

Southwest Idaho Treatment Center

Office of Performance Evaluations
Idaho Legislature





Senator Mark Harris (R) and Representative Mat Erpelding (D) cochair the committee.

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Joint Legislative Oversight Committee 2017–2018

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Senators



Mark Harris

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Michelle Stennett

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Representatives



Mat Erpelding

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From the director

January 16, 2019

Members
Joint Legislative Oversight Committee
Idaho Legislature

The operational model of the Southwest Idaho Treatment Center (SWITC) is no longer tenable. The center lacks enough clients for economies of scale to support the variety of expertise needed. In addition, its institutional setting prevents the center from replicating community living for individuals with intellectual disabilities. Often these vulnerable individuals have co-occurring mental illnesses, complex medical and behavioral issues, and history of violence or involvement with criminal justice system.

Idaho lacks a long-term vision for how to have an effective and efficient system of care for these individuals. This lack of vision has contributed to a culture of constant crisis at SWITC, resulting in stress, anxiety, and despair on the part of staff and gaps in the quality of care provided to SWITC clients.

The Department of Health and Welfare, with policy guidance from the Legislature, needs to create a long-term vision for how Idaho is going to serve these individuals in crisis.

The department also needs to establish strong leadership and management practices at SWITC, starting with a formal strategic plan and a formal quality improvement system.

I want to commend SWITC's staff and management for their hard work in difficult circumstances and for the help they gave us during this evaluation. I would like to thank the clients at SWITC for letting us into their home.



Sincerely,

A handwritten signature in blue ink that reads "Rakesh Mohan".

Rakesh Mohan, Director
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**Formal
responses from
the Governor and
the Department
of Health and
Welfare are in
the back of the
report.**



Ryan Langrill conducted this evaluation with the assistance of Casey Petti. Margaret Campbell copy edited and desktop published the report.

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**Historic, black and white
photos were provided by
the Department of Health
and Welfare.**

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Executive summary



Why we were asked to do this study.

The Southwest Idaho Treatment Center (SWITC) is the highest level of residential treatment for Idahoans with intellectual disabilities. Clients served at SWITC have needs that could not be met in the community or have been placed by the court into the custody of the Department of Health and Welfare. In 2017 SWITC was thrust into the spotlight after six employees left after findings of abuse or neglect, a client committed suicide, and failed inspections threatened to lose the state \$8 million per year in federal matching funds.

What we found.

Idaho lacks a coherent vision for services to individuals with intellectual disabilities who are in crisis. Efforts in recent years have focused on keeping individuals in the community and out of institutions. These efforts have transformed the role of the state as the provider of last resort without a clear focus on the individuals whose needs meet the level of care at SWITC. Every client at SWITC has complex behavioral or medical needs, and many have co-occurring mental illnesses and a history of assault or self-harm.

Management does not have an effective approach to solving problems. SWITC's constant focus on putting out fires has undermined its ability to make progress on long-term objectives. Management's decisions lack buy in from staff, and changes are made without effective follow-through and monitoring.

SWITC exhibits symptoms of organizational trauma. Attitudes and practices developed for survival in times of crisis have become normalized and are passed on to new staff. Many in leadership and clinical positions came during crisis, did

not have effective training, and have struggled to understand their role.

Staff trauma and injury is significant. For the first half of 2018, one in ten staff days was spent out on injury; on one shift that number was one in five. Injuries also lead to medical layoffs or staff quitting for fear of further injury. Staff are frequently assaulted, sustaining both severe and chronic injuries. While physical injuries are addressed, psychological trauma remains, and staff lack adequate tools for self-care. These unaddressed needs lead to dysfunctional relationships with clients.

Understaffing has continued to get worse. For six of the first nine months in 2018, SWITC lost more staff than it hired. Understaffing threatens client and staff safety, in turn worsening turnover and putting clients at risk of abuse and neglect.

The approach to treatment is reactive rather than proactive. Exacerbated by understaffing and a crisis mentality, direct care staff are often described as babysitters waiting for the next behavioral crisis. As new staff are hired into an environment where being reactive is the norm, efforts to encourage proactive solutions get more difficult.

SWITC has made significant changes in the past two years. However, much more needs to be done. Staff care deeply for clients and the organization. They have great energy and ideas. After the traumatic events of 2017, SWITC made changes to address gaps in management, staffing, and training. SWITC hired a program manager from out-of-state, implemented a two-week staff training program, and significantly increased pay for new hires and existing staff. Other efforts include improved relationships with adult protective services and trainings for investigative staff.

The department acknowledged SWITC's obsolescence in its plan to sell the campus and build a new facility elsewhere. The plan was abandoned due to barriers selling the land, not changes in the state's needs. In the meantime, expectations that SWITC's facilities were to be demolished had discouraged the department's long-term investment in maintenance and improvement.

What to do next.

We made recommendations to address system-wide issues and issues with SWITC's operations and treatment standards. The key to making long-term progress rests with two core recommendations:

We recommend that the Department of Health and Welfare develop a strategic plan and a formal quality improvement process at SWITC. This process should be done in a way to ingrain staff buy in, accountability, and formal evaluation of efforts into SWITC's organizational culture. Priorities for program improvement include addressing staff trauma and injury, understaffing, gaps in training and supervision, a reactive approach to treatment, and problems with the discharge process. Improvements in SWITC's leadership and management are necessary. We recommend that the department present the strategic plan and updates on its quality improvement process to the legislative Health and Welfare committees at the start of the 2020 legislative session.

We recommend the Legislature direct the Department of Health and Welfare to develop a long-term vision for Idaho's system of crisis care and its role as provider of last resort for those with intellectual disabilities. The Legislature should provide policy guidance for this vision. Stakeholders and other states should be included as appropriate.

In addition to these two core recommendations, we recommend the following:

SWITC should ensure that it conforms to requirements for adult protection and child protection when it conducts preinvestigations of allegations of abuse and neglect.

The Legislature should consider establishing a registry of perpetrators of abuse or neglect of vulnerable adults to exclude perpetrators from working as a caregiver.

The Legislature should also consider supporting SWITC's efforts to improve staff recruitment and retention by making early retirement available for staff, in recognition of their high rate of injury.



1

Introduction

Legislative interest

In March 2018 the Joint Legislative Oversight Committee asked us to evaluate the Southwest Idaho Treatment Center (SWITC). SWITC is overseen by the Department of Health and Welfare. It only serves Idahoans with intellectual disabilities who have been committed to the department by the courts or who are in crisis and cannot be served in a less restrictive setting.

In 2017 SWITC failed a recertification survey and a subsequent follow-up conducted by the department's Bureau of Facility Standards. If SWITC were to lose certification, the state would lose almost \$8 million per year in federal matching funds. SWITC passed a second follow-up survey, but legislators who requested this evaluation reported that complaints about serious noncompliance continued to persist. Their request letter is in appendix A.

In August 2017 a client was found dead of apparent suicide. The coroner reported that the client had been dead for six or seven hours, despite staff documenting that they had checked on him every 30 minutes. Reports surfaced throughout the summer of 2017 about an internal department investigation that led to the involuntary termination of six staff for abuse or neglect.

SWITC's secure treatment facility, which the Legislature authorized in 2017 but has yet to open, does not have federal oversight, unlike much of SWITC's operations. Some stakeholders suggested that the configuration of state oversight by the department may not be sufficiently independent.

Transformations

In the past, across the country, state-operated institutions served as long-term homes for individuals with intellectual disabilities, isolating them from the wider community. Today, states focus on providing services to individuals with intellectual disabilities in the community. As services in the community have become available, fewer individuals are served in institutions. In 1977 more than 155,000 individuals with an intellectual disability lived in state-operated institutions. That number declined to 56,000 in 2003 and 31,500 in 2015.

In Idaho, SWITC's population has declined more dramatically, as shown in exhibit 1. With the decline in the number of individuals living in institutions, the purpose of institutions has changed. Rather than serving anyone with an intellectual disability, institutions tend to serve only those with complex medical or behavioral needs, who are difficult to serve in the community.

In 2015 the Department of Health and Welfare adopted a strategic initiative to “develop a therapeutic stabilization and transition center for clients” with an intellectual disability. The initiative noted that “the department does not currently have the proper facilities or services to adequately care for or treat” individuals who have an intellectual disability and who are a threat to themselves or others.

The Legislature established the Idaho State Sanitarium in 1911. White Hall, the first residential building and today the administration building, was completed in Nampa in 1918 by state penitentiary prisoners. At its peak, the campus was a long-term home to almost 1,000 residents with disabilities.



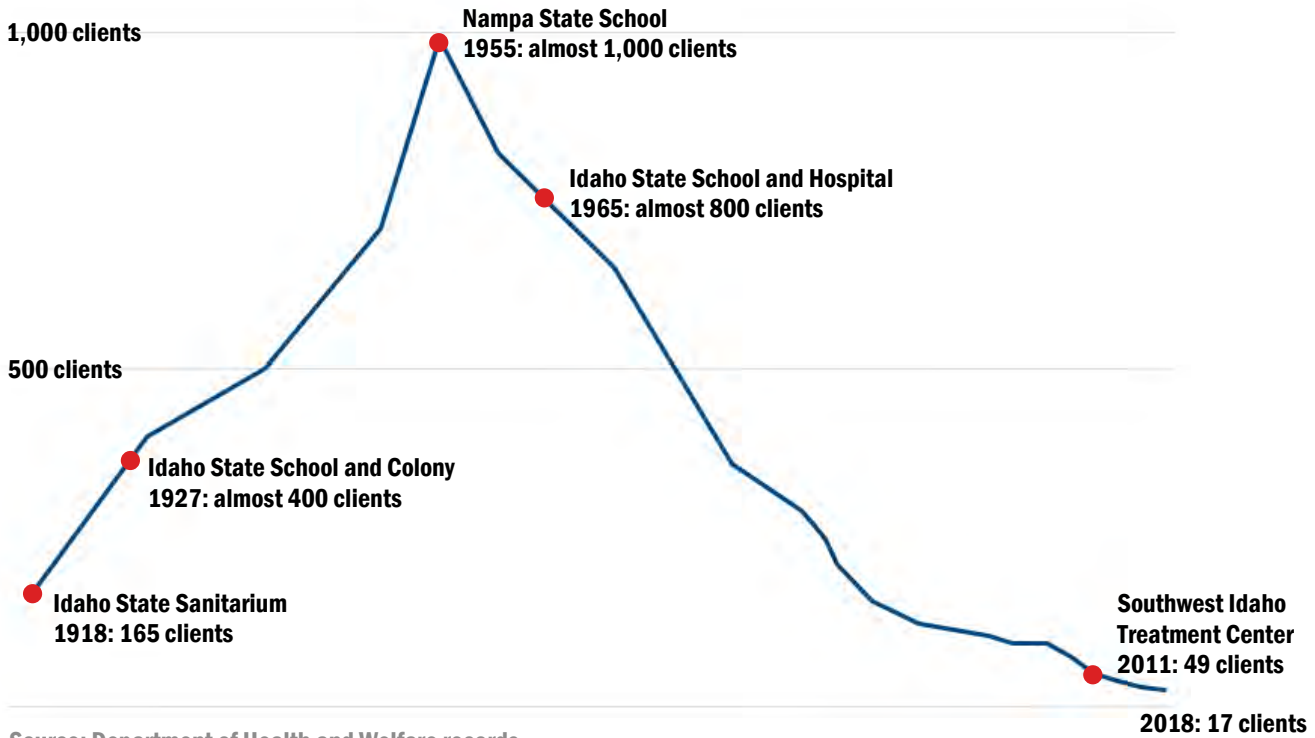
Today SWITC offers short-term crisis care for individuals with complex behavioral or medical needs. Its mission is to “support... individuals in crisis to become stable, develop skills, and successfully transition to the community.”

The 600-acre campus is owned by the state. More than 500 acres are leased for two golf courses, a work release center, job corps, and a juvenile corrections facility.

Exhibit 1

In its 100-year history, the Southwest Idaho Treatment Center has undergone several **name changes.**

The population has varied greatly though the location has stayed the same.



In 2015 and 2016, the department intended to accomplish this initiative by “build[ing] an improved facility at an alternative location.” This improved facility would have replaced SWITC’s current location. The department conducted a conceptual study and developed blueprints for this improved facility. In 2017 the goal for the improved facility was dropped after the department decided not to sell the 600-acre campus. The goal was replaced by an alternative goal to establish a secure treatment facility.

During the 2017 legislative session, the Legislature authorized the creation of a state-licensed secure treatment facility at SWITC. The secure treatment facility would be used for residents who have been found by a court to be a substantial threat to the safety of themselves or others.

Evaluation approach

SWITC is overseen by multiple outside entities. In 2017 and 2018, the Bureau of Facility Standards conducted eight recertification or complaint surveys. Surveys are intended to ensure that SWITC complies with minimum regulatory standards. During our scoping process, stakeholders said they believed compliance to federal regulations was necessary, but compliance alone was not sufficient to ensure that SWITC offered the best possible quality of care.

