REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

SETTLEMENT AGREEMENT

UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 1, 2018 – March 31, 2019

Respectfully Submitted By

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Independent Reviewer
June 13, 2019

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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's fourteenth Report on the status of compliance with the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress and compliance during the fourteenth review period from October 1, 2018 through March 31, 2019.

During the past three years, the Commonwealth developed and implemented three broad initiatives to make substantive changes, which were essential precursors to improving its community-based services system and to fulfilling the requirements of the Agreement. The Commonwealth:

- Completed a complex, multi-year process to approve and implement redesigned waiver programs;
- Completed a multi-step process to revise and emergency DBHDS Licensing Regulations; and
- Implemented a multi-facetted initiative to improve and transform CSB case management services.

Although the Commonwealth has made other needed system-wide changes, these three initiatives are strategic in that they were carefully designed to allow specific changes required by the Agreement where it's progress had been hamstrung. The Commonwealth, through these initiatives, now has developed, defined, and begun implementation of these foundational elements of its service system to achieve the overall goals of the Agreement. Effective implementation of the Commonwealth's redesigned HCBS waiver and program structure, its revised waiver and licensing regulations, and its clarified case management expectations for service planning, coordination, and monitoring will allow substantial changes that can achieve compliance, increased integration and programs that promote self-sufficiency. Evidence gathered by the Independent Reviewer during the fourteenth period documents progress brought about by these initiatives. The Independent Reviewer will prioritize studying the additional outcomes of these initiatives during the next, the fifteenth, review period.

During the fourteenth review period, the Commonwealth made substantial progress in several areas. It created 628 HCBS waiver slots in Fiscal Year 2019, which is 243 (+63%) more than required. In addition, since implementing its housing plan, the Commonwealth has exceeded its housing goals by more than sixteen percent. Through the fourteenth period, it had created 613 new independent living options and provided 925 individuals with their own homes. The Independent Reviewer found improved case management functioning for a sample of thirty-five individuals. The Commonwealth's single-point of entry processes for nursing and large private Intermediate Care Facilities (ICFs) successfully diverted children to community-based services and away from living their child-development years in long-term institutions with shift-based care. Finally, during the recent year period (April 1, 2018, to March 31, 2019), the Commonwealth transitioned ninety-five individuals from living in its Training Centers to more integrated and community-based settings. The census of the Training Centers has declined from 1,084 on July 1, 2011, to 120, as of April 30, 2019.

In other areas, the information gathered and analyzed by the Independent Reviewer highlighted system-wide problems that the Commonwealth has not yet adequately addressed. The Commonwealth does not have either a sufficient quantity or the needed geographic distribution of the most integrated community-based residential service options. It also does not have enough service providers to support individuals in these options, especially the members of the target population with particular needs.

These individuals include adults who have complex behavioral or medical support needs, and others who need, and are able, to live:

- In settings that provide more independence;
- In their own homes with more integrated daily lives;
- In sponsored home settings in northern Virginia; and
- Children who need a family-like home when they cannot live with their own families.

Without these residential options, adults with these particular needs frequently live in large congregate care settings and are isolated from their communities. Children who need family-like homes, but are instead admitted to, or continue to live in, nursing homes and ICFs, are experiencing their vitally important child-development years living in long-term institutional settings with shift-based care. They too are isolated from their communities. These current outcomes conflict with the purpose and goals of the Settlement Agreement.

For individuals with the above needs, the Commonwealth's service system has a similar lack of integrated day service options. Of the twenty-seven individuals visited as part of the Individual Services Review study, eighteen (66.7%) did not have a day service in place five to nine months after their moves. Many had their applications for admission rejected by the day programs that had been listed as "potential viable options" during transition planning meetings. Three of the twenty-seven individuals had transitioned to large outdated and outsized ICFs that look and operate much like the facilities that the Agreement defines as "other institutions" (i.e. nursing facilities and large private ICFs) from which the Commonwealth is trying to divert admissions. Finally, for individuals living with their families, nurses and direct support professionals remain unavailable for many of the approved hours of service. This lack of availability, which is due in large part to the poor wage rate, is increases the likelihood that families will place their loved ones in out-of-home settings which are sufficiently reimbursed and are able to offer continuous and essential staff support.

Since the Agreement was approved, the Parties had substantial disagreements about the requirements of many of the vaguely worded Agreement provisions. They also did not agree as to how compliance would be determined. The Court's 2018 directive to the Parties to negotiate and propose agreed upon measurable indicators of compliance was very fruitful. In response to the Court's order, the Parties each retained and consulted with subject matter experts about the substance of the indicators. The Parties each then developed and shared draft proposed compliance indicators. They discussed and explored each other's proposed indicators, and subsequently developed and shared counter proposals. Gradually, the differences between the Parties' proposed indicators became fewer and narrower. The Parties and their respective experts worked collaboratively, made considerable progress, and, immediately prior the Court hearing on April 23, 2019, reached agreement on the indicators of compliance for the Agreement's case management and crisis services provisions with which the Commonwealth has not yet achieved sustained compliance. The Parties continue to negotiate the compliance indicators for the remaining provisions of the Agreement.

It is the Independent Reviewer considered opinion that Virginians with IDD and their families are best served by compliance indicators about which the Parties agree. When the Parties consult with subject matter experts, wrestle with different choices, and eventually reach agreement on proposed indicators, there is more ownership of responsibility for the system's policy direction and goals. Following the recent negotiations, the Commonwealth's leaders had more understanding of, and commitment to, what will be required to achieve the indicators, how to go about achieving them, and why the indicators can and should be used to determine compliance.

In the future, the Independent Reviewer will utilize these indicators to determine compliance. For this fourteenth review period, the Independent Reviewer utilized the Parties' agreed upon compliance indicators to determine that the Commonwealth had achieved compliance with III.C.1.b.i-viii and c.i-iii. To determine compliance in previous Reports, the Independent Reviewer utilized both a quantitative indicator, "creating and prioritizing the required quantity of waiver slots" and a qualitative indictor, "ensuring the effective implementation of diversion and transition programs for all children referred to, or living in nursing facilities or large ICFs." In future Reports to the Court, the Independent Reviewer will consider "effective implementation of diversion and transition programs for children" as an indicator of compliance for Section III.D.1. (i.e., "*serving individuals in the target population in the most integrated setting consistent with their informed choice and needs*").

The Independent Reviewer's compliance ratings are included in the "Summary of Compliance" table that follows. These compliance ratings are best understood by reviewing the comments in this table, as well as the detailed information in the Findings section of this Report and in the consultant reports, which are included in the Appendices. The Independent Reviewer's recommendations are included at the end of this Report. In the Summary of Compliance table, only the provisions with a compliance determination that are in bold print were reviewed and rated during the fourteenth period. (The other compliance determinations were established during previous review periods.)

During the fifteenth review period, the Independent Reviewer will study the status of the Commonwealth's compliance with most provisions that were not studied during the fourteenth period. For these reviews, the Independent Reviewer will utilize the newly agreed upon indicators to determine compliance. The Independent Reviewer will prioritize studying progress related to provisions that the Commonwealth's has not yet achieved, rather than the provisions with which it has sustained compliance for a full year. Therefore, the Independent Reviewer has prioritized for study during the fifteenth review period: An Individual Services Review study of individuals with needs that will be determined with input from the parties; Integrated Day Activities, including Supported Employment; Regional Support Teams; Risk Management; Mortality Review; Data to Assess and Improve Quality; Providers; Licensing; Training; and Public Reporting.

Throughout the fourteenth period, the Commonwealth's staff have been accessible, forthright and responsive. Attorneys from DOJ gathered information that has helped accomplish effective implementation of the Agreement; and they have worked collaboratively with the Commonwealth in negotiating performance indicators for the provisions. Overall, the willingness of both Parties to openly and regularly discuss implementation issues, and any concerns about progress towards shared goals, has been critical and productive. The involvement and contributions of the advocates and other stakeholders have helped the Commonwealth make measurable progress. The Independent Reviewer greatly appreciates the assistance that was so generously given by the individuals at the center of this Agreement and their families, their case managers and their service providers.

II. SUMMARY OF COMPLIANCE

Settlement Agreement Reference	Provision	Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	**Compliance ratings for the ninth, eleventh, twelfth and thirteenth periods are presented as:** 11th period 12th period (13TH period) **14th period**	**Comments include examples to explain the ratings and status. The Findings Section and attached consultant reports include additional explanatory information.** ***The Comments in italics below are from a prior period when the most recent compliance rating was determined.***
III.C.1.a.i-viii	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community … vii. In State Fiscal Year 2019, 35 waiver slots	Compliance Compliance **Compliance**	The Commonwealth created sixty Community Living waiver slots during FY 2019, twenty-five more than the minimum number required for individuals to transition from Training Centers.
III.C.1.b.i-viii	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) … vii. In State Fiscal Year 2018, 325 waiver slots.	Non Compliance Non Compliance **Compliance**	The Commonwealth created 568 new waiver slots in FY 2019 exceeding the total required for the former ID and IFDDS slots. The Independent Reviewer will consider the effectiveness of the discharge and transition process at NFs and ICFs as an indicator of compliance for III.D.1.
III.C.1.c.i-viii	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) … viii. In State Fiscal Year 2019, 25 waiver slots"	Non Compliance Non Compliance **Compliance**	The Commonwealth created 568 new waiver slots in FY 2019 exceeding the total required for the former ID and IFDDS slots. The Independent Reviewer will consider the effectiveness of the discharge and transition process at NFs and ICFs as an indicator of compliance for III.D.1.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.2.a-b	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2018, a minimum of 1000 individuals will be supported.	Non Compliance **Non Compliance**	The Commonwealth continues to meet the quantitative requirement by providing financial support to more than 1000 individuals during Fiscal Year 2019, but has not fulfilled the requirements of an individual and family supports, as defined in II.D.
III.C.5.a	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	Compliance (Compliance) **Compliance**	126 (100%) of the individuals reviewed in the individual services review studies during the tenth, eleventh, twelfth, thirteenth and fourteenth periods had case managers and current Individual Support Plans.
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.i.	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	Non Compliance **Non Compliance**	The Case Management study of thirty-five individuals found that the DBHDS initiatives have improved case management functioning. In the next review period, the Commonwealth will collect data and maintain records to determine the extent to which it is fulfilling the requirements of the newly agreed compliance indicators for case management services.
III.C.5.b.ii	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	Non Compliance **Non Compliance**	See comment immediately above.
III.C.5.b.iii	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	Non Compliance **Non Compliance**	See comment regarding III.C.5.b.i.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.5.c	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	Non Compliance Non Compliance (Non-Compliance) **Compliance**	The Individual Services Review studies during the tenth, eleventh, twelfth, and thirteenth periods found that case managers had offered choices of residential and day providers. The offer of a choice of case managers is now documented as part of the ISP process and was documented for all 27 (100%) of the individuals studied in the fourteenth period.
III.C.5.d	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	Non Compliance (Non-Compliance)	*Licensing protocols do not include a review of the adequacy of case management services, including a review of whether case managers are fulfilling their responsibilities to determine whether services are being delivered appropriately and remain appropriate to the individual.*
III.C.6.a.i-iii	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall: i. Provide timely and accessible support … ii. Provide services focused on crisis prevention and proactive planning … iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual …	Non Compliance Non Compliance (Non-Compliance) **Non Compliance**	This is an overarching provision. Compliance will not be achieved until the Commonwealth is in compliance with the components of Crisis Services as specified in the provisions of the Agreement.
III.C.6.b.i.A	The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	Compliance Compliance (Compliance) **Compliance**	CSB Emergency Services are utilized. REACH hotlines are operated 24 hours per day, 7 days per week, for adults and for children with IDD.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.6.b.i.B	By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.	Compliance Compliance **Compliance**	REACH trained 3,701 CSB staff and 986 ES staff during the past four years. The Commonwealth requires that all ES staff and case managers are required to attend training**.**
III.C.6.b.ii.A.	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	Non Compliance Non Compliance **Non Compliance**	The CSB – ES are not typically dispatching mobile crisis team members to respond to individuals at their homes. Instead the CSB-ES continues the pre-Agreement practice of meeting individuals in crisis at hospitals or at CSB offices. This practice prevents the provision of supports to de-escalate crises.
III.C.6.b.ii.B	Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.	Non Compliance (Non-Compliance) **Non Compliance**	See comment immediately above re: III.C.6.b.ii.A. During the fourteenth review period, REACH developed substantially fewer Crisis Education and Prevention Plans, when many more individuals needed crisis intervention.
III.C.6.b.ii.C	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.	Compliance Compliance **Compliance**	During the thirteenth and fourteenth review periods law enforcement personnel were involved in 45% (842 of 1,874) of REACH crisis responses;' an additional 734 received training by REACH.
III.C.6.b.ii.D	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	Compliance Compliance **Compliance**	REACH Mobile crisis teams for children and adults are available around the clock and respond on-site at all hours of the day and night.
III.C.6.b.ii.E	Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	Compliance (Compliance) **Compliance**	In each Region, the individuals provided in-home mobile supports received an average of three days of support. Days of support provided ranged between a low of one and a high of eighteen days.

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III.C.6.b.ii.H	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	Compliance Compliance **Compliance**	The Commonwealth did not create new teams. It added staff to the existing teams. REACH teams in all five Regions responded within the required average annual response times during the fourteenth review period.
III.C.6.b.iii.A.	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services	Compliance Compliance **Compliance**	All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults
III.C.6.b.iii.B.	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	Non Compliance Non Compliance **Non Compliance**	For adults with IDD who are offered admitted to the programs, crisis stabilization programs continue to be used as a last resort. Crisis Stabilization programs, however, were not yet available for children.
III.C.6.b.iii.D.	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	Non Compliance Non Compliance **Non Compliance**	The Regions' crisis stabilization programs continue to routinely have stays that exceed 30 days, which are not allowed. Transitional and therapeutic homes that allow long- term stays are being developed.
III.C.6.b.iii.E.	With the exception of the Pathways Program at SWVTC … crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	Non Compliance Non Compliance **Non Compliance**	The Commonwealth does not have sufficient community-based crisis stabilization service capacity to meet the needs of the target population in the Region.
III.C.6.b.iii.F.	By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.	Compliance Compliance **Compliance**	Each Region developed and currently maintains a crisis stabilization program for adults with ID/DD.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.6.b.iii.G.	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	Non Compliance Non Compliance **Non Compliance**	The Commonwealth determined that it is not necessary to develop additional "crisis stabilization programs" for adults in each Region. It has decided to add two programs statewide to meet the crisis stabilization/transitional home needs of adults who require longer stays. Children's crisis stabilization programs are also planned, but developments have again been delayed.
III.C.7.a	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	Non Compliance (Non Compliance)	*This is an overarching provision. Compliance will not be achieved until the component provisions of integrated day, including supported employment, are in compliance.*
III.C.7.b	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy… (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in the ISP.	Non Compliance Non Compliance (Non Compliance)	*The Individual Services Review study found that employment services and goals were not developed and discussed for 22 of 25 individuals (88.0%). ISP documents had boxes checked to indicate employment was discussed, but there were no records that goals were developed and discussed to pursue employment as the first option.*
III.C.7.b.i.	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreation opportunities, and other integrated day activities.	Non Compliance (Compliance)	*The Commonwealth had previously developed a plan for Supported Employment. It has revised and improved its implementation plan with stronger and required elements for integrated day opportunities/activities.*
III.C.7.b.i.A.	Provide regional training on the Employment First policy and strategies through the Commonwealth.	Compliance (Compliance)	*DBHDS continued to provide regional training on the Employment First policy and strategies.*

Settlement Agreement Reference	Provision	Rating	Comments
III.C.7.b.i. B.1.	Establish, for individuals receiving services *through the HCBS waivers*, annual baseline information regarding:	Compliance (Compliance)	*The Commonwealth has significantly improved its method of collecting data. For the third consecutive period, data were reported by 100% of the employment service providers. It can now report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a, b, c, d, and e below.*
III.C.7.b.i. B.1.a.	The number of individuals who are receiving supported employment.	Compliance (Compliance)	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.b.	The length of time individuals maintain employment in integrated work settings.	Compliance (Compliance)	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.c.	Amount of earnings from supported employment;	Compliance (Compliance)	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.d.	The number of individuals in pre-vocational services.	Compliance (Compliance)	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.e.	The length-of-time individuals remain in pre-vocational services.	Compliance (Compliance)	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.2.a.	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	Non Compliance (Non Compliance)	*The Commonwealth set targets to meaningfully increase the number. By the end of Fiscal Year 2018, the number of individuals with HCBS waivers had increased substantially, but only to 74.9% of the target. Systemic obstacles have not been addressed.*
III.C.7.b.i. B.2.b	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	Compliance (Compliance)	*Of the number of individuals who were employed in June 2017, 91% had retained their jobs twelve months later in June 2018, which exceeded the 85% target set in 2014.*

Settlement Agreement Reference	Provision	Rating	Comments
III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. … shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly … Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	Compliance (Compliance)	*The RQCs continue to meet each quarter, to consult with the DBHDS Employment staff, both members of the SELN (aka EFAG), and to review progress toward targets.*
III.C.7.d.	The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.	Compliance (Compliance)	*The RQCs reviewed the employment targets and the State's progress for FY 2018. The RQCs have discussed and endorsed the future FY 2016 – 2019 targets.*
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	Non Compliance	*A review found that DMAS /Broker have implemented previous recommendations and DMAS added them to its RFP, which it has had to reissue. Sustained improvements and a functioning quality improvement program will not be able to be evaluated until 2019.*
III.C.8.b.	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access	Non Compliance **Non Compliance**	DBHDS has continued to make progress, but has not yet implemented components of its multi-part plan for publishing guidelines.
III.D.1.	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	Non Compliance **Non Compliance**	Implementation of the redesigned waivers has increased options. However, there are not enough "most integrated settings", or providers, to serve * individuals with intense needs, * individuals wanting increased independence, * children who are growing up living in institutions without an integrated out-of-home family-like residential option.

Settlement Agreement Reference	Provision	Rating	Comments
III.D.2.	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources.	Compliance **Compliance**	As of 3/31/19, the Commonwealth had created new options for 925 individuals, now living in their own homes, exceeding its targeted goal for 6/30/19 of 796. Its Outcome-Timeline schedule is to provide independent community-based housing to 1866 individuals by the end of FY 2021.
III.D.3.	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	Compliance **Compliance**	The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies.
III.D.3.a.	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ...	Compliance **Compliance**	A DBHDS housing service coordinator developed and updated the plan with these representatives and with others.
III.D.3.b.i-ii	The plan will establish for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and recommendations to provide access to these settings during each year of this Agreement.	Compliance **Compliance**	The Commonwealth estimated the number of individuals who would choose independent living options. It has revised the Housing Plan with new strategies and recommendations.
III.D.4	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing from a one-time fund of $800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii.	**Compliance and Completed**	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds received permanent rental assistance.

Settlement Agreement Reference	Provision	Rating	Comments
III.D.5	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	Non Compliance Non Compliance **Non Compliance**	Peer to peer and family-to-family programs were not active for individuals who live in the community and their families.
III.D.6	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	Non Compliance Non Compliance (Non Compliance)	*Although DBHDS has made substantive process improvements, case managers continue to submit RST referrals late (after or concurrent with the individual's move) at approximately the same rate as it has previously.*
III.D.7	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home …	Compliance (Compliance) **Compliance**	The Commonwealth included this term in the performance contracts, developed and provided training to case managers and implemented an ISP form with education about less restrictive options.
III.E.1	The Commonwealth shall utilize Community Resource Consultant ("CRC") positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office…The CRCs shall be a member of the Regional Support Team ...	Compliance (Compliance) **Compliance**	Community Resource Consultants (CRCs) are located in each Region, are members of the Regional Support Teams, and are utilized for these functions**.**
III.E.2	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	Non Compliance (Compliance)	*DBHDS has reviewed and improved the RST processes. When case managers submit timely referrals, CRCs and the RSTs fulfill their roles and responsibilities and the Regional Support Teams frequently succeed at their core functions.*

Settlement Agreement Reference	Provision	Rating	Comments
III.E.3.a-d	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	Compliance (Compliance)	*DBHDS established the RSTs, which meet monthly. The CRCs refer cases to the RSTs as required.*
IV	**Discharge Planning and Transition**	**Compliance ratings for the ninth, eleventh, twelfth and thirteenth periods are presented as:** 11th period 12th period (13TH period) **14th period**	**Note: The Independent Reviewer gathered information about individuals who transitioned from Training Centers and rated compliance during the first, third, fifth, seventh, ninth and twelfth review periods.** ***The Comments in italics below are from the period when the compliance rating was determined.***
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	Compliance **Compliance**	The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It has continued to implement improvements in response to concerns identified by the Independent Reviewer.
IV.A	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	Non Compliance **Non Compliance**	This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Discharge section are determined to be in compliance.
IV.B.3.	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	Compliance **Compliance**	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	Non Compliance **Non Compliance**	Discharge plan goals did not include measurable outcomes that promote integrated day activities. Two (8.3%) of the 24 individuals studied were offered integrated day opportunities and one (3.7%) had typical days that included regular integrated activities. Eighteen (66.7%) of the 27 studied did not have day programs five to nine months after moving to the community.
IV.B.5.	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan will be developed within 30 days prior to discharge.	Compliance **Compliance**	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans are well documented. All individuals studied had discharge plans.
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	Compliance **Compliance**	The documentation of information provided was present in the discharge records for 72 (100%) of the individuals studied during the ninth, twelfth, and fourteenth review periods.
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	Compliance **Compliance**	The discharge plans included this information.
IV.B.5.c.	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	Compliance **Compliance**	For 122 of 124 individuals (98.4%) studied during the fifth, seventh, ninth, twelfth and fourteenth review periods, the discharge records included these assessments.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	Compliance **Compliance**	The PSTs select and list specific providers that provide identified supports and services.
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	Compliance **Compliance**	The Training Centers document barriers in six broad categories as well as more specific barriers.
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	Compliance **Compliance**	The severity of the disability has not been a barrier in the discharge plans.
IV.B.5.e.ii.	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	Compliance **Compliance**	DBHDS has identified the factors that led to readmission and has implemented steps to support individuals with intensive needs.
IV.B.6	Discharge planning will be done by the individual's PST…Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	Non Compliance **Non Compliance**	The Individual Services Review Study found that the discharge plans lacked recommendations for services in integrated day opportunities and such opportunities were not provided. The fourteenth period ISR study also found that 18 of 27 (67%) individuals did not have any day service five to nine months after moving, and that only 1 of 27 (3.7%) had a typical day that included regular integrated activities
IV.B.7	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	Compliance **Compliance**	The Commonwealth's discharge plans indicate that individuals with complex needs can live in integrated settings.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.9.	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	Compliance **Compliance**	The Individual Services Review studies during the fifth, seventh, ninth, twelfth, and fourteenth review periods found that 124 (100%) of individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST.
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	Compliance **Compliance**	Discharge records included evidence that the Commonwealth had offered a choice of providers.
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the … community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	Compliance **Compliance**	The ninth, twelfth and fourteenth individual services reviews found that 39 of 45 individuals (86.7%) and their ARs did have an opportunity to speak with individuals currently living in their communities and their family members. All (100%) received a packet of information with this offer, but discussions and follow-up were not documented for four individuals.
IV.B.9.c.	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	Compliance **Compliance**	PSTs and case managers assisted individuals and their Authorized Representative. For 100% of the 72 individuals studied in the ninth, twelfth and fourteenth ISR studies, providers were identified and engaged; provider staff were trained in support plan protocols.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.11.	The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	Compliance **Compliance**	During the fifth, seventh, ninth, twelfth and fourteenth review periods, the reviews found that 116 of 124 individuals /Authorized Representatives (93.5%) who transitioned from Training Centers were provided with information regarding community options.
IV.B.11.a.	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	Compliance **Compliance**	The Independent Reviewer confirmed that training has been provided via regular orientation, monthly and ad hoc events at all Training Centers, and via ongoing information sharing.
IV.B.11.b.	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches … will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	Compliance **Compliance**	The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training. All Training Centers have person-centered coaches. DBHDS reports that regularly scheduled conferences provide opportunities to meet with mentors. An extensive list of trainings was provided and attendance is well documented.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.15	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	Compliance **Compliance**	See Comment for IV.D.3.
IV.C.1	Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.	Compliance **Compliance**	The Independent Reviewer found that for the ninth, twelfth, and fourteenth ISR studies, residential staff for all 72 individuals participated in the pre-move ISP meeting and were trained in the support plan protocols.
IV.C.2	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	Compliance **Compliance**	During the fifth, seventh, ninth, twelfth, and fourteenth periods, the Independent Reviewer found that 121 of 124 individuals (97.6%) had moved within 6 weeks, or reasons were documented and new time frames developed.

