central IOC reviews, by law, all incidents of abuse, neglect and human rights violations of the members who reside in Central Phoenix.

The Independent Oversight Committee is now within the Department of Administration.

Jeffrey Yomamoto is the liaison for District Central Independent Oversight Committee.

District Central Independent Oversight Committee met through February 2020, until the Coronavirus prevented in-person meetings. Consequently, March and April meetings were cancelled. Prior to the pandemic, the committee and the District Central Quality Assurance department had an excellent working relationship. Currently, receiving incident reports and reviewing them has been sporadic. Incident reports are redacted, which is a slow and difficult process. Consequently, the Incident Reports have been delayed and are difficult for the Committee to obtain. The Committee is responsible for reviewing incidents of abuse, neglect and human rights violations. Our concerns for and resolution of the IR's become a problem when the incident reports are not received within an appropriate and efficient time-frame. The District IOC is proposing that the redactions for incident reports and Behavior Plans (which are also reviewed by the IOC) are not necessary. Because it is very time consuming to follow the redaction procedures, Members are not being protected from abuse, neglect and human rights violations. This will take legislative review and action.

From July 2019 through June 2020 a total of 9,331 Incident Reports received by the District Central QA. 1,437 were classified "open cases" and 7,894 were "closed" Incident Reports. The District Central IOC did not receive for review all of the 9,331 Incident Reports because those categorized as Abuse and Neglect are sent to APS for review. After the APS investigation, the case comes back to DDD QA either "substantiated" or "unsubstantiated and closed". At that point, because the case is closed, the IOC has no input on the incident. Because incidents of "abuse and neglect" must be referred to Adult Protective Services (APS) for investigation, many months may pass before resolution of abuse and

neglect are reported to the committee. Only 2% of all APS incidents, not just limited to DDD, are substantiated. For an Incident Report to be substantiated, APS must meet a legal standard which can be upheld in court. There needs to be an intermediate level of substantiation, which will validate that the incident occurred, but does not necessarily meet the legal requirements in order to be upheld in a Court. As it is currently, if it does not meet the legal standard, the Incident Report is unsubstantiated and the case is closed without validating that the incident did indeed occur. The District Central IOC recommends that legislation be proposed which would allow DDD to examine the events that fall under the abuse and neglect categories, as has been done in previous years under previous administrations. This will take legislative review and action. During the year, the ADOA developed an IOC manual.

Members who have challenging behaviors, disabilities, and are difficult to serve, have had to go without necessary services. Members who do not fit into an existing program remain unserved or underserved. A major stumbling block is

Article 21. Agencies do not have to accept members when vendor calls are sent
out. Often, the newest and least experienced agencies are accepting the most difficult and challenging cases. These agencies are often not aware or prepared to serve the difficult cases, but see accepting these cases as a way to enter into the DDD residential services. There needs to be a unit for complex cases, such as has been developed by the insurance company, United Health Care.

Competitive employment is being prioritized nationally with the goal of eliminating sub-minimum wage pay. Vocational Rehabilitation is responsible for transitioning students from school to work. For the members who do not qualify for Voc Rehab, there is a real concern for members who attend Group Supported Employment but cannot compete with minimum wage jobs. The GSE programs need to remain in place.

One of the responsibilities of the IOC is monitoring and oversight. Our committee believes that the once-a-year monitoring, which is the current practice, is not adequate enough to provide oversight for the community programs. Because approximately 90% of the DDD Members served reside in their own homes, there should be an ambitious and continuous way to regularly oversee the remaining 10% who live in residential homes supported and paid for by DDD.

Supported Decision-Making (SDM) was introduced last legislative session. SDM is a process that allows members with disabilities to make their own decisions with the assistance of supporters (the Team) when requested. The committee believes that the SDM process is an effort to discourage families from seeking guardianship when their son or daughter becomes a legal adult at age 18. Guardianship is decided by the courts and will not take away the independence of members who are able to make their own decisions. A law is not needed for this. Currently, members can invite anyone they wish to help in decision making. Guardianship is a protection for incapacitated adults. While this bill has not passed the legislative process due to COVID shut-downs, it is still before the legislature and needs to be monitored for both individual protections and liability concerns.