DisAbility Rights Idaho is the state's federally mandated protection and advocacy agency. Its investigative authority revolves around protecting individuals from abuse and neglect. In October 2018 it released a report titled *No Safe Place to Call Home*. The report reviews serious breakdowns in oversight at SWITC that contributed to an ongoing abuse of clients from January 2017 to January 2018. The report reviews internal investigations for abuse and neglect and concludes by suggesting that the state should consider closing the facility. Nineteen recommendations are directed toward revising SWITC's practice or state policy.

SWITC's responses to ongoing oversight activities and its internal quality improvement efforts mean that SWITC's operations have evolved throughout this evaluation. Our evaluation seeks to fill a gap not addressed by other oversight activities. This gap is to seek solutions by looking at SWITC as a system. We focus on concerns of external oversight and on issues of operations and management that appear to be persistent or appear to be the root cause of more visible issues. The scope of our evaluation is in appendix B. The methods for the evaluation are discussed in appendix C.

2

Long-term vision

Idaho has mirrored the nationwide effort to move individuals with intellectual disabilities out of institutions and into the community. This effort has resulted in a dramatic decline of individuals living at SWITC in the past several decades. The most recent step in this effort came in 2009. The Legislature directed the Department of Health and Welfare, which oversees SWITC, to create a plan to transition residents into the community.

The resulting plan led to legislation in 2011 that renamed the Idaho State School and Hospital to SWITC. In addition, legislation limited admission, except in cases of emergency, to (1) those who had exhausted all community options or (2) those committed to the department's custody by the courts. The plan led to a further decline in the number of clients, from 62 in 2009 to 17 in September 2018.

SWITC is no longer a long-term home for clients. Its mission now is to help in crisis situations those with the most complex needs in the state to become stable, to develop skills, and to successfully transition to the community.



SWITC's transformation occurred without a coherent long-term vision for crisis care.

The decline in SWITC's population speaks to the department's success at moving individuals into the community. This success, however, has changed SWITC. SWITC has transformed in the past 30 years from serving 200 clients with a wide range of needs to serving fewer than 20 clients. The focus on moving individuals out of SWITC came without an assessment of how to best serve the clients who stayed.

Each client at SWITC has unique and complicated needs. These needs range from full control of food intake because a disorder prevents the client from feeling full to the management of complex seizure disorders. Behavioral concerns include histories of physical assault, sexual assault, self-injurious behavior, and the ingestion of inedible objects. Mental health diagnoses include schizophrenia, bipolar disorder, borderline personality disorder, and posttraumatic stress disorder. SWITC serves both adults and minors. A federal surveyor who has visited facilities throughout the nation for decades commented during an October 2018 survey that SWITC's clients were the most complex and interesting group she had ever seen.

SWITC's staff and operational structure were insufficiently prepared for the changing mission and population. Some long-term staff, hired to work with clients whose primary needs were feeding and toileting, reported never being trained enough to manage complex behavioral issues. Similarly, as SWITC downsized, staff with specialized functions were eliminated without sufficient plans to replace those functions.

A seasoned federal surveyor said that SWITC's clients were the most complex and interesting group she had ever seen.

► **Hallway and common area.** The resident's common area has a television and an exit to a fenced-in courtyard.

From no location in a unit can someone see the entirety of a unit.

SWITC's facilities are not well-suited for its mission.

Residential buildings were completed in 2002. In interviews we conducted for an earlier evaluation in 2005, staff of the then Idaho State School and Hospital commented that buildings were too institutional. They said that individuals with knowledge about actual operations were not consulted in the design of these buildings.



The design of the buildings was not initially conducive to client treatment or to staff or client safety. With fewer staff and more complex clients, the design is even less effective today. The department acknowledged this limitation in its 2015 and 2016 strategic plans.

Safety issues

Deficits noted by staff include poor lines of sight. From no location in a unit can someone see the entirety of a unit. Staff also reported that blind corners and nooks allow clients to hide or stalk others, putting other clients and staff at risk. Several exit routes from each building makes it difficult to follow clients attempting to leave without permission.

The design of the residential buildings also contributes to a sense that clinical and administrative staff are isolated from the day-to-day client care. Although some staff have offices located in the residential buildings, no office has direct access to units.

Unlike models of crisis care in some states, SWITC's facilities do not mirror any living arrangements available in the community.

The department reported that some clients struggle with the institutional model of living, which exacerbates the antisocial behavior that SWITC was meant to address. In addition, SWITC's campus is more isolated from resources in the community than other places clients could live. It is at the center of more than 600 acres zoned only for agricultural use. As of September 2018, the campus contained more buildings, though many abandoned, than it did clients.

As of September 2018, the campus contained more buildings, though many abandoned, than it did clients.

Residential buildings

Clients reside in three nearly identical buildings: Aspen, Birch, and Pine. Aspen and Birch are each divided into two residential units, comprised of a kitchen and dining area, a day hall or common area, rooms for laundry, storage, giving medication, and 10 bedrooms. Of the 10 bedrooms, one has been converted to a private room for clients to relax or use the phone. Three to six bedrooms are occupied, and the rest are vacant.

Between each unit are hallways with staff offices and a client computer room. Each unit has a fenced-in courtyard.

Pine is also divided into two units: one side is a crisis bed and the other side is the secure treatment facility. The crisis bed is occupied by one client at a time, at most, and is staffed by direct care staff who normally work in other buildings. The secure treatment facility has been modified from the other units: a fire door closes off the kitchen and dining areas and alterations have been made for enhanced safety and more restrictive interventions.



◀ Kitchen and dining area. Staff noted that someone in this layout can easily get behind staff. Staff working in the kitchen do not have a line of sight and are vulnerable to objects thrown from the dining area.

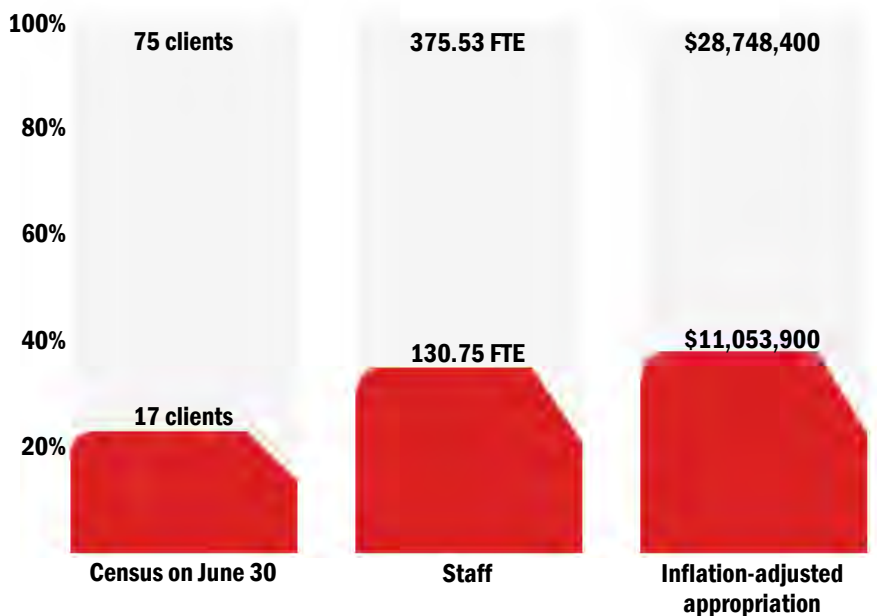
Operations suffered when SWITC lost economies of scale.

When SWITC was home to a much larger population, it supported a variety of specialized staff. Full-time staff were dedicated to training, occupational therapy, physical therapy, vocational services, quality assurance, pharmacy, and admission and discharge. They included a full-time dietician, a chaplain, and a school teacher. Their positions were not eliminated for a lack of need by clients or the organization. Rather, the needs of such few clients did not justify a full-time position. Exhibit 2 shows the decline in SWITC's population, staff, and budget over the past 10 years.

Exhibit 2

The size of SWITC's population, staff, and budget has dropped 60–80% in the past 10 years.

Fiscal year **2018's level** as a percentage of 2009's.



Source: Department of Health and Welfare records and legislative budget books. Appropriation adjusted to 2017 dollars using data from the US Bureau of Labor Statistics, Consumer Price Index for all urban consumers.

SWITC attempted to replace work performed by the eliminated full-time staff using alternative methods:

- Assigning additional duties to existing personnel
- Hiring or contracting with part-time personnel
- Using community providers
- Delegating responsibilities elsewhere in the department

Each of the methods to replace full-time staff has led to shortcomings:

Duties assigned to existing personnel were too often neglected, particularly as crises arose.

Part-time personnel and community providers have not been well integrated with the treatment team, and the difficulty serving SWITC's clients in the community created unmet needs for SWITC's clients.

Responsibilities moved elsewhere in the department, most notably discharge coordination, have been done without enough communication and coordination with SWITC.

SWITC was downsized without a sufficient vision for the organization. Many programs that had been in place, such as training and quality assurance, have faded. Staff have been assigned these functions again, but they must establish new processes. Establishing new functions takes more effort than maintaining existing ones. This is particularly true given the exodus of staff with institutional knowledge and the need to adapt these functions to SWITC's new size and mission.

Downsizing, by itself, poses systemic challenges due to many factors, such as a loss of economies of scale and the change in the profile of clientele. The department, as the parent agency of SWITC, had a responsibility to ensure that SWITC received the support necessary to avoid the struggles it has gone through. Although downsizing is inherently difficult, SWITC did so while being neglected by the department and while losing much of its institutional knowledge.

SWITC was downsized without a sufficient vision for the organization.

SWITC's operational model is neither effective nor efficient for the long-term.

SWITC is a vestige of an old treatment model and has large fixed costs, both from its old campus and its variety of treatment needs. It has the fewest clients of any state-operated intermediate care facility in the nation that is not currently closing. It carries the costs of a large, isolated treatment center without benefits from economies of scale.

The department acknowledged SWITC's obsolescence in its plan to sell the campus and build a new facility elsewhere. The plan was abandoned due to barriers selling the land, not changes in the state's needs. In the meantime, expectations that SWITC's facilities were to be demolished had discouraged the department's long-term investment in maintenance and improvement.

Other states also struggle to serve an increasingly complex population. As they expanded services in the community, institutions have served an increasingly complex population. Some states continue to have large populations in institutions because of policy decisions or larger overall populations. Some states have done away with state-operated institutions, and others have smaller, home-like crisis facilities. We did not find any single best system for Idaho to replicate. However, recent changes and continuing struggles in other states represent an opportunity for Idaho to learn from and collaborate with them.

Recommendation

The Legislature should direct the department to develop a long-term vision for Idaho's system of crisis care and its role as provider of last resort for those with intellectual disabilities. The Legislature should provide policy guidance for this vision. Stakeholders and other states should be included as appropriate.



At a minimum, long-term vision should address the following questions:



What series of living arrangements would enable the state to provide the most effective care? How would these arrangements be licensed?

Would a centralized crisis center or smaller regional centers be more effective and efficient?

How will resources in the community be developed to ensure that individuals are receiving the least restrictive care?

How will SWITC be coordinated with other elements of the department, such as the state psychiatric hospitals and the crisis prevention and court services team?

How will the state ensure access to specialists and the integration of specialists into clients' care?

What plans will be in place to ensure clients undergo any transition smoothly?

How will the state leverage the expertise of existing staff?

Will crisis beds be licensed and possibly access federal Medicaid matching funds?

Idaho's neighbors have a variety of methods for serving individuals with intellectual disabilities in state-operated settings. A detailed discussion of models in other states and licensing options is in appendix D.

3

Oversight

Multiple organizations are formally charged with the oversight of SWITC or of its client rights. Issues of noncompliance and client abuse led to a significant engagement of these oversight organizations, including eight surveys in the past two years and a report by DisAbility Rights Idaho. Nevertheless, stakeholders raised concerns that surveyors—employed by the Department of Health and Welfare—might not be sufficiently independent to oversee SWITC, particularly given that decertification would cost the department \$8 million per year in federal matching funds.

Additionally, advocates learned that former SWITC staff fired for abuse in June 2017 have continued to work with vulnerable adults. The continued employment of individuals with a history of abuse raises questions about the system’s ability to protect vulnerable adults from individuals with a history of abuse.

Who oversees SWITC?

Administration

SWITC is part of the Department of Health and Welfare, within the Division of Family and Community Services. The department’s human resources, contracts, financial operations, and facilities oversee SWITC’s operations. The Office of the Attorney General provides SWITC’s legal representation.

Bureau of Facility Standards

Within the department, as part of the Division of Licensing and Certification, the bureau conducts health surveys and fire, life, and safety surveys. The Centers for Medicare and Medicaid Services, a federal agency, oversees state surveys for federal certification requirements and occasionally conducts follow-up surveys.



Who oversees SWITC? (cont.)

Developmental Disabilities Council

The Idaho Council on Developmental Disabilities is an independent state agency. Its role is to understand barriers at the system level, to empower advocates, and to work with stakeholders to create changes.