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.3	The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	Compliance **Compliance**	The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions. During the fifth, seventh, ninth, twelfth and fourteenth review periods, the ISR studies found that for 124 (100%) individuals, PMM visits occurred. The monitors had been trained and utilized monitoring checklists. The look-behind process was maintained during the seventh period.
IV.C.4	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	Compliance **Compliance**	The Individual Services Review studies during the ninth, twelfth and fourteenth review periods found that: For 71 of 72 individuals (98.6%), the Commonwealth updated discharge plans within 30 days prior to discharge.
IV.C.5	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge.	Compliance **Compliance**	The reviewers confirmed that the Personal Support Teams (PSTs), including the Authorized Representative, had determined and documented, and the CSBs had verified, that essential supports to ensure successful community placement were in place prior to placement.

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.6	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.	Compliance **Compliance**	The discharge records reviewed in the ninth, twelfth, and fourteenth review periods indicated that all twenty-six individuals (100%) who moved to settings of five or more did so based on their informed choice after receiving options.
IV.C.7	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	Compliance **Compliance**	The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans.
IV.D.1	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	Compliance **Compliance**	Community Integration Managers (CIMs) are working at each Training Center.
IV.D.2.a	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	Compliance **Compliance**	CIMs reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals.
IV.D.3	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	Compliance **Compliance**	During the twelfth period, there were improvements in the timeliness of referrals to the RST, which is essential to allow sufficient time for the CIM and RST to resolve identified barriers. During the fourteenth period, the ISR study of individuals who moved from Training Centers, found that 11 of 12 (91.3%) were referred timely.

Settlement Agreement Reference	Provision	Rating	Comments
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	Compliance **Compliance**	The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.
V.	**Quality and Risk Management**	**Compliance ratings for the ninth, eleventh, twelfth and thirteenth periods are presented as:** 11th period 12th period (13TH period) **14th period**	***The Comments in italics below are from a prior period when the most recent compliance rating was determined.***
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	Non Compliance (Non Compliance)	*This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Quality section are determined to be in compliance.*
V.C.1	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	Non Compliance (Non Compliance)	*The Commonwealth does not yet have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks.*
V.C.2	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	Compliance (Compliance)	*DBHDS implemented a web-based incident reporting system. Providers report 87% of incidents within one day of the event. Some duplicate reports are submitted late.*
V.C.3	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	Non Compliance (Compliance)	*DBHDS revised its licensing regulations, increased the number of investigators and supervisors, added expert investigation training, routinely includes double loop corrections in CAPs for immediate and sustainable change, and requires 45-day checks to confirm. implementation of CAP s re: health and safety.*

Settlement Agreement Reference	Provision	Rating	Comments
V.C.4	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	Non Compliance (Non Compliance)	*DBHDS has not yet completed the initial step of obtaining relevant and reliable data for the development of a QI/risk management framework. It has not finalized or disseminated "Draft Resource Tool to Develop a Provider Quality Improvement/Risk Management (QIRM) Framework."*
V.C.5	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The …mortality review team … shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death; … (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems … and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	Non Compliance (Non Compliance)	*A Mortality Review Committee (MRC) has significantly improved its data collection, data analysis, and the quality of mortality reviews. It has begun a quality improvement program. The MRC rarely completed such reviews within 90 days. The newly recruited member, who is independent of the State, attended only 4 of 17 (24%) of the MRC meetings.*
V.C.6	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider.	Non Compliance (Non Compliance)	*DBHDS cannot effectively use available mechanisms to sanction providers, beyond use of Corrective Action Plans. DBHDS is making progress by increasingly taking "appropriate action" with agencies which fail to report timely.*

Settlement Agreement Reference	Provision	Rating	Comments
V.D.1	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	Non Compliance (Non Compliance)	*This is an overarching provision that requires effective quality improvement processes to be in place at the CSB and state level, including monitoring of participant health and safety.*
V.D.2.a-d	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement.	Non Compliance (Non Compliance)	*DBHDS continues to expand and improve its ability to collect and analyze consistent, reliable data. Concerns remain with their reliability and availability. Data are not being used to identify trends, patterns, strengths and problems at the individual, service-delivery, and systemic levels or to analyze the quality of services, service gaps, or accessibility of services.*
V.D.3.a-h	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	Non Compliance (Non Compliance)	*DBHDS staff proposed draft measures for a portion of the eight domains. However, the draft measures required significant additional work to collect valid and reliable data. Sources of data were not defined, which is an important step toward providing reliable data.*

Settlement Agreement Reference	Provision	Rating	Comments
V.D.4	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	Non Compliance (Non Compliance)	*This is an overarching provision. It will be not be rated in compliance until reliable data are provided from all the sources listed and cited by reference in V.C. and in V.E-G.*
V.D.5	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	Non Compliance (Non Compliance)	*DBHDS shared and RQCs reviewed data including: employment, OLS, OHR, and other data. The RQCs, however, had limited and frequently unreliable data available for review. See comment re: V.D.5.b. below.*
V.D.5.a	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	Compliance (Compliance)	*The five Regional Quality Councils include all the required members.*
V.D.5.b	Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	Non Compliance (Non Compliance)	*The RQCs met quarterly, but had limited discussion. Their use of relevant data and analysis to identify trends and to recommend responsive actions, however, remains in its infancy. The DBHDS Quality Improvement Committee directed the RQCs work.*
V.D.6	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability … and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	Non Compliance (Non Compliance)	*DBHDS expected that its restructured website would be available for public reporting after March 2018, but it was not available in September 2018.*
V.E.1	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program including root cause analysis that is sufficient to identify and address significant issues.	Non Compliance (Non Compliance)	*The Commonwealth has approved new Regulations that require providers to have QI programs, but it has not yet informed providers of the minimum requirements for complying with its revised Licensing regulations.*

Settlement Agreement Reference	Provision	Rating	Comments
V.E.2	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	Non Compliance (Non Compliance)	*The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS revised Licensing Regulations which require providers to have risk management and QI programs. The Commonwealth has not yet informed them of its expectations regarding the measures that CSBs and providers will be expected to report.*
V.E.3	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	Non Compliance	*The Commonwealth's contractor completed the second annual QSR process. There are problems with the validity of the contractor's tools and process and, therefore, with the reliability of data collected and the accuracy of the results.*
V.F.1	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	Compliance Compliance (Compliance)	*The eleventh period case management study and the thirteenth ISR study found that 44 of the 47 case managers (93.6%) were in compliance with the required frequency of visits. DBHDS reported data that some CSBs are below target.*
V.F.2	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs….	Non Compliance **Non Compliance**	See comment for III.C.5.b.i.

Settlement Agreement Reference	Provision	Rating	Comments
V.F.3.a-f	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	Compliance Compliance **Compliance**	The ninth, twelfth, and fourteenth ISR studies found that the case managers had completed the required monthly visits for 72 of 73 individuals (98.6%).
V.F.4	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	Non Compliance Non Compliance	*DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to assess CSB compliance with their performance standards relative to case manager contacts.*
V.F.5	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	Non Compliance Non Compliance	*DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to capture case manager/support coordinator findings regarding the individuals they serve.*
V.F.6	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	Compliance	*The Commonwealth developed the curriculum with training modules that include the principles of self-determination. The modules are being updated.*
V.G.1	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	Compliance (Compliance)	*OLS regularly conducts unannounced inspection of community providers.*
V.G.2.a-f	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Compliance (Compliance)	*OLS has maintained a licensing inspection process with more frequent inspections.*

Settlement Agreement Reference	Provision	Rating	Comments
V.G.3	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	Non Compliance Non Compliance (Non-Compliance)	*The DBHDS Licensing process does not incorporate protocols that include assessing the adequacy of the individualized supports and services provided.*
V.H.1	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	Non Compliance (Non-Compliance)	*The Commonwealth drafted and subsequently revised and improved direct support professional and supervisory competencies. To achieve compliance, it must inform providers of its expectations and the measurable criteria providers must meet. The thirteenth ISR study found that residential staff are not receiving competency-based training.*
V.H.2	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	Non Compliance (Non-Compliance)	*Same as V.H.1 immediately above.*
V.I.1.a-b	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	Non Compliance Non Compliance	*It was not possible to determine the reliability and validity of the data gathered or the effectiveness of the proposed QSR process when fully implemented.*
V.I.2	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting	Non Compliance Non Compliance	*Same as V.I.1. immediately above*

Settlement Agreement Reference	Provision	Rating	Comments
V.I.3	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	Non Compliance	*The Commonwealth's contractor completed the second annual QSR process. There are problems with the validity of the contractor's tools and process and, therefore, with the reliability of data collected and the accuracy of the results.*
V.I.4	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	Compliance	*The Commonwealth's contractor completed the second annual QSR process based on a statistically significant sample of individuals.*
VI	**Independent Reviewer**	**Rating**	**Comment**
VI.D.	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with the, … shared with Intervener's counsel.	Compliance (Compliance) **Compliance**	The DBHDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.
IX	**Implementation of the Agreement**	**Rating**	***Comment***
IX.C.	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented …	Non-Compliance (Non-Compliance) **Non Compliance**	The Independent Reviewer has determined that the Commonwealth did not maintain sufficient records to document proper implementation of the provisions, including crisis services and case management.

Notes: 1. The independent Reviewer does not monitor services provided in the Training Centers. The following provisions are related to internal operations of Training Centers and were not monitored: *Sections III.C.9, IV.B.1, IV.B.2, IV.B.8, IV.B.12, IV.B.13, IV.D.2.b.c.d.e.f., and IV.D.3.a-c.* The independent Reviewer will not monitor *Section III.C.6.b.iii.C.* until the Parties decide whether this provision will be retained.

III. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

The Independent Reviewer and his independent consultants monitored the Commonwealth's compliance with the requirements of the Agreement by:

- Reviewing data and documentation produced by the Commonwealth in response to requests by the Independent Reviewer, his consultants and the Department of Justice;
- Discussing progress and challenges in regularly scheduled Parties' meetings and in work sessions with Commonwealth officials;
- Examining and evaluating documentation of supports provided to individuals;
- Visiting sites, including individuals' homes and other programs; and
- Interviewing individuals, families, provider staff, and stakeholders.

During this, the fourteenth review period, the Independent Reviewer prioritized the following areas for review and evaluation:

- Home and Community-Based Services;
- Individual and Family Support Program;
- Case Management;
- Crisis Services;
- Independent Housing;
- Children in Nursing Facilities and Private Intermediate Care Facilities;
- Discharge Planning and Transition from Training Centers; and
- Guidelines for Individuals and Families.

The Independent Reviewer retained nine independent consultants to conduct the reviews and evaluations of these prioritized areas. For each study, the Independent Reviewer asked the Commonwealth to provide all records that document that it has properly implemented the related requirements of the Agreement. The consultants' reports are included in the Appendices of this Report.

For the fourteenth time, the Independent Reviewer utilized his Individual Services Review (ISR) study process to evaluate the status of services for a selected sample of individuals. For the seventh time, the Individual Services Review study focused on individuals who transitioned from Training Centers. By utilizing the same questions over several review periods, for different subgroups and in different geographical areas, the Independent Reviewer has identified findings that include positive outcomes as well as areas of concern. The size of the selected sample allows findings to generalize to the cohort (i.e., by studying twenty-seven randomly selected individuals, findings can generalize to the cohort of forty-five individuals with a ninety percent confidence factor). After carefully reviewing these findings, the Independent Reviewer has identified and reported themes.

The other studies completed by the Independent Reviewer's consultants for this Report examined the status of the Commonwealth's progress toward achieving or sustaining compliance with specific prioritized provisions that were targeted for review and evaluation. The Independent Reviewer shared with the Commonwealth the planned scope, methodology, site visits, document review, and/or interviews and requested any suggested refinements to the plans for the studies. The Independent Reviewer's consultants reviewed the status of program development to ascertain whether the Commonwealth's initiatives had been implemented sufficiently for measurable results to be evident. The consultants conducted interviews with selected officials, staff at the State and local levels, workgroup members, providers, families and staff of individuals served, and/or other stakeholders.

To determine the ratings of compliance for the fourteenth period (October 1, 2018 through March 31, 2019, the Independent Reviewer considered information about the period, that was provided by the Commonwealth prior to May 1, 2019. The Independent Reviewer also considered the findings and conclusions from the consultants' studies, the Individual Services Review study, the Commonwealth's planning and progress reports and documents, and other sources. The Independent Reviewer's compliance ratings are best understood by reviewing the comments in the Summary of Compliance table, the Findings section of this Report, and the consultant reports, which are included in the Appendices. Information that was not provided for the studies is not considered in the consultants' reports or in the Independent Reviewer's findings and conclusions regarding the status of the Commonwealth fulfilling the requirements of the Agreement. If the Commonwealth was not able to provide sufficient information to demonstrate that the indicators of compliance for a provision had been achieved, the Independent Reviewer determined a rating of non-compliance.

Finally, as required by the Agreement, the Independent Reviewer submitted this Report to the Parties in draft form for their comments. The Independent Reviewer considered any comments by the Parties before finalizing and submitting this, his fourteenth, Report to the Court.

B. Compliance Findings

1. Providing Home and Community Based Services (HCBS) Waivers

The Independent Reviewer previously reported that the Commonwealth had redesigned and amended its existing Intellectual Disabilities (ID), Individual and Family Developmental Disabilities Support (IFDDS), and Day Support Home and Community Based Waiver Programs for individuals with IDD. The purpose of redesigning waiver programs was to move from inflexible and outdated waivers that included financial incentives for providers to serve individuals in large congregate day and residential settings to waivers that aligned with the goals of Agreement--community integration, self-sufficiency, and quality services. The redesign made all waivers open to individuals with either ID or developmental disabilities (DD) other than intellectual disabilities. The redesign also restructured and merged the ID and IFDDS waitlists. The restructuring included merging and restructuring the individuals on the waitlists into three new categories, using a consistent set of criteria to define who was considered to be "most in need." Redesign of the waivers also included defining many new types of services that create opportunities for recipients to receive supports that promote increased community integration and independence. The Independent Reviewer reported previously that the Commonwealth's substantial modifications to its HCBS waiver programs require new criteria to determine whether it is fulfilling the requirements of the Agreement to create a certain number of new waiver slots during Fiscal Year 2018 through Fiscal Year 2021. The Independent Reviewer determined that, unless the Parties agree to revise the language of the Agreement to align with the Commonwealth's redesigned waiver programs, the Independent Reviewer would utilize the criteria listed below to determine whether the Commonwealth is fulfilling the requirements for the number of waiver slots created pursuant to provisions III.C.1.a.vii-ix, b.vii-ix, and c.vii-ix.

1.) The funding that the Commonwealth approves for the number of slots created must be equal to or greater than the budgeted amount for the total number of slots that would have been required prior to the redesign of its HCBS waiver programs.

2.) The total number of slots that the Commonwealth creates must also:

- Be equal to or greater than the sum of waiver slots required by these provisions prior to the redesign of the HCBS waivers;
- Include the number of slots that the Commonwealth projects for each redesigned waiver program that will be required to meet the needs and informed choices of the individuals who are expected to fill the slots; and
- Include the number of slots that the Commonwealth projects for:
  - transfers, if needed, from the new FIS and BI waivers to the CL waiver;
  - diversion or transition from institutional care (i.e. nursing facilities, large private ICFs, psychiatric facilities, and other institutions); and
  - emergencies.

Findings

Under the Settlement Agreement the Commonwealth has created 4,402 new HCBS waiver slots, which exceeds the 3,295 required by 1,107 (33.6%).

TABLE 1
HCBS Waiver Slot Allocation Summary Fiscal Years 2012 -2017 and 2018- 2019
Settlement Agreement – *required / actually created*

HCBS *** Waivers	2012	2013	2014	2015	2016	2017	Total FY12-17	HCBS **** Waivers	2018	2019	Total FY18-19
CL-TC	60 /60	160 /160	160 /160	90 /90	85 /85	90 /90	645 /645	CL-TC	/100	/60	/160
CL-ID	275 /275	225 /300 (**25)	225 /575 (**25)	250 /25 (**25)	275 /325 (**25)	300 /300	1550 /1800 (**100)	CL/IDD	/80	/154	/234
IFSDD	150 /165	25 /50 (**15)	25 /130 (**15)	25 /15* (**15)	25 /40 (**25)	25 /340* (**10)	275 /740 (**80)	FIS-IDD	/344	/414	/758
								BI-IDD	/60	/0	/60
Total	485 /500	410 /510	410 /865	365 /130	385 /650	415 /770	2,470 /3,425	**Total**	440 ***** /584	385 ***** /628	825 /1,212

* From reserves,

** Prioritized for children in NF/ICFs

*** Previous HCBS Waivers: Community Living (CL) – Training Center (TC) and Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFS-DD)

**** Current HCBS Waivers: Community Living (CL) - Intellectual and Developmental Disability (IDD), Family and Individual Support-IDD (FIS), Building Independence-IDD (BI)

***** Note: The requirements for a specific number of slots per waiver does not apply to the redesigned waivers.

The Commonwealth has created 4,637 wavier slots, which is 1,107 (33.6%) more that the 3,295 waiver slots required by the Agreement in Fiscal Years 2012 through 2019. During the first six fiscal years, it created 3,190 waiver slots or 720 (29.1%) more than the 2,470 slots required. During the past two years, the first two full fiscal years since approval of its redesigned HCBS waiver programs, the Commonwealth created 1,212 waiver slots, 46.9% more than the Agreement required. In its recently approved budget for Fiscal Year 2020, the General Assembly provided funds for 1,067 waiver slots which is 627 (+142.5%) more than the 440 required by the Agreement.

Conclusion

The Commonwealth has fulfilled the requirements for the number of waiver slots created and prioritized pursuant to provisions III.C.1.a.i- viii, b.i-viii, and c.i-viii.. For the fourteenth and future review periods, the Independent Reviewer will consider the qualitative issues related to the diversion, discharge and transition of children from other institutions (i.e. nursing facilities and large private ICFs) as indictors of compliance for Section III.D.1.

2. Case Management

The Independent Reviewer retained the same independent consultants to conduct a follow-up study to their April 2017 review of the Case Management requirements of the Agreement. This fourteenth period review was based on onsite interviews with DBHDS leadership, interviews with case managers and their supervisors, and document reviews for thirty-five (35) individuals.

This review found that DBHDS has exerted concentrated efforts on additional case manager improvements. These efforts were coordinated and organized under the Case Management Steering Committee (CMSC), which implemented initiatives to improve the efficiency and effectiveness of case management functioning. To achieve needed progress and change, through working with the CSBs, DBHDS has:

- Clarified expectations;
- Simplified processes (e.g. quarterly ISP reports);
- Moved some functions from CSB Case Managers to DBHDS;
- Retrained Case Managers;
- Improved data processing;
- Created new resources (i.e., searchable Case Management Manual);
- Developed new tools (i.e., supervisor audit tool), formalized technical assistance; and
- Launched a culture change to move Case Managers from transactional (operational, administrative) tasks to transformational (engagement, developmental) tasks.

DBHDS has completed, or has work underway to:

- Support CSBs in their self-assessment and improvement planning around Case Management:
- Revise Case Manager training modules;
- Incorporate new sources of information into findings regarding the CMSC's performance monitoring activity;
- Make CSB generated electronic ISPs accessible to DBHDS systems; and
- Raise the value and importance of employment in the ISP process.

To inform the conclusions of this review, the Independent Reviewer included a qualitative targeted review of thirty-five (35) randomly selected individuals, who were listed by DBHDS as receiving Enhanced Case Management (ECM) in ten CSBs representative of the five DBHDS Regions. Although this sample is too small to generalize findings, its purpose is to understand the general extent, and in what areas, DBHDS has "gotten its arms around" the task of improving the Case Management function. Each of the thirty-five individual reviews included: a) a qualitative evaluation of the ISP and recent Case Manager progress notes, b) Case Manager interviews, c) Case Manager supervisor interviews and d) a follow-up assessment of the individual's well-being via personal visits and/or interviews with caregivers and/or Authorized Representatives (ARs), when available. The consultants then conducted a discrepancy analysis to determine whether gaps existed between each individual's assessed needs and ISP goals (as documented in the Case Management system reports and documents) and the services and supports that were actually being provided.

The discrepancy analysis suggested the issues that were the most frequent systemic shortcomings in the Individual Support Plans for the thirty-five individuals. The discrepancy rates from the analysis of twenty-seven (27) items in the Case Management Review Tool for thirty-five (35) individuals suggested an overall discrepancy rate of eight percent across ten CSBs from all five Regions. This is a significant improvement over the discrepancy rate of twenty percent that was identified in a similar audit of four CSBs in 2017. (See consultants' report, Appendix C, Tables 1 and 2).

The consultants' report identifies the four most frequent systemic shortcomings in the Individual Support Plans reviewed. Each of these consultants three studies over different samples of individuals found that the most persistent problem is: *If needed, has the individual's Individual Support Plan (ISP) been modified during the past year in response to major events?* Although the case management services for the thirty-five individuals reviewed this period showed improvement on this item to a near acceptable rate of fifteen percent, it appeared that, even when the Case Manager becomes aware of a major event, Case Managers are generally hesitant to modify ISPs in between annual reviews. Some of this hesitancy may be due to the Case Manager being responsible for gathering all the electronic signatures of team members for any substantive change to the ISP.

The consultant's study reviewed the methodology used by the Commonwealth to determine the adequacy of supports cited in previous studies around the DBHDS Data Dashboard: there is an unavoidable bias in effect when Case Managers directly responsible for coordinating the supports are asked to report on and evaluate those supports. This self-report bias makes the results of this assessment unusable, even when the immediate Case Manager's supervisor is part of the conversation.

To the extent that these processes and structures are made permanent, some systemic improvements in Case Management are apparent and should continue. This is critical because effective Case Management is often the linchpin to competent service delivery. DBHDS has expended considerable effort on behalf of improved Case Management competence.

At the Court Hearing on April 23, 2019, the Parties informed the Court of their agreement to a list of measurable indicators that they propose to use to determine the Commonwealth's compliance with the case management provisions of the Agreement. During the fifteenth review period, the Commonwealth will review and revise the data it gathers and the records that it maintains so that it will be able to demonstrate that it is properly implementing the case management provisions and achieving the newly agreed upon compliance indicators. The Commonwealth expects that this information will not be sufficiently complete to demonstrate compliance until the sixteenth review period. In the final section of the consultant's report (Appendix C, Table 3), the consultants show that their previously used audit questions have gathered information in response to many of the new indicators. During the sixteenth review period, the consultants' study will incorporate a review the Commonwealth's methodology, findings and conclusions from its system of monitoring compliance with the agreed upon case management compliance indicators. Their study will also include a look-behind audit to verify the Commonwealth's findings and conclusions regarding its progress toward achieving the agreed upon case management indicators.

3. Crisis Services

For the fourteenth review period, the Independent Reviewer again retained the same independent consultant who completed several previous studies of the Commonwealth's crisis services system. This review gathered current facts and analyzed the status of the Commonwealth's accomplishments in implementing and fulfilling the Agreement's requirements. These requirements expect that the Commonwealth will:

- Develop a statewide crisis system for individuals with ID and DD;
- Provide timely and accessible supports to individuals who are experiencing a crisis;
- Provide services focused on crisis prevention and proactive planning to avoid crises; and
- Provide mobile response, in-home and community-based crisis services to resolve crises and to prevent the individual's removal from his or her home, whenever practical.

As with her previous studies, the independent consultant reviewed the records that the Commonwealth maintains to demonstrate its progress toward properly implementing the requirements of the Agreement. She also interviewed DBHDS administrators, crisis services staff, and the Case Managers of individuals served by the crisis services system. To more fully inform its findings and conclusions, this study also included a qualitative review of crisis supports and related community services for sixty individuals, thirty children and thirty adults, who were referred to REACH during November 2018 of the fourteenth review period. The study's overarching goal was to determine whether the Commonwealth's community service capacity is sufficient and deployed to assist individuals with IDD, who have behavioral and/or mental health co-occurring conditions, to remain in their homes with appropriate ongoing services. This goal will reduce unnecessary hospitalizations and, if the individuals are admitted, lengths-of-stay.

To present her study's findings, the independent consultant organized and compared the Commonwealth's statewide crisis system performance data into four full year periods from April 1, 2015 through March 31, 2019. These years correspond with eight review periods under the Agreement. For example, Year Four, April 1, 2018, through March 31, 2019, includes the thirteenth and fourteenth review periods. Attached at Appendix D is the consultant's report with tables that compare REACH performance data for Year One through Year Four. The study's Appendix 1, includes the summary of findings from the qualitative review of sixty individuals.