ON-GOING ISSUES:

Nursing homes are not appropriate for long term DDD Members because the Nursing Homes are regulated under the Dept of Health Services, not DDD. The Members do not receive DDD programming while in nursing homes. They are only appropriate for rehabilitation or illness.

Article IX rewrite still has not been completed. Our committee does not believe a “rewrite” is necessary.

There is still concern about the wages of direct care providers. Their pay is not commensurate with the work and challenges required of them. We still continue to have concern regarding the turn-over of DDD Support Coordinators, which contributes to the continuity of services and understanding of the needs of each Member. In addition, the only connection the Member and/or the Member’s family have to DDD is the Support Coordinator, who lacks any authority for approvals/authorizations, when the Support Coordinator is the primary connection (gate-keeper) to the “System.”

Families cannot connect with each other because of the lack of advocacy organizations. Also, DDD uses HIPAA as an excuse to not divulge information, even though families not only want it, but have given approval for the information to be shared. This is especially true in Group Homes.

The IOC has experienced fewer members in attendance (because not all members have access to or understanding of the virtual communication practices) which results in lack of quorum and therefore cancellation of our meetings. We also have a lack of information because of social isolation/COVID restrictions. The **autonomy** and the **survivability** of the IOCs are grave concerns.

Respectfully Submitted,

Karen VanEpps

Karen VanEpps
District Central Independent Oversight Committee Chairperson

DDD DISTRICT WEST INDEPENDENT OVERSIGHT COMMITTEE

Division of Developmental Disabilities

2020 ANNUAL REPORT

Arizona Department of Economic Security

District West Independent Oversight Committee 2019/2020 Annual Report
Maricopa County (West Area)

INTRODUCTION AND BACKGROUND:

The Independent Oversight Committees (IOC) formerly the Human Rights Committees, supported by the Arizona Department of Economic Security (DES), were established into law under ARS. 41-3801 and function as independent advisory and oversight committees to the Division of Developmental Disabilities (DDD). Independent Oversight Committees (IOC) were established to promote and protect the rights of members with developmental disabilities who receive services from the Division of Developmental Disabilities.

District West IOC is located on the west side of Maricopa County and extends south including portions of the Gila River Indian Reservation, to North Phoenix, and West to the border of Arizona, In 2019/2020 District West served over 10,000 members.

District West IOC continues to be one of the fastest growing districts in membership for the DES and DDD. The monthly meetings are held at the Peoria DES office in Peoria Arizona but since April 2020 have been held electronically (see https://ioc.az.gov/committees/ddd) due to the COVID-19 Pandemic Restrictions. The committee meets on the fourth Tuesday of month for approximately two hours.

RESPONSIBILITIES AND DUTIES OF THE INDEPENDENT OVERSIGHT COMMITTEES:

The Independent Oversight Committees (IOC) are made up of dedicated volunteers who donate their time to serve the members within their districts. The IOC operates under the Open Meeting Laws of Arizona and follows specific IOC Guidelines created by their district. The District West Committee meets approximately ten times per year.

The committee provides independent oversight, review, research and makes recommendations to the Department of Developmental Disabilities. The committee reviews incidents of including Physical Abuse, Sexual Abuse and Other Abuse, Neglect, Accidental Injury, Missing Clients, Emergency Measures, Human Rights Violations, Medication Errors, Death, Suicide, Hospitalization, Incarcerations, Theft and Property Destruction. The committee members also review Behavior Plans (BPS) and make recommendations for changes.

DISTRICT WEST HUMAN RIGHTS COMMITTEE MEMBERSHIP:

The District West Independent Oversight Committee (IOC) is composed of dedicated community members including parents, family members, professionals and paraprofessionals who volunteer their time and knowledge to advocate for DDD members.