SWITC advisory board

The director established an advisory board for SWITC in November 2018. The board includes 7–15 members including SWITC's administrator, the supervisor of the Crisis Prevention and Court Services team, the administrator of the Division of Family and Community Services, representatives from each of the Legislature, law enforcement, the Department of Correction, the courts, private providers, and family of SWITC clients. The director appoints members to the board. Its bylaws are in appendix E.

Who oversees client rights?

Adult protective services and child protective services

SWITC is required to notify a protection agency with an allegation of abuse or neglect. If an adult is the victim, SWITC notifies adult protective services within the Idaho Commission on Aging. If a child is the victim, SWITC notifies child protective services within the Division of Family and Community Services in the Department of Health and Welfare.



Protection and advocacy agency

DisAbility Rights Idaho, a nonprofit organization, has federal authority to monitor and investigate conditions in facilities that serve individuals with disabilities. It also provides legal representation to individuals with disabilities.

Human rights committee

SWITC is required by federal regulations to have a human rights committee to review, approve, and monitor any restrictive interventions. The committee is made up of four to ten members, two of whom are not employed by the facility and are appointed by the administrative director of SWITC.

The independence of Idaho surveys relies on the separation of management within the department.

A credible oversight entity requires independence from the entity it oversees. A full discussion of independence, based on the 2018 Government Auditing Standards from the US Comptroller General, which guides our work, can be found in appendix C.

The primary threat to the independence of state surveyors is structural: the line of management for surveyors includes the director of the department. The director has several responsibilities that could create a conflict: (1) the director is ultimately responsible for operations at SWITC, which includes maintaining federal funding, (2) the director has custody of many clients at SWITC, and (3) the director has the authority to revoke the secure treatment facility's license.

Idaho's survey process has three safeguards to independence:

As shown in exhibit 3, there are distinct lines of management from the director to the Division of Licensing and Certification and to SWITC.

The Centers for Medicare and Medicaid Services (CMS) oversees state surveys of intermediate care facilities. The decision to revoke SWITC's certification lies with CMS, not with the Division of Licensing and Certification.

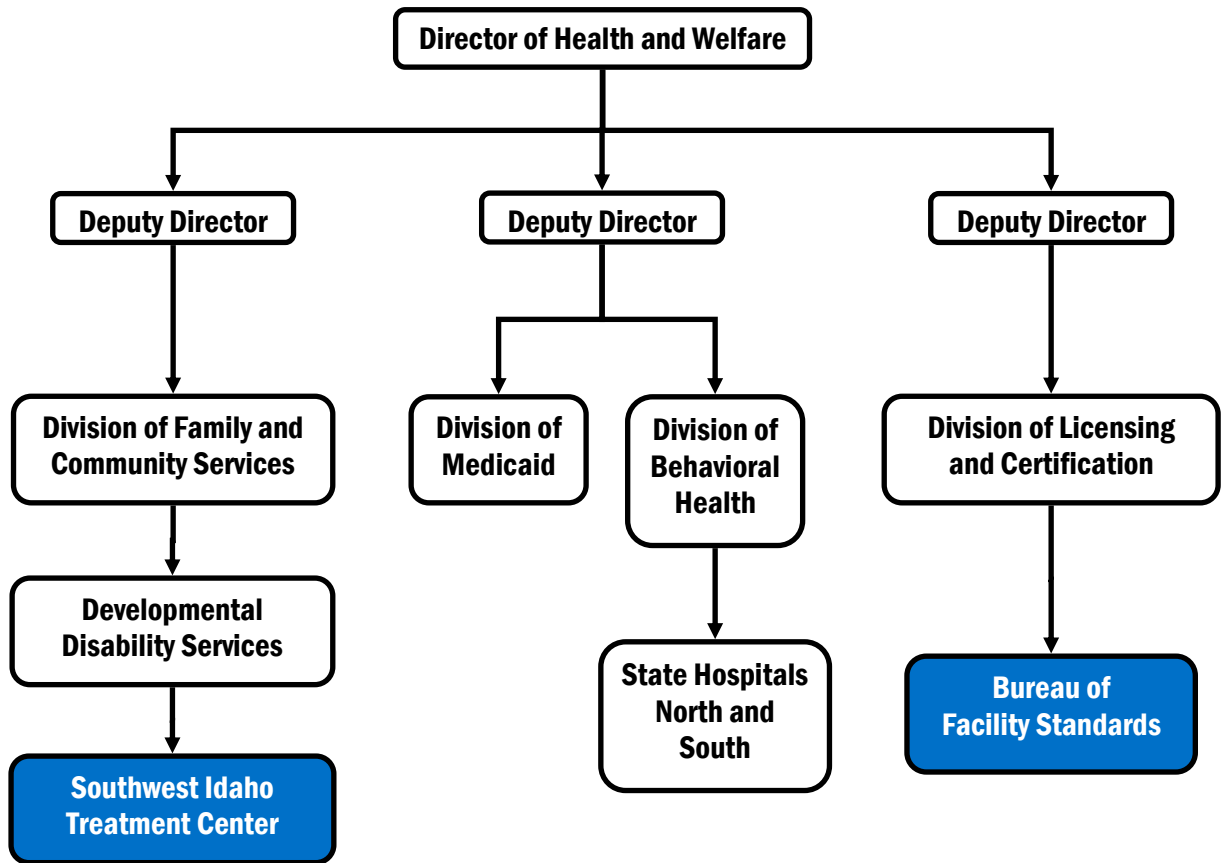
In September 2018, the Division of Licensing and Certification agreed to contract with Healthcare Management Solutions to conduct surveys of SWITC. This company is one of few that CMS authorizes to supply surveyors to state agencies and represents the consultation of a third party.

There are seven distinct levels of management between SWITC and the Bureau of Facility Standards. Of 16 states that have state-operated intermediate care facilities and the state survey agency within the same department, only four have as many degrees of separation as Idaho.¹

1. One state, California, did not have sufficiently detailed organizational charts available.

Exhibit 3

Lines of management separate the Bureau of Facility Standards, which oversees surveys, and SWITC.



Source: Department of Health and Welfare.

Eighteen states with state-operated intermediate care facilities operate the facilities and the survey agencies in different departments. For example, Utah's Department of Human Services operates the state developmental center, while the Utah Department of Health surveys the center. Other states operate facilities under departments dedicated to providing services to those with disabilities.

Of the three safeguards to independence, only one—the separation of management—exists for the secure treatment facility. There is no federal oversight of the secure treatment facility. When threats to independence without adequate safeguards exist, the survey agency is responsible to refuse engaging in a survey. If surveyors believe the structural

separation between them and SWITC is inadequate to ensure independence, the department and the Legislature have options for additional safeguards:

Involve third-party oversight and consultation in the survey process, such as an advocacy group.

Hire a third-party accreditation group to conduct, or participate in, the survey of the secure treatment facility. For example, the Arkadelphia Human Development Center in Arkansas is accredited by the Commission on Accreditation of Rehabilitation Facilities in addition to being certified by the state survey agency.

Create additional structural protections for the Division of Licensing and Certification. The 2018 Government Auditing Standards includes several options, such as allowing independence in personnel decisions, requiring that the department report a decision to remove the head of the division and the reasons for the removal to the Legislature, or requiring the survey agency to report to the Legislature or another independent governing body on a recurring basis.



SWITC has stricter criteria for abuse or neglect than adult protective services.

Statute and rule require caregivers to report all allegations of abuse and neglect to adult or child protective services. SWITC outlines steps in policy for notifying adult or child protective services of allegations that prompt an investigation.

We reviewed every investigation of abuse, neglect, or mistreatment between February and September 2018—investigations that were not included in DisAbility Rights Idaho’s report—for a total of 20 investigations. Of these 20 investigations, SWITC substantiated abuse, neglect, or mistreatment in six.

We confirmed with adult protective services that SWITC reported to it every allegation from the investigations. Because of SWITC’s stricter definition of abuse and neglect, only one of the six allegations was forwarded by adult protective services to law enforcement.

Adult protection and the criminal history unit



Idaho Code § 39-5308(2) establishes that the Commission on Aging "shall provide to the [D]epartment [of Health and Welfare] on at least a quarterly basis a listing of all alleged perpetrators against whom an allegation of adult abuse, neglect or exploitation has been substantiated. Upon request, all available supportive information shall be provided to enable the department to conduct criminal background checks and other required investigations."

Idaho administrative rule 16.05.06.230.02.a allows a substantiated adult protection complaint to lead to a conditional denial of employment on a background check. However, the Commission on Aging does not substantiate that a perpetrator caused abuse or neglect, only that abuse or neglect occurred. Therefore, the department's criminal history unit can only use a substantiated care report to check to see if the alleged perpetrator has any disqualifying crimes.

Since February 2018, SWITC has taken steps to improve its investigations. In August 2018, SWITC's two investigators attended a significant incident investigation training by Labor Relations Alternatives, Inc. SWITC's administrator and investigators have established recurring meetings with an investigator from adult protective services. Adult protective services reported to us a positive and improving relationship with SWITC.

In addition to the 20 investigations, SWITC conducted 65 preinvestigations between February and September 2018. Preinvestigations may be done, according to SWITC policy:

For those allegations that seem impossible or implausible or when there is a client who we have identified as consistently mak[ing] false allegations.

For example, a client may accuse an all male staff of abuse so the client can interact with female staff. A preinvestigation requires that all witnesses be interviewed and video be reviewed. If evidence is found that makes the allegation seem plausible, then SWITC begins a full investigation.

SWITC does not notify adult or child protective services for allegations that prompt a preinvestigation, unless the preinvestigation becomes a full investigation. This process has the potential to lead to delayed notification of allegations that are eventually substantiated.

Recommendation

SWITC should work with adult and child protective services to ensure its policy and practices involving preinvestigations meet the requirements to report possible abuse and neglect to adult and child protective services.



Unlicensed caregivers with a history of abuse are not excluded from care giving employment in Idaho.

Idaho employers have two methods to exclude individuals with a history of abuse from working with vulnerable populations: background checks and professional licensing.

We reviewed the personnel files of one direct care staff hired in each of the past 12 months between September 2017 and August 2018. Because no direct care staff were hired in April 2018, we reviewed 11 files. We found that SWITC had completed a required background check for every file.

Unfortunately, background checks for unlicensed caregivers in Idaho do not effectively screen for individuals who have abused or neglected vulnerable adults. Although we did not learn of anyone with a prior history of abuse being hired at SWITC, the background check process is not likely to catch such applicants.

Background checks will disqualify individuals based on various criteria:

- Criminal history

- Inclusion on the sex offender registry

- Relevant records on the child abuse registry, nurse aide registry, or Medicaid exclusion registry

Professionals who must be licensed to work in their field, such as nurses, social workers, and physicians, are overseen by licensing boards. To have a license revoked, or to have a record included on the child abuse or nurse aide registry, a third party conducts an investigation and makes a finding based on a preponderance of evidence.

The only standard by which an unlicensed individual can be excluded from employment in Idaho for committing abuse or neglect of a vulnerable adult is if the abuse is proven beyond a reasonable doubt in a criminal conviction. This standard is higher than what is required to exclude other professionals from employment.

The role of adult protective services

Although adult protective services investigates allegations of abuse and neglect, these investigations are intended to protect a vulnerable adult from abuse or neglect and to get them access to services, not to substantiate whether a caregiver committed abuse or neglect. Until recently, adult protective services did not systematically record the name of the accused, only of the victim.

According to Idaho administrative rule 15.01.02.031.05, an adult protection worker substantiates a report of abuse or neglect “when, based on limited investigation and review, the [adult protection] worker perceives the report to be credible.” A substantiated report is referred to law enforcement for possible criminal investigation and prosecution. Except for criminal action, the current process for investigating accusations of abuse does not include a full investigation of the allegation or due process for the accused. Without a full investigation and due process, the department cannot issue a denial for a background check. Efforts to address this gap have been underway with workgroups involving the Department of Health and Welfare and the Commission on Aging.

Other states have addressed the gap in accountability of unlicensed caregivers for abuse and neglect by establishing registries dedicated to adult protection. These registries include third-party investigations and may make conclusion based on a preponderance of evidence. Options for these registries are included in appendix F.

Most staff working directly with clients at SWITC or working with individuals with intellectual disabilities in the community are not licensed. Therefore, these staff are unlikely to be excluded from employment even with a history of probable abuse.

Recommendation

The Legislature should explore steps to ensure that unlicensed caregivers who are accused of abuse or neglect of vulnerable adults are investigated to substantiate the accusation. The Legislature should also consider options to ensure that Idaho’s background check process can exclude perpetrators of abuse or neglect from employment as an unlicensed caregiver of vulnerable adults.



Management and leadership

4

In our 2016 report, *Child Welfare System*, we evaluated the organizational culture of Child and Family Services. Like SWITC, Child and Family Services is managed under the Division of Family and Community Services. The culture at Child and Family Services, we wrote, “is characterized by a conflicted sense of efficacy in the face of difficult demands and limited resources... each aspect of the culture is undercut by a need to address the constant feeling of crisis.”

We found that within Child and Family Services, short-term demands conflicted with the program’s long-term mission and vision. The program lacked consistency in its management, accountability, and approach to conducting business.