During the fourteenth period, crisis calls to the CSB's Emergency Services (ES) "hotlines" continued to result in assessments of individuals in crisis after they have been removed from their homes and taken to the local hospital or CSB office. As a result, the Regional REACH mobile crisis teams' responded to these out-of-home locations. The crisis system's failure to respond before individuals are removed from their homes undermines the REACH teams' demonstrated abilities to de-escalate crises, to put in place short-term supports, to plan and implement in-home prevention strategies, and, frequently, to offer the last resort option in one of the statewide crisis system's crisis stabilization programs. When given the opportunity, receiving REACH mobile crisis supports frequently succeeds. Only six percent of the individuals who were not hospitalized at the time of crisis assessment and who received mobile crisis supports were hospitalized after receiving mobile supports compared to thirty-six percent who were hospitalized at the time of the crisis assessment.

A higher percentage of crisis assessments are occurring in out-of-home locations, the opposite of what the Agreement requires. The Commonwealth's current structure and use of the CSB ES "Single Point of Entry" process is not working properly or as the Agreement requires.

Data from the fourteenth review period allowed comparisons and identification of overall changes in REACH services over the past two years. Comparing Year Four to Year Two, significantly more individuals with IDD in crisis needed REACH services. The REACH Teams responded on-site to more crisis calls, completed more crisis assessments, and processed more crisis and non-crisis referrals. Although the Commonwealth's REACH Teams continued to respond on-site to the increased number of calls and did so, commendably, within the required one or two-hour timeline to arrive on-site, the quantity of supports provided by REACH Teams was significantly reduced in many areas.

Tables A through D below show the changes over two years in the workload and supports provided. There was a significant increase in the number of children and adults with IDD and a corresponding increase in the need for every element of the state's crisis service supports. Despite this significant increase, REACH continued to provide the elements of mobile supports to the same number of individuals and to provide the same combined number of hours of mobile supports and crisis stabilization as it had two years earlier.

During the period when the number of children's crisis referrals to REACH increased from 854 to 1410 (+65%) and the number of mobile assessments conducted increased from 613 to 968 (+58%), the number of children who received Crisis Education and Prevention Plans declined from 430 to 262 (-39%) and the number who received mobile supports declined from 601 to 278 (-54%). Overall, over the past two years, REACH responded to significant increased crisis service needs, in part, by reducing the provision of many crisis services, especially when measuring the services provided per individual.

Positive indications were found in the data between Year Three and Year Four. For example, there were fewer children admitted to psychiatric hospitals, and, in some Regions, REACH provided some elements of crisis services more often. However, the central conclusion of the Independent Reviewer's consultant is in regard to the impacts on the services provided due to the extent of increase in need. Positive changes in trends related to the effectiveness of services provided are vitally important, needed and are occurring. The extent of any improvement, however, is not the Commonwealth's core challenge at this time; rather, it is ensuring that sufficient resources are available and deployed in a manner to meet the requirements of the Agreement and the crisis services needs of the target population. The increases in the number of individuals in crisis, in contrast with the decreases in the quantity of crisis supports provided, underscore that the current statewide crisis system does not have a sufficient number of filled REACH staff positions, crisis stabilization beds, therapeutic host homes, or transition homes.

Overall, the facts gathered during the fourteenth review period indicate that the Commonwealth's statewide crisis service system is not functioning as described in the Agreement. Due to an increased number of people in crisis (i.e. workload), CSB-ES "single point of entry" and Regional REACH resources appear stretched beyond the capacity or ability to fulfill a number of the Agreement's Crisis Service provisions.

In the following Tables, the REACH workload and performance indicators are organized in: 1) separate tables for children and adults; 2) indicators of increased need; and 3) indicators of declining supports provided with the negative consequences for individuals.

TABLE A
Children's REACH System Workload and Performance: Year Two vs. Year Four
Increased needs

	Year Two	Year Four	+/- change %
children referred (table 1)	854	1,410	+ 65.1%
children's crisis calls/responses (table 2)	617	970	+ 57.2%
children's non-crisis calls (table 2)	2,449	3,469	+ 41.6%
children's mobile crisis assessments (table 4)	613	968	+ 57.9%
children's out of home assessments	61%	67%	+ 6.0%

TABLE B
Children's REACH System Workload and Performance: Year Two vs. Year Four
Decreased or unchanged services, increased negative outcomes

	Year Two	Year Four	+/- change %
children evaluated (table 6)	472	284	(- 39.8%)
children received education/prevention plan (table 6)	430	262	(- 39.1%)
children home with mobile supports (table 3)	601	278	(- 53.7%)
children stays in Crisis Therapeutic Home	0	0	
psychiatric admissions at crisis assessment (4)	152	340	+ 124%
psychiatric admissions (table 7)	237	390	+ 64.5%

TABLE C
Adult REACH System Workload and Performance: Year Two vs. Year Four
Increased needs

	Year Two	Year Four	+/- change %
adults crisis referrals (table 8)	647	888	+ 37.2%
adults non-crisis referrals (table 8)	600	789	+ 31.5%
adults crisis calls/responses (table 9)	1,159	2,229	+ 92.3%
adults non-crisis calls to REACH (table 9)	2,690	11,702	+ 335.0%
adults mobile crisis assessments (table 10)	1,574	2,222	+ 41.2%

TABLE D
Adult REACH System Performance: Year Two vs. Year Four
Decreased or unchanged services, increased negative outcomes

	Year Two	Year Four	+/- change %
adults received REACH service elements (table 17)	941	929	.0%
adult hours of mobile supports and CTH (table 16)	25,481	25,687	.0%
adults home w/mobile supports at assessment (table10)	200	352	+ 76.0%
adults home without mobile supports (table10)	669	884	+ 32.1%
adults received mobile crisis supports & CTH (table 15)	1,075	785	(- 30.0%)
adults to the CTHs when assessed (table 10)	136	112	(- 17.6%)
assessments out-of-home (i.e.ER or CSB) (table 18)	933	1,425	+ 34.5%
adult psychiatric admissions when assessed (table 10)	515	808	+ 56.9%

The data in the above tables depict the increased numbers, during the past two years, of individuals with IDD in crisis and the decrease in crisis supports provided. With these increased demands, the Commonwealth's statewide crisis system has, in most areas, continued to fulfill the functional responsibilities described in the Agreement. The Regional REACH Teams answered more crisis calls, completed more on-time responses, and more mobile assessments. The system-wide problem is the dramatic reduction in the per person provision of crisis supports that are needed and required by the Agreement.

Other findings and conclusions about the status of the statewide crisis system include:

Statewide Crisis System
Many elements of the statewide crisis service system have been developed and implemented. The Independent Reviewer has found continuing and significant challenges regarding the location of the statewide crisis system's initial crisis assessments in contrast to the reduction in service provision in the face of increased needs.

Ongoing obstacles to meeting the overarching goals of the Commonwealth's crisis service system is that it does not have a sufficient number of behavioral specialists or an adequate provider capacity for serving individuals with intense behavioral and medical needs. Adequate and appropriate behavioral support elements of ISPs must be in place to allow the mobile crisis teams and their short-term supports, planning, and training resources to sustain individuals in their homes. The lack of availability of new long-term residential options with quality behavioral support services for individuals who experience a crisis appears to be a significant contributing factor to longer crisis stabilization stays at the Crisis Therapeutic Home (CTH) or to the psychiatric hospitalization of individuals after providing REACH mobile crisis supports.

The findings from the independent qualitative review of sixty individuals who had engaged the crisis system underscore the need for more behaviorists, "behavioral support services, continues to be the least available and most needed support to assist individuals and families who have co-occurring conditions and present behavioral challenges". Of the sixty individuals studied: ten had behaviorists, fifteen did not need behaviorists, and thirty-five (58%) were not able to access behaviorists, but needed behavioral support services.

Crisis Point of Entry
The crisis services system's "Point of Entry," the CSB-Emergency Services, operate "hot lines" twenty-four hours, seven days a week, as required. They are able to assess crises and assist the caller in connecting with local resources. Calling the CSB "hotlines" typically results in a crisis assessment occurring at an out-of-home location, rather than the required in-home responses.

Mobile Crisis Teams
Mobile crisis teams respond on-site within the time requirements of the Agreement, one hour in urban designated areas and two hours in rural designated areas. These responses are often to CSB offices or local hospitals, the locations where the individuals are often taken to be assessed.

Mobile crisis team members are adequately trained to address the crisis. When the individuals have not been removed from their homes and receive mobile crisis supports, the REACH mobile team members have provided the quantity of in-home crisis supports called for in the Agreement.

Mobile crisis teams work with law enforcement. REACH Teams have continued to provide training to more than 600 officers in each of the past four years.

Mobile crisis teams identify and implement prevention strategies and provide in-home support for up to three days, and more, for individuals who receive mobile crisis supports.

The Commonwealth did not add a second mobile crisis team to each Region in 2013. Instead, it added staff to increase the capacity to have adequate resources to respond on-site and to deliver the crisis de-escalation, supports, services, and treatment without removing individuals from their home; and to offer crisis prevention strategy and planning, short-term support capacity in the home, and the crisis stabilization "last resort" alternative to hospitalization. The mobile crisis teams have continued to respond on-site to crisis calls, as required.

For both children and adults, however, as depicted in Tables A through D above, the mobile crisis teams have dramatically reduced the amount of supports and services, and out-of-home crisis stabilization, provided to each person. As needs increased dramatically between Year Two and Year Four, and staff and stabilization capacity did not, there was an increase in negative outcomes for children and adults in crisis. It is the Independent Reviewer's conclusion that the dramatic increase in the number of individuals referred is a significant factor in the decrease in the quantity of crisis services available and provided to each person. Furthermore, the limited availability of mobile crisis supports and crisis stabilization capacity has contributed to an increase in negative outcomes, including unnecessary and avoidable admissions to psychiatric hospital.

Crisis Stabilization Programs

Each Region has a Crisis Stabilization Program that has no more than six beds and that offers short-term alternatives for adults to institutionalization or hospitalization.

No Region has a Crisis Stabilization Program that offers short-term alternatives for children. The two six-bed statewide children's crisis stabilization homes that have been planned, which DBHDS calls Crisis Therapeutic Homes (CTH), are substantially behind schedule. Due to recent construction related delays, DBHDS now projects that these homes will become available during the next review period.

Having too few residential providers with the capacity to provide good quality behavioral support services undermines the Commonwealth's provision of effective crisis services, which are designed to provide short-term interventions, crisis prevention planning and training. To remain stable for the mid and long term, many individuals need good quality on-going behavioral supports. Many individuals who experience a crisis are not allowed to return to their former residence; frequently their residential service provider has ejected them. Regrettably, the lack of available and qualified providers with behavioral capacity appears to be a significant contributing factor to longer stays at the CTH or to the psychiatric hospitalization of individuals after REACH has provided mobile crisis supports.

The fact that the number and percentage (67%) of assessments are conducted in out-of-home locations, either at hospitals or CSB offices, is evidence that the Commonwealth's crisis service system is not being implemented by the CSBs to comply with a very specific requirement of the Agreement's goal. It is the considered opinion of the Independent Reviewer that the location of the crisis assessment is the rudder of the crisis system. When on-site responses occur in the home, more individuals are provided with mobile crisis supports and fewer are admitted to psychiatric hospitals. Crisis services' onsite responses are required to occur, whenever possible, without the individual being removed from the home. The fact that individuals who receive their initial assessments at these out-of-home locations are much more likely to be hospitalized is additional evidence that the crisis system is not preventing the individual from being removed from his or her residence. Once the individual is removed from his or her home, it is no longer possible for the REACH Teams to demonstrate their successful provision of *"services, supports and treatment to de-escalate crisis without removing individuals from their homes, whenever possible."*

The Parties have informed the Court that they have agreed to measurable indicators of compliance for the crisis services provisions of the Agreement. The Independent Reviewer and expert consultant will incorporate these indicators into future studies of the Commonwealth's status of fulfilling these requirements.

The Commonwealth has remained in compliance with Sections III.C.6.b.i.A.; III.C.6.b.ii.C., D., E., and H.; III.C.6.b.iii.A. and III.C.6.b.iii.F. It has made progress, but remains in non-compliance with III.C.6.a.i-iii; III.C.6.b.ii.A. and B.; III.C.6.b.iii.B., D., E., and G.

4. Individual and Family Support Program

For the fourteenth period review, the Independent Reviewer retained the same independent consultant who previously reviewed the status of the Commonwealth's progress related to the Individual and Family Support Program for the sixth, eighth, and twelfth Reports to the Court, dated June 6, 2015, June 6, 2016, and June 13, 2018, respectively. In the twelfth Report to the Court, one year ago, the Independent Reviewer found the Commonwealth had again met the pertinent annual quantitative requirements by providing IFSP monetary grants to at least 1,000 individuals and/or families, but had not met the qualitative requirements. The Commonwealth's Individual and Family Support Program did not include:

1.) A comprehensive and coordinated set of strategies to ensure access to person and family-centered resources and supports, as required by the Program's definition in Section II.D., and

2.) The Commonwealth's determination of who is most at risk of institutionalization was based on a single very broad criterion and did not prioritize between individuals on the urgent and non-urgent waitlists or those with greater or more urgent needs.

Concurrent with this fourteenth review period, the Court requested that the Parties submit statements in measurable terms of what the Commonwealth would have to accomplish to fully comply with the decree. This included the IFSP. The Parties' proposed indicators for the IFSP were not identical and were still being negotiated, but were closely aligned with the areas of concern identified in the Independent Reviewer's previous Reports to the Court and that were used for the current study of the IFSP. It is the Independent Reviewer's considered opinion that final compliance indicators will continue to have these same focus areas. With that prospect in mind, the consultant's report for the fourteenth review period (Appendix E) presents findings within the context of these focus areas and the Parties' respective proposed indicators.

These focus areas include:

1) The definition of who would be considered "most at risk for institutionalization" for the purposes of the IFSP;

2) Determination of whether, and how, Case Management options available to individuals on the waitlist would be integrated as a part of a comprehensive set of individual and family support strategies;

3) Notification regarding the availability of individual and family supports to individuals and families; and,

4) Identification of indicators to assess performance and outcomes of the IFSP, including the development of capacity for the collection and the analysis of the needed data.

The twelfth Report to the Court documented the Commonwealth's extensive planning, organizing and development efforts to address the IFSP requirements of the Agreement. This fourteenth review period study again found that, at a systemic level, DBHDS continued to coordinate the development and implementation of various state level IFSP-related programs and initiatives. The Commonwealth's initiatives now relate to an evolved and more connected set of program elements in four domains. These include the IFSP Funding Program, the IFSP Community Coordination Program, the Virginia Commonwealth University (VCU) Partnership for People with Disabilities' peer-to-peer and family-to-family programs, and the Senior Navigator's "My Life, My Community" (MLMC) website. The consultant's attached report includes a review of the initiatives in each domain.

The Commonwealth has made progress in each of its IFSP initiatives. Other than the IFSP Funding Program, however, they have not been fully implemented. For example, DBHDS has continued to collaborate with the Senior Navigator to re-brand and expand the MLMC website. Organizing information and training of the MLMC call-center personnel has occurred, so they were prepared to provide answers on a variety of commonly asked questions and provide referral information. IFSP staff continued to serve as back-up when call center personnel were not certain about the appropriate responses during the most recent annual IFSP funding cycle. The on-line informational website, which had its "soft launch" at the end of the fourteenth review period, is expected to be officially launched in May 2019, during the next review period.

Most at Risk for Institutionalization

At the time of the twelfth period review, for those eligible for IFSP funding, DBHDS had not yet defined criteria to determine "most at risk for institutionalization." It had drafted administrative rule changes to remove the statutory requirement to distribute IFSP funding on a "first come-first served" basis. The draft rule changes would allow DBHDS to define administratively "most in need" and any prioritization criteria, with the advice of the IFSP State Council. DBHDS also needed to clarify whether the criteria that it established to create three "most in need" levels for the waiver waitlist would also apply to the IFSP Funding Program. The Independent Reviewer recommended that DBHDS continue to examine the definition of "most at risk for institutionalization," including whether the current prioritization of the waiver waitlist would apply to the IFSP.

As of the fourteenth review period, although it had considered alternatives, DBHDS had not yet determined how to address the "most at risk" criteria. Further, DBHDS had not yet submitted, nor planned to submit, any proposed regulatory changes to replace the existing statutory "first come-first served" requirement. DBHDS staff cited concerns about the potential for appeals by IFSP applicants who did not receive funding. DBHDS staff also reported that they had considered using the "most in need" waiver waitlist priority status, as defined in the emergency waiver regulations, but decided that application of these criteria to IFSP funding would compromise programmatic flexibility. DBHDS staff were in the early stages of considering a hybrid approach that might combine first come-first serve and urgency of need criteria, but these ideas have not yet been explored with its Regional and Statewide Family Councils.

Waitlist Case Management

At the time of the twelfth review period, DBHDS had issued emergency regulations in conjunction with the roll-out of its re-designed HCBS waivers. These regulations indicated that individuals on the waiting list could receive, or be eligible for, individual Case Management services from the CSBs; however, the Commonwealth had not clearly defined expectations for the Case Management options that would be available as part of its comprehensive strategies for the IFSP. It had also not widely shared information about these options. For individuals and families, Case Managers are often the primary source of information regarding how and where to access services; therefore, for them, knowing how to access Case Management services is foremost to accessing the correct point of entry to all other services.

DBHDS has published *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: The Basics October 2017 Sixth Edition*, which informed readers that individuals on the waiver waitlist may be eligible for Case Management services. It further indicated that those interested should contact their local CSB to find out whether they might be eligible, but the Commonwealth had not established guidelines, standardized procedures or criteria for making such eligibility determinations. The lack of existing guidance to individuals and their families regarding how to access case management services was confirmed as well during the Independent Reviewer's current study of Case Management (Appendix C). In this study, all seventeen Case Managers/supervisors (100%) interviewed acknowledged carrying a caseload of waitlisted individuals, but none could provide local guidance or policy.

IFSP performance and outcome measures

At the time of the twelfth period review, the Independent Reviewer determined that DBHDS needed to:

- Define measurable indicators to assess performance and outcomes of the IFSP; and
- Develop the capacity for, and implement, the collection and the analysis of the needed data.

Development of these indicators is an essential step for the Commonwealth to determine and maintain sufficient records to document that the requirements of this Agreement are being properly implemented. Collecting reliable data regarding the extent to which the actual performance of the IFSP has, or has not, achieved these indicators is needed for the Commonwealth to be able to analyze both accomplishments and shortcomings to decide what priority quality improvement initiatives are needed.

The Independent Reviewer has recommended that DBHDS:

- Identify indicators and the sources of data needed to adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports, the impact on the risk of institutionalization, the notification of individuals, their families and appropriate agencies, and individual and family satisfaction.
- Implement collection and analysis of these data in an expeditious manner to provide for data-based decisions about any additional policy and procedural decisions in this area.

As of this fourteenth period review, DBHDS had updated the IFSP State Plan (revision date February 6, 2019) and identified a set of outcome targets for each of the short-term goals. These thoughtfully addressed some of the recommended measures such as access, as measured by individual and family levels of awareness of the IFSP, and individual and family satisfaction. The consultant's report attached as Appendix E includes the compliance indicators and adherence measures that were developed and proposed by the Commonwealth and by DOJ.

It was positive that IFSP staff had developed a data collection matrix to guide its current and future efforts at data collection, that the matrix included both quantitative and qualitative measures, and that it identified the data collection schedule (i.e., quarterly or annually). Data collection had begun for some of its outcome targets. DBHDS projects that collection of data related to many of the outcome targets will begin at later dates. Generally, this current set of data to be collected will measure system outputs, such as the number and types of events where IFSP materials were presented and the number of trained family navigators, rather than outcomes experienced by the individuals/families, such as increased awareness or other results.

Going forward, DBHDS will want to consider additional measures to assess the:

- Impact of IFSP on risk for institutionalization;
- Comprehensiveness of the IFSP strategies, considering the expressed needs of recipients; and the
- Degree and adequacy of coordination, both on a systemic and individual basis.

DBHDS will also need to consider how it will integrate key IFSP measures into its overall Quality Improvement/Risk Management Framework. The IFSP staff indicated that this Framework is still in its infancy and that DBHDS intends to integrate the IFSP Plan outcomes, as it is finalized.

Peer-to-Peer and Family-to-Family Programs

At of the twelfth review period, DBHDS planned to contract with Virginia Commonwealth University's Partnership for People with Disabilities to administer the required Peer-to-Peer and Family-to- Family programs. The Independent Reviewer found that the proposed Memorandum of Agreement (MOA) between DBHDS and VCU was broadly stated and did not specify how the proposed program would interface with the annual individual service planning and informed choice processes, or how these interfaces might serve to increase the number of individuals and families who choose to participate. At that time, DBHDS staff indicated a more detailed workplan was to be developed once the contract was finalized.

Previous reviews have used the following criteria to evaluate compliance with this section:

- Does the Commonwealth's annual individual service planning process document an offer of family-to-family and peer-to-peer meetings and discussions to facilitate community placement consistent with the individual's informed choice?
- Does the Commonwealth offer families and/or individuals who may be considering different types of residential settings an opportunity to have discussions with families and/or individuals who have had such residential experiences; and if the family and/or individual expresses an interest, does the Commonwealth facilitate such family-to-family or peer-to-peer discussions?

For this fourteenth review period, the Independent Reviewer requested materials including:

- Any finalized or draft policy, procedures, tools or protocols related to the family-to-family and peer programs;
- Any data collected regarding individuals and families who have participated in the family-to-family and peer programs, and any related analyses completed;
- Any data collected regarding programmatic outcomes of the family-to-family and peer programs, and any related analysis completed; and,
- Any draft or finalized versions of indicators, tools, processes and/or any quality improvement strategies to be used to assess programmatic outcomes, as they relate to family-to-family and peer programs.

Other than the MOA with VCU, DBHDS did not provide any of the documentation or materials listed above. The MOA again did not specify the interfaces with the annual individual service planning and informed choice processes, as described during the twelfth review period.

Conclusion

DBHDS again provided funding to 1,000 individuals, and or families, who are not receiving waiver-funded services. Therefore, it has sustained compliance with the quantitative requirement of III.C.2.a-g.. It has made progress on many of its IFSP initiatives, but has not yet achieved compliance with the program definition or the qualitative requirements of Sections II.D., III.C.2., or III.D.5.

*5. Publishing **Guidelines for Families***

A year ago, in his twelfth review period Report, the Independent Reviewer documented that the Commonwealth had planned a multi-pronged plan for publishing guidelines that could be used effectively to direct individuals in the target population to the correct point-of-entry to access services. At that time, although some components were in the early planning stages, the Independent Reviewer reported that the IFSP communication plan was promising. The Independent Reviewer also identified that the Section III.C.8. requirement, which is designed to benefit individuals not already receiving services under HCBS waivers and states that *"the Commonwealth shall publish guidelines for families seeking services … on how and where to apply and obtain services*" and the requirement that the Commonwealth would develop Individual and Family Support Programs (IFSP) that incorporated "*a comprehensive and coordinated set of strategies … to ensure that families … have access to … resources, supports, services and other assistance" which* were not fully implemented. The IFSP needed to consider and provide guidelines to families regarding how to access Case Management options available to individuals on the waitlist. Doing so would address the role of Case Management services in the Commonwealth's comprehensive set of individual and family supports strategies. It also needed to ensure notification to individuals and families, and appropriate agencies, of the availability of individual and family supports resources and programs.

The fourteenth review period's study found that DBHDS had continued to develop and implement a multi-pronged strategy for publishing and disseminating guidelines. When fully and effectively implemented, its multi-pronged strategy could be used to direct individuals in the target population and their families to the correct point of entry to access services. The Commonwealth has implemented some, but not all, of the essential elements of its plan. For example, DBHDS relied on the IFSP Regional Councils as local vehicles for information-sharing. With support from the DBHDS IFSP staff, the Regional Council members had been energetically engaged in various outreach, information-sharing and networking activities. Whereas, the MLMC website, which is an essential component of the overall communication plan to promote widespread availability of needed information, continues to be in the developmental stage.

Providing guidelines to families about the availability of IFSP funds is critical. Individuals and family members would have to know when, where and how to look for the on-line announcements to be able to participate. While DBHDS continued outreach efforts to those on the waiting list regarding the IFSP Funding Program, the independent consultant found that stakeholders continue to express concern that everyone on that list did not receive direct notification of the IFSP funding opportunity. Their concern was that those who lacked a current and ongoing connection to the service system were those who were also least likely to be informed about available funding. Stakeholders viewed this as perpetuating a system in which people who had access to information and resources obtained additional access, by virtue of their ongoing connections, while others did not.