Current members for the 2019/2020 year are:
Diedra Freedman (De) (Chairperson),Pat Thundercloud (Vice Chairperson), Bernadine Henderson, Brad Doyle, Cynthia Macluskie, Laurene Zemis, Julie Heineking and Pamela Grady. All the current members have appointments by the Arizona Department of Administration or the Division of Developmental Disabilities if appointment was prior to August of 2019.
Recruitment efforts from July 2019 to June 2020 gained 0 new members bringing the total current to 8 members.

DISTRICT WEST INDEPENDENT OVERSIGHT COMMITTEE, VOLUNTEER HOURS:

The District West IOC volunteered 255 hours of their time in 2019/2020.

INCIDENT REPORTS

District West IOC reviewed a total of 10,095 Incident Reports (IRS) for over 10,000 members from July 2019 to June 2020.

In 2019/2020 the District West IOC will received every type of "open" Incident Report, including Physical Abuse, Sexual Abuse and Other Abuse, Neglect, Accidental Injury, Missing Clients, Emergency Measures, Human Rights Violations, Medication Errors, Death, Suicide, Hospitalization, Incarcerations, Theft and Property Destruction. We look forward to working with DDD to create a secure electronic review system so District West IOC Members can better review Incident Reports.

BEHAVIOR PLANS

District West IOC reviewed a total of 585 Behavior Plans in 2019/2020.

Pat Thundercloud and Bernadine Henderson attended the 2019/2020 District West Program Review Committee (PRC) meetings as representatives of the District West IOC. Pat and Bernadine were consistently involved in attending the PRC meetings and are strong advocates for the process. However, the number of Behavior Plans needing review and the hours needed for an IOC Member to personally attend every District West Program Review Committee (PRC) meeting is beyond the availability of the current District West IOC Members who all are volunteers. We do the best we can and look forward to increasing the number of District West IOC Members so that we better can fulfill our statutory responsibilities. We look forward to working with DDD to create a secure electronic review system so District West IOC Members can review Behavior Plans and comment on them before the District West Program Review Committee (PRC) meeting reviewing that Behavior Plan, especially when no District West IOC Members are available personally to attend that District West Program Review Committee (PRC) meeting.

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DDD DISTRICT NORTH INDEPENDENT OVERSIGHT COMMITTEE

Division of Developmental Disabilities

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2020 INDEPENDENT OVERSIGHT COMMITTEE REPORT

District North

Cynthia McKinnon Chair

Robert Malloy Vice Chair

Sandra Malloy

Maegan Van Wyck

Danielle Lawrence Jody

BonDurant-Strong

Jeffrey Yamamoto (IOC LIAISON)

INCIDENT REPORTS 2020

January Open 72

Closed 373

February Open 73

Closed 604

March. Open 50

Closed 539

April Open 49

Closed 261

May. Open 38

Closed 242

June Open 77

Closed 317

Total : Open 369

Closed 2,336

Total. 2,705

AT LEAST 1,863 IR's NOT DISTRIBUTED FOR REVIEW

BEHAVIOR PLANS

District North was sent 257 Behavior Plans (although NOT ALL WERE DELIVERED) thus not reviewed

1. The HRC repeatedly reviews Behavior Treatment Plans and Incident Reports which address instances of sexual assault (both of victims and perpetrators), inappropriate touching ,disrobing or exposure in public ,and public masturbation. As sexuality is a normal human expression it is necessary that DDD members are allowed to express themselves in an appropriate manner. A comprehensive sex Ed program such as that used in Maine digitalcommons.usm.maine.edu would be appropriate as it is appropriate for all levels of comprehension and has been successful in many states as well as being strongly supported by members families
   . A program which taught such information was , in the past , a normal part of the Behavior Plans .
2. There continues to be a need for guardians to protect individuals who have severe cognitive disability .
3. Dental care is lacking for DDD members and extraction is most often the choice of treatment after years of neglect. Lack of appropriate dental care is a health threat and the cause of chronic pain in those unable to communicate. We urge full funding of dental care.
4. Housing support for high functioning individuals who need assistance for physical care but are otherwise independent is necessary. These individuals are often housed with severely behavioral individuals or in individual homes where a normal interaction with the community is difficult to obtain. We are aware of support for particular (higher functioning autism spectrum individuals) groups and look forward to the DDD committing to the same attention to high functioning individuals with physical disabilities.
5. Once again the HRC reiterates the need for a Step Down Facility for DDD members who have been in mental health facilities , in hospital , or have undergone medication changes to allow transition time with supervision