We see a similar dynamic at SWITC. The lack of a coherent system-wide vision and haphazard downsizing process have contributed to gaps in management and leadership, but not all gaps can be explained by these external forces. Although efforts at defining a long-term vision for Idaho’s system of crisis care will be important, SWITC as an organization must also address issues of management and leadership regardless of its long-term vision.



We found that many SWITC employees had a deep affection for clients, coworkers, and the organization.

SWITC has identified and made efforts to correct many of its systemic issues.

Since 2017 SWITC has been responding to many issues identified by external and internal stakeholders. We confirmed through observation, interviews, and data review that the following initiatives have occurred:

A nationally recognized expert in treating clients with co-occurring mental illness and intellectual disabilities was brought in to train clinical staff and consult with clinicians.

In response to survey concerns, two clinicians from the court and crisis team were reassigned to SWITC to address a backlog of assessments and program writing.

A program manager was hired from out-of-state to coordinate and improve treatment standards.

A 12–15 day new employee training was established and, partway through the year, client participation in the training was included.

Staff meetings, which had formerly been held separately for each building, were combined into a single meeting to improve staff relationships between buildings and to ensure that staff were qualified to work with all clients.

Periodic meetings were held with adult protective services, which has increased communication between the two entities.

Starting salaries for new nurses and direct care staff were increased by more than 10 percent.

The pay for most existing nurses and direct care staff were increased by 3 to 15 percent, depending on tenure.

A career ladder was developed for advanced direct care staff to receive training or certification as registered behavior technicians.

We found that many employees at SWITC had a deep affection for clients, coworkers, and the organization. We also found that many employees were aware of problems and many had energy and ideas for solving problems and improving SWITC.

SWITC exhibits symptoms of organizational trauma.

Organizations that undergo traumatic experiences can exhibit symptoms analogous to individual trauma. Organizational trauma reinforces itself by spreading attitudes and practices to new staff. Stress, anxiety, despair, and beliefs of helplessness and hopelessness become embedded in the organization. Addressing individual trauma in these circumstances is necessary, but it is not enough to solve organizational trauma.

Several events of the past two years have been traumatic at SWITC: the deaths of two clients, including last year's suicide; the death of a beloved head nurse; multiple failed surveys and surveys with findings of immediate jeopardy; and the discovery of ongoing abuse. We found that the aftermath of these events undermined staff morale, trust, and focus on long-term goals. The frequent media coverage of these problems has retraumatized staff and contributed to their feelings of isolation.

The past two years have been traumatic at SWITC.

Symptoms of organizational trauma



Closed boundaries between the organization and the external environment

Focus on insider relationships and a mistrust of outsiders

Loss of faith in organizational identity and purpose

Spreading of stress and anxiety

Depression expressed through fear or anger

Despair and loss of hope

Adapted from *Organizational Trauma and Healing* by Pat Vivian and Shana Hormann (CreateSpace, 2013).

Steps to address organizational trauma



Create processes for organization-wide dialogue and learning

Establish connection to organizational history

Strengthen core identity and building organizational esteem

Institute processes to address organizational culture—what aspects to retain, strengthen, and dismiss

Open the system to outside energy and information

Address individual trauma and implementing self-care initiatives

Adapted from *Organizational Trauma and Healing* by Pat Vivian and Shana Hormann (CreateSpace, 2013).

SWITC's approach to solving problems has serious flaws, some of which relate to organizational trauma.

Many staff have compassion for clients and ideas for improvement. They also have a widespread sense of defeatism. Some direct care staff described their role as babysitters or as punching bags. Some long-term staff said they felt that SWITC only received support from the department when SWITC received negative media attention. Most conveyed a sense that they were in a constant sense of crisis, moving from fire to fire.

Aspects of SWITC's organizational culture have undermined its operational effectiveness. These aspects are at the root of many problems and reduce the effectiveness of efforts for program improvement.

Most staff conveyed a sense that they were in a constant sense of crisis, moving from fire to fire.

SWITC's organization

Throughout this evaluation, we interviewed current and former department staff. Some have held multiple roles. We refer to staff in multiple categories:



Management refers to positions that report to the department's central office, positions that report directly to the administrative director, and client service managers, who supervise each building.

Clinical staff includes nurses, clinicians, and developmental specialists.

Supervisors are senior psychiatric technicians who directly supervise direct care staff.

Direct care staff are psychiatric technicians. Most of their time is spent interacting directly with clients.

Constant sense of crisis

Program improvement has largely been driven by crisis. Some improvements have been significant, but a crisis approach to problem solving has some drawbacks:

The urgency of situations prevents buy in from all stakeholders.

The focus on crisis discourages an analysis of problems using a systems perspective.

After the crisis ends, insufficient follow up reduces the long-term effectiveness of improvements.

Crisis is exhausting and creates bad habits. Staff's level of anxiety remains high, leading to burnout and emotional depletion. Short-term responses to crisis situations—foregoing breaks, not eating, shirking paperwork—become normal practices. Individuals promoted to fill gaps in leadership receive little training or preparation. Responsibilities outside of normal job duties are assumed when positions become vacant. These responsibilities become permanent without proper training or an assessment of workload.

Chronic nature of problems

Some of SWITC's biggest problems are long-standing and lead to a sense that dysfunction is normal or that the problem is inevitable or unsolvable.

Staff turnover has historically been very high. In our 2006 report *Management in the Department of Health and Welfare*, we reported that SWITC's turnover rate was the second highest of 25 programs in the Department of Health and Welfare.

In addition to high turnover, long-term staff reported a sense of mistrust between direct care staff and management. This mistrust, though it has waxed and waned, has reportedly existed for decades.

Mistrust and a lack of buy in

Although not universal, many direct care staff reported a rift between them and management or clinical staff. This rift is symbolized by the distance between White Hall and the residential buildings. Some reported being unwilling to provide

feedback. They believed that past feedback had caused them or others to be reprimanded. Some believed that direct care staff were scapegoated for the failings of managers or the organization. One staff member wrote, in an anonymous letter:

“ If you try to find something to fire a staff [for], we all do something wrong trying to make it through the day.

In interviews and observations, we found that direct care staff have the perception that changes in operations or in client treatment happen without their input or buy in. Even when SWITC made a change directly in response to a staff survey—moving many direct care staff to four ten-hour day workweeks—many staff felt that the change was imposed on them.

Direct care staff regularly expressed the desire for management and clinical staff to visit units more frequently. They would like to see management and clinical staff engage more meaningfully with direct care staff and clients. Some direct care staff reported being abandoned during a crisis and believed that management and clinical staff should take a more active role during crises.

Other staff focused on the need for better communication. When SWITC closed its pool and a building containing a full gym and several activity rooms, staff reported discovering the closure upon visiting the buildings with their clients.

Insufficient ownership and follow-through

In 2017 two clinicians from the Crisis Prevention and Court Services team helped SWITC complete overdue assessments and develop programs for client needs and behaviors. They were brought in to help after SWITC was found noncompliant in its assessment of treatment planning. Their effort brought SWITC back into compliance. However, many programs were abandoned because the clinicians did not stay involved with operations.

A similar lack of follow-through was reported by others who had worked with SWITC. Outside resources can be invaluable in helping program staff accomplish large initiatives. Program staff may have the resources to maintain these initiatives, but only if they continue to consult with outside resources. Outside resources can help program staff to adapt the initiatives to unforeseen challenges and to ensure fidelity. Without efforts to maintain long-term changes, including an assignment of ownership for follow-through and an assessment of progress, SWITC's investments in these outside resources may be wasted.

Direct care staff believed that past feedback had caused them or others to be reprimanded.

SWITC has had little opportunity to develop institutional knowledge for those in clinical or leadership roles.

Many in clinical or leadership roles described themselves as ‘winging it.’

Unclear responsibilities and inexperienced leadership

As discussed in chapter 2, about two-thirds of SWITC’s positions have been eliminated since 2011. Entire departments—including training and quality assurance—were eliminated or added to the responsibilities of individuals unprepared or untrained to carry out those responsibilities.

SWITC has had little opportunity to develop institutional knowledge for those in clinical or leadership roles. Prior incumbents, including the previous administrator, left in circumstances that were not conducive to the continuity of knowledge. Many now in these roles described themselves as ‘winging it,’ having received minimal training from peers or predecessors. At various levels of the organization, staff were unclear about who their direct supervisor was. Job descriptions were described as vague and dissimilar from actual job responsibilities.



Guardians and family

Most of our discussion focuses on staff buy in and engagement. Equally or more important is buy in and engagement from clients and their families or guardians.



We surveyed family members listed as primary contacts for clients at SWITC. Our survey was limited because most client contacts are a commitment custodian rather than a family member. Commitment custodians are members of the Crisis Prevention and Court Services team.

Family members were complimentary of SWITC's management and staff. Overall, they rated the care at SWITC an 8.9 out of 10.

Comments included a dissatisfaction with the residential units, feeling that the units were too clinical, and a dissatisfaction with clients being allowed to smoke.

The complete results of the survey are discussed in appendix C.

**Family members
rated the care at
SWITC an 8.9 out
of 10.**

Lack of measurement and systems perspective

As an intermediate care facility, SWITC must adhere to federal requirements to develop programs for each client. These programs usually aim to teach a skill that promotes the client's independence. The program has a specific goal, and data is collected to ensure that progress is being made and the goal is appropriate. A built-in review process encourages frequent reflection on the program.

This approach largely does not exist for organizational issues. For example, data is tracked for injuries and turnover, but it has not been centrally available and used for quality improvement.

The problems at SWITC relate to one another in many ways; some complex. The line between staff injury and training or retention can be clearly drawn. The connection between staff injury and activities or facility design, while real, is less apparent. Without an effort to measure the impact of various interventions, addressing problems in a systematic way is difficult.



Recommendation

The Department of Health and Welfare should develop a strategic plan and a formal quality improvement process at SWITC. The department should present the strategic plan to the Health and Welfare committees at the start of the 2020 legislative session.

The priorities for program improvement are discussed in the next chapter. The approach for addressing these priorities should involve every level of internal stakeholders. The department should develop and monitor formal measures, clearly assign responsibility, and ensure regular and periodic review and reflection. As necessary, third-party expertise from elsewhere in the department or from outside subject-matter experts should be consulted.

The Division of Family and Community Services has begun to implement a quality improvement process for child welfare, establishing a new Bureau of Operational Design. The division may wish to expand the scope of this bureau to include operations at SWITC. In our 2016 report *Child Welfare System*, we highlighted the continuous quality improvement framework for program accountability. It identifies, describes, and analyzes a program's strengths and problems. It then tests, implements, learns from, and revises solutions. It is proactive and promotes continuous learning. It is grounded in the overall mission, vision, and values of the program.

Another approach could be to develop a quality assurance and program improvement process, as required by the Centers for Medicare and Medicaid for skilled nursing facilities. Colorado, for example, requires its state-operated crisis facilities to follow these requirements.

Efforts to improve SWITC as an organization should not be subsumed under efforts to develop a long-term vision for crisis care in Idaho. Although these efforts should be coordinated, organizational changes do not need to wait for the long-term vision.

Priorities

5

The previous chapter discussed the approach SWITC needs to take to improve programs, which includes a strategic plan and formal quality improvement system. This chapter identifies areas of highest priority for SWITC to address in its strategic plan and quality improvement system. It also includes a recommendation for consideration by the Legislature to address staff recruitment, retention, and morale by offering early retirement for SWITC direct care staff in recognition of the demanding, high-risk nature of their work.

We discuss the priorities separately, but they cannot be addressed separately. SWITC must take a systems approach to solving its problems. Staff trauma and safety, hiring and retention, initial and ongoing training, communication and coordination of treatment planning, and a successful discharge process all affect one another.

Over the course of this evaluation, we discussed many of our concerns with management at SWITC to ensure that we had reviewed all available information. When we made SWITC management aware of our findings, we found them in agreement and open to feedback. In many cases, management has already started implementing corrective action to address our concerns. However, the problems discussed in this chapter have not yet been resolved.



Staff trauma and injury are significant and affect retention, treatment standards, and morale.

In the first half of 2018, staff spent almost 10 percent of their workdays out on injury. For the afternoon shift in one of the two buildings, that rate was almost 20 percent. Rates of injury and other leave are shown in exhibit 4. SWITC employees filed 66 workers compensation claims for intentional injuries by another person between July 2017 and March 2018.

Staff reported that they are spit on daily and assaulted weekly. They are verbally assaulted: they are frequently threatened, cursed at, subject to racial or homophobic epithets; one pregnant staff member received threats to kill her unborn child. Staff have received serious head injuries, wounds from human bites that would not heal, and chronic issues from years of assault. Staff have been sexually assaulted and subjected to attempted rape.

They reported that the worker's compensation process was smooth, and they received adequate treatment for immediate physical injury. However, the same was not true for psychological damage. In addition, staff reported chronic physical problems resulting from years or decades of injury and compassion fatigue resulting from unaddressed psychological trauma.