As documented in the previous report for the twelfth review period, the primary remaining concern continued to be ensuring the dissemination of information and guidelines about the IFSP, and in particular for the funding program and Case Management options, to everyone on the waitlist. While DBHDS did not yet have the needed capacity in place to address this significant gap, it had developed a plan to ensure notification to everyone at the time of enrollment on the waitlist and at least annually thereafter. DBHDS was nearing completion of a project to verify, and maintain, current contact information for all individuals on the waiver waitlist in its Waiver Management System (WaMS). Using these data, DBHDS further planned to begin an annual attestation letter process in which all current waitlist enrollees would be contacted and asked to update the contact information. At the same time, DBHDS would provide information about the availability of IFSP supports, including the funding program and case management options. IFSP anticipated this process would be operational in Summer 2019.

The Commonwealth has made progress; however, it has not achieved compliance with III.C.8.b.

6. Children in Nursing Facilities and ICFs

The Independent Reviewer retained the same independent consultant to assess the Commonwealth's efforts to divert and to transition children from two nursing facilities (NFs) and two large private Intermediate Care Facilities (ICFs) specifically.

The Agreement requires the IDD target population, including those on a waitlist or who meet criteria for a waitlist, will have dedicated waiver slots to prevent or transition from placement in an NF or ICF. Placement will be in the most integrated setting consistent with the individual's informed choice and need and, if placement in an NF or a congregate facility of five or more is being considered, it will first be reviewed by the Community Resource Consultant (CRC) and/or the Regional Support Team (RST) to identify and address obstacles to placements in more integrated settings.

The review for this period's Report to the Court focused on an assessment of the Commonwealth's processes and plans to divert from admission and to transition children from living in NFs and ICFs to home- and community-based settings. The study included review of the service documentation for the selected sample of children and interviews with DBHDS staff regarding admission of children with intellectual and developmental disabilities (IDD to NFs or large private ICFs. The selected sample included all children who were admitted during calendar 2018 to any one of four facilities (two NFs and two private ICFs) was completed. The selection of this sample allowed the study of the impact(s) of DBHDS's efforts since 2017 to divert and transition children from the four facilities.

The purpose of this study was to assess the Commonwealth's efforts to divert children from being admitted to an NF/ICF and to facilitate the transition of children away from childhoods of long-term institutional care to living in the family home, or, if that is not possible, in an integrated community-based setting, such as a family-like setting with a long-term caregiver. The consultant found that the Commonwealth's processes for diverting children from being placed in these types of institutions is largely in place. These processes, including the single point of entry screening,

have effectively diverted children from admission. This effectiveness is limited by a community-based service system that has significant systemic obstacles to receiving needed home-based care (e.g., families and Case Managers know that in-home nurses and direct support professionals are not available to consistently fill the hours that the Commonwealth confirms are needed.) To facilitate transitions, the Commonwealth has engaged with the staff at the four facilities included in the consultant's study. In reviewing the outcomes from this collaboration, the consultant established that the transition of children into more home and community-based settings has occurred at three of the four facilities. Although, the requisite processes appear to be in place and functioning, their effectiveness is limited by the lack of viable community-based options for children. DBHDS reports that there is a current census of 170 children in these four nursing and private ICF facilities. Although, this is a reduction from the census of 196 children reported in 2015, it essentially represents no change in the census of children in these four institutions since our last study in 2017 (171).

The children who remain living in these facilities are often children who, for various reasons, cannot return to their family homes. To avoid unnecessary institutionalization, these children need a viable family-like sponsor home alternative. For the children who could return home, in-home nurses and direct support professionals must be available to consistently provide in-home hours of support that the Commonwealth confirms are needed. The Commonwealth's processes for diversion and transition are described in Appendix F.

DBHDS is effective at diverting children from unnecessary placement in the two identified NFs and at working with one NF to return children to their families or home communities. This latter mechanism, transitioning children home, does not yet function well with NF2, which discharged only two of the thirty-one children living at NF2. With the single point of entry controls in place DBHDS is now able to ensure there are no inappropriate ICF admissions, but its effectiveness at diverting ICF admissions may now depend on the availability of community-based settings that serve the specialized needs of those with medical or behavioral challenges. DBHDS should consider a Departmental Instruction to CSBs that affirms its preference that young children should be raised by families or in family-like settings, where bonding with a continuous caregiver can occur, rather than in congregate settings with shift-based staffing.

7. Independent Housing

The Independent Reviewer retained the same independent consultant who previously reviewed the status of Virginia's *Plan to Increase Independent Living Options (Plan)* in November of 2013, November 2014, June 2016, and November 2017. For this most recent review in April 2019, the consultant reviewed the updated version of this Plan, its Provider Data Summary: *The State of the State*, and supporting documents, and then had clarifying discussions with DBHDS staff, providers and advocacy group representatives.

The DBHDS Independent Housing Outcomes Table shows that as of March 31, 2019, 925 individuals in the Agreement population were living in their own homes, an increase of 582 individuals since July 2015, and that 613 new independent housing options had been created. The Commonwealth has been most successful in funding individuals in independent housing using housing resources through VHDA Vouchers, State rental assistance, and local PHAs, but has not listed any independent housing options as a result of the Low Income Housing Tax Credit (LIHTC) properties. This is notable because the Commonwealth's *2018 Plan to Increase Independent Living Options - Dashboard* reports that, in 2016, 128 housing units were allocated because of the LIHTC and another 84 were projected in 2017. Yet, there is no indication that any of these LIHTC units were filled by the target population.

With its June 30, 2019 targeted goals of 796 individuals living in their own homes and 522 options created, DBHDS has continued to stay ahead of its Outcome-Timeline, which projects providing 847 new independent living options and 1866 individuals living in homes of their own by the end of Fiscal Year 2021. It should be noted that the last two years of the proposed development schedule (Fiscal Year 2020 and Fiscal Year 2021) call for a much more aggressive expansion with DBHDS having to almost double the number of individuals living in independent housing options from the current number of 925 to the target of 1866 by June 30, 2021.

As previously reported to the Court, the Commonwealth requires significant provider development to provide more integrated residential and day service models, especially for individuals with complex medical needs. For individuals to successfully secure one of the independent housing opportunities, their Case Managers must ensure that the support resources and equipment that are needed are in place when the housing becomes available. With too few providers of the required support services, doing this successfully and timely would challenge any service system. The reported weaknesses in the Commonwealth's current CSB Case Management system may provide additional obstacles to helping more individuals with IDD to experience more independent living options and to develop more self-sufficiency. An effective Case Management system, which is critical for coordinating services for a successful independent community housing program, would include effective long-range planning, specific and measurable goals and objectives that will increase integration and self-sufficiency, and routinely implemented protocols that determine the appropriateness of current services.

Since last reviewed in late 2017, DBHDS staff developed a comprehensive statewide baseline/ongoing evaluation of existing support services and targeted specific areas of the Commonwealth that are struggling with producing needed supported independent housing. The first six-month post baseline evaluation shows slight improvement, but this first evaluation period is probably too short to ascertain the productivity of DBHDS activities in this area.

While the DBHDS provider development baseline and its newly launched provider development activities show promise, the fact that DBHDS has yet to promulgate permanent regulations for the newly developed waiver is an obstacle to needed provider development. DBHDS should advance its regulatory framework. By doing so, it will convey to the provider community the sustainability needed to commit to undertaking a new service business model. Providers require a clear picture of DBHDS's future expectations, or they will be reluctant to develop the necessary new services to support individuals who choose to live, and receive their support services, in one of the new independent community living options.

The consultant also recommends that actions are required to ensure that the Commonwealth has the needed housing infrastructure in place for housing opportunities for individuals with mobility impairments. As DBHDS looks ahead in its long-term planning, the Independent Reviewer encourages it to anticipate this challenge and to facilitate the development of options specific to expanding housing opportunities for people using wheelchairs.

The Commonwealth's current focus is on offering apartment living to single individuals as the primary path to independent community living. This approach significantly limits the reach of housing opportunities. In addition, based on the Independent Reviewer's experiences and interviews with case managers, many individuals, who would otherwise choose to live in more independent housing, do not prefer to live alone. Also, the option of offering apartment living to single individuals is viable only to those whose support needs can be met within the tight service limitations of the current waiver program. For example, the Commonwealth's Independent Living Supports waiver service, which is in its Building Independence Waiver, has a limitation of no more than 21 hours of support a week, and the Shared Living waiver service in its Community Living Waiver has a limitation that ADL and IADL supports account for no more than 20% of the companionship time.

It is recommended that DBHDS explore approaches that allow individuals with disabilities to choose to live together and "combine" their supports and rent subsidy budgets. This option, once introduced, will open the possibility for many more individuals to move into community-based independent living settings who would not otherwise have that choice.

The Commonwealth has sustained compliance with *Sections III.D., III.D.3., 3a,.3bi-ii.,* and *4.*

8. Discharge Planning and Transition from Training Center

Individual Services Review (ISR)

During the fourteenth review period, the Independent Reviewer completed the seventh Individual Services Review (ISR) study of the Commonwealth's process and outcomes for individuals who transitioned from one of its Training Centers. This was the same focus as the Independent Reviewer's first study, in September 2012, to determine the extent that the Commonwealth had fulfilled its responsibilities, as described in the Agreement's Section I.V.

Annually, since 2012, the Independent Reviewer has monitored the Commonwealth's compliance with the discharge and transition provisions, in part, by completing a recurring ISR study focused on individuals who had transitioned to and living in community-based settings for six to twelve months. For each study, the Independent Reviewer selected a cohort of individuals who had transitioned from designated Training Centers (see Appendix A). The cohorts for the seven studies included a total of 303 individuals who had moved to all five Regions and from all of the Training Centers. At the end of the twelfth review period, the Independent Reviewer reported that the Commonwealth had achieved thrcompliance with thirty of these provisions but was not in compliance with three.

For the ISR study during the fourteenth review period, Independent Reviewer selected individuals who transitioned from Virginia's Training Centers between April 1, 2018 and November 30, 2018. A random sample of twenty-seven individuals were selected from the forty-five individuals who met the Independent Reviewer's ISR study criteria. This selection provides a 90% confidence level that the findings from this study, as with previous ISR studies, can be generalized to the larger cohort.

The Commonwealth has continued to achieve compliance with most of these provisions and overall positive service outcomes have been noted for the individuals studied. Its discharge and transition process has been, and continues to be, well organized and well documented. The DBHDS staff have improved processes based on recommendations from previous studies.

However, this study again found very similar, but more significant, areas of concern in the Commonwealth's community-based service system. Although some improvements were noted, there are still too few day and residential providers to serve the number of individuals with intense behavioral and medical needs. There are also too few behavior specialists. Although the Commonwealth now has more group homes with four or fewer residents with IDD and hundreds of individuals are receiving Community Engagement services, there are too few providers of integrated day activities and most integrated residential service options. Many individuals

Although there were individual exceptions, the following themes and examples of both positive outcomes and areas of concern were found in the study of the transitions and services for these twenty-seven individuals. These themes, both the positive outcomes achieved and the identified areas of concern, are very similar to the findings from previous ISR studies.

The discharge planning and transition processes were well-organized and well-documented. The individuals' personal support teams, including the Authorized Representative, identified essential supports needed for successful placement. They documented, and CSBs confirmed, that such essential supports were in place prior to transition. The selected residential providers were involved in the discharge planning process and the residential provider staffs received training in the individuals' health and safety protocols. The Post-Move Monitor (PMM) visits occurred as expected, and, if concerns were identified, extra PMM follow-up visits occurred to confirm resolution. Overall, placements were found to be successful.

The individuals' new community homes were clean, well maintained and had been inspected by the Office of Licensing Services. Homes were accessible, based on the individuals' needs for environmental modifications, and needed adaptive equipment and supplies were available. The DBHDS Licensing Specialists had recently inspected all congregate residential homes.

There were many positive healthcare process outcomes for virtually all the individuals studied. Thirty-four health care outcomes were studied for each of the twenty-seven individuals studied. For example, twenty-six out of the twenty-seven individuals (96.7%) had had an annual physical within twelve months and all (100%) had their primary care physicians' recommendations implemented within the timeline, as ordered. The Commonwealth achieved 100% compliance for most healthcare-related provisions and exceeded 88% percent for thirty-three out of thirty-four health care outcomes. (See Appendix A for details.)

The individuals made successful transitions and had settled well into their new home environments. This theme was also documented in previous ISR studies of individuals who had transitioned from Training Centers. The Reviews again found several impressive examples of individuals with significant histories of problematic behaviors who now were experiencing significantly fewer and less severe incidents. One of these individuals had been restrained more than any other resident at his Training Center. Since living in his quiet and supportive sponsored home and being regularly engaged in integrated activities, with the active support of his sponsor, the number of his behavioral episodes has declined sharply and they now occur rarely.

The individuals who transitioned were not offered available day or supported employment opportunities and lacked integration opportunities. Generally, the Commonwealth determined that day services were not an essential support for successful community placement; and overall the ISR studied verified that placements were successful. However, eighteen of the twenty-seven (66.7%%) individuals did not have a day service in place five to nine months after transition. The Post-Move Monitoring teams verified that day services were an essential support after the individuals were placed and confirmed their lack of availability. Referrals of many individuals, some of whom have intense medical needs, had been rejected or put on waiting lists by the day programs that were listed as "potentially available day service options" that are frequently cited as the day services options during the discharge process. Only three (11.1%) of the twenty-seven individuals participated in community engagement services and one (3.7%) had a typical day that included integrated activities.

Four individuals (15%) moved to old large congregate facilities, which the Commonwealth still categorizes as more integrated "community-based" options, rather than the outdated institutional design, outsized, and usually isolating facilities that should be considered "other institutions" like nursing homes and large private ICFs, to which they are more similar in character, appearance, operations, and lack of personalization. This clearly is a contraindication in terms and defeats the stated intent of the Agreement.

Conclusion

The Commonwealth has continued to maintain well-organized and well-documented discharge planning, transition and post-move monitoring processes. These have led to substantially successful placements for individuals in community-based services.

As reported above, the Individual Services Review study has identified areas of concern that will impact the 120 individuals who remain at the Training Centers, but will also be obstacles to hundreds and possibly thousands of Virginians with IDD from living and having typical days in integrated settings. Although some improvements have occurred, there are too few day and residential providers to serve the number of individuals with intense behavioral and medical needs. There are also too few behavior specialists. Although more group homes now have four or fewer residents and hundreds of individuals are receiving Community Engagement services, there are too few providers of integrated day and smaller more integrated residential services, especially for individuals with complex needs and for individuals who want to live in more independent settings.

Given the goals of the Agreement's Section I.V. Discharge Planning and Transition from Training Centers, it is particularly unfortunate that DBHDS continues to offer outdated and outsized congregate facilities that are arguably not more integrated than the Training Centers. These institution-like facilities often have other residential, day, and office buildings or suites, on the same, or adjacent, property and house six to sixteen or more individuals. These facilities typically isolate individuals from their communities, and appear and operate more like nursing facilities or large private Intermediate Care Facilities, "other institutions", than smaller "integrated community-based options." The provider typically transports groups of the facility's residents to large congregate day programs, a routine that does not allow for any integration and few personal growth opportunities. As a result individuals who transition from Training Centers to these facilities will likely not spend more time in either integrated settings or activities. It is the Independent Reviewer's considered opinion that a planned discharge to one of these facilities does not increase the likelihood that *the individual will achieve outcomes that promote the individual's growth, well-being, and independence"* … in any of the … *domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships)"*, and should not be offered as community-based options to individuals with IDD. Living in these facilities should not be considered a long-term community-based option to an institutional care program, such as a Training Center.

The Commonwealth had previously achieved, and in the fourteenth period maintained, a rating of compliance with most of the Discharge Planning and Transition provisions. As exemplified by the Individual Services Review study themes described above and by the Tables in Appendix A, consistent compliance with these provisions of the Agreement has resulted in many positive outcomes for the individuals who transitioned.

The Independent Reviewer has provided the Individual Services Review reports to the Commonwealth so that the Commonwealth and its providers will review the issues and areas of concern identified for each individual. The Independent Reviewer has asked the Commonwealth to share the reports with the individual's residential service provider and Case Manager and, by March 30, 2020, to provide updates on the actions taken and their results in regard to any issues identified.

Selected Tables with the Individual Services Review study's findings are attached (Appendix B). The Independent Reviewer has separated findings from the study into Tables focusing on positive outcomes and areas of concern. Additionally, the Independent Reviewer cites findings from the fourteenth period and previous Individual Services Review studies, as well as patterns from multiple independent consultant studies, in the explanatory comments included in the Summary of Compliance table.

IV. CONCLUSION

During the fourteenth review period, the Commonwealth through its lead agencies, DBHDS and DMAS, and their sister agencies, sustained compliance with provisions of the Agreement that it had previously accomplished and that were prioritized for study. It also newly achieved compliance with three provisions: offering choices of services providers including case managers, creating waiver slots, and prioritizing a required number of such slots for children with ID or DD, other than ID, who reside in nursing homes or the largest ICFs.

The Commonwealth continued to make progress implementing its multi-year effort to develop and implement its redesigned Home and Community-Based Waiver programs and its revised emergency Licensing Regulations. These initiatives will continue to allow progress toward fulfilling the requirements and achieving the goals of the Agreement: integration, self-sufficiency and quality services. Although not yet sufficient to document compliance, progress was also evident from several other DBHDS initiatives. These include the initiative to improve and transform the Commonwealth's case management system for children and adults with ID/DD; the single-entry-point process to prevent inappropriate admissions and to divert children from spending their critical child development years in nursing homes or Intermediate Care Facilities; and the implementation of individual and family support initiatives.

Of the provisions studied during the fourteenth period, the Commonwealth remains challenged to address and resolve obstacles to needed progress. It's statewide crisis service system is not working properly; the CSB Emergency Services "single point of entry" process is not functioning as required and the REACH teams are not able to meet the mobile crisis supports and crisis stabilization needs of the significantly increased number of individuals with ID/DD in crisis. Although living with their families is the most desirable option in most cases. However, due in large part to the Commonwealth's current very low pay rates, families and agencies that arrange in-home support services frequently cannot recruit and retain nurses and direct support professionals for approved hours of service. Furthermore, families, case managers and providers cannot locate behavior specialists to meet essential behavioral service needs. Children who cannot live in their family homes lack alternative family-like residential options. There are not enough providers of integrated settings and services for either individuals with intense services needs or those who are able to live with more independence and integration. The Commonwealth focuses on offering apartment living to single individuals as the primary path to independent community living, which significantly limits the reach of more integrated housing opportunities. The Commonwealth continues to utilize six to sixteen bed facilities that isolate individuals from their communities and that operate and appear like institutions.

During the fourteenth review period, at the direction of the Court, the Parties negotiated and agreed to measurable compliance indicators for the Crisis Services and Case Management provisions of the Agreement. These agreements reflect the Commonwealth's leaders increased understanding of, and commitment to, what will be required to achieve and to objectively measure progress and determine compliance. Where previously the Parties had substantial disagreements about how to measure compliance with vaguely worded provisions of the Agreement, the Commonwealth's managers now have clearly defined, measurable and agreed upon compliance indicators. These indicators will allow the Commonwealth to plan for further

development of its services with confidence and to identify and gather the data and records needed and required to document compliance. Based on the Independent Reviewer's personal management experience, it is much easier and more efficient for managers to design and implement a plan when there is a fixed and objectively measurable goal line. It is very positive that the Parties continue to explore and negotiate compliance indicators for the remaining provisions of the Agreement. They will report progress to the Court following the fifteenth review period, which ends September 30, 2019.

The Commonwealth's leaders have continued to meet regularly, to communicate effectively and positively with the Independent Reviewer and with DOJ, and to collaborate with stakeholders. They also continue to develop and implement plans to address needed improvements and to express strong commitment to fully implement the provisions of the Agreement, the promises made to all the citizens of Virginia, especially to those with IDD and their families.

V. RECOMMENDATIONS

The Independent Reviewer's recommendations to the Commonwealth regarding services for individuals in the target population are listed below. The Independent Reviewer requests a report regarding the Commonwealth's actions to address these recommendations and the status of implementation by September 30, 2019. The Commonwealth should also consider the recommendations and suggestions in the consultants' reports, which are included in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the fifteenth review period (April 1, 2019 – September 30, 2019).

Compliance Indicators

1. The Commonwealth should assess the records that it maintains and determine the additional records needed to document that the requirements of the Agreement are being properly implemented as measured by the agreed upon compliance indicators. The data gathered should reflect quarterly performance for Fiscal Year 2020.

Case Management

2. DBHDS should consider revising and updating the Case Management Steering Committee (CMSC) charter, in to further focus the CMSC on performance monitoring to advance its efforts at system-wide improvements in Case Management.

3. DBHDS should consider reviewing the ISP procedural guideline requiring re-signing by all Parties, in the event the ISP is modified; changing the ISP should be a flexible process that ensures a paper trail to the logic and background to the change, rather than one that is an obstacle to making needed modifications to the ISP.

4. The Commonwealth should ensure that Case Managers understand, and have the tools needed to fulfill, their responsibilities to assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual. The Commonwealth should also ensure that the Case Managers have written protocols and check lists or forms needed to ensure that these job expectations are fulfilled properly.

Crisis Services

5. The Commonwealth should review the root causes of the failure of the CSB-ES "Crisis Point of Entry" process to function as required by the Agreement. The Commonwealth should provide the Independent Reviewer with its plan to ensure that mobile crisis teams respond to the home, or other community setting where the crisis occurs, of the individual, whenever possible.

6. The Commonwealth should provide the Independent Reviewer with its assessment, determine and plan to provide sufficient resources needed by the increased number of individuals with IDD who call and are referred to REACH for crisis services.

Integrated Community-based Homes

7. DBHDS should issue a Departmental Instruction to CSBs and providers that affirms its preference that:

   - adults who are not able, or choose not, to live in their family homes should be offered most integrated residential options (i.e. own home or leased apartment, sponsored, shared, or supported living), rather than in large congregate settings; and
   - young children should be raised by families, or in family-like settings, where bonding with a continuous caregiver can occur, rather than in congregate settings with shift-based staffing.

8. The Commonwealth should explore and pursue approaches that allow, and a community-based strategy that facilitates, individuals with disabilities to choose to live together and "combine" their supports and rent subsidy budgets. This option, once introduced, will open the possibility for many more individuals to move into independent community living settings who would not otherwise have that choice.

9. The Commonwealth should finalize its HCBS waiver manual by September 30, 2019, to give providers a clear picture of DBHDS's future expectations and to convey the sustainability needed for providers to undertake new integrated housing option service and business model.

10. The Commonwealth should consider diverting admissions from private congregate facilities that house six to sixteen or more residents, which isolate individuals from their communities. These facilities often operate other residential, day or office buildings or suites, on the same or adjacent property and transport their residents in groups between settings. It is the Independent Reviewer's considered opinion these facilities should not be considered long-term community-based alternatives to an institutional care program like the Training Center.

11. The Commonwealth should take needed action to ensure the development of sufficient day and residential provider capacity, and behavior specialists, to offer most integrated settings and service options for the members of the target population in all regions of the Commonwealth. Actions should address the current shortage of such settings and services especially for who have average needs who live in large congregate settings, for individuals with intense behavioral needs, and for children who cannot live with their own families but need family-like residential options.

Individual and Family Support Program

12. DBHDS should define expectations for Case Management options available to individuals on the waitlist, as those relate to facilitating access to the IFSP Funding Program as well as for the broader array of individual and family supports which they might be eligible. This would include defining specific policy and procedure that would standardize the eligibility determination process across the CSBs. DBHDS should include this information in its guidelines for individuals and families seeking services.

13. DBHDS should continue to examine the definition of "most at risk for institutionalization" as the requirement for IFSP funding. In the process, DBHDS should consider whether/how the current prioritization of the waiver waitlist is, or should be, applicable to IFSP and fully inform individuals and families in its guidelines for families seeking services.

14. DBHDS should finalize and implement a process by which all individuals on the waitlist and their families receive timely announcements and information about the IFSP Funding Program.

15. DBHDS should finalize a set of indicators needed to adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports, impact on the risk of institutionalization and individual, and family satisfaction. DBHDS should implement collection and analysis of these data in an expeditious manner.

Discharge Planning and Transition from Training Centers

16. The Commonwealth should report the status of day services for individuals who transitioned from Training Centers during 2018; specifically, the date of their moves, the day services the individual was referred, the status of each referral, the date when day services begin, the type of day service, and whether these are licensed day services.

I. APPENDICES

APPENDIX A.