6. Providers are ever more frequently utilizing law enforcement for behaviors addressed in the BTP rather than following the interventions described in the BTP.
7. Involving law enforcement in this situation violates both the intention of the BTP and is an inappropriate use of public resources for the benefit of a private entity.
8. The suppression of minimum wage and underfunding of DDD providers by the State of Arizona has caused difficulty in hiring and retaining appropriate , skilled , and dependable workers for group homes and has caused providers to flee Flagstaff. Increase of statewide minimum wage and increased payment for providers as is necessary to the safety and proper supervision , protection, and improvement of quality of life for all members.
9. The IOC did not receive Incident Reports from May to November. A total of 1823 (perhaps more) were NOT reviewed for rights violations in a timely manner.
10. The IOC is extremely concerned about the fact that IR's having to do with COVID infection or deaths DO NOT INCLUDE THE PROVIDER OR THE RESIDENCE . This prevents the independent legally mandated oversight to occur .

DDD DISTRICT SIERRA VISTA INDEPENDENT OVERSIGHT COMMITTEE

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2020 ANNUAL REPORT

Arizona Department of Economic Security

DISTRICT SOUTH (SIERRA VISTA)

District South (Sierra Vista) ANNUAL REPORT

January 1, 2020 through December 10, 2020

Independent Oversight Committee

INTRODUCTION AND BACKGROUND.

This report reviews the activities of the Independent Oversight Committee (IOC) based in Sierra Vista serving the southeastern counties of Arizona. The current IOC is the extension of the Human Rights Committee (HRC) established in that area in 2016. The IOC has 7 members currently and had a high number of 10 members at one time.

ORGANIZATION AND RESPONSIBILITIES.

The IOC provides protective oversight of the human rights of members receiving services from the Department of Economic Security Division of Developmental Disabilities (DES/DDD) due to certain disabling conditions. The IOC reviews reports of service to determine that no human rights violations have occurred. If violations are suspected the IOC requests further investigation and reports to the proper authorities, if substantiated. The IOC completed and approved guidelines for committee procedures in November of 2018, which were reviewed and then approved by the ADOA in January of 2019. The guidelines provide for a chairperson, vice chairperson, terms of office and reelection, and requirements for continued membership. All requirements for government meetings are included in the guidelines.

THE COMMITTEE AND COVID-19.

With the pandemic spread of Coronavirus-19 at the beginning of the year the committee has had issues with consistency of meetings. With several things happening throughout the state and in our county, everyone's lives have changed including the committee, DDD and the DDD member population. Examples of these changes due to the COVID-19 are:

1. The committee only officially met 5 times this year. Jan, Feb, March, Oct, and Dec 2020 due to the COVID-19 cancelling many of them
2. The IOC meetings are now being conducted virtually rather than meeting in person at the DDD office.
3. The committee has a reduced number of members and now sits at 7 members. 4. The IOC has not gone into executive session since meeting virtually. 5. The availability and reliability of the internet has affected attendance to virtual meetings.

CONCERNS AND ACTIONS.

The issues that have been raised from the committee:

1. The information provided in the Incident Reports the committee reviews is very often insufficient to understand what happened during the incident. The description of what was done to resolve or follow up the incident is very often lacking or insufficient. The vendors should be responsible for making sure reporting is sufficient.
2. The committee has been welcomed to attend the Program Review Committee (PRC) meetings monthly and several persons have been attending. This helps a great deal with filling the information gap the committee has experienced in the past. Thank you, Keith Jansen, and Michelle Talley, for attending.
3. The inconsistency of the Incident Reports coming from DDD.
4. There needs to be a way to be able to state our concerns concisely and easily. In the next year, the IOC will possibly be able to read and comment on IRs electronically.
5. It would be very helpful to have a format for the ADOA annual report including the specific data that should be maintained and reported.
6. Early this year, several members of the IOC visited the Arizona Training Program in Coolidge.
7. Recruitment for new IOC committee members was put on hold due to the pandemic, however these efforts will start again when it is safe to do so.