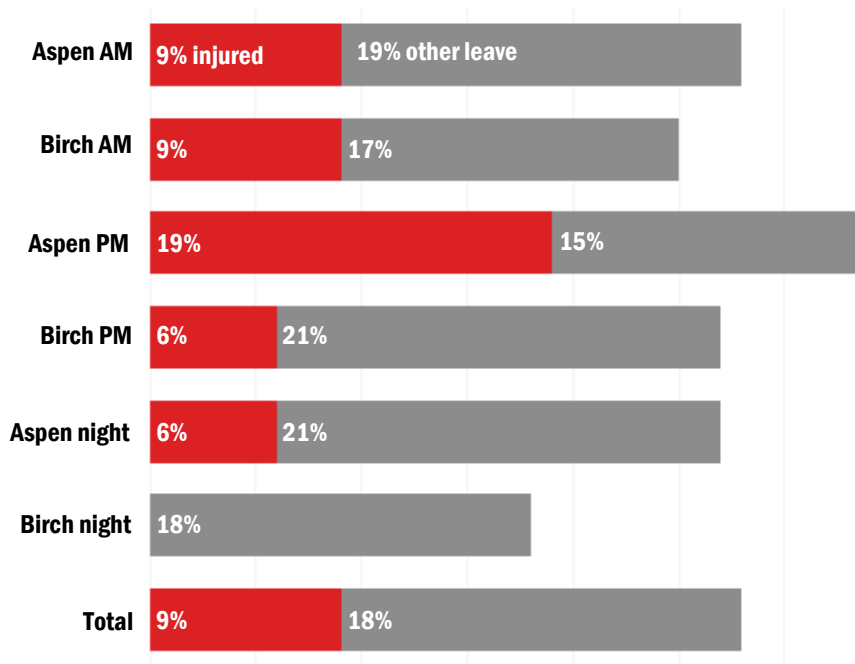
Staff reported calling on radios for help with client behavior and not receiving backup or being alone when clients acted out. They worried for their safety and they worried for their job. The only approved physical restraints in emergency situations require two people. One staff member wrote in his resignation letter:

“ Staff have been placed in a spot where we feel it is a lose/lose situation...staff feel [that] if I do something wrong, I will get fired for abuse, if I do not do something, I will get fired for neglect. If I stand in the way, I will get hurt and run out of [sick leave] and lose my job.

In multiple instances in 2018, long-term staff who were highly respected by other staff, well-liked by clients, and praised for their empathy, ‘snapped’ and resigned after substantiated findings of abuse or mistreatment. Two of these staff had received awards for “devoted service to the handicapped” from the Idaho State School and Hospital’s parent and guardian association in the 1990s.

Exhibit 4

Direct care staff spent almost one day in ten out on injury over the first half of 2018.



Source: Analysis of SWITC's as-worked schedules for psychiatric technicians and senior psychiatric technicians, January–June 2018. Other leave includes sick leave, vacation, training, administrative leave, and other infrequent types of leave.

Research indicates that when direct care staff are stressed or feel disempowered, clients are at a greater risk of being abused. In addition, clients respond to staff stress in ways counterproductive to their treatment. Rather than treatment allowing clients to better regulate their emotions and behavior, stressed or traumatized staff undermine clients' emotional regulation.

Addressing staff safety and mental health is essential to ensure the well-being of both staff and clients. The training for new employees has recently integrated staff stress management and self-care, but these skills must become ingrained in SWITC's operations and culture.

To address staff injury and trauma, SWITC's operational changes may include formally tracking staff calls for help and the ability of staff to respond, ensuring more resources are available at times when injury rates are typically high, and developing protocols for nondirect care staff to assist in crisis situations.

Stressed or traumatized staff can undermine clients' emotional regulation, a dynamic called co-dysregulation.

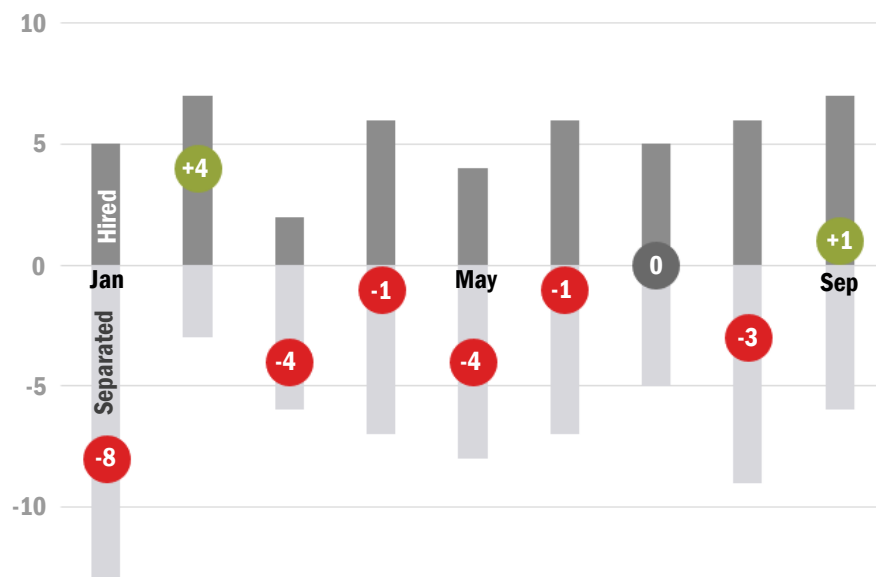
SWITC lost 64 employees and hired 48 in the first nine months of 2018.

Hiring has not kept up with turnover.

More employees left SWITC than were hired six out of the nine months between January and September 2018. As shown in exhibit 5, during that time, SWITC lost 64 employees and hired 48. Staff trauma and injury exacerbates employment terminations: nine direct care staff either resigned after a work injury or were laid off for medical reasons. Others resigned for fear of injury or fear of working with clients who had histories of violence. As of September 1, 2018, 28 of 92 direct care staff positions were vacant.

Exhibit 5

SWITC lost more employees than it hired in six of the first nine months of 2018.

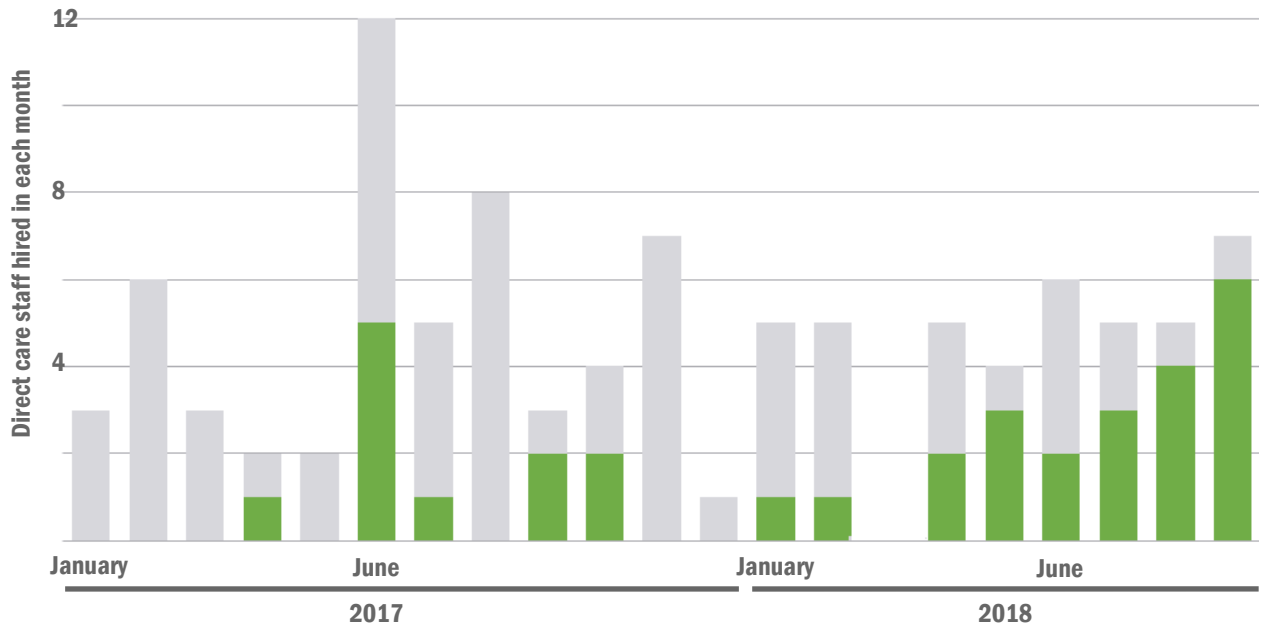


Source: Office of the State Controller, Idaho Business Intelligence System (IBIS).

The turnover of direct care staff has been magnified by an inability to retain new hires. As shown in exhibit 6, of 56 direct care staff hired in 2017, only 11 were still employed in September 2018. The problem persisted in the first half of 2018: a similar proportion of new hires left within 90 days as compared with 2017.

Exhibit 6

By September 2018, few direct care staff hired in 2017 and early 2018 were **still employed by SWITC.**



Source: Office of the State Controller, Idaho Business Intelligence System (IBIS). Employees hired as direct care staff who are still employed, but not in direct care, are considered still employed.

SWITC has made efforts to improve recruitment and retention. As discussed in the previous chapter, it introduced pay increases for new and existing staff in October 2018. This and other interventions may improve retention, but it is too early to measure effectiveness.

Findings from research

High turnover among direct care staff is a common issue in the long-term care industry and has been the topic of research. This research found that several practices can attract and retain quality direct care staff:

An article in *The Gerontologist* discussed how workers across long-term care settings were calling for “better work relationships including communication; supervision; and being appreciated, listened to, and treated with respect.”

Adequate staffing prevents burnout and turnover and allows for a workload that makes time for training and empowerment. Inadequate staffing exacerbates turnover, creating a cycle that is difficult to overcome.

Realistic job previews ensure that potential hires know what the job entails. By understanding job duties, applicants can make informed decisions about whether to accept the job.

Opportunities for advancement and competitive compensation and benefits should be highlighted when recruiting.

An organizational culture that encourages direct care staff to participate in operations improves buy in and retention. Further, direct care staff are invaluable sources of information on what can benefit clients.

Strong training, engaged supervision, and peer mentoring have been shown to improve outcomes and increase retention.

In addition, research suggests that understaffing contributes to unreported abuse or neglect. Those who report abuse or neglect may have to cover the shift of someone placed on administrative leave during an investigation.

SWITC's approach to treatment is reactive rather than proactive.

In the previous chapter, we discussed how SWITC's approach to program improvement was driven by crisis, reactive rather than proactive. We found the same pattern in client treatment and activities, for many of the same reasons. In addition, staff stress and turnover contribute to a pattern of only addressing crises; a pattern that ultimately creates more staff stress and turnover.

We found the reactive approach to client treatment in the following ways:

A lack of activities leaves clients without daily structure. Staff reported that clients often do not have anything to do. On a designated day of shopping, clients might wake up on time, shower, and brush their teeth. However, on days without a planned activity, clients were unmotivated. Direct care staff described their only option to encourage structure was to badger the clients, which many staff were not inclined to do.

Staff described situations where a client would ask to do an activity, such as go on a walk or ride their bike around campus. Because there were not enough staff to supervise, staff would inform the client that they could not do the activity. Staff believe that client boredom and agitation contributes to client assaults.

A lack of tools reinforces the lack of activities. As discussed in chapter 2, when SWITC downsized, specialized positions were eliminated and replaced with insufficient alternatives. The same is true for physical resources, such as the two buildings containing a pool and another containing a full gym, a therapeutic room for sensory input, and activity rooms. Some staff reported using these buildings frequently before their closures, though others reported that these buildings were never used. Staff reported bringing their own sporting equipment—basketballs or soccer balls—for client activities, as SWITC's was often damaged or not of high quality.

A lack of tools and activities reduces opportunities for positive reinforcement. Good client behavior and progress with skills is supposed to be reinforced with things clients enjoy, such as outings, special foods, or activities. Federal rules for intermediate care facilities prohibit the use of punishment to decrease negative behaviors. Staff reported feeling unable to

Staff believe that client boredom and agitation contributes to client assaults.

provide clients any consequences: they lacked the time or resources to reward someone making real progress, and they lacked the authority to punish someone for violent behavior. Staff reported feeling helpless to encourage clients to learn or take care of themselves.

Over the past year, SWITC has increasingly relied on client restrictions in response to bad behavior, the most common being a 24-hour restriction from outings. These restrictions were developed to protect client and community safety, rather than to punish.

However, some clinical and direct care staff reported believing that these restrictions were intended to take something that clients valued away. Surveyors in October 2018 cautioned SWITC about the use of restrictions but did not issue any citations related to those restrictions.

SWITC's efforts for program improvement should include initiatives to make treatment more proactive. A proactive approach would assess tools needed for active treatment with input from direct care staff. The approach should include plans to train and hold staff accountable for using the tools and to reward staff for finding ways to be proactive.

Gaps in training for direct care staff persist despite recent improvements.