SEVEN INDIVIDUAL SERVICES REVIEW STUDIES
Discharge and Transition Planning

Completed by:
Donald Fletcher, Team Leader
Elizabeth Jones, Team Leader
Marisa Brown, RN, MSN
Shirley Roth RN, MSN
Barbara Pilarcik, RN BSN
Julene Hollenbach, RN BSN NE-BC

Demographic Information

SEVEN INDIVIDUAL SERVICES REVIEW STUDIES

of

Individuals who transitioned from Virginia's Training Centers

between 10/1/2011 and 11/30/2018

NOTE: The Independent Reviewer completed seven Individual Services Review Studies of the service outcomes for individuals who completed the discharge planning and transition process from Training Centers. The 184 individuals studied transitioned from all Training Centers to live in community-based homes. They were selected from a cohort of 303 individuals who moved between October 2011 and November 2018. The random selection of 184 individuals gives 90% confidence that the findings from these studies can be generalized to the larger cohorts.

ISR Studies	**1st Period**	**3rd period**	**5th Period**	**7th Period**	**9th Period**	**12th Period**	**14th Period**	**Totals 3/6/12-3/31/19**
# of individuals studied	32	28	28	24	26	19	27	**184 individuals studied**
(#) in the cohort	(58)	(44)	(44)	(42)	(46)	(24)	(45)	**findings generalized to 303**
Gender # (%) males	21 (65.6%)	16 (57.1%)	13 (46.4%)	16 (66.7%)	15 (57.7%)	10 (52.6%)	10 40.1%	**101 (54.9%) males**
Age # (%) fifty-one or older	20 (62.5%)	21 (75.0%)	22 (78.5%)	17 (70.9%)	17 (65.4%)	14 (73.7%)	19 (70.3%)	**130 (70.7%) age 51 or older**
Mobility # (%) use wheelchairs	12 (37.5%)	13 (46.4%)	11 (39.3%)	9 (37.5%)	13 (50.0%)	17 (89.5%)	12 (44.4%)	**87 (47.3%) use wheelchairs**
Communication # (%) use gestures, vocalizations, or facial expressions as highest level	25 (78.1%)	19 (67.8%)	18 (64.3%)	17 (70.8%)	15 (57.7%)	17 (89.5%)	21 (77.7)	**132 (71.7%) use gestures, vocalizations**
Type of Residence # (%) live in congregate residential programs	info not collected	24 (85.7%)	26 (92.9%)	21 (87.5%)	24 (92.3%)	18 (94.7%)	25 (92.6%)	**138 (90.8%) Live in congregate residences**
Relationship w/ Authorized Rep. is individual's parent or sibling	info not collected	21 (75%)	24 (85.7%)	22 (91.6%)	18 (79.2%)	13 (68.4%)	25 (92.6%)	**123 (80.9%) AR is parent or sibling**

APPENDIX B.

INDIVIDUAL SERVICES REVIEW
DISCHARGE PLANNING AND TRANSITION
FROM TRAINING CENTERS

October 1, 2018 – March 31, 2019

Completed by:
Donald Fletcher, Team Leader
Elizabeth Jones, Team Leader
Marisa Brown RN, MSN
Barbara Pilarcik RN BSN
Shirley Roth, RN MSN
Julene Hollenbach, RN BSN NE-BC

Demographic Information

Sex	n	%
Male	11	40%
Female	16	59.3%

Age ranges	n	%
Under 21	0	0.0%
21 to 30	0	0.0%
31 to 40	3	11.1%
41 to 50	5	18.5%
51 to 60	5	18.5%
61 to 70	13	48.1%
71 to 80	0	0.0%
Over 80	1	3.7%

Relationship with Authorized Representative	n	%
Parent or Sibling	25	92.6%
Other Relative	1	3.7%
Other e.g. friend	0	0.0%
Public Guardian	1	3.7%

Type of Residence	n	%
ICF-ID	3	11.1%
Group home	23	85.2%
Sponsored home	1	3.7%
Own home	0	0.0%

Levels of Mobility	n	%
Ambulatory without support	11	40.7%
Ambulatory with support	3	11.1%
Total assistance with walking	1	3.7%
Uses wheelchair	12	44.4%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	3	11.1%
Limited spoken language, needs some staff support	3	11.1%
Communication device	0	0.0%
Gestures	9	33.3%
Vocalizations	11	40.7%
Facial expressions	1	3.7%

Discharge Planning Items - positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Did the individual and, if applicable, his/her Authorized Representative participate in discharge planning?	27	96.3%	3.7%	0.0%
Was the discharge plan updated within 30 days prior to the individual's transition?	27	100.0%	0.0%	0.0%
Was it documented that the individual, and, if applicable, his/her Authorized Representative, were provided with information regarding community options?	27	100.0%	0.0%	0.0%
Did person-centered planning occur?	27	100.0%	0.0%	0.0%
Were essential supports described in the discharge plan? a. Did the discharge plan include an assessment of the supports and services needed to live in most integrated settings, regardless of whether such services were currently available?	27 27	100.0% 100.0%	0.0% 0.0%	0.0% 0.0%
Were barriers to discharge identified in the discharge plan?	27	100.0%	0.0%	0.0%
Was it documented that the individual and, as applicable, his/her Authorized Representative, were provided with opportunities to speak with individuals currently living in the community and their families?	26	100.0%	0.0%	0.0%
Was the moving timeline followed or were explanations documented?	27	100.0%	0.0%	0.0%
If a move to a residence serving five or more individuals was recommended, did the Personal Support Team (PST) and, when necessary, the Community Integration Manager (CIM) and the Regional Support Team (RST) identify barriers to placement in a more integrated setting?	12	91.7%	8.3%	0.0%
Was placement, with supports, in affordable housing, including rental or housing assistance, offered?	26	100.0%	0.0%	0.0%
Did discharge occur within six weeks after completion of trial visits?	27	100.0%	0.0%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	27	100.0%	0.0%	0.0%
Does the discharge plan (including the Discharge Plan Memo) list the key contacts in the community, including the licensing specialist, Human Rights Officer, Community Resource Consultant and CSB supports coordinator?	27	100.0%	0.0%	0.0%
Did the Post-Move Monitor, Licensing Specialist, and Human Rights Officer conduct post-move monitoring visits as required?	27	100.0%	0.0%	0.0%
Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists?	27	100.0%	0.0%	0.0%

Individual Support Plan Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the individual's support plan current?	27	100.0%	0.0%	0.0%
Is there evidence of person-centered (i.e. individualized) planning?	27	100.0%	0.0%	0.0%
Was the individual or family given a choice of service providers, including the Case Manager/Support Coordinator?	27	100.0%	0.0%	0.0%
Are essential supports listed?	27	92.6%	7.4%	0.0%
Does the individual's Support Plan/Plan of Care address barriers that may limit the achievement of the individual's desired outcomes?	27	96.3%	3.7%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	27	100.0%	0.0%	0.0%
Medical	27	100.0%	0.0%	0.0%
Dental	27	92.6%	7.4%	0.0%
Health	26	100.0%	0.0%	0.0%
Recreation	27	92.6%	7.4%	0.0%
Transportation	27	100.0%	0.0%	0.0%
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her individual support plan?	27	96.3%	3.7%	0.0%
For individuals who require adaptive equipment, is staff knowledgeable and able to assist the individual to use the equipment?	22	100.0%	0.0%	0.0%
Does the Individual's Support Plan/Plan of Care have specific and measurable outcomes and support activities?	27	18.5%	81.5%	0.0%
If yes, do they lead to skill development?	5	100.0%	0.0%	0.0%

Individual Support Plan Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Does the Individual's Support Plan/Plan of Care have specific and measurable outcomes and support activities?	27	22.2%	77.8%	0.0%
If yes, do they lead to increased integration?	6	100.0%	0.0%	0.0%
If yes, do they lead to increased integration?	6	83.3%	16.7%	0.0%
If applicable, were employment goals and supports developed and discussed?	26	7.7%	92.3%	0.0%
If yes, were they included?	2	50.0%	50.0%	0.0%
If no, were integrated day opportunities offered	24	7.7%	92.3%	0.0%
Does typical day include regular integrated activities?	27	3.7%	96.3%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Mental Health (behavioral supports)	19	84.2%	15.8%	0.0%

Residential Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the support person supporting the individual as detailed (consider the individual's Behavior Support Plan or ISP regarding the level of support needed)?	27	88.9%	11.1%	0.0%
Is there evidence the support person has been trained on the desired outcome and support activities of the Individual's Support Plan/Plan of Care?	27	100.0%	0.0%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's likes and dislikes?	27	100.0%	0.0%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's talents/contributions and what's important to and important for the individual?	27	100.0%	0.0%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	27	100.0%	0.0%	0.0%
a. Is residential staff able to describe the individual's behavior related needs and their role in ensuring that the needs are met?	9	100.0%	0.0%	0.0%
Are services and supports available within a reasonable distance from your home?	27	96.3%	3.7%	0.0%
Do you have your own bedroom?	27	92.6%	7.4%	0.0%
Do you have privacy in your home if you want it?	27	92.6%	7.4%	0.0%
Has there been a transfer to a different setting from which he/she originally transitioned?	27	0.0%	100.0%	0.0%

Residential Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Is there evidence of personal décor in the individual's room and other personal space?	27	77.8%	22.2%	0.0%

Environmental Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the individual's residence clean?	27	96.3%	3.7%	0.0%
Are food and supplies adequate?	27	96.3%	3.7%	0.0%
Does the individual appear well kempt?	27	92.6%	7.4%	0.0%
Is the residence free of any needed repairs?	27	92.6%	7.4%	0.0%
Has there been a Licensing Visit that checked that smoke detectors were working, that fire extinguishers had been inspected, and that other safety requirements had been met?	27	100.0%	0.0%	0.0%
Does the individual require an adapted environment?	27	51.9%	48.1%	0.0%
If yes, has all the adaptation been provided?	14	85.7%	14.3%	0.0%

Integration Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
If applicable, were employment goals and supports developed and discussed?	17	11.8%	88.2%	0.0%
If yes, were they included?	2	50.0%	50.0%	0.0%
If no, were integrated job opportunities offered?	24	7.7%	92.3%	0.0%
Does typical day include integrated activities?	27	3.7%	96.3%	0.0%
Within the last quarter, have you participated in community outings on a consistent weekly basis?	27	81.5%	18.5%	0.0%
Do you go out primarily with your housemates as a group?	25	72.0%	28.0%	0.0%
Is attending religious services important to you/your family	27	22.2%	0.0%	77.8%
If yes or CND, do you have the opportunity to attend a church/synagogue/mosque or other religious activity of your choice?	27	54.2%	45.8%	0.0%
Do you belong to any community clubs or organizations?	27	44.4%	55.6%	0.0%
Do you participate in integrated community volunteer activities?	27	18.5%	81.5%	0.0%
Do you participate in integrated community recreational activities?	27	33.3%	66.7%	0.0%
Do you participate in grocery shopping?	27	70.4%	29.6%	0.0%

Healthcare Items - positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Were appointments with medical practitioners for essential supports scheduled for and, did they occur within 30 days of discharge?	27	88.9%	11.1%	0.0%
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	27	96.3%	3.7%	0.0%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	25	100.0%	0.0%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	27	96.3%	3.7%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	24	100.0%	0.0%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	22	95.5%	4.5%	0.0%
If ordered by a physician, was there a current psychological assessment?	8	100.0%	0.0%	0.0%
If ordered by a physician, was there a current speech and language assessment?	1	100.0%	0.0%	0.0%
If ordered by a physician, was there a current occupational therapy assessment?	5	100.0%	0.0%	0.0%
If ordered by a physician, was there a current nutritional assessment?	12	91.7%	8.3%	0.0%

Healthcare Items - positive outcomes - continued				
Item	**n**	**Y**	**N**	**CND**
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?				
Nutrition	23	91.3%	8.7%	0.0%
Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	23	87.0%	13.0%	0.0%
Is lab work completed as ordered by the physician?	26	100.0%	0.0%	0.0%
If applicable per the physician's orders, Does the provider monitor fluid intake?	15	100.0%	0.0%	0.0%
Does the provider monitor food intake?	14	100.0%	0.0%	0.0%
Does the provider monitor tube feedings?	2	100.0%	0.0%	0.0%
Does the provider monitor bowel movements	18	100.0%	0.0%	0.0%
Does the provider monitor weight fluctuations?	18	100.0%	0.0%	0.0%
Does the provider monitor seizures?	14	100.0%	0.0%	0.0%
Does the provider monitor positioning protocols?	11	100.0%	0.0%	0.0%
If applicable, is the dining plan followed?	11	100.0%	0.0%	0.0%
If applicable, is the positioning plan followed?	10	100.0%	0.0%	0.0%
If applicable, is there documentation that caregivers/clinicians Did a review of bowel movements?	27	100.0%	0.0%	0.0%
Made necessary changes, as appropriate?	9	100.0%	0.0%	0.0%
After a review of food intake, Made necessary changes were made, as appropriate?	24	100.0%	0.0%	0.0%
	13	92.3%	7.7%	0.0%
Did a review of fluid intake? Made necessary changes, as appropriate?	22	100.0%	0.0%	0.0%
	5	100.0%	0.0%	0.0%
Did a review of tube feeding? Made necessary changes, as appropriate?	2	100.0%	0.0%	0.0%
	2	100.0%	0.0%	0.0%
Did a review of seizures? Made necessary changes, as appropriate?	14	100.0%	0.0%	0.0%
	6	100.0%	0.0%	0.0%
Did a review of weight fluctuations? Made necessary changes, as appropriate?	27	100.0%	0.0%	0.0%
	14	92.9%	7.1%	0.0%
Does the individual require adaptive equipment?	27	81.5%	18.5%	0.0%
If yes, is the equipment available?	22	100.0%	0.0%	0.0%
If available, is the equipment in good repair and functioning properly?	22	86.7%	13.6%	0.0%
Has the equipment been in need of repair more than 30 days?	3	100.0%	0.0%	0.0%
Has anyone acted upon the need for repair?	3	33.3%	66.7%	0.0%
Is the support staff present, knowledgeable and able to assist the individual to use the equipment?	22	100.0%	0.0%	0.0%
Is the support staff present, assisting the individual to use the equipment as prescribed?	22	100.0%	0.0%	0.0%

Healthcare Items - areas of concern				
Item	**n**	**Y**	**N**	**CND**
If ordered by a physician, was there a current physical therapy assessment?	11	81.8%	18.2%	0.0%
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?				
OT	4	75.0%	25.0%	0.0%
PT	11	72.7%	27.3%	0.0%
Speech/Language	1	0.0%	100.0%	0.0%
Psychology	17	88.2%	11.8%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Mental Health (psychiatry)	17	88.2%	11.8%	0.0%
Are there needed assessments that were not recommended?	27	33.3%	66.7%	0.0%
Is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	15	53.3%	46.7%	0.0%
Have there been any events related to the individual's high-risk factors (i.e. aspiration, choking, constipation, falls, etc.)	27	11.1%	88.9%	0.0%
If yes, are those who support the individual aware of any BDHDS alert about the risk factor(s)?	2	100.0%	0.0%	0.0%
If yes, have any protocols or procedures been created or modified as a result?	2	50.0%	50.0%	0.0%

APPENDIX C.

CASE MANAGEMENT

Completed by:

Ric Zaharia Ph.D.

And

Deni Duroy-Cunningham M.Ed.

Report to the Independent Reviewer
United States v. Commonwealth of Virginia

Case Management Requirements

By

Ric Zaharia, Ph.D., &
Deni DuRoy-Cunningham, M.Ed.

Consortium on Innovative Practices

April 24, 2019

Executive Summary

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a follow-up to our April 2017 review of the Case Management requirements of the Agreement. This review was based on onsite interviews with DBHDS leadership, interviews with case managers and their supervisors, and document reviews for thirty-five (35) individuals.

This review found that the Department has exerted concentrated efforts on additional case manager improvements, which were coordinated and organized under a Case Management Steering Committee (CMSC). We believe the past year's work has enabled the Department to begin to "get their arms around" the task of improving the case management function. The Committee has focused Department efforts in the areas of reducing redundancy in the ISP (Individual Support Plan), development of a comprehensive, searchable Case Management Manual, offloading waitlist maintenance tasks from CSB case managers to the Department, creation of CSB-centered data dashboards around IDD metrics, establishment of a new supervisor audit tool to replace the tool previously used to confirm Appendix H assurances, formalization of a technical assistance follow-behind visit from QMD (Quality Management Division) staff to validate and support CSB supervisor audits, and launching a culture change to move case managers from transactional (operational, administrative) tasks to transformational (engagement, developmental) tasks.

Collateral work is completed or underway to support CSBs in their self-assessment and improvement planning around case management, to revise case manager training modules, to incorporate QMR (Quality Management Review), Qlarant (i.e. Quality Services Reviews) and OL (Office of Licensing) findings into the CMSC's performance monitoring activity, to retrain case managers in observable, measurable outcomes, to make CSB generated electronic ISPs accessible to DBHDS systems, and to raise the value and importance of employment in the ISP process. An ancillary benefit has been the establishment of forums for collaboration and improved understanding between CSB supervisors and DBHDS managers.

To the extent that these processes and structures are made permanent, systemic improvements in case management are apparent and should continue.

For this targeted review, we focused on thirty-five (35) randomly selected individuals, who were listed as receiving Enhanced Case Management (ECM) in ten CSB's representative of the five DBHDS Regions. Each review included: a) a qualitative evaluation of the ISP and recent case manager progress notes, b) case manager interviews, c) case manager supervisor interviews and d) a follow-up assessment of the individual's well-being via personal visits and/or interviews with caregivers and/or Authorized Representatives (ARs), when available. We then conducted a discrepancy analysis using our Review Tool (see Attachment A) to determine if gaps existed between the individual's assessed needs and ISP goals (as documented in the case management system reports and documents) and the services and supports that were actually being provided.

Our discrepancy analysis suggested that the most frequent systemic shortcomings in the individual service plans for this sample were:

If the individual appears to need a special diet (choking, obesity), has she/he been referred for a professional assessment? (Item #21).

If there are goals/outcomes for which there is no progress, has the case manager/team attended to these goals by modifying them? (Item #4).

If any referrals are needed, have they been scheduled? (Item #19).

DBHDS has expended considerable effort on behalf of improved case management competence. Discrepancy rates compared to our 2017 review have improved. This is critical because effective case management is often the linchpin to competent service delivery.

Methodology for this Report

- Interviewed DBHDS leadership;
- Conducted discrepancy analyses of services to thirty-five (35) randomly selected individuals receiving enhancement case management in ten CSBs representative of all five regions, by reviewing thirty-five (35) ISPs, interviewing 35 case managers, and interviewing individuals, caregivers and/or Authorized Representatives (ARs) as appropriate;
- Interviewed seventeen (17) case managers and their supervisors regarding "adequacy of supports and services" and wait lists.

Case Management Leadership

This review found that the Department has exerted concentrated efforts on additional case manager improvements, most of them coordinated and organized under a Case Management Steering Committee (CMSC). The Committee has focused Department efforts in a number of areas:

- reducing redundancy in the ISP document, which relieves some documentation burdens on the case managers (e.g. quarterly review document is significantly shorter);
- development of a comprehensive, searchable Case Management Manual, which should serve as a common source of policy and guidance for all case managers and their supervisors as to the expectations for delivery of the service;
- offloading waitlist maintenance tasks from CSB case managers to the Department, which should ensure improved accuracy of the waitlist and a more efficient updating of the needs of individuals on the waitlist;
- creation of CSB-centered data dashboards around IDD metrics, which should enhance CSB focus on the outcomes expected by the Department;
- revision of the supervisor audit tool previously used to confirm Appendix H assurances, which should enhance local performance monitoring of case managers;
- formalized the use of technical assistance, follow-behind visits from QMD (Quality Management Division) staff to validate and support CSB supervisor audits; and
- launched a culture change to move case managers from transactional (operational, administrative) tasks to transformational (engagement, developmental) tasks.

Collateral work guided by the CMSC that is completed or underway:

- supporting CSBs in their self-assessment and improvement planning around case management;
- revising case manager training modules, which should orient new personnel to the nuanced and heightened expectations for case management;
- incorporating QMR (Quality Management Review), Qlarant (QSR) and OL (Office of Licensing) findings into the CMSC's ongoing role of collecting and reviewing all relevant case management performance data;
- retraining case managers in ensuring observable, measurable outcomes, which should be apparent system-wide in ISPs generated after March 2019;
- making CSB generated ISPs accessible to DBHDS through electronic retrieval systems, which should permit more rapid assessment and aggregation of individual planning documentation; and
- raising the value and importance of risk assessment and employment in discussions at the annual ISP.

This review and study of the Commonwealth's system of IDD case management verified renewed efforts around case management performance monitoring at all levels.

Case Management ISP Reviews

Methods:
We conducted discrepancy audits of thirty-five (35) cases over a two week period in March 2019. All individuals, who were listed as receiving Enhanced Case Management with an ISP date of October 2019 or later in ten selected CSBs, were identified. From among these individuals 3-6 were randomly selected from each of the ten CSBs. This yielded thirty-five (35) individuals from ten CSBs drawn from all five DBHDS Regions. The questions (and discrepancy rates) from the Case Management Review Tool that we used are included in Attachment A.

In-person interviews were conducted with the current Case Manager and the individual and/or Guardian/Authorized Representative/Agency Provider. Case Manager interviews were conducted in their CSB offices. Most of the interviews with the individuals were conducted in their homes or their day/work support program. During some Case Manager interviews supervisors joined us for a few questions around the adequacy of support services and the local handling of waitlists. In advance, we reviewed ISP documentation and recent Case Manager progress notes, in order to determine what gaps exist between the individual's assessed needs, ISP goals and services, and the services and supports actually being provided. We defined a discrepancy as *a difference between 'what is' based on the case manager record review and interview and 'what should be' based on our assessment of the individual, their situation and 'what should be' based on the Settlement Agreement provisions or the Commonwealth's rules or regulations.*

Findings:
Of the thirty-five (35) cases reviewed, twenty (20) were male and fifteen (15) were female. The individuals ranged in age from 11 to 81. We visited eight (8) individuals at their day or work program, ten (10) at their own or family home, and thirteen (13) at their group home. Four (4) were unavailable or non-responsive to our contacts.

Case Managers were positive and cooperative during the interview process. In general, the Case Managers knew the individuals on their caseloads well. The median length of time supporting the individual was again, as in our previous studies, about 18 months with a range of two months to 15 years. The average caseload size was again about 1:34.

Our discrepancy analysis (see Attachment A) suggested that the top challenges faced in this sample were: **If the individual appears to need a special diet (choking, obesity), has she/he been referred for a professional assessment?** (Item #21). Out of the thirty-five, three individuals appeared to warrant nutritional evaluation, but only one had received or been referred for a professional assessment. A further challenge in this sample was: **If there are goals/outcomes for which there is no progress, has the case manager/team attended to these goals by modifying them?** (Item #4). Out of ten cases where we found a lack of progress, only five had been modified by the case manager/team. And a third area where a significant discrepancy rate was

identified was: **If any referrals are needed, have they been scheduled?** (Item #19). Out of the thirty five cases, nine were identified as in need of a referral, but only three referrals were scheduled or made.

In 2017 we identified Item #2, **Does the ISP have specific and measurable outcomes?** as having the highest discrepancy rate (64%) in that forty-seven (47) person sample. In the sample for this study, the discrepancy rate for this item improved to 24%. Retraining in appropriately stated outcomes had been delivered statewide during the past quarter by Regional trainers. Under questioning, it was clear the training was fresh on all case managers' minds. We were able to verify that most case managers understood the changes in statement of outcomes that were being promoted by the Department trainers (more specific and measurable/observable outcome statements). The Case Managers were also clear on the ways in which many current outcomes would need to be re-written, when we reviewed with them outcomes that we found that were not specific and measurable.

The results from the analysis of twenty-seven (27) items in the Case Management Review Tool for thirty-five (35) individuals suggested an overall discrepancy rate of 8% across ten CSBs from all five Regions; this is a significant improvement over the discrepancy rate of 20% that we identified in 2017's similar audit of four CSBs.

The most persistent problem across the three samples which we have assessed (2019-35 individuals, 2017-47 individuals, 2016-25 individuals) was Item #1: **If needed, has the individual's Individual Support Plan (ISP) been modified during the past year in response to major events?** This item has improved to a near acceptable rate of 15% in this most recent review. However, it appears to us through our interviews that, even when the case manager becomes aware of a major event, there is a general hesitancy among case managers to modify ISPs in between annual reviews. We believe that some of this hesitancy may be traced back to a requirement that the case manager gather all the electronic signatures of team members for any substantive change to the ISP.

While not directly comparable, Tables I and II below attempt to benchmark system performance in case management. In 2016 we identified the discrepancy rates across four CSBs (representing three Regions). Using DBHDS metrics from its Data Dashboard, one of the CSBs exceeded the target, two were approaching the target, and the fourth was below the target. This year we identified in Table II four Regions that exceeded target and one Region that was approaching target. Although a qualified conclusion, it appears that the DBHDS focus on case management over the past year, including attention from the Commissioner's Office, has positively impacted case management performance.