8. Members of the IOC committee were invited to a meeting with Leah Gibbs on December 17 to discuss the impact of Prop 207 on DDD services and members.

SPECIAL RECOGNITION

The Program Review Committee (PRC) Chair, Barbara Carty wanted to bestow a special thanks and recognition to Mr. Keith Jansen for his diligent work with the PRC on attending the PRC meetings since his invitation earlier in the year. She reports that he has attended 67 meetings and approved around 300 behavior plans. She also wanted to thank Ms. Mary Haynes (retired from committee) for her contributions, also for attending 10 meetings before she left. Jerry Regan was a long-time member and co-chairperson of the IOC committee who retired from the committee this year.

CURRENT DISTRICT SOUTH (SIERRA VISTA) COMMITTEE MEMBERSHIP

- Chere Solórzano (SV IOC Chairperson)
- Margarita Fate (SV IOC Member)
- Amy Schroeder (SV IOC Member)
- Keith Jansen (SV IOC Member)
- Gloria Brunell (SV IOC Member)
- Patsy Sartain (SV IOC Member)
- Michelle Talley (SV IOC Member)

CURRENT STATE OF ARIZONA STAFF ROSTER

- Eric Houghtalin (DDD IOC Liaison) Jan 2020-Oct 2020
- Jeffrey Yamamoto (DDD IOC Liaison) Oct 2020-present
- Richard Kautz (DDD Chief Advocate)
- Mike Valdez (DDD Quality Assurance Retired/Volunteer)
- Larry Allen (ADOA Independent Oversight Committee Manager)
- Pauline Selmer (DDD Quality Assurance Manager)
- Barbara Carty (DDD District South PRC Chairperson)

INCIDENT REPORTS AND BEHAVIOR PLANS FROM 2020.

- Behavior Plans reviewed by the Sierra Vista IOC:

Over 300 behavior plans.

- January -12 Incident reports
- February –0 Incident Reports
- March – 139 Incident Reports
- April-October- 643 Incident Reports
- **Total for the Year** = 909 Incident Reports

DDD DISTRICT TUCSON INDEPENDENT OVERSIGHT COMMITTEE

Division of Developmental Disabilities

2020 ANNUAL REPORT

Arizona Department of Economic Security

ANNUAL REPORT 2020
District South-Tucson

INTRODUCTION AND BACKGROUND

It is a pleasure to submit our 2020 Annual Report for the Independent Oversight Committee (IOC) in Tucson with support to Yuma because there is no IOC operating in Yuma. The new Sierra Vista committee is operational.

Human Rights Committees, now known as Independent Oversight Committees, were established under ARS 41-3801 and function as independent advisory and oversight bodies across the State. The Committee includes professionals and paraprofessionals, as well as interested parties.

RESPONSIBILITIES OF THE INDEPENDENT OVERSIGHT COMMITTEE The Human Rights Committee of dedicated volunteers, in addition to providing independent oversight and review and making recommendations, functions under the Open Meeting Law and follows District-specific Bylaws/Guidelines.

SPECIFIC CHALLENGES

This calendar year brought the pandemic due to COVID-19 and changed the basic functioning of the Tucson Human Rights Committee as we all worked toward moving to and attending virtual meetings. As mentioned in previous year's reports, Behavior Treatment Plans continue to be inconsistent in structure and order and are difficult to read. The Tucson committee feels that the lack of consistent quality and general unreadability of the BTPs represent real violations of human rights for members due to the inability of caregivers and service providers to understand the plans. We would like to see a more consistent format for BTPs and the use of wording that is easily understood by all service providers.

The committee in Tucson had a decline in members due to resignations and the removal of members due to attendance issues. Moving toward virtual meetings brought the hope of increased attendance by all members. With committee members taking on new job opportunities, we had four number of meetings where we did not meet quorum. The committee continuously works to accommodate and amend meeting times to meet people's schedules and consider the holidays affecting specific months.