Before 2018 direct care staff received training as they worked the floor. But this on-the-job training had uneven efforts and results. In early 2018 SWITC implemented a 12–15 day training program, depending on experience, for newly hired direct care staff. Staff are to complete the training before they work with clients. The training includes a review of important policies and procedures; lectures on mental illness, intellectual disability, and applied behavior analysis; behavior management training; hands-on nonviolent crisis intervention; reviews of client programs and histories; and on-the-floor observation and training. Recently the training has directly involved clients. The training incorporates a section on staff trauma and self-care, as well as a review of client trauma histories.

Staff said they believed that the new employee training is an improvement over the old model. They reported that new staff are better prepared and have a better understanding of the job than those hired before the new training.

Direct care staff must also receive ongoing training as they work with new clients and as new programs are introduced. Ongoing training primarily happens in staff meetings where clinicians or program writers discuss changes to client programs. Updates to policies and procedures or client programs are primarily communicated in lecture or in writing.

The new training and the ongoing trainings do not assess retention of knowledge. Direct care staff reported situations where two staff interpreted programs differently, leading to inconsistent treatment. They also reported large gaps in knowledge for new hires despite a topic being addressed in the new hire training.

New training and ongoing trainings do not match the format preferred by staff. We received feedback from new hires and existing staff for more on-the-job shadowing, a greater focus on getting to know clients, and more hands-on training from lead staff and clinical staff. Staff also believed that there was a greater opportunity to integrate video into initial and ongoing training, particularly for crisis management.

Staff reported that new staff are better prepared and have a better understanding of the job than those hired before the new training.

Direct care staff reported situations where two staff interpreted programs differently, leading to inconsistent treatment.

Supervisors' lack of training is exacerbated by chronic understaffing.

Clinical staff and direct care supervisors do not receive adequate training, leading to gaps in accountability.

Supervisors have each been promoted from among direct care staff. Usually two supervisors in each building for each shift direct and monitor the work of direct care staff. Supervisors also coach and train. They are assigned to work with clients in the most difficult situations. Beyond a training for all managers within the department, supervisors have not received adequate training for their duties.

Just 38 percent of supervisors of direct care staff reported in a department-wide survey that they had received the training needed to do their job well. The same low percentage reported that their supervisor takes the time to coach and mentor them—compared with 81 percent of nonsupervisor direct care staff.

Supervisors' lack of training is exacerbated by chronic understaffing, where supervisors are often required to work as direct care staff. Though experienced supervisors maybe able to coach and hold accountable their staff while working with them, supervisors had neither the training nor experience to do so effectively.



The result is a systematic lack of accountability throughout the organization. In the training program, this lack of accountability is evidenced by not requiring staff to demonstrate a mastery of the material before training concludes. In addition, staff reported that many direct care staff do not record data or do not follow programs. One staff recounted being seriously injured for attempting to direct clients to use the client phone instead of the staff phone. When returning from injury, the staff member found that other staff were routinely letting clients use the staff phone. Clinical staff and other nonsupervisory staff reported having to hold direct care staff accountable despite a lack of supervisory authority.

Clinical staff also reported that the treatment team was not well coordinated. Full-time staff reported that the part-time psychiatrist, pharmacist, and physician were not well integrated into the treatment team. They believed that community providers were even more poorly integrated. Disagreements within the treatment team—from differences in treatment philosophy to concerns about specific reinforcements—were often unresolved.

Clinical staff reported that the treatment team was not well coordinated.

The Crisis Prevention and Court Services program for individuals with intellectual disabilities is SWITC's front and back door.

Clients with both mental illness and intellectual disabilities receive fractured care and may not be at the place that can best treat them.

Coordination is weak for discharge and behavioral health treatment.

Two programs within the Department of Health and Welfare may play a significant role in a client's care at SWITC. The Crisis Prevention and Court Services program for individuals with intellectual disabilities is SWITC's front and back door. The program must approve client admissions into SWITC. When the courts commit a client to the custody of the Department of Health and Welfare, a representative of the program oversees the client's commitment. Discharge from SWITC is also a joint effort between SWITC and the Crisis Prevention and Court Services program.

The Division of Behavioral Health operates Idaho's two state-operated psychiatric hospitals, State Hospital North and State Hospital South. These hospitals care for individuals in psychiatric crisis. Some clients served at SWITC have been to the state hospitals or vice versa. The state hospitals may use restrictive interventions in these circumstances, such as forcibly administering medication. SWITC may only use restrictive interventions after exhausting all lesser ones.

Psychiatric care

The clients served at SWITC have needs related to their intellectual disability and mental illness. The Division of Behavioral Health manages the state's psychiatric hospitals and department staff who specialize in mental illness.

The state psychiatric hospitals serve individuals, including those with an intellectual disability, who are unable to be in the community because of their mental illness. Staff at SWITC reported that it was not always straightforward to discern between mental illness and intellectual disability as the cause of behaviors leading to institutionalization. These staff felt that they were being asked to treat mental illness without the tools to do so.

There is a lack of coordination between those responsible for serving clients with mental illness and those responsible for serving clients with an intellectual disability. As a result, clients with both needs receive fractured care and may not be at the place that can best treat them.

Discharge

One staff member described admission to SWITC as branding a client with a scarlet letter. Once SWITC admitted someone, many community providers were reluctant to consider that individual for admission.

This problem was familiar to SWITC's counterparts in other states. To overcome this stigma, states practice two strategies:

- Develop discharge criteria based on the needs that were unable to be met in the community and focus treatment on those needs.

- Be a resource for the client and community provider during and after discharge.

Colorado, for example, formally documents the reason a client cannot be served in the community. It develops and frequently reviews goals specific to the client's needs alongside the person-centered plan required by federal regulations. The reason a client cannot be served in the community is unique, and the client's resources in the community—family, friends, and other providers—are also unique. An explicit focus on these would help ensure treatment is able to return someone to the community as quickly and effectively as possible.

SWITC should also formally develop postdischarge plans of care. Other states reported sending staff trusted by the client to the client's new home. Oregon, for example, offers staff 24 hours a day for three to five days during transition. In California, staff from developmental centers visit clients in formal, predefined intervals (5 days, 30 days, 90 days, 6 months, and 1 year).

Postdischarge plans of care should include an assessment of SWITC's role in client care once the client has moved to the community. SWITC could be available for short-term crises, medication management, or consultation for the new provider. SWITC should also ensure that if it makes a commitment to a community provider, the commitment is prioritized. Failing to be available for crisis care makes community providers more reluctant to accept individuals discharged from SWITC.



Recommendation

The Legislature should consider supporting SWITC's efforts to improve staff recruitment and retention, and thereby improve overall operations, by extending early retirement to staff with a high risk of injury working in facilities at the Department of Health and Welfare. Other states, such as Oregon, recognize the demanding nature of working with high-risk clients and include staff who work in stabilization and crisis units on their early retirement plan.

Categories of retirement

Idaho Code has two categories of membership in the state's retirement system:



General members may retire with a full benefit at age 65 or if their age plus years of service equals 90. The minimum retirement age is 55.

Peace officers, probation and parole officers, firefighters, and many employees of the Department of Correction may retire with a full benefit at age 60 or if their age plus years of service equals 80. The minimum retirement age is 50.

To offset shorter careers, both employer and employee contribute more for peace officer retirement. The employee covers 82 percent of the higher contribution rate. For 2018, general members contributed 6.79 percent of their pay and the employer 11.32 percent. For peace officers, the rates were 8.36 percent and 11.66 percent.

Request for evaluation



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SENATOR CHERIE BUCKNER-WEBB

Assistant Minority Leader

March 12, 2018

Joint Legislative Oversight Committee
Attn: Co-chair Senator Cliff Bayer
Attn: Co-chair Representative Mat Erpelding

Dear Senator Bayer and Representative Erpelding,

The Southwest Idaho Treatment Center (SWITC) has been featured in a series of news media pieces featuring complaints of abuse and neglect of residents. In July 2017, SWITC's license was suspended for being out of compliance in the areas of governance and management, client protections, facility staffing, active treatment services, and client behavior-related facility practices. In September 2017, a subsequent review found SWITC out of compliance with minimum standards in all of these same areas. Although the license was restored in October 2017, complaints of serious problems in these areas persist.

During the period that verified client abuse was occurring, the Department of Health and Welfare sought and obtained statutory authority to create a new facility (the Developmental Disability Secure Facility), for some of the same residents, which would *not need* to meet the federal standards for client protection and active treatment. The new facility would be housed on SWITC grounds and administered and staffed by the same people. As Idaho starts this new facility, funded by state general fund dollars without the federal Medicaid match, we would be well served to have a complete understanding of the serious problems and compliance failures at SWITC as well as whether improved management, staffing, and training could resolve these issues.

We request the following questions be specifically addressed by the Office of Performance Evaluations:

1. What roles do the Developmental Disability Council and Department of Health and Welfare have over SWITC?
2. What governance and accountability models are already in place?
3. Is there a conflict of interest presented by Licensing & Certification overseeing SWITC?
4. In addition to meeting minimum federal and state licensing standards, do SWITC practices align with best treatment standards? We're specifically interested in:
 - a. Staffing ratios and qualifications being sufficient for the population
 - b. Management practices for supervising and overseeing direct care staff
 - c. Training to address medication management
 - d. Training and oversight regarding individual treatment plans

March 12, 2018

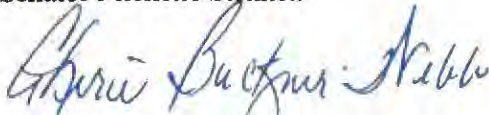
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- e. The notice and inclusion of guardians in treatment planning following an incident
- f. Collection of trauma history to implement trauma-informed treatment
- g. Training and oversight of trauma-informed care

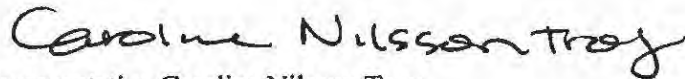
Sincerely,



Senator Michelle Stennett



Senator Cherie Buckner-Webb



Representative Caroline Nilsson Troy



Evaluation scope

External oversight. We will describe governance and accountability external to the Southwest Idaho Treatment Center and evaluate the following:

Mechanisms that ensure the independence of the Division of Licensing and Certification to survey a facility managed by the same department

Certification or licensing options that may be appropriate for the center's new mission

Information available to potential employers about abuse or neglect by direct care staff

Internal management and operations. We will evaluate whether practices align with best treatment standards. We will identify causes of any deviations and strategies for improvement in areas such as:

Management practices and staff oversight

Staff mix, qualifications, workload, and training

Development, supervision, and implementation of individual treatment plans

We will consult treatment standards developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association for Persons with Developmental Disabilities and Mental Health Needs (NADD).

Methods



We were asked to evaluate the operations and management of the Southwest Idaho Treatment Center and some aspects of Idaho's oversight process. The letter requesting this evaluation specifically asked about governance and accountability models, whether the Division of Licensing and Certification has a conflict of interest in evaluating SWITC, and whether SWITC's practices align with best treatment standards.

The letter specified seven practices: staffing ratios and qualifications, management practices for direct care staff, training for medication management, training and oversight of individual treatment plans, notice and inclusion of guardians after an incident, the collection and incorporation of trauma histories, and training and oversight of trauma-informed care.

Scoping

As part of our scoping process for the evaluation, we conducted background research, held introductory interviews with management at the Department of Health and Welfare, toured SWITC, and held several meetings with advocacy groups.

Early fieldwork and discussions with stakeholders and study requesters led us to focus on system-wide issues. At the heart of stakeholders' concerns was the worry that Idaho could not ensure that clients at SWITC were safe and receiving adequate treatment. In addition, advocacy groups expressed concerns about the treatment philosophy of the department and of SWITC, with the secure treatment facility representing a move away from contemporary treatment practices and toward institutionalization.

Evaluation of oversight

We set out to address specific aspects of oversight:

Mechanisms to ensure the independence of the Division of Licensing and Certification

Certification or licensing options more appropriate for SWITC's new mission and population

Information available to potential employers about abuse or neglect by direct care staff

To address the independence of Licensing and Certification, we did the following:

Interviewed leadership of the Bureau of Facilities Standards and of the survey team responsible for surveying SWITC

Interviewed personnel working in California, Colorado, Kentucky, and Oregon about any practices to preserve the independence of the survey process

Reviewed documents from the Government Accountability Office about the independence of audit functions, generally, and of state survey agencies, specifically

Reviewed organizational charts from each state with a state-operated intermediate care facility

Compared survey citation rates at SWITC with those of other Idaho intermediate care facilities

We developed criteria by which to evaluate the independence of the Division of Licensing using the Government Auditing Standards, 2018 Revision. Standards for independence are found in chapter 3 of that document, available online at <https://www.gao.gov/products/GAO-18-568G>.

Alternative licensure and caregiver misconduct registries are discussed in appendixes D and F.

Evaluation of SWITC operations

To understand the background and context of SWITC's operations, we did the following:

Interviewed former staff.

Reviewed documents from the department, including a master plan for the use of the SWITC campus from 2013, a conceptual study of the future of SWITC from 2016, and current and previous strategic plans.

Reviewed minutes from regular and interim committees from 2009 to 2011 to understand changes in SWITC's mission, and minutes from 2017 regarding the secure treatment facility.