Table 1
2016 Compliance Rates Based on Discrepancy Analyses of Four CSBs

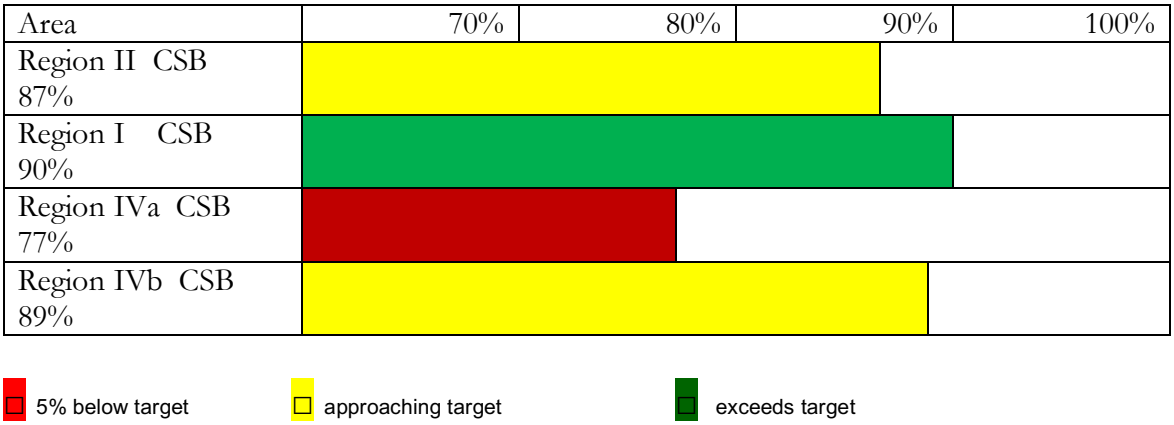
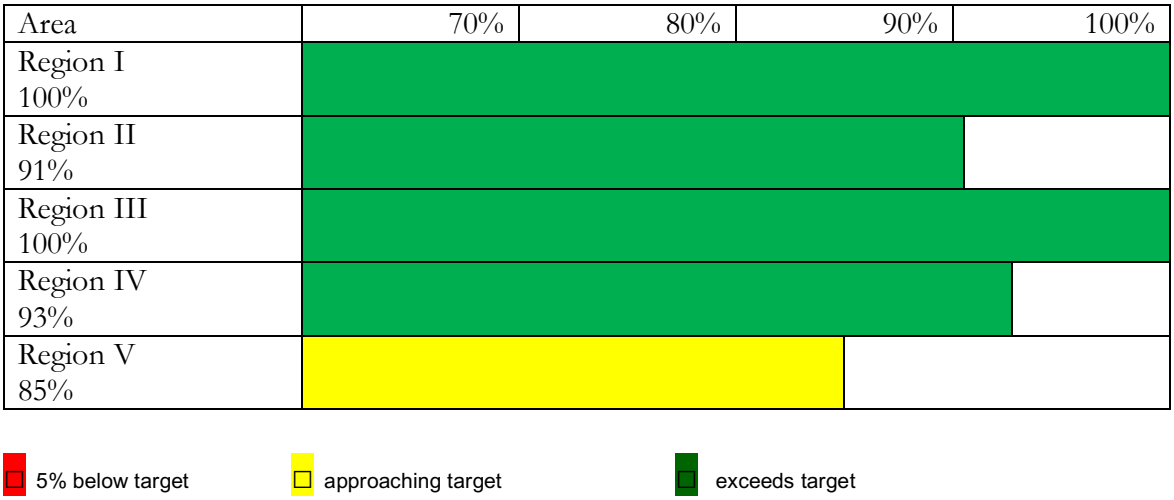


Table 2
2019 Compliance Rates Based on Discrepancy Analyses of Ten CSBs



Finally, the Parties to the Settlement have tentatively identified to the Independent Reviewer twelve distinct compliance indicators for the case management area of the Settlement Agreement (Attachment A, #315-1, 4/12/19). The ten queries in this study that specifically tapped those indicators are identified in Table 3 below, along with their discrepancy rate from this study. With some wordsmithing our queries in this study can be modified to enable an assessment of the compliance indicators the Parties have agreed to for future studies and comparisons.

Two compliance indicators agreed to by the Parties and not included in this study's queries include:

> III.C.5.b.i., #7 (The ISP was developed with professionals and non-professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served.) and,
> III.C.5.b.1, #10 (The CSB has in place, and the case manager uses, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including but not limited to reconvening the planning team.)

These can be easily incorporated into future studies.

Table 3
Discrepancy Rate across 35 Case Managers

	2019 Case Management Review Items Identified as Compliance Indicators	d/o*
1	If needed, has the Individual Support Plan (ISP) been modified in response to major events in the past year?	2/13 (15%)
	III.C.5.b.i, #4 (…the plan has been modified as needed)	
2	Does the ISP have specific and measurable outcomes?	8/34 (24%)
	III.C.5.b.i, #6 (The ISP includes specific and measurable outcomes….)	
3	Are all essential supports and services listed in the ISP?	4/35 (11%)
	III.C.5.b.i, #8 (The ISP includes the necessary services and supports to achieve the outcomes….)	
5	If there have been any recent changes in status to previously identified risks, has the team made changes to the ISP?	3/9 (33%)
	III.C.5.b.i, #3 (The case manager assesses risk and risk mediation plans are in place as determined by the ISP team.)	
6	If there have been any recent changes in physical health, has the team made changes in the ISP?	2/7 (29%)
	III.C.5.b.i, #4 (The case manager assesses whether the person's status or needs for services and supports described in the ISP have changed….)	
13	Has the case manager visited the individual as required during the past three months?	none/35
	III.C.5.b.i, #9 (The case manager completes assessments that the individual's ISP is being implemented appropriately….)	
14	Is it documented that the individual was offered choice among providers, including case managers, in the last annual ISP meeting?	none/35
	III.C.5.b.i, #1&2 (The CSB has offered each person the choice of case manager. Individuals have been offered the choice of providers for each service.)	
15	Did the team discuss supported employment/employment services in the last annual ISP?	none/31
	III.C.5.b.i, #6 (The ISP includes…evidence that employment goals have been developed and discussed.)	
15a	If yes, were employment goals and supports developed/updated and discussed in the last ISP?	1/7 (14%)
	III.C.5.b.i, #6 (The ISP includes…evidence that employment goals have been developed and discussed.)	
18	Are supports and services consistent with the individual's choices, preferences, and with self-determination?	none/35
	III.C.5.b.i, #5 (The case manager develops ISPs that address all of the identified risks, identified needs, and preferences.)	

*d/o = # discrepancies/#opportunities; this does not include items marked as NA

In summary, we reviewed case management services for thirty-five (35) individuals who DBHDS identified as receiving enhanced case management. Thirty-one (31) were receiving enhanced case management (ECM), however, four (4) were receiving regular case management services. This is an 11% (4/35) difference between what DBHDS reported as ECM status and what the case managers reported. This ECM rate is comparable to the rate identified in our 2017 study and may represent the natural flux and lag in changing criteria in individual circumstances.

Adequacy of Supports and Services

Section V.G.3 of the Settlement Agreement lays out eight domains across which the Commonwealth agreed to assess the adequacy of supports. These are identified in Table 4 below in the form of queries. We interviewed seventeen (17) case managers with their supervisors, structured around the questions in Table 4.

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We conclude that the approach used in this study to assess the adequacy of supports has the same flaws we have previously cited around the Data Dashboard: there is an unavoidable bias in effect when those directly responsible for coordinating the supports are asked to report on and evaluate those supports. This self-report bias makes the results of this assessment unusable, even when the immediate supervisor is part of the conversation.

Table 4
Adequacy of Supports and Services, V.G.3,
Reported by 17 Case Managers and Supervisors

During the past year, did the team:	% adequate where applicable
1. Need to take any action to protect the individual from harm**? For example**, abuse in the home, retrain direct support staff, separate roommates?	100% (5/5)
2. Have to do anything to address the individual's physical, mental and behavioral health**? For example,** arrange an appointment with a physician, take them to an ER, introduce some calming techniques?	100% (5/5)
3. Have to do some things during the past year to avoid crises? **For example**, arrange for increased staffing, implement a short term stay at t a respite home, ask family members to refrain temporarily from contacts?	100% (2/2)
4. Need to do anything to ensure the best, possible quality in the individual's supports/services? **For example**, arrange for a consultant to train staff, increase the hours of a behavior specialist, install monitoring devices?	100% (6/6)
5. Need to do anything to address provider members of the team competency, stability, etc.? **For example**, identify alternative placements, arrange for technical assistance to the provider, change behavior specialists?	100% (4/4)
6. Do anything to ensure the individual becomes more a part of their community? **For example,** helped enroll them in a church choir, mall visits once a week, volunteer?	100% (11/11)
7. Have to do anything to support the individual in accessing needed services? **For example**, connect individual with Voc Rehab, arrange a med review appointment, complete a swallow study?	100% (12/12)
8. Do anything to maximize individual's choices and preferences? **For example**, add options to the recreation choices on weekends, job sampling, arrange participation in menu planning	100% (10/10)

Parenthetically, we rated supervisors' knowledge of the individual cases: fourteen (14) of the seventeen (17) supervisors were rated as acceptable or better. Only three (3) had an unacceptable level of knowledge, notwithstanding the majority (12/17) reporting that individual cases were discussed between supervisors and the case manager monthly or more frequently. Two of the three supervisors with an unacceptable level of knowledge reported discussing individual cases with case managers only as needed, which may suggest a practice expectation that needs to set for supervisors (i.e., a monthly review of individual cases by supervisors).

Again, we believe the approach used in this study to having case manager/support coordinators evaluate the Adequacy of Supports regarding the results of their own work produces biased results and therefore does not provide a viable measurement of system performance. We would suggest that metrics that aggregate experiential events over time across individuals will be more useful. For example, the first query could be better addressed in part by sampling and trending Special Incident Reports across time and settings.

The discussions have continued with the Independent Reviewer and DBHDS leadership about the most useful approaches to assessing these domains and creating substantive findings about which continuous improvement activities can be based. These discussions should continue with a focus on clarifying the most reliable, accessible data sources and the most effective collection methods to distill information that will yield actionable findings for DBHDS managers.

Case Management for Wait-listed Individuals

As part of our review we probed the case management of individuals who are IDD/Medicaid eligible, who are wait-listed for Waiver services and who choose to receive targeted case management (TCM), which is available to all Medicaid eligible individuals, regardless of whether they have been awarded Waiver slots. We conducted structured interviews with seventeen (17) case managers with their supervisors (Attachment B).

Generally, we found that almost all case managers interviewed were responsible for 3-5 persons who have been wait-listed and opted for TCM. These cases are in addition to the 25-35 individuals who have waiver slots and are receiving either regular case or enhanced case management services.

Because the case management services provided to individuals without Waiver-funded services are financed by Medicaid's TCM program, their case management services appear marginal compared to services provided to those receiving Waiver-funded services; obviously the latter have richer service packages due to the Waiver. However, for many persons on the waitlist, targeted case management may represent their one and only link to the service world and constitute their sole ability to survive the impact of a disability or, in some cases, represent all the services needed in order for these individuals to <u>not</u> utilize a Waiver slot. These individuals are dependent on discretionary funds (e.g., IFSP funding), generic welfare services (e.g., housing subsidies), or charitable organizations (e.g., Salvation Army). These community linkages are often available only with the information and referral resources made available to them by a case manager. The large majority of waitlisted individuals are very likely young children who are eligible for IDD services and are living with their families.

In our interviews with seventeen (17) case managers/supervisors, all acknowledged carrying a caseload of waitlisted individuals, but none could provide us local (CSB) guidance or policy to use in supporting these folks; all referenced targeted case management policies for their guidance. All were knowledgeable as to the local and state resources they could connect these folks to, including IFSP funding at DBHDS.

DBHDS has recently strengthened the capacity of CSBs to meet the needs of wait listed individuals by offloading the task of annually updating and documenting their continuing interest in Waiver services. In the future these annual updates will be initiated at DBHDS.

Suggestions for Departmental Consideration

DBHDS should consider revising and updating the CMSC charter, in order to further focus the Committee on performance monitoring and to renew the Department's commitment to system-wide improvements in case management.

DBHDS should consider reviewing the ISP procedural guideline requiring re-signing by all Parties, in the event the ISP is modified; changing the ISP should be a flexible process that ensures a paper trail to the logic and background to the change, rather than one that is an obstacle to making needed modifications to the ISP.

Attachment A

	2019 Case Management Review Items (Abbreviated)	d/o*
1	If needed, has the Individual Support Plan (ISP) been modified in response to major events in the past year?	2/13
2	Does the ISP have specific and measurable outcomes?	8/34
3	Are all essential supports and services listed in the ISP?	4/35
4	If there are goals/outcomes for which there is no progress, have the CM and the team attended to modifying them?	5/10
5	If there have been any recent changes in status to previously identified risks, has the team made changes to the ISP?	3/9
6	If there have been any recent changes in physical health, has the team made changes in the ISP?	2/7
7	If there were any new assessments in the past year, have the results been incorporated into the ISP?	5/5
8	If there were any recent issues of safety, freedom from harm, abuse, use of seclusion/restraints, were these addressed by the CM and team?	1/4
9	If the individual or AR is not satisfied with major services, was action being implemented to resolve his/her concerns?	8/8
10	If the individual or AR have interests in any additional services, supports or activities, is action being taken to address these concerns?	6/6
11	Did the case manager provide information to the individual or AR in the last ISP about less restrictive services?	none/33
12	Has the case manager supported the individual in accessing needed services in the ISP?	2/33
13	Has the case manager visited the individual as required during the past three months?	none/35
14	Is it documented that the individual was offered choice among providers, including case managers, in the last annual ISP meeting?	none/35
15	Did the team discuss supported employment/employment services in the last annual ISP?	none/31
15a	If yes, were employment goals and supports developed/updated and discussed in the last ISP?	1/7
15b	If yes, did the case manager take necessary steps to support the individual towards employment?	1/6
15c	Is the individual making progress on the employment goals in the ISP?	1/6
16	If there were any behavioral crises or emergencies in the past year, did the CM coordinate communication among agencies?	1/7
17	If the behavioral crisis suggests a change in ISP was needed, did the case manager coordinate a team discussion?	none/5
18	Are supports and services consistent with the individual's choices, preferences, and with self-determination?	none/35
19	If there are any needed referrals, have they been scheduled?	3/9
20	If the individual is following a special diet, has he/she been re-evaluated in the past 3 years?	4/14
21	If the individual appears to need a special diet, has he/she been referred for a professional assessment?	2/3
22	If the individual requires an adapted environment or equipment, have they been implemented and are they being monitored?	none/21
23	Are services and supports being provided in the most integrated setting appropriate to the individual's needs?	none/34
24	If appropriate, has he/she been supported to acquire subsidized housing, rent assistance or bridge funding?	none/1

*d/o = # discrepancies/#opportunities; this does not include items marked as NA

Attachment B
Supervisor/Case Manager Interview

During the past year did the team:
1. Need to take any action to protect the individual from harm**? For example**, abuse in the home, retrain direct support staff, separate roommates?
2. Have to do anything to address the individual's physical, mental and behavioral health**? For example,** arrange an appointment with a physician, take them to an ER, introduce some calming techniques?
3. Have to do some things during the past year to avoid crises? **For example**, arrange for increased staffing, implement a short term stay at t a respite home, ask family members to refrain temporarily from contacts?
4. Need to do anything to ensure the best, possible quality in the individual's supports/services? **For example**, arrange for a consultant to train staff, increase the hours of a behavior specialist, install monitoring devices?
5. Need to do anything to address provider members of the team competency, stability, etc.? **For example**, identify alternative placements that might be more suitable or stable, arrange for technical assistance to the provider, change behavior specialists?
6. Do anything to ensure the individual becomes more a part of their community **For example,** helped enroll them in a church choir, mall visits once a week, volunteer?
7. Do anything to support the individual in accessing needed services? **For example**, connect individual with Voc Rehab, arrange a med review appointment, complete a swallow study?
8. Do anything to maximize individual's choices and preferences? **For example**, add options to the recreation choices on weekends, job sampling, arrange participation in menu planning?
9. How often do you jointly staff this case?
10. Do any of your case managers have wait listed people on their caseloads?
11. What case management options can be made available to individuals on the waitlist?
12. Supervisors knowledge of the case?

Attachment C
Case Management Settlement Requirements

I.A.
The Parties intend that the goals of community integration, self-determination, and quality services will be achieved.
III.C.5.a-d.
5. Case Management
a. The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.
b. For the purposes of this Agreement, case management shall mean:

- *i. Assembling professionals and non-professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.*
- *ii. Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP; and*
- *iii. Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.*

c. Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.
d. The Commonwealth shall establish a mechanism to monitor compliance with performance standards.

Section III.D.1-2 and III.D.5-7
Community Living Options

1. *The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.*
2. *The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources, including local, State, or federal affordable housing or rental assistance programs (tenant-based or project-based) and the fund described in Section III.D.4 below.*
5. *Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services and supports consistent with the terms of Section IV.b.9 below.*
6. *No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's choice and has been reviewed by the Region's Community Resource Consultant and, under circumstances described in Section III.E below, by the Regional Support Team.*
7. *The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home (and, if relevant, to their authorized representative or guardian).*

Section III.C.7.a.
To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.
Section III.C.7.b.
.....The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings where they are paid

minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in ISPs.

Section V.A.

To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships)…

Section V.F.1-4.

F. Case Management

1. *For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.*
2. *At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.*
3. *Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals who:*
   a. Receive services from providers having conditional or provisional licenses;
   b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS") category representing the highest level of risk to individuals;
   c. Have an interruption of service greater than 30 days;
   d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;
   e. Have transitioned from a Training Center within the previous 12 months; or
   f. Reside in congregate settings of 5 or more individuals.
4. *Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.*

V.F.5.

5. *Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observations and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3 above.*

APPENDIX D.

CRISIS SERVICES

Completed by:

Kathryn du Pree MPS

CRISIS SERVICES REVIEW OF THE VIRGINIA REACH PROGRAM FOR THE INDEPENDENT REVIEWER FOR THE COMMONWEALTH OF VIRGINIA VS. THE US DOJ

PREPARED BY KATHRYN DU PREE, MPS
EXPERT REVIEWER
May 1, 2019

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SECTION 1: OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer, has contracted with independent consultant, Kathryn du Pree, as the Expert Reviewer, to perform the review of the crisis services requirements of the Settlement Agreement. This review is for 10/1/18-4/30/19, the fourteenth review period. It includes a qualitative study of sixty individuals who were referred to REACH during this review period. This review will analyze the Commonwealth of Virginia's status toward implementing the following requirements: The Commonwealth shall:

- develop a statewide crisis system for individuals with ID and DD (IDD),
- provide timely and accessible supports to individuals who are experiencing a crisis,
- provide services focused on crisis prevention and proactive planning to avoid potential crises, and
- provide mobile response, in-home and community-based crisis services to resolve crises and to prevent the removal of the individual from his or her current setting whenever practicable.

SECTION 2: PURPOSE OF THE REVIEW

All areas of the crisis services requirements for both children and adults will be included and reported on in terms of accomplishments and progress toward fulfilling the requirements of the Settlement Agreement (SA). This study will review the status of the Commonwealth's progress toward fulfilling the provisions that are detailed in Section III.C.6.a-b. of the SA, which includes the subset III.C. b. ii. A and B, as well as III.C.6.iii.A, D, E, and G. Additionally, it will include a qualitative review of the crisis supports and other needed and related community services for sixty individuals, thirty children and thirty adults, who were referred to REACH during the second quarter (Q2) of Fiscal Year (FY) 2019 (i.e. 9/30/18 – 12/31/18). The focus of the study is to determine the effectiveness of REACH programs and community behavioral, psychiatric, and psychological supports to: de-escalate and prevent crises; to stabilize individuals who experience crises that result in a psychiatric hospitalization; and to provide successful in-home and out-of-home supports that assist the individual to retain his or her community residential setting at the time of the crisis or post hospitalization. The study's overarching goal is to determine whether the Commonwealth's community service capacity is sufficient to assist individuals with IDD who have behavioral and/or mental health co-occurring conditions to remain in their homes with appropriate ongoing services and thereby minimize hospitalizations and, if admitted, the lengths-of-stay.

The foci of this review will be:

- The status of the REACH programs' functioning to respond to crises in children and adults' homes
- The Commonwealth's ability to provide crisis prevention and intervention services that include timely assessments, services and supports to de-escalate crises without removing individuals from their homes
- REACH programs' effectiveness planning and identifying strategies for preventing future crises
- REACH programs' provision of short-term crisis supports in the home and use of the CTH to stabilize crises

The review will also track the progress of the Commonwealth's development of out-of-home crisis stabilization services for children and out-of-home transition homes for adults with co-occurring conditions.

SECTION 3: REVIEW PROCESS

The Expert Reviewer reviewed relevant documents and interviewed key DBHDS administrative staff, REACH administrators, REACH staff and Case Managers to gather the data and information necessary to complete this study. The information gathered was analyzed to determine the current status of implementation of the crisis services requirements of the Agreement. The documents reviewed included those provided by the Commonwealth that it determined were sufficient to demonstrate its progress toward properly implementing the requirements of the Agreement.

Documents Reviewed:

1. Children's REACH Quarterly Reports: FY18Q4, FY19Q1, FY19Q2, FY19Q3
2. Adult REACH Quarterly Reports: FY18Q4, FY19Q1, FY19Q2, FY19Q3
3. DBHDS Quarterly Qualitative Reviews of Children's and Adults REACH Programs for FY18Q4, FY19Q1, FY19Q2, FY19Q3
4. Records of the thirty children and thirty adults selected for the qualitative study

Interviews with DBHDS and REACH staff: I interviewed Heather Norton, Director, Community Support Services; Sharon Bonaventura, DBHDS REACH Regional Crisis Manager for Regions I and II, Nathan Habel, DBHDS REACH Regional Crisis Manager for Regions III, IV and V; Denise Hall Children's REACH Program Director for Region III; Autumn Richardson, Children's REACH Program Director for Region IV; Brandon Rodgers, REACH Program Director for Region V; numerous staff from the REACH teams in Regions III, IV and V; and CSB Case Managers. The REACH staff and Case Managers were all interviewed as part of the qualitative study of the sixty individuals who received REACH services during this, the fourteenth, reporting period. I appreciate the REACH Directors involvement to coordinate the schedules for all of these interviews and the time that everyone gave to contribute important information for this review.

SECTION 4: A STATEWIDE CRISIS SYSTEM FOR INDIVIDUALS WITH ID and DD

The Commonwealth is expected to provide crisis prevention and intervention services to children and adults with either intellectual or developmental disabilities. This responsibility is described in Section III.6.a of the Agreement:

The Commonwealth shall develop a statewide crisis system for individuals with ID and DD. The crisis system shall:

i. *Provide timely and accessible support to individuals who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families;*
ii. *Provide services focused on crisis prevention and proactive planning to avoid potential crises; and*
iii. *Provide and community –based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable.*

The Independent Reviewer determined that there is sufficient history with the implementation of the REACH program to compare data and trends over twelve-month periods of time. This report is based on data for four years that is cumulated as follows:

Year 1: FY15 Q4- FY16 Q3 (seventh and eighth review periods)
Year 2: FY16 Q4- FY17 Q3 (ninth and tenth review periods)
Year 3: FY17 Q4- FY18 Q3 (eleventh and twelfth review periods)
Year 4: FY18 Q4- FY19 Q3 (thirteenth and fourteenth periods)

The year periods do not match fiscal years or calendar years because review periods do not align with either fiscal or calendar years. The review periods are the six-month periods: April through September, and October through March. These time periods are reflected in the definition of Years 1, 2, 3 and 4 above. It must be noted that the children's REACH program did not begin reporting until the third quarter (Q3) of FY16. Therefore, Year 1 for the children's data includes only six, rather than twelve months of information.

A. Review of The Status of Crisis Services to Serve Children and Adolescents

The information provided below includes information from the four Children's REACH Quarterly Reports that DBHDS provided for Fiscal Year (FY) 2018 Quarter 4 and FY 2019, Quarters 1, 2 and 3. These four quarterly reports cover the one-year time period April 1, 2018 – March 31, 2019; these data are reflected as the data for Year 4.

REACH Referrals- The number of children who were referred to the Children's REACH crisis services programs continues to increase. This includes children newly referred or referred again after being previously discharged from REACH. There were 205 children referred in Year 1; 854 referred in Year 2; 1,269 referred in Year 3; and 1410 referred in Year 4. There was a significant increase in overall referrals in both Year 2 and Year 3, and a more moderate increase in Year 4 of 11.1% over Year 3.