The committee recognizes the challenges faced by the Quality Assurance team over the past year and wishes to commend Pauline Selmer for her devotion to the Division and its members and her continued professionalism in the face of less than ideal working conditions. Ms. Selmer has consistently provided information as requested and has excelled in her explanations of situations for which the committee had questions.

The Tucson HRC committee continued to meet at the downtown office located in the Department of Economic Security building located at 400 W. Congress Street. This facility can accommodate our growing group very well. Liaison Jeffrey Yamamoto reserves our meeting rooms, notifying members of upcoming events, obtaining the Incident Reports and Behavior Treatment Plans for committee review, recording

and drafting meeting minutes, and numerous other tasks required to support the committee. He has greatly improved the functioning of the committee and has not only provided guidelines to keep the committee in compliance with meeting laws, but has actively advocated within the Division to help the committee to function better and more efficiently. This committee is deeply grateful for the addition of Mr. Yamamoto in the administrative capacity and we value his dedication to the goal of helping the committee live up to the potential and vision in the protection of human rights for the population served by the Division.

The Tucson committee is working to find efficient and effective ways to protect the rights of individuals with developmental disabilities through ever-evolving procedures and systems. We continue to work with the OIFA/HERO team to develop new channels of inter-agency communications so that we can do our job more effectively. We have found that our new oversight by the Department of Administration has changed very little in the way that we function. We are optimistic that we will be able to better fulfill our purpose as we continue to work with the State and community agencies to serve the members here in District South.

MEMBERSHIP

The Tucson Committee

The Tucson committee membership grew throughout the 2020 year. The members include in December of 2020:

Genevieve Valenzuela
Lynne Tomasa
Tyler DeMers
Jessica Richards (Chair)
Christine Small
Shereen Shoulders
Bonner Raskob
Bianca Pimentel

DES Staff supporting the committee include:
Jeffrey Yamamoto, Human Rights Committee Liaison
Department of Economic Security
Division of Developmental Disabilities

Richard Kautz, CPM
Advocacy and Special Projects Manager
Department of Economic Security
Division of Developmental Disabilities

The Tucson committee membership is continuing recruiting efforts to increase our membership

RECRUITMENT AND TRAINING

Donna-Marie Terranova, Volunteer Coordinator for District South, had actively recruited new members for the Sierra Vista region as well as Eric Houghtalin DDD IOC liaison.

ORGANIZATIONAL STRUCTURE

The IOC's are groups of volunteers with DDD staff offering clerical support and providing the committee with Incident Reports to review and Behavior Treatment Plans to approve.

STATISTICS

	IRs Reviewed District South	**BTPs Reviewed District South**	**Meetings Held**
Tucson annual 2019 (6 months)	3305	>150	3
Tucson fiscal 2020 (6 months)	4107	>150	3*

*Due to DDD Canceling building Access during COVID-19 – 1 meeting cancelled

OTHER ACTIVITIES

The District South committee has utilized the DDD systems to track and review Incidents throughout our District. As a result, we have stopped using our own tracking system. We do have concerns that the Division uses too many resources printing out Incident Reports that we do not need and have not requested. These extraneous reports simply are shredded, unread. If the output could be better filtered and tailored to our needs, we feel we would not be wasting so many resources like paper, toner, and, most importantly, time by Division staff. The blanket requirement that all IRs be printed out is wasteful. We would like to work with the Division to reduce this waste in the future. The Division is working to find an electronic method of delivering IRs for review.

The Cross-Agency IOC Chair meeting is at a point where they can be re-established and meet on a regular basis. These meetings will be held quarterly. The IOC District Chairs meet virtually with Arizona Health Care Cost Containment System (AHCCCS) and DES to share recent efforts and revised flow charts around the QOC and IOC processes. This was a recommendation from the Abuse and Neglect Prevention Task Force.

This concludes the annual report of the Independent Oversight Committee, District South - Tucson.

Respectfully submitted,

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Jessica Richards
District South - Tucson Independent Oversight Committee

Chairperson _____