Reviewed literature from academic, state, and federal government sources about trends in state-operated intermediate care facilities.

Reviewed other relevant documents, including newspaper articles, federal regulations, interview notes from previous evaluations, and surveys done by Idaho's Bureau of Facilities Standards.

SWITC provided the evaluation team lead with an on-site office in White Hall. The team lead was on site at least one or two days a week for most weeks during fieldwork. While on site, we conducted unscheduled observations of the residential units and had discussions with staff and clients. In addition to these unscheduled activities, we used the following methods to evaluate SWITC's operations and management:

Interviewed direct care staff, supervisors, management, clinical staff, and other employees.

Attended relevant portions of the new-employee training, including nonviolent crisis intervention, applied behavior analysis, and discussions on policies on abuse and neglect. We gave copies of certain trainings to a member of an advocacy group for their feedback.

Interviewed relevant contacts in other states about their systems for managing crises for individuals with intellectual disabilities.

Reviewed trainings and policy and procedure documents provided by state-operated programs in other states, primarily California, Colorado, and Oregon.

Interviewed and corresponded with nationally recognized subject-matter expert Dr. Julie Brown on treating individuals with both mental illness and intellectual disability.

Obtained access to and reviewed documentation on SWITC's network drives, including those specific to client treatment records and medical records and to investigations.

Surveyed and interviewed parents and guardians of current SWITC clients.

Interviewed representatives of the Commission on Aging, Area on Aging III, the Medicaid Fraud Control Unit, and the Division of Licensing and Certification.

Reviewed documentation on staffing, including schedules, hiring and separation records, and exit interviews for the past two fiscal years.

Reviewed internal department correspondence from various sources.

Obtained 24-hour video for each of more than 60 cameras in SWITC's residential units and strategically reviewed.

Overall, we conducted almost 50 formal interviews and informally spoke with dozens of staff and clients.

Survey of parents and guardians

We requested the names and contact information for parents or guardians of each client at SWITC on September 7, 2018. We received the names of 24 individuals representing 17 clients. We excluded 8 individuals from the Crisis Prevention and Court Services program, representing individuals committed to the state, from our survey. One individual had no email address, and two individuals—parents of a client—shared a single email address. Overall, we included 15 individuals at 14 unique email addresses in our survey. These individuals represented 9 clients. We received 9 responses, for a 64 percent response rate.

We divided the questions on the survey into the following four topics.

Communication

The following questions address family members' assessment of SWITC's communication.

In the past six months, if you asked for information about your family member, did you receive a quick response?

Always	Usually	Sometimes	Never
37.5%	62.5%	0%	0%

In the past six months, if you asked for information about your family member, did you get the information you requested?

Always	Usually	Sometimes	Never
87.5%	12.5%	0%	0%

When you interact with any member of the administration, are you treated with respect?

Always	Usually	Sometimes	Never
100%	0%	0%	0%

When you interact with direct care staff, are you treated with respect?

Always	Usually	Sometimes	Never
100%	0%	0%	0%

What, if anything, can SWITC do to improve their communication with you?

We received one comment suggesting improvement:



Always keep us informed of what is going on. We like knowing right away, night or day.

Handling concerns

The following questions assess family members' perception of SWITC's responsiveness to concerns and whether family members have any reluctance to raise concerns out of fear of retaliation.

In the past six months, have you had issues or concerns with the care your family member received at SWITC?

Yes	No
25%	75%

In the past six months, did you discuss any issues or concerns with someone at SWITC?

Yes	No
100%	0%

In the past six months, were you satisfied with the way SWITC handled issues or concerns that you brought to their attention?

Always	Usually	Sometimes	Never
62.5%	37.5%	0%	0%

In the past six months, did you ever stop yourself from talking to someone at SWITC about your concerns because you thought they might take it out on your family member?

Yes	No
0%	100%

What, if anything, can SWITC do to improve their responsiveness to your concerns?

Respondents did not have any suggestions; four responses reiterated satisfaction with SWITC's responsiveness to concerns.

Involvement in care planning

The following questions assess whether family members are given the opportunity to participate in the care of the individual at SWITC.

Did you participate in your family member's person-centered plan meeting this year?

Yes	No
100%	0%

What, if anything, can SWITC do to improve the effectiveness of that meeting?

One respondent conveyed that SWITC communicate correct scheduling information to family members.

Two commented that they wished SWITC would establish more realistic and achievable goals.

One desired better follow through with family members about when changes are going to start, or if they are going to start immediately.

One wanted to ensure the client wasn't bored during the meeting.

How often are you involved, as much as you want to be, in care decisions?

Always	Usually	Sometimes	Never
87.5%	12.5%	0%	0%

Do you receive adequate notice if your family member is involved in an incident, to the extent that you want to be?

Always	Usually	Sometimes	Never
62.5%	37.5%	0%	0%

Are you encouraged to take part in any care planning following an incident?

Always	Usually	Sometimes	Never
14.3%	71.4%	14.3%	0%

What, if anything, can SWITC do to involve you more in the care of your family member?

One respondent indicated that they would like to be notified of incidents sooner.

One respondent was satisfied with SWITC's efforts to involve them but was unhappy with the unavailability of services at SWITC's level of care anywhere but in Nampa.

Overall care

Using any number from 1 to 10, where 10 is the best care possible and 1 is the worst care possible, what number would you use to rate the care at SWITC?

Average: 8.9

What, if anything, can SWITC do to improve the quality of care for your family member?

One respondent commented that their rating of '7' reflected the facility, not the staff.

“ I wish it looked less clinical and a little more like a home.

One respondent was unhappy with SWITC's inability to keep clients from smoking.

All five respondents to the question indicated appreciation for SWITC.

Other state models



As discussed in chapter 1, the nationwide trend has been to focus on providing services to individuals with intellectual disabilities in the community, rather than in institutions. This trend of deinstitutionalization has led to significant declines in the number of individuals in state-operated facilities and to closure of many of those facilities.

Many institutions have closed in states surrounding Idaho. According to the Institute on Community Integration at the University of Minnesota, Montana closed one of its state-operated intermediate care facilities and plans to close its last one; Nevada has closed one of its two; Oregon had closed all three by 2009; and Washington has closed two of its six institutions. Utah and Wyoming, like Idaho, have only one institution that is still in operation.

Although many individuals are successfully served in the community, states continue to operate systems of care that act as providers of last resort, or to serve those who have needs that cannot be met in the community because of behavioral or medical issues. In addition, some states have chosen to discharge all residents whose needs can be met in the community. Other states have allowed individuals who have spent much of their life at the state institution to choose whether to stay.

Residential models

As discussed in chapter 2, SWITC's operations suffer from serving less than two dozen clients in facilities and an operational model designed to serve hundreds. While some states continue to operate large institutions, other states have developed alternative models.

Regional centers

One way states manage the need for large fixed costs in an institution meant to serve individuals with a variety of complicated needs is by managing institutions as part of a regional center meant to serve both residents and nonresidents.

For example, the Desert Regional Center in Nevada is home to about 40 clients. The center provides or coordinates services for anyone with an intellectual disability. In addition to a state-operated intermediate care facility, the center provides assessments and counseling. It coordinates service, respite care, vocational training, in-home habilitation, and supported living services in small-home intermediate care facilities or home- and community-based settings.

Colorado has three regional centers. Each regional center includes residential settings—both intermediate care facilities and Medicaid waiver facilities.

The regional center model allows for the state to employ specialists to serve clients at state-operated facilities while also serving individuals who do not reside at the facility.

Small homes

States have also established chains of small homes, either in addition to or as a replacement for large institutions. Small homes create a more community-like setting while allowing the state to have homes specialized for individuals with similar needs. As clients learn new skills, they could move to homes with a smaller staff-to-client ratio and housemates at a similar stage of learning.

These homes are designed to be like those operated by private community providers. The similarity makes transition out of the state system easier.

Small homes may also be certified as intermediate care facilities or licensed as group waiver homes; both are eligible for Medicaid funding. Of Idaho's neighbors, Colorado, Montana, Oregon, and Washington have state-operated group waiver homes, and Colorado and Nevada have group homes certified as intermediate care facilities. Both group waiver homes and intermediate care facilities feature the same ability to impose restrictions based on the needs of the individual.

Licensure options

SWITC has two different licenses: a license to be an intermediate care facility for individuals with intellectual disabilities and a license to be a secure treatment facility. An intermediate care facility must adhere to federal certification requirements to receive federal Medicaid matching funds. The secure treatment facility, funded entirely by state funds, must adhere to state rules.

A third option is to be a state-licensed facility that is eligible to receive Medicaid matching funds. Medicaid pays for services one of two ways: through the state plan or through a Medicaid waiver. The state plan, with some flexibility, must adhere to federal requirements and is limited in the types of services that are reimbursable. A Medicaid waiver allows the state flexibility to provide services within broad federal guidelines. Idaho has multiple Medicaid waivers and receives the same federal match rate, about 71 percent, for both types of expenses.

States provide residential treatment to individuals with intellectual disabilities under both state plan and Medicaid waiver services.

Facilities in other states that receive funding through a Medicaid state plan must adhere to federal certification requirements as either a skilled nursing facility—a nursing home—or an intermediate care facility. Though SWITC at one time had a unit certified as a skilled nursing facility, these requirements are more appropriate for the medically fragile and are not a reasonable option for SWITC's mission.

Intermediate care facility

Certification as an intermediate care facility is an option for both large institutions and small homes located in the community. The facility coordinates all aspects of an individual's treatment. The requirements are highly structured and focus on training skills for activities of daily living such as eating, money management, and personal hygiene. Certification requires a focus on providing active treatment. Active treatment, according to federal regulation, refers to "aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services." Active treatment is focused on developmental deficits that prevent an individual from living in a more independent setting.

Stakeholders, including those at SWITC, expressed concern that certification as an intermediate care facility was inappropriate for SWITC’s mission and population. Among states that operate intermediate care facilities, none had expressed similar concerns. Colorado reported that it had a conflict with its survey agency regarding what constituted active treatment for high-functioning individuals with behavioral issues. However, it reported that the issue was resolved amicably.

Group waiver homes

Individuals may receive Medicaid funded services in state-licensed residential care settings. In Idaho, individuals on the developmental disability waiver may receive services in a certified family home: a home with, most commonly, one or two residents cared for by the homeowner. Commonly, this arrangement involves family taking care of family. For the aged and disabled waiver, individuals may receive services in certified family homes or in assisted living facilities.

State-operated waiver homes, like state-operated intermediate care facilities, may be reimbursed by Medicaid based on the cost of services provided.

Idaho does not have a licensure type appropriate for individuals who receive care at SWITC. The Department of Health and Welfare has been exploring opportunities for alternative facility types to serve those who need care at SWITC.

Colorado, Montana, Oregon, and Washington have state-operated group waiver homes for individuals with complex needs. Colorado reported that group waiver homes did not allow as much consistency of treatment as do intermediate care facilities. Part of federal requirements for group waiver homes is that individuals select their own providers, whereas intermediate care facilities can employ the necessary specialists.

Advisory board bylaws



Southwest Idaho Treatment Center Advisory Board Bylaws

I. Southwest Idaho Treatment Center

For the purpose of these bylaws, the Southwest Idaho Treatment Center (“SWITC”) and the term facility refers to both the Intermediate Care Facility for Individuals with Developmental and Intellectual Disabilities (ICF-IID) and the Secure Facility located on the Nampa Campus of the Southwest Idaho Treatment Center.

II. Membership

- A. The Southwest Idaho Treatment Center Advisory Board shall be comprised of no less than seven (7) and no more than fifteen (15) voting members appointed by the Director of the Idaho Department of Health and Welfare.
- B. Membership may include:
 - 1. Two members of the Idaho Legislature.
 - 2. One representative from the Governor’s office.
 - 3. One member who is a parent or guardian of an individual currently or formerly residing at SWITC.
 - 4. One member representing the Third or Fourth Judicial District to be selected from names provided by the Idaho Supreme Court.
 - 5. One member from the Developmental Disabilities Council.
 - 6. One member from law enforcement to be selected from a list of names submitted by the Nampa Police Department, Canyon County Sheriff’s Office, and/or the Idaho Sheriff’s Association.
 - 7. One member from the Idaho Department of Corrections or the Idaho Department of Juvenile Corrections.
 - 8. The remaining members will be selected from organizations serving persons with a developmental disability.
- C. Board membership shall be for a term of two years and shall not be limited. Terms shall be staggered so that some members shall be appointed in alternate years.
- D. Vacancies shall be filled by appointment by the Director of the Department of Health and.

Southwest Idaho Treatment Center

Advisory Board Bylaws

- E. Members unable to attend meetings shall notify the Chairperson of the Board or the Administrative Director prior to the meeting. Three successive absences without good cause shall be deemed a default termination of membership.
- F. Board membership shall not include anyone with a financial conflict of interest, such as a supplier of goods or services to the Facility. Employees of SWITC and relatives of employees of SWITC cannot serve as Board members with the exception of the Administrative Director of SWITC who will serve as a non-voting, ex-officio member.
- G. Board members will sign non-disclosure agreements for any confidential/protected information they receive as a result of their membership.