The number of crisis referrals has dramatically increased from 108 during six months in Year 1; 464 in Year 2; 672 in Year 3; and 752 Year 4. Non-crisis calls also increased each year from only 97 in Year 1; to 390 in Year 2; 597 in Year 3; and 658 calls in Year 4. The percentage of crisis versus non-crisis calls remains consistently at 53% of the total number of calls, statewide. However, there is wide variation across the Regions in the number and percentage of crisis calls. For example, in Year 4 Region II received only sixty-nine crisis calls, the fewest of any of the five Regions; whereas, Region V received 357 crisis calls, which was the most. In that same year, of all calls received by REACH Teams, crisis calls were 30% in Region II compared with 78 % in Region V.

The REACH Children's programs are becoming more known throughout their communities. They are a source of information and support for families during crises and for preventive services. It will be important that the Commonwealth maintains a sufficient number of staff to effectively respond to the number of calls received, especially those that result from crises, recognizing Regions have differential caseloads of crisis calls that require on-site responses.

CSB's Emergency Services (ES) were the primary sources of crisis referrals for REACH services in Years 2 and 3, accounting for 41% and 39% respectively of the total referrals. ES continued as the primary referral source in Year 4, but declined to 35% of the referrals. Hospitals consistently referred 11% of children for crisis services during Years 1, 2 and 3, and accounted for 10% of the referrals in Year 4. Direct referrals for families accounted for 25% of the children referred during each of the first three years but increased to 30% of the referrals in Year 4. Families, however, accounted for a higher percentage of the referrals in Regions II and V, and a consistently lower percentage in Regions I and III. Overall in Year 4, case managers referred 13% of the children to REACH, but case manager referrals represented a higher percentage in Region I and III at 36% and 27% respectively. Together families and case managers accounted for 43% of the referrals in Year 4. A higher percentage of children being referred to REACH directly by case managers and families indicates more children being referred for crisis intervention before becoming involved with pre-screenings at hospitals and CSB offices. Such direct referrals present more opportunities for crises to be addressed at the home or school before the children are removed from their homes.

Conclusion: These data indicate that there continues to be referrals from all of the expected referring entities and that ES and hospital personnel are aware of the need and do contact REACH when a referral for a hospital admission is made**.** The sources of the referrals are remaining very constant across reporting periods. Although, the crisis referrals from families has increased by 5%, the number of referrals not from families has continued to increase as the total number of referrals has increased.

*Table 1 s*ummarizes the number of referral calls for Years 1, 2, 3 and 4

Table 1 ***Total Children's Referrals***			
Year	***Crisis***	***Non-crisis***	***Total***
Year 1	*108*	*97*	*205*
Year 2	*464*	*390*	*854*
Year 3	*672*	*597*	*1,269*
Year 4	*752*	*658*	*1,410*

Time of Referral- The REACH programs track the time and dates of referral calls. The calls that were received during weekdays have increased steadily, from 72% of the calls in Year 1 to 81%, 85%, and 86% of the calls in Years 2, 3, and 4, respectively.

REACH programs do not report whether the time of the day during which calls are received is different on weekdays versus weekend days. Previously DBHDS reported when calls were received in four time periods. DBHDS reduced reporting to three time periods during Year 3. These three periods reflect the three shifts that staff works. The data do not distinguish calls that were made after 5 PM in any reporting period. In Years 1 and 2 92% of the calls were received between 8 AM and 8PM. In Years 3 and 4, 93% of the calls were received between 7 AM and 11PM; the remaining calls were received between 11PM and 7AM. The overall number of calls, however, has increased. The increase in the number of calls received between 11PM and 7AM only increased by six calls between Year 3 and Year 4.

Conclusion: It is evident that the REACH on-call system remains available 24 hours a day and 7 days per week as is required by the Agreement.

Referrals for Individuals with IDD- The Children's REACH Program continues to serve a high percentage of individuals with developmental disabilities, other than intellectual disabilities, versus individuals with intellectual disabilities. These data are broken out by three categories: intellectual disability only (ID-only); ID and DD; and a developmental disability only (DD-only). During the four years, the percentage of children referred:

- with an ID only diagnosis, ranged from 12%-20%;
- with both ID and DD, ranged from 12%- 28%; and
- with a diagnosis of DD, only ranged from 52% -72%.

There was a marked increase from 52% of the referrals with DD-only in Years 1 and 2 to 65% in Year 3, and to 72% in Year 4. This increase in the actual number of children referred with DD-only from 451 in Year 2 to 830 (+84%) in Year 3, and to 1010 (+22%) in Year 4 is very significant. The increase is evidence of this REACH programs' outreach and usefulness to this population. The number and percentage of referrals for children with ID only and ID and DD continues to decrease. In Year 3 195 children with ID only were referred to REACH. This number declined to 167 children with ID only in Year 4. The decline in the number of children with both an ID and DD diagnosis has declined steadily since Yea 2 from 243 to 186 in Year 3 and 170 in Year 4. This decline is curious. DBHDS staff report it may be because families of children who receive a diagnosis of autism may not seek a further diagnosis of an intellectual disability, nor do they need to have this diagnosis to access REACH services.

The number and percentage of individuals referred with DD only continues to increase. This pattern may indicate that there are a higher number of children with autism or mental health diagnoses than there are among adults. This is borne out by the diagnosis of many of the children in the qualitative study. This may have implications for the training REACH staff will need and the type of community resources and clinical expertise that will be needed to maintain children in their home settings.

Conclusion: The REACH Children's Program continues to receive an increased number of referrals in each reporting period. The number increased by 208 (50%) between Year 2 and Year 3, and another 80 in Year 4. These increases demonstrate that the programs' efforts to reach out are connecting children in need with the statewide children's crisis services. The Commonwealth's outreach efforts are reaching individuals with diagnoses that are across the spectrum of intellectual and developmental disabilities. It is of noteworthy, however, that for children with ID only diagnoses continue to decline. The REACH programs may need to focus attention and outreach to stakeholders representing this disability group to make sure they are aware of the REACH services.

Calls Received by REACH- The Children's REACH programs track all calls received in addition to new referrals during each quarter. These calls are defined as crisis, non-crisis and information calls. There are far more calls received by REACH each year than new referrals. The REACH teams respond to all crisis calls. These have increased from 134 in Year 1 to 970 in Year 4. Non-crisis calls have increased exponentially from 304 calls in Year 1 to 3,469 calls in Year 4. Informational calls alone accounted for 854 calls in Year 2; 1,183 calls in Year 3; and 2,612 calls in Year 4. Regions have increased the number of staff positions assigned to the REACH programs in the past four years. However, the number of additional positions has not kept pace with the increase in crisis calls or referrals, and the REACH programs have a number of vacant positions. These are described later in this report. As the number of referrals and crisis calls to the REACH programs increase, it is critical that each REACH Children's Program has sufficient staffing resources to answer these calls and to respond on-site as required to meet the crisis intervention needs of these children and their families. Table 2 depicts the change the number of all calls between Year 1 and Year 4. The number of crisis calls has continued to increase but the rate of increase

slowed in Year 4. Non-crisis calls decreased by 2,558 (42%) between Years 3 and 4 after previously increasing steadily. Informational calls also decreased significantly.

Table 2 ***REACH Calls***				
Year	**Crisis Calls**	**Non-Crisis Calls**	**Info Calls**	**Total**
One	134	304	401	839
Two	617	2449	854	3920
Three	929	6027	1183	8139
Four	970	3469	2612	7051

Response Time- In all five Regions throughout Year 4, the REACH staff responded onsite within the required **average** response times. The Regions designated as rural Regions, with the exception of the rural area of Region II, respond on average in seventy minutes or less. The averages in response time across the four quarters for rural Regions range from 46-70 minutes. The average response times for the rural section of Region II averages between 71 and 102 minutes, which are still under the required 120 minutes to respond on time. The average response times for the two urban Regions range from 41-62 minutes across the four quarters of Year 4. Region II has the average of 62 minutes for FY19Q2 but all other quarters are under 60 minutes for average response times. Region IV averages between 41 -49 minutes for its average response times.

DBHDS has designated Regions I, III and V, as rural. This designation requires these Regions to respond onsite to crisis calls within two hours. In Year 4, these three Regions, responded on-time 98%, 97%, and 92% of the time, respectively. Region IV, an urban region, which is expected to respond onsite within one hour, met this expectation 92% of the time during Year 4. Region II continues to have the most significant difficulty responding to calls within the one-hour expected timeframe in its urban area. Region II improved from a percentage of 62% in Year 1 and 60% in Year 2, to 79% of on-time responses in Year 3. However, its percentage of on-time response in Year 4 dropped to 70% when twenty-nine of its ninety-five calls were not responded to within one hour. In 2017 DBHDS added to Region II CSBs in a rural area, which was formerly part of Region I. Its on-time responses for this part of the Region are met 83% of the time with fifteen of eighteen crisis calls responded to in less than two hours. The reasons for untimely responses include weather and traffic. For the individuals in the qualitative study the Regions responded to 93% of the calls and were on time for all of these calls.

Over the past four periods, DBHDS has reported a breakdown of response time in 30-minute intervals. This is useful information as it helps to determine how many of the calls can be responded to fairly quickly. While the Agreement requires a one or two-hour response time depending on urban or rural designation, these expectations may not be consistent with the time needed to actually have a REACH staff respond on site in time to participate fully in the crisis screening. During this review period, REACH staff responded onsite to crisis calls within 30 minutes for 18% of the calls; within 31-60 minutes for 45%;

within 61-90 minutes for 23%; and within 91-120 minutes for 12%. The remaining calls (2%) were not responded to within the required two-hour timeframe. When responding to a crisis in a family's home, the consequence of responding in more than thirty minutes is that the crisis may not have been stabilized at that location. The child may have been removed and be in route to a hospital to be screened by the CSB ES staff.

Overall, the Commonwealth's timely onsite response rate was 91% with 879 of the 968 calls responded to within the expected one-hour or two-hour timeframes in Year 4. This compares positively to Year 1, 2 and 3 when 87%, 86%, and 90% of the calls respectively, were responded to on-time. This is particularly noteworthy because forty-three more calls required a face-to-face on-site response during Year 4 than during Year 3.

All Regions' REACH Teams continue to respond onsite to the vast majority of crisis calls. The number of crisis calls responded to is higher than the number of new crisis referrals during the review period. This is the result from a number of crisis calls for individuals who had already been involved with REACH and were not counted as a new referral. In this reporting period five crisis calls were not responded to face-to-face. Two of these calls occurred in Region II and one in Region I. The teams responded by telephone because of severe weather. Region V did not respond to two calls. In one case there was no pre-screening and the individual was transported directly to a psychiatric facility. In the other the REACH staff was told by the pre-screener not to attend.

The number of mobile crisis assessments that were completed during Year 4 was 968 compared to 926 in Year 3, a 4.5% increase. There were 631 assessments conducted during Year 2. Only 104 crisis assessments were conducted in Year 1, which included only a six-month period of time.

The locations where mobile assessments occur are also included in the data provided. Hospitals, where 503 (52%) of the 968 assessments occurred, remained the most frequent assessment setting in Years 2, 3, and 4. The percentage of assessments conducted at the hospital increased from 49% of all crisis assessments in Year 3 to 52% of all crisis assessments in Year 4. Only 25% of the assessments in Year 1 occurred at hospitals. When hospitals are combined with the ES CSB office locations, there has been a steady increase in the percentage of assessments that occur in these out-of-home locations. The percentages of these out-of-home assessments are 53%, 61%, 67%, and 67% of the assessments, respectively for the four years. Whereas, the percentage conducted in a family's home has steadily declined from 40% in Year 1, to 34% in Year 2, and to 27% in Years 3 and 4. The percentage of screenings that occurred in the child's home or other community setting was only 20% for the children in the qualitative study.

Conclusion: The number of REACH crisis assessments in Year 4 is only a 4% increase compared with Year 3. In light of the larger increases in the number of crisis calls and new referrals, this small increase may be an indication of the usefulness of REACH services. Providing linkages and ongoing prevention services may deter future crises for children with IDD. The fact that the number and percentage (67%) of assessments are conducted in out-of-home settings, either hospital and the ES/CSB locations, is evidence that the Commonwealth's crisis service system is not being implemented by the CSBs to comply with the specific requirements or the goal of the Agreement that crisis services respond onsite to prevent the individual from being removed from the home. The fact that individuals who receive their initial assessments at these out-of-home locations are much more likely to be hospitalized is additional evidence that the crisis system is not preventing the individual from being removed from his or her home/current placement. Not preventing the removal of the individual from his or her home, also eliminates the possibility of fulfilling the Agreement's requirement that, "services, supports and treatment to de-escalate crisis without removing individuals from their homes, whenever possible".

DBHDS data do indicate that REACH continues to be notified of the pre-admission screenings by CSB ES staff and are able to respond. The REACH Children's Programs continue to experience some increase in both referrals and requests for mobile crisis assessments. Recent numbers, however, may indicate leveling. REACH is being informed of possible psychiatric admissions for a higher number and higher percentage of individuals now that the program is more established and the Commonwealth's outreach efforts have continued.

Mobile Crisis Support Services- In Year 1 there were only 123 children who received mobile supports over the six-month period. The number of children receiving mobile supports in Years 2 and 3 is remarkably consistent: 601 and 602, respectively. However, the number of children receiving mobile supports in Year 4 has decreased significantly from 602 in Year 3 to 278 in Year 4. The Regions vary considerably in terms of how many individuals receive mobile crisis supports over the three years. Region I decreased by 192 children (80%) in Year 4 compared to Year 3; Region II decreased by 160 children (84%) and Region IV dropped by twenty-seven children (28%). Region III served approximately the same number of children. Region V increased the number of children served by thirty-six (82%) but is still serving far fewer children than the Region did in Year 2. The number of children served by Region is depicted in Table 3 below.

Table 3
Children Receiving Mobile Supports

Region	Year 2 Total	Year 3 Total	Year 4 Total
RI	163	238	46
RII	177	190	30
RIII	30	34	33
RIV	85	96	89
RV	146	44	80
Totals	**601**	**602**	**278**

The number of crisis calls is relatively consistent between Years 3 and 4 so it is surprising that far fewer individuals are being provided with mobile crisis supports. With an increase in the number of crisis calls and in referrals for crisis services, the dramatic statewide reduction of more than 50% in the provision of mobile crisis services does not appear to result from either fewer individuals in crisis or those in crisis having substantially fewer needs. Rather, resource limitations, either too few staff or funding, may lead to service reduction. The staffing of the Regions' programs is discussed in the Summary section of the report.

The number of children receiving mobile crisis supports counts both new individuals and readmissions. Readmission is defined as children who are receiving mobile supports for a subsequent time. The percentage of readmissions is under 14% for all four years. It may be inferred that mobile supports have been successful and that the children's situation stabilized with other community supports thereby not necessitating follow-up mobile supports.
The numbers of the children who receive mobile crisis supports, as detailed in Table 3 above, are all higher than the number of children who were reported to have used REACH as a result of a crisis assessment, as described in Table 4 below. The number of children who receives mobile crisis supports includes open cases and non-crisis cases, as well as the number of children who were served as the result of a crisis assessment during the review period.

DBHDS reports on the disposition at both the time of the crisis assessment and of the completion of the mobile support services. There has been an overall increase in the number of children assessed at the time of a crisis from Year 2 when 613 children had a crisis assessment, to Year 3 and 4 when 928 and 968 children had crisis assessments, respectively. Unfortunately, a smaller percentage of the children remained home regardless of whether they did or did not receive mobile supports. Both a significantly higher number and percentage of the children are being hospitalized. The number increased by 178 children between Years 2 and 3, which represented 36% versus 25% of the children who were assessed for a crisis. The percentage of hospitalizations remained similar between Years 3 and 4 with 340 children hospitalized. Unfortunately, the maturing of the REACH crisis service for children has not reduced the percentage of children who were hospitalized at the time of the crisis assessment. The number of children referred for crisis assessment and support in Years 3 and 4 is very similar. However, far fewer children and families are benefitting from mobile crisis supports in Year 4 than have previously. In Year 4, 603 (62%) of the 968 children assessed for a crisis returned home. However only 184 (30%) were afforded crisis mobile supports. In Year 3, 583 of the children who were assessed remained at home and 304 (52%) of them used mobile support. This is a startling decrease in the number of families benefitting from mobile crisis supports at a time when the number of children hospitalized is not decreasing and REACH has not opened its CTH program for children. DBHDS must monitor this growing need and response from REACH and take needed steps to ensure that the programs have adequate resources to continue to provide needed supports.

DBHDS should carefully study the lack of change in the number of hospitalizations for children at the time of the crisis and determine what changes are needed to the response to crises and the provision of crisis services to reduce psychiatric admissions. Making systemic changes that are needed to increase the number and percentage of children who receive the initial assessment at the children's homes, rather than at hospitals after a child has been removed from the home, is a critical component of making substantial progress. REACH responds to crises at the family home whenever possible but REACH staff needs to be accompanied by CSB ES staff for a change to occur in where crisis response and assessment are conducted. It is also evident that it is critical to have crisis stabilization (Crisis Therapeutic Home) settings for children that are available as an alternative to hospitalization. Fourteen children in Year 4 did benefit from crisis stabilization programs offered by community providers.

Table 4 below illustrates the disposition at the time of assessment in Years 1, 2, 3, and 4.

Table 4
Disposition at the Time of Crisis Assessment

Year	Psychiatric Admission	Other	Community Crisis Stabilization Program	Home with Mobile Supports	Home without Mobile Supports	Total
1	13	5	0	28	10	**56**
2	152	11	7	168	275	**613**
3	330	8	7	304	279	**928**
4	340	11	14	184	419	**968**

The REACH reports include data regarding the disposition for individuals at the completion of mobile crisis supports. The data demonstrate that the vast majority of children are able to continue to live at home. The number who stay home represent 90% of the children who used REACH in Year 4, an increase of 4% from the number in Year 3. This includes a small number of children and families who continue to receive mobile supports. The continuation of mobile support was the highest in Year 3 when it was only 30 of the 604 children. In Year 4 only eighteen (6%) continued to use REACH mobile supports. The percentage of children who were hospitalized after using mobile crisis supports dropped from of 14% of the children who received mobile supports in Year 3 to 8% in Year 4 which is a similar percentage to Years 1 and 2. The fewest number of children were hospitalized after using REACH crisis mobile supports in Year 4 compared to all previous years. This is a demonstration of the success of crisis mobile supports in assisting children and families to stabilize after a crisis.

The decrease in hospitalizations after REACH programs have been involved is the outcome that was expected and desired by the creation of the REACH teams.

Table 5 *Disposition at the Completion of Mobile Supports*						
Year	**Psychiatric Admission**	**Alternative Residential**	**Home with Extended Mobile Supports**	**Home without Mobile Supports**	**Other**	**Totals**
1	8	3	0	101	7	**119**
2	42	7	6	458	12	**525**
3	82	1	30	489	2	**604**
4	21	3	18	234	2	**278**

Number of Days of Mobile Support- REACH is expected to provide up to three days of mobile crisis support on average for children and adolescents. Every Region provided at least an average of three days of mobile support in Year 4. The average ranged from 3-13 days. Region III served the fewest children but continues to provide the highest average number of eleven days of mobile supports in Year 4.

The mobile crisis support services include: comprehensive evaluation; crisis education prevention plan (CEPP); consultation; and family/provider training. The evaluation, CEPP and consultation are required elements of service for all REACH participants. It is difficult from the presentation of the data to determine if everyone received a CEPP who should have one because the child may have had a CEPP competed during an earlier interaction with REACH. However, there should be an evaluation and consultation for each individual at the time of mobile support. The following table is comprised from two data sets in the REACH quarterly reports. The column that is labeled Mobile Supports is from the table in the REACH quarterly reports that summarizes the total number of children who received mobile supports. The data regarding evaluations, CEPPs, consultation and provider training are derived from the table in the REACH quarterly reports that summarizes all of the service elements the REACH team provides to participants. Table 6 portrays this information below.

Table 6 *Children Receiving Mobile Supports and CEPP*					
Year	**Mobile Support**	**Evaluation**	**CEPP**	**Consultation**	**Provider Training**
1	123	58	66	84	84
2	601	472	430	400	375
3	602	568	539	568	487
4	278	284	262	270	264

The number of children who received mobile crisis supports in the review period may be higher than the number who have a CEPP developed, because some children were REACH participants before the reporting period, had previously been evaluated, and already had a CEPP completed. However, everyone who receives mobile support is required to have an evaluation and consultation each time REACH is used. The reports from Regions II and III in Year 4 reflect compliance with this requirement. These two Regions have evaluated everyone who received mobile supports and provided them with consultation. The data from Region V included the most variation in the total number of children who received mobile supports compared to those who received any of the service elements. Evaluations appear over reported in Regions I and V for the total number of individuals receiving mobile supports. Region I reports offering fifty-nine individuals each service element listed but only reports serving forty-six individuals.

***Conclusion**:* Of the number of children served in Year 4:
95% received the required evaluation and consultation that DBHDS requires
92% received a CEPP
93 % did received provider training

Provider training has increased since the previous year when only 81% of the providers were trained in the crisis plans. This training should enhance the families and providers skills and improve the chances of successfully avoiding future crises.

CEPPs were written for 63% of the thirty children in the qualitative study.

Training- Only Region I has a separate Children's REACH program. The training conducted by the other Regions is portrayed in the Training Table under the Adult REACH section. The staff of the Region I Children's program continues to provide training to stakeholder groups. During Year 4 the Children's Team trained 359 individuals in Region I. CIT Officers, Case Managers, Residential Providers, and Families were trained. However, the program staff did not train any ES staff and only trained one hospital staff.

Crisis Stabilization Programs (aka Crisis Therapeutic Homes – CTH) The Children's REACH programs still do not have crisis stabilization homes in any of the Regions. DBHDS now calls these settings Crisis Therapeutic Homes (CTH). In the Agreement, the Commonwealth committed to develop such programs for children as of June 30, 2012. Two homes are being constructed. Each will have the capacity to serve six children. DBHDS believes that these two homes when supplemented with prevention services and therapeutic host home options will be sufficient to meet the needs of children who need time out of their family homes to stabilize and for mobile supports to be put in place, if needed. DBHDS has finalized contracts with providers, properties have been purchased for the two homes in Regions II and IV, and construction is underway. The home in Region II is now expected to open by July. It will serve children from Regions I and II. The home in Region IV will serve children from Regions III, IV and V. This construction of these second home has experienced delays and will not be opened by July 2019. DBHDS and Region IV have agreed that the home being constructed as an adult transition setting will be used as the Region IV Children's CTH until the planned CTH home for children is ready. This is an eighteen-month delay from the original projected opening.

DBHDS was planning to execute contracts for the out-of-home therapeutic prevention host homes, but it has not yet identified providers to offer this service. Staff is still working with the REACH programs and the provider community to develop and implement this critically needed out-of-home as an alternative to hospitalization for children who need time away from the family setting.

Psychiatric Admissions- DBHDS reported that 390 children with IDD were admitted to psychiatric hospitals in Year 4. This is the first year since 2016 in which fewer children have been hospitalized. There were 67 children admitted to psychiatric hospitals in Year 1 and 237 children in Year 2. The increase between Year 2 and 3 represents an 88% increase in admissions. In Year 3, 447 individuals were admitted which represented a 47% increase over the admissions in Year 2. The decrease in the number of children who were hospitalized in Year 4 is a 13% decrease from Year 3. Also promising is the consistent percentage in both Years 3 and 4 of children admitted to hospitals who were active with REACH prior to the crisis. The children who were hospitalized who had previously received assistance from REACH, represented 37% of all admissions in Years 1 and 2 but represents 30% of the hospital admissions in Years 3 and 4. This indicates the benefit of first providing REACH mobile supports, when they can be offered and provided, to prevent first time admissions or readmissions to hospitals. Table 7 summarizes this data regarding hospital admissions.

Table 7
Children's Admission to Hospitals

Year	*Referrals*	*Active Cases*	*Total*
1	42	25	67
2	149	88	237
3	314	133	447
4	268	122	390

Conclusion: The Children's REACH programs continue to be involved with almost all children with IDD once they are admitted to state-operated psychiatric institutions. This finding is supported in the qualitative study conducted by this consultant. REACH is still not able to offer crisis stabilization homes or therapeutic host homes as diversions from hospital admissions for children. Without the availability of these settings, it is impossible to determine if any of the admissions of children to psychiatric hospitals could have been appropriately prevented, or if the length of time a child was hospitalized could have been reduced. It is particularly troubling that these alternative community-based settings remain undeveloped in light of the number of hospitalizations for behavioral and/or psychiatric reasons over the past four years. Although it is positive that the number of children who were hospitalized decreased in Year 4, there were still 390 children who were not offered or provided community-based alternatives to divert them from hospitalization. Fifteen (50%) of the thirty children who experienced a crisis were hospitalized.