III. Meetings

Regular meeting of the Board shall be held quarterly. Additional meetings may be called as business dictates.

- A. Special meetings may be called, or meetings may be cancelled by the Chairperson.
- B. Fifty percent (50%) of membership shall constitute a quorum. The Board may meet without a full quorum, but a quorum is necessary for binding decisions by the Board.
- C. The Chairperson of the Board and the Facility Administrative Director shall prepare an agenda in advance. Board members and Facility staff may make suggestions for items to be included on the agenda. The agenda and pertinent informational materials shall be distributed two weeks in advance of meetings to Board Members, the Director of the Department of Health and Welfare, and the Administrator of the Division of Family and Community Services.
- D. The Executive Committee shall meet prior to Advisory Board meetings to assist with decision-making regarding proposed agenda topics, vacant positions, and other business in support of the Board function.
- E. All meetings shall comply with Idaho Code §74-201 et. seq.

IV. Purposes

- A. Provide input and develop recommendations to the Director of the Department of Health and Welfare about a specific activity, problem or event including but not limited to major complaints related to resident services.

Southwest Idaho Treatment Center

Advisory Board Bylaws

- B. Reflect and represent community and stakeholder interests providing opportunities for diverse community representation on the Board.
- C. Provide input and support for the mission, goals and objectives of the facility.
- D. Provide input and support for appropriate legislation relevant to the facility.
- E. Make recommendations to the Director of the Department of Health and Welfare and other stakeholders as appropriate regarding the facility's needs.
- F. Educate and communicate facility purpose and mission to other members of the community.
- G. Provide information to the facility's Administrative Director about any activities or issues which may have an impact on the facility.

V. Policies

- A. Staff assistance shall be provided by the facility to record and distribute minutes along with agenda material and other appropriate informational material. Staff shall also provide notice of meeting dates and locations.
- B. All recommendations shall be based upon majority vote of those present. Decisions shall only be binding if a quorum is present.
- C. Board members shall serve without compensation but may be reimbursed at the usual and customary rate for travel and incidental expenses incurred in the performance of official duties. Reimbursement shall be paid from the operating budget of the facility.
- D. Individuals members shall not speak for the Board except on specific delegation.
- E. In the event a Board member believes he or she has a conflict of interest regarding a specific discussion, the Board member shall recuse him or herself from the meeting during the discussion. Additionally, the Chairperson has the authority to declare a conflict of interest exists for a Board member and recuse the Board member from the meeting during the discussion.

VI. Officers

- A. The officers of the Board shall consist of the Chairperson and Vice-Chairperson.

Southwest Idaho Treatment Center Advisory Board Bylaws

- B. Officers shall be appointed by the Director of the Department of Health and Welfare and shall serve a term of one year. Officers may be re-appointed to serve consecutive terms.
- C. Vacancies in offices shall be filled by the Director of the Department of Health and Welfare for the unexpired term in the manner described in this section.
- D. The Chairperson shall preside at all meetings and shall conduct such business as the Board directs.
- E. The Vice-Chairperson shall act as an aid to the Chairperson and shall perform the duties of the Chairperson in the absence or inability of the Chairperson to act.

VII. Executive Committee

- A. The Executive Committee shall consist of:
 - 1. The current Chairperson of the Board
 - 2. Current Vice-Chairperson of the Board
 - 3. SWITC Administrative Director
- B. The Executive Committee shall meet as described in Section III and at such times as the Committee may determine, or upon call of the Chairperson; or in the event of a quorum of the regular Board is not present, the Chairperson can call an executive Committee meeting.
- C. The Executive Committee shall be prepared to present the substance of their Committee meeting to the Board as a whole for its review and approval.

VIII. Committees

- A. Committees may be appointed by the Chairperson as needed and shall perform such duties as may be required at the time of the appointment.
- B. Committee members may be appointed from outside the Board membership, such as the community at large or other organizations and agencies that have a direct or indirect interest in Developmental Disabilities/Intellectual Disabilities.

Southwest Idaho Treatment Center Advisory Board Bylaws

IX. Parliamentary Authority

Robert's Rules of Order, newly revised, shall be the governing authority for the order of business and conduct of all meetings of the Board and committees when not in conflict with the bylaws.

X. Amendments

These bylaws may be altered, amended, or repealed at any regular or special meeting of the Board and must be approved by the Director of the Department of Health and Welfare. Any changes shall be presented to the Board members in writing at least fifteen (15) days prior to the meeting at which they are to be voted upon. A two-thirds (2/3) majority vote of the full membership is required for approval of amendments.

These by-laws have been adopted this 16th day of November, 2018.



Russell S. Barron
Director, Idaho Department of Health and Welfare

Caregiver misconduct registry



In chapter 3 we discussed Idaho's inability to prevent perpetrators of abuse of vulnerable adults from working with vulnerable adults. Two methods can be used to prevent individuals from being employed in caregiver positions. The first is requiring professional licensure for employment and establishing a process by which allegations of abuse or neglect are investigated by a professional board or other third-party entity, and substantiation can lead to a revoked license. The second is a misconduct registry, where allegations of abuse or neglect are investigated by a third-party, and substantiated allegations can lead to placement on the registry and a failed background check.

For Idaho to develop a misconduct registry, several key questions must be addressed:

1. What offenses will place an individual on a misconduct registry?

Before placing individuals on a misconduct registry, decisions must be made for which offenses constitutes misconduct. Although abuse and neglect may be an adequate starting point, the severity of offenses, particularly for neglect, are not uniform and typically must be further expanded.

New York's Justice Center for the Protection of People with Special Needs has four categories of abuse or neglect. An individual is permanently excluded from employment as a caregiver with a category 1 offense or two category 2 offenses that occur within three years. New York also has a category of offenses for substantiated instances of neglect that are not the fault of the caregiver, but of the facility employing the caregiver.

2. Who will be included on the registry, and who must check the registry before hiring?

Illinois's registry includes individuals who have trained or begun training as a developmental disability aide, or who work as nursing assistants, home health aides, or child care aides. Any individuals who will have direct contact with clients or client finances must be cleared first. New York's registry, on the other hand, only includes individuals who committed abuse or neglect while working for the state's (rather extensive) state-operated residential facilities for individuals with intellectual disabilities.

3. Who will conduct investigations of misconduct to decide whether an allegation is substantiated?

The entity that administers the registry is usually responsible for investigating allegations of abuse or neglect. For Idaho's nurse aide registry, surveyors working for the Bureau of Facility Standards conduct investigations. New York's Justice Center retains a network of investigators, such as retired law enforcement personnel, to conduct investigations.

4. What due process protections will be in place for individuals placed on the registry?

The state must ensure that individuals, for whom placement on a registry could result in the denial or conditional denial of employment, are timely notified of the placement and consequences of placement on the registry. It must establish appeals processes. In some states, such as Illinois, individuals who would otherwise be excluded from employment may request waivers if they can show rehabilitation from the offense that placed them on the registry.

Responses to the evaluation



I support the recommendation that the Idaho Department of Health and Welfare work with other stakeholders to develop a strategic long-term vision for crisis care in Idaho and provide clarity for how SWITC fits into the equation.

—Brad Little, Governor



I appreciate the recommendations OPE offered in this report. In my opinion, these recommendations are absolutely on target for ensuring SWITC is positioned to provide the best services possible to the right populations with the right outcomes.

**—Dave Jeppesen, Director
Department of Health and Welfare**



BRAD LITTLE
GOVERNOR

January 14, 2019

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson, Suite 202
Boise, ID 83702

Dear Director Mohan,

Thank you for the Office of Performance Evaluation's thorough report on the Southwest Idaho Treatment Center (SWITC). I appreciate your approach to reviewing the mission of SWITC as well as the important topic of coordinated crisis care throughout our state for individuals with developmental disabilities.

The approach to crisis care for individuals with intellectual and developmental disabilities is critical to ensure we are providing the appropriate level of care and treatment to some of our most vulnerable citizens. The report points out that Idaho lacks a coherent vision for services to individuals with intellectual disabilities who are in crisis. This gap must be addressed but cannot solely be solved by improvements at SWITC. Changes in our system of crisis care will only be resolved through a collaborative effort with advocacy groups, guardians, health care specialists, law enforcement, the courts, and policy makers. They are willing to come to the table and find realistic solutions to providing care and treatment for individuals with complicated co-occurring behaviors and also oftentimes criminal charges and/or histories of assault or self-harm.

I support the recommendation that the Idaho Department of Health and Welfare work with other stakeholders to develop a strategic long-term vision for crisis care in Idaho and provide clarity for how SWITC fits into the equation. I look forward to working with our Developmental Disabilities Council, the Idaho Department of Health and Welfare, and Adult Protection on strategies to improve outcomes for these vulnerable citizens.

Thank you again for your time and commitment to evaluating Idaho's current environment in crisis care.

Sincerely,

A handwritten signature in blue ink, appearing to read "Brad Little", is written over a horizontal line.

Brad Little
Governor



IDAHO DEPARTMENT OF HEALTH & WELFARE

Brad Little - Governor
Dave Jeppesen - Director

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January 10, 2019

Sent Via USPS and Email to: rmohan@ope.idaho.gov

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson, Suite 202
Boise, ID 83702

Re: South West Idaho Treatment Center Report

Dear Mr. Mohan;

I want to thank you and your staff for the time and effort spent on the Southwest Idaho Treatment Center (SWITC) evaluation. The Department is fully supportive of the Office of Performance Evaluations' review of the systemic challenges at SWITC.

As the report highlights, the vision and mission of SWITC has significantly changed over the last five years, as it has moved from an institution for individuals with severe intellectual disabilities and complex medical and behavioral needs to a short term therapeutic stabilization and transition center for these clients, most of whom have been committed to the Department because of criminal activity or severe behaviors. The goal is to help them move to less restrictive community placements for long term services. As the report points out, many states have adopted a similar strategy to serve clients with complex intellectual disabilities and like Idaho, have faced similar challenges with this population.

I appreciate the recommendations OPE offered in this report. In my opinion, these recommendations are absolutely on target for ensuring SWITC is positioned to provide the best services possible to the right populations with the right outcomes.

The Department will prioritize a formal strategic plan and quality improvement process to address issues identified in the report that continue to present challenges in our delivery of care, including staff trauma and injury, high turnover, gaps in training, and a more deliberate focus on proactive rather than reactive treatment. The Department will provide transparency to all stakeholders on the strategic direction of SWITC.

The report also recommends that the legislature work with the Department to develop a long-term vision for Idaho's system of crisis care and its role as provider of last resort for those with intellectual disabilities. Addressing the system of care for individuals with intellectual disabilities all the way from guardian care to community residential care to SWITC and even county jails must be addressed with a solid vision to ensure that some of our most vulnerable Idaho citizens are safe and able to live in an appropriate setting while also ensuring safety in our communities.

To accomplish these two recommendations, the Department will continue to build on some changes that have been started in the past year. Most notably, an Advisory Board was created in October 2018, which is made up of experts and stakeholders from multiple agencies with a charter to make recommendations to the Director and eventually the Governor as to the right strategic focus for SWITC as well as advice on how crisis care can best be managed in our communities. Treatment models have transformed over the years from institutional care to community-based services, SWITC was originally built as an institutional model and then moved to a treatment center and is now morphed into a stabilization and transition center for clients with criminal or severe behaviors. Determining how we best serve the needs of individuals with intellectual disabilities with a large spectrum of behaviors and challenges must be addressed, and I commit to working closely with policy makers on the development of these strategies.

I do want to acknowledge the hard work of our staff and leadership team at SWITC. As the report indicates, 2017 was a very difficult year. I can assure you that since these incidents, there have been some significant improvements, including the impressive results on an annual survey for licensure in October of 2018 with no significant findings or conditions for licensure. The third-party licensing team that conducted the survey indicated in their report that of all the surveys they have conducted for Intermediate Care Facilities in the country, they have never seen a client population that matches SWITC in terms of complex and complicated behaviors. I know our staff care deeply about the treatment and well-being of our clients and continue to come to work every single day despite the absolute that they will have to deal with very challenging behaviors and often dangerous work environment. Turnover at SWITC in 2018 was 41% and of the 8 involuntary separations in 2018, three of them were due to medical layoffs where staff had injuries due to client assaults. We had 52 worker's compensation claims due to intentional injury by clients. Despite this, staff are committed to serving this population and care deeply about the work they do every single day.

With that said, this type of work environment is unacceptable, and we must do better. A thorough review of the mission and strategic focus of crisis care in Idaho and how SWITC fits into that equation must be addressed. I am confident that through the knowledge and expertise of law enforcement, corrections staff, guardians, behavioral specialists, adult protection, the courts, advocates, policy makers, and leadership, we can develop a strategic approach that will improve crisis care for these clients.

Thank you again for the time and effort you invested to improve the care for individuals with developmental disabilities in Idaho.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. Jeppesen', with a stylized, cursive script.

DAVE JEPPESEN
Director

DJ/lw