One factor that needs to be addressed and is discussed in more detail in the summary of the qualitative study is the fact that screenings for hospitalization are always conducted at the ES office or, more frequently, a hospital Emergency Room (ER). This past pre-Settlement Agreement systemic approach consistently results in children being removed from their homes to be hospitalized rather than being provided services to de-escalate the crisis and stabilize the home situation or offered an alternative as a diversion from being hospitalized. This continuing systemic approach to provide initial assessment outside the individuals' homes is the opposite of what is required by the Agreement and it clearly leads to the exact opposite result than what the Commonwealth agreed was desired. Clearly an additional contributing factor to the number of children with IDD who are hospitalized is insufficient diversion opportunities without any CTH programs available for children.

Separate from whether all of the admissions of these children were clinically appropriate, since REACH programs were put into place to prevent and to provide alternatives to psychiatric hospitalizations, the number of children with IDD who have been admitted for psychiatric hospitalization is in part due to the pre-Settlement Agreement systemic approach that continues to be used by the Commonwealth and its CSBs to complete initial assessments at a hospital or ES rather than in the individuals' homes. This result is the opposite of what was expected, desired, or planned.

Involvement of Law Enforcement-DBHDS reports the number of crisis responses that involve police officers. This percentage was 44% for both Years 3 and 4, compared to 22% when DBHDS began reporting this data a year ago. During this past year, Law enforcement was involved in the highest percentage of the crisis calls in Regions II, III and V: an average of 62%, 59%, and 52%, respectively. Region I experienced police involvement in 30% of the crisis calls and Region IV experienced police involvement in only 20% of the crisis calls. It is unclear what the involvement of law enforcement indicates about the crisis system, since police always accompany ambulances that transport an individual to a hospital and families may call them to respond to an emergency. The high number of crisis cases that involve police officers is strong support for the need for REACH staff to continue to train police officers so they are better prepared to address crises involving children with an I/DD, especially children with autism spectrum disorders.

B. Reach Services for Adults

New ***REACH Referrals***- the number of referrals to the Adult Region REACH Programs continues to increase. Regions received 2258 referrals of adults with IDD in Year 4, as compared to 1677,1247 and 705 referrals in Years 3, 2 and 1, respectively. The number of referrals received in Year 4 is a 35% increase from the previous year. A comparison of the number of referrals across all of the Regions illustrates a dramatic difference in Region V. Region V experienced 971 of the total referrals accounting for 43% of the 2258 referrals. The referrals in the other four regions ranged from 232-389. DBHDS reports that Region V has significantly more new referrals because of the location of military bases and a commensurate number and turnover of a portion of the military families in this Region. The number and percentage of crisis calls in Year 4 decreased by thirty-one from Year 3.

Table 8 *Adult Referrals to REACH*			
Year	**Crisis**	**Non-Crisis**	**Total**
1	Not reported	Not reported	705
2	647	600	1247
3	888	789	1677
4	1401	857	2258

DBHDS reports that a total of 785 individuals received REACH mobile or CTH services in Year 4. This includes 487 individuals who used mobile supports and 298 who used the CTH. This is a significant decline in the total of 1,024 adults that DBHDS reported received REACH services in Year 3. Of these 486 individuals had received mobile crisis support services and 538 adults had used the crisis stabilization homes (CTH). Virtually the same number of individuals received REACH mobile supports in Years 3 and 4, 487 and 486, respectively. This was significantly fewer than the numbers of individuals who received these services in Years 1 and 2. The number of individuals who used the CTHs in year 4 is significantly fewer than in any previous year. The decreased utilization of the CTHs is inconsistent with the increase in the number of referrals, of both a crisis and non-crisis nature, an increase in the number of hospitalizations and a decrease in the provision of mobile support services. The decrease in the amount of crisis stabilization services is another indication that there are in insufficient staff and other resources to meet the crisis needs of the increased number of referral and individuals being served by the REACH programs.

The decreased utilization of both of these crisis services will be described in greater detail later in this report and is described in Tables 15 and 16. The above numbers are not an unduplicated count of individuals because they include both admissions and readmissions, and some individuals use both mobile supports and the CTH program. Overall 62% of the calls to the Adult REACH Programs were of a crisis nature in Year 4, which is a significant increase compared to Years 2 and 3 when crisis calls accounted for 52% and 53% of the calls. (These data were not reported in Year 1.) The total of calls is very skewed by the number of non-crisis calls received by Region V that totaled 831. However, with the exception of Region V all of the Regions are either receiving far more non-crisis calls than crisis calls, or, in the case of Region I, a similar number. This may be an indication of REACH's success serving many individuals over the past years who continue to use REACH as a crisis prevention service.

Table 9 depicts the number of calls and the nature of the call.

Table 9 ***Total Adult Calls***			
Year	**Crisis**	**Non-crisis**	**Total Calls** **Including Information only calls**
Year 1	1,380	2,052	4,525
Year 2	1,159	2,690	5,101
Year 3	1,906	6,584	11,528
Year 4	2229	11,702	16,813

Calls to REACH are reported separately from referrals.

The number of calls the REACH programs receive continues to increase each year, including those calls that are for information only. The data in the REACH reports include all non-crisis calls as well as calls seeking only information support. The total number of calls received is more than the number of referrals. This occurs when the same individual is the subject of multiple crisis calls and, therefore, is counted more than once. The total number of calls statewide during Year 4, including calls for information only, was 16,813 compared to 11,528, 5,101 and 4525 in the previous three years. Of these calls, 11,702 were non-crisis calls compared to 6.584, 2,690 and 2,052 in the previous three years, whereas 2229 were crisis calls, which was an increase of 17% compared to the 1,906 crisis calls in Year 3. There were 1159 crisis calls in Year 2 and 1380 crisis calls in Year 1, a higher number than in Year 2.

In year 4, CSB Emergency Services continued to make the majority of the referrals (38%) to REACH. ES and hospitals together made 47% of all referrals compared to previous years when CSB ES's and hospitals made 49%, 42%, and 19% of the REACH referrals in Years 3, 2, and 1, respectively. In addition, of the individuals in Year 4, case managers referred 18% and families 16%. In year 1, case managers were the primary source of referrals, making 56% of the referrals. The increase in referrals from ES and hospitals in Years 2, 3 and 4 is an indication that the requirements on these providers to notify REACH of any prescreening for hospitalization is being implemented. Twelve referrals were made by law enforcement in year 4. This is the second-year referrals have been made by police officers, who made six referrals in Year 3.

Conclusion: Referrals to REACH continue to increase with a similar pattern of referral sources.

DBHDS reported the dispositions for adults who experienced a crisis and were assessed. The following two tables provide information regarding the dispositions for individuals referred for crisis services. Table 10 provides the disposition after the individuals' initial REACH assessments. At the time of disposition, a majority of the individuals served by REACH continued to retain their residential setting at the time of the initial assessment. In Year 4, this was 1,236 (56%), compared to 1,135 (60%), 869 (56%) and 736 (69%) in Year 3, 2 and 1, respectively. This illustrates the continued increase in the number of individuals referred to REACH, and the decrease in the percentage who retained their homes, whether with and without REACH mobile crisis supports. While the percentage who used mobile crisis support at the time of crisis assessment is similar across the possible outcomes of crisis assessment for Years 1, 2, and 3, this percentage increased from 13% to 18% in Year 4. The actual number of individuals who used such services increased by 18%, 21% and 45% in year Year 2, and Year 4, respectively. This significant increase was primarily attributable to Region V, which accounted for 274 of the 352 individuals who retained their setting with REACH assistance.

While REACH has experienced an increase in both the number of crisis calls and the number of referrals, there has also been a significant increase in the number of individuals who are hospitalized at the time of the crisis assessment from 210 in Year 1 to 808 (+385%) in Year 4. The percentage that were hospitalized at the time of assessment also increased substantially, from 20% in Year 1 and 33% and 31% in Years 2 and 3, respectively, to 36% in Year 4. The data from the qualitative study that is portrayed later in this report indicates that DBHDS could provide alternative community-based options and thereby divert more hospital admissions, if the required crisis stabilization beds (CTH beds) were available.

In Year 1, the percent of individuals who used crisis stabilization services was 47% of the number admitted to psychiatric hospitals; whereas, in Year 4, only 14% used this "last resort option". Since Year 2, the decline in the use of the crisis stabilization alternative to hospitalization at the time of the crisis assessment, when the number of individuals in crisis has steadily increased, is clear and compelling evidence that the Commonwealth does not have adequate crisis stabilization bed capacity. The Commonwealth is not fulfilling the requirements to offer this "last resort option" as an alternative to institutionalization, nor has it developed a second crisis stabilization program in each Region. The use of the CTH at the time of the crisis assessment has declined since Year 2.

Table 10 illustrates the disposition at the time of assessment across Years 1, 2, 3 and 4.

Table 10
Disposition for Adults at the Time of Crisis Assessment

Year	Psychiatric Admission	Home with Mobile Supports	Home without Mobile Supports	CTH*	New Provider	Other	Total
1	210	170	566	99	3	15	**1063**
2	515	200	669	136	1	53	**1574**
3	595	243	892	128	0	46	**1904**
4	808	352	884	112	0	66	**2222**

** The CTH column includes alternative CSU beds in each year of 7, 33, 27and 36 respectively*

Table 11 below shows the outcomes for individuals at the completion of their crisis assessments. The "Home without REACH supports" column is the number of individuals who REACH reported did not require or receive REACH mobile support services. The number of individuals who retained their home setting with the assistance of mobile support services is captured in the " Home with Mobile Support" row.

REACH provides critical crisis supports that do reduce the number of hospitalizations when such supports are made available at the time of the crisis assessment. Table 10 lists the disposition after the individuals received either mobile or crisis stabilization/CTH services from REACH. This table shows where the adult REACH participants are residing after either mobile crisis supports or use of the CTH has ended. More than three out of four of the individuals in all three years retained their home settings after receiving REACH mobile crisis supports, as reflected in the column labeled "*Home without REACH supports*".

In Year 4, a higher percent (36%) of individuals were hospitalized at the time of assessment compared with the 6% who were hospitalized after receiving REACH mobile crisis support services and the 9% who were hospitalized after using the CTH program. These percentages of individuals hospitalized after REACH services have increased slightly since Year 3. Seventy-three individuals either continued to use the CTH's past this reporting period (58) or after receiving mobile supports (15), compared to eighty-one individuals who continued to use the CTH in Year 3, sixty-one individuals who continued to use the CTH in Year 2 and the 102 adults who continued to use the CTH in Year 1. Fewer individuals used REACH services in Year 4 compared to the previous years but a greater number were hospitalized after using these services than in previous years.

Table 11 also indicates that the use of alternative residential option represents a similar percentage compared to the number of individuals who retained their home settings without mobile crisis supports across all four years but the number has decreased as follows:

- *84 (8%) in Year 1*
- *77 (10%) in Year 2*
- *74 (10%) in Year 3*
- *64 (10%) in Year 4*

This lack of availability of new long-term residential options with quality behavioral support services for individuals who experience a crisis appears to be a significant contributing factor to longer stays at the CTH or to the psychiatric hospitalization of individuals after providing REACH mobile crisis supports.

Involvement of Law Enforcement-DBHDS reports the number of crisis responses that involve police officers. This percentage is 45% for Year 4. DBHDS reports a total of 1874 calls in Year 4, and that Police were involved in 842 of these crisis responses. During this past year, law enforcement was involved in the highest percentage of the crisis calls in Regions II, III and V with an average of 57% in Region II, 52% in Region III and 53% in Region V. Region I experienced police involvement in 41% of the crisis calls and Region IV experienced police involvement in only 26% of the crisis calls. This pattern is similar for the REACH crisis

responses for children in Year 4. It is unclear what the involvement of law enforcement indicates about the crisis system, since police always accompany ambulances that transport an individual to a hospital and families may call them to respond to an emergency. There are many instances when police officers and REACH staff are able to stabilize the crisis and divert a hospitalization from occurring. The high number of crisis cases that involve police officers is strong support for the need for REACH staff to continue to train police officers so they are better prepared to address crises involving children with an I/DD, especially children with autism spectrum disorders.

Table 11 below illustrates the disposition at the end of REACH services (mobile crisis supports or CTH) for Years 1, 2, 3 and 4. The numbers in the CTH column include both individuals who continued using the CTH at the end of the reporting period and those who transitioned from mobile crisis support to the CTH at the end of receiving mobile crisis supports.

Table 11
Disposition for Adults at the Completion of REACH Services

Year	Psychiatric Admission	Alternative Residence	Home without REACH Supports	CTH	Jail	Other	Total
1	79	84	994	102	0	35	1294
2	66	77	760	61	5	29	988
3	48	74	754	81	3	29	989
4	58	64	607	73	1	17	820

Conclusion: Table 10 shows the outcome for individuals who have received REACH services after their crisis assessments. The data support that many more individuals retain their home setting and avoid hospitalization if they receive REACH mobile supports or use the crisis stabilization homes/CTH program. Fewer individuals who use REACH services are admitted to hospitals than individuals who did not use REACH services. The support of either mobile crisis services or the CTH appears to contribute to the stabilization of individuals who experienced a crisis without them being admitted to psychiatric hospitals.

Overall the number of adults who were hospitalized decreased in Year 3 but increased again in Year 4. While many of these individuals may require hospitalization, it is apparent from the information gleaned in past years' reviews and this year's qualitative study that there is a lack of sufficient quantity and quality of diversionary services. The CTH Crisis Stabilization programs are not consistently available to be offered as a "last resort" to divert individuals from hospitalization when they are first screened in response to a crisis or after receiving REACH services, if these services have not sufficiently stabilized the individual.

Psychiatric hospitalizations-DBHDS provides an addendum to its quarterly crisis services reports. The addenda report additional data on the outcomes for individuals who were hospitalized as a result of crises. DBHDS also reports whether these are new or active cases. DBHDS is to report whether these individuals eventually return to their previous home setting or whether an alternative residential placement needed to be, and was, located. In *Tables 9 and 10*, the total number of individuals who had contact with REACH and who were admitted to psychiatric hospitals was 866, 808 occurred at the time of the crisis assessment and 58 after REACH services were provided.

The addenda provide different data regarding psychiatric hospitalizations and the known dispositions of individuals who were admitted. These data, which also reported all hospitalizations including recurrences, indicate that DBHDS was aware of 383, 647, 832 and 833 psychiatric hospitalizations of individuals with ID/DD in Years 1, 2, 3, and 4, respectively. This is the first time in the four years of reporting that the total number of hospitalizations counted from the time of initial assessment and including after REACH services, is a higher number than the total number of hospitalizations in the addenda. DBHDS has always reported that the number of hospitalizations in the addenda will be a higher number than the total of hospitalizations at the time of crisis assessment plus the number of hospitalizations after REACH services. This variation is because the numbers in the addenda can include voluntary admissions; admissions to private psychiatric hospitals if the families at some point contacted REACH; and individuals with multiple admissions. The number of hospitalizations in the REACH report is broken down by active cases and new referrals.

The Department notes that these data in the addenda do not reflect, and that the Department does not know, the total number of individuals with IDD who are admitted to private psychiatric institutions.

The number of hospitalizations of individuals with IDD has continued to increase as has been presented earlier in this report. These data indicate that the number of individuals who were hospitalized increased by over 200 individuals between Years 3 and 4. Based on the data from Tables 9 and 10 in this report, this equates to a 35 % increase in the adults with IDD who were hospitalized as the result of a crisis.

It is positive that the percentage of active participants who received REACH services and were hospitalized has decreased each year, while the number of individuals who were newly referred and were hospitalized at the time of the crisis has increased. From Year 3 to Year 4, the actual number, as well as the percentage, of active participants in REACH services, who were hospitalized, also decreased, from 405 to 351 individuals. This difference may indicate the value of receiving REACH services, and the effectiveness of the linkages provided by REACH, to reduce the need for hospitalization.

The almost 250% increase in the number of new referrals from Year 1 to Year 4 is very significant. The increase in the number of new referrals to REACH at the time of a crisis has implications for the opportunity for REACH to actually avert a hospitalization. In such circumstances, REACH has no existing relationship with the family or provider and has no knowledge of the individuals' needs, behaviors or medical conditions. This lack of information impacts the programs' ability to intervene, especially if REACH is contacted after the individual is in route to the ES office or hospital. In these situations, REACH staff cannot help to de-escalate and stabilize the situation at the individual's home, which is their central purpose.

If the number of active participants who are hospitalized continues to decrease, it may be another indicator of the REACH programs' success in preventing future hospitalizations for individuals for whom REACH provides crisis services. Given this, the decline in the provision of such services for new referrals is a significant concern. Table 12 below depicts these data.

Table 12
Number of Hospitalizations for REACH Adult
Active Participants vs. New Referrals

Year	Active Participants	New Referrals	Total
1	247 (65%)	136 (35%)	383
2	335 (52%)	312 (48%)	647
3	405 (49%)	427 (51%)	832
4	351 (42%)	482 (58%)	833

Year 4 is the first year in which all of the Regions knew about all of the individuals whose hospital admissions were reported to DBHDS. The REACH programs were aware of 77% of the admissions during Year 3, whereas they were aware of 90% of the admissions to psychiatric facilities during Year 2, and 75% during Year 1.

DBHDS reports that the difference in the two data sources is that the Addendum of Psychiatric Admissions includes all involuntary and voluntary admissions. Heather Norton explained that the CSB ES is not involved in screenings for individuals who are seeking voluntary admission, and that the state operated hospitals do not always notify REACH of these admissions. A family member may inform REACH during or subsequent to the hospitalization. The Independent and Expert Reviewers have recommended in the past that DBHDS and these Regions' REACH teams work with hospitals to ensure their awareness of the importance of, and requirement to inform REACH of these admissions so that REACH staff can be involved in proactive discharge planning**.** It appears from the data for Year 4 that this outreach is occurring and has been effective in ensuring that REACH staff knows about all admissions to publicly operated psychiatric hospitals.

Conclusion: The CSB ES staff and/or hospital are notifying REACH staff of the screenings for involuntary admissions. It is essential that CSB ES teams notify REACH, so the REACH teams can offer community-based crisis supports as alternatives to hospital admission, when clinically appropriate, and can begin proactive discharge planning that may result in shortened stays in the facilities for individuals with IDD who are admitted. It is equally important for REACH staff to be involved with voluntary admissions to provide IDD clinical expertise to hospital staff and to begin planning for crisis intervention and stabilization services that can take effect at the time of discharge.

DBHDS cannot report on how many different individuals with IDD have been admitted to psychiatric hospitals, but rather on how many hospitalizations occurred during the reporting period. Some individuals may have had multiple hospitalizations. It is necessary to have DBHDS be able to report specifically on the actual number of:

- Individuals admitted to psychiatric hospitals,
- Individuals with multiple hospitalizations, and
- The number of hospitalizations for each individual with multiple admissions

The number of hospitalizations, as reported in this section of the DBHDS report, continues to increase, more than doubling since Year 1 and increasing by 19% between Years 3 and 4. The pattern of dispositions changed in Year 4; outcomes were not positive. (An increased number of individuals have remained hospitalized each year, reaching 174 in Year 4 and ranged from 14%-20% of all individuals hospitalized over the four years. The actual number of individuals who remained hospitalized in Year 4 increased by 31% compared to the number of individuals who remained hospitalized in Year 3. The individuals who used the CTH after a hospitalization ranged from 8% to 12%. The percentage of individuals who retain their home setting dropped to 51% in Year 4 from 59% and Years 2 and 3. (In the qualitative study 70% of the thirty adults retained their residence.) Table 13 below depicts these data.

Table 13
Disposition for Adults Hospitalized

Year	Remain in Hospital	Home with Mobile Supports	Home without Mobile Supports #, (% of Total)	CTH	New Provider	Other	Total
1	56	2	244, (61%)	46	24	25	**397**
2	105	3	402, (59%)	54	52	68*	**684**
3	133	1	437, (59%)	77	53	46*	**747**
4	174	18	458 (51%)	71	74	100*	**887**

- *Includes individuals about whom the outcome is not known*

These data do not provide sufficient information to determine whether the individuals who remain hospitalized need continued hospitalization or whether they remain in the hospital because of the lack of an appropriate and available provider, residence, crisis stabilization bed, or other needed community supports. However, the continuing trend of an increasing number and percentage of individuals who remain hospitalized each year. The individuals who are hospitalized for extended periods may benefit if the REACH programs are able to reduce the length-of-stays at the CTHs and by the development of the transition homes. When the Commonwealth reduces the number of stays that exceed the thirty-day maximum required by the Agreement, the CTH programs will have more available beds to offer as alternatives for individuals who would otherwise be admitted to a psychiatric hospital or as a step-down option for individuals who are ready to be discharged.

DBHDS reports that the REACH programs remain actively involved with all individuals who are hospitalized when REACH staff is aware of their hospitalizations. DBHDS expects the involvement of REACH staff during the hospitalization of an individual with IDD.

When an individual with IDD is screened for admission, the revised REACH standards require REACH staff to:

- join with the ES staff for every admission screening and
- stay involved with everyone who is hospitalized as a result of the screening.

If individual is hospitalized, REACH standards require REACH staff to:

- participate in the admission,
- attend commitment hearings,
- attend treatment team meetings, and
- participate in discharge planning.

The community-based service alternatives to institutionalization that the Agreement required be available cannot be effective unless the CSB ES and hospital's staff contact REACH for all psychiatric screenings of individuals with I/DD and unless the screenings occur at the individual's home, whenever possible. However, for the adults in the qualitative study, the Regions' REACH Teams' provided hospital support for 87% of the fifteen adults who were hospitalized, who accepted REACH support.

Training-The REACH quarterly reports document that the REACH Adult Programs continued to provide extensive training to a range of stakeholders. The five Regional REACH programs trained 6,274 individuals during Year 4, compared to 4,747 in Year 3, 3,942 in Year 2, and 3,458 in Year 1. Far more providers were trained than in any other year. The "other" category increased significantly but there is no specification as to what stakeholders are included under "Other". The majority of individuals trained under the "Other "category was in Region V in FY18Q4 when 1726 stakeholders were trained. This is summarized in Table 14 below:

Table 14 *Training by REACH Program Staff*								
Year	***CIT/Police***	***CSB***	***ES***	***Providers***	***Hospital***	***Family***	***Other***	***Total***
Year 1	727	967	153	307	250	0	1,054	3,458
Year 2	659	1061	347	885	101	27	862	3,942
Year 3	743	712	189	584	437	1524	558	4,747
Year 4	734	961	297	1534	250	453	2,045	6,274
Total	**2,863**	**3,701**	**986**	**3,310**	**1,038**	**2,004**	**4,519**	**18,421**

DBHDS has partnered with the Department of Criminal Justice Services, the Virginia Board of People with Disabilities, and Niagara University to develop comprehensive training for law enforcement. The focus of the training is disability awareness. The training was piloted in FY18 Q2 and the training was enhanced based on feedback from the pilot training, which occurred in FY18 Q3. The Commonwealth is using the train-the-trainers model. The training of the law enforcement trainers will begin May 2018. One law enforcement agency is each Region was identified to have trainers trained. These trainers will then be responsible to train other law enforcement staff in their Region. DBHDS reported that 129 law enforcement personnel were trained in FY19 Q3. The topics included IDD, Mental Health Disorders, and Acquired Brain Injury. This was the first quarterly report that included the number of people trained.

***Conclusion*:** All Regions completed extensive training across all stakeholder groups. It is not possible to know what percentage of police, ES staff, provider and relevant hospital staff has been trained since the total number needing training in these groups is not identified. All case managers are required to be trained in crisis services. It is not surprising that there are not incremental increases in each stakeholder category since tenured staff will not need to be retrained.

Serving individuals with developmental disabilities-During Year 4, the REACH programs continue to serve an increased number of individuals with DD, other that ID, than has been reported during earlier review periods. REACH served 585 individuals with DD only, which was 26% of the total referred. This represented a 54% increase over the 379 individuals with DD only who were referred in Year 3, which was a significant increase over the 186 individuals with DD only served in Year 2. Only forty-four individuals with DD only were referred in all of Year 1.

Conclusion: Outreach to the DD community has resulted in REACH serving more, and an increased percentage, of individuals diagnosed with DD only. These increases may also result from CSBs now being responsible for providing, or arranging for, case management for individuals who have a developmental disability that is not an intellectual disability.

Qualitative Study of Individuals Referred to REACH- The Independent Reviewer seeks to inform the findings and conclusions of this study with a qualitative analysis of the supports and services that have been provided to individuals. This qualitative analysis makes the findings of this study more robust because it focuses on the outcomes in the lives of members or the target population, and not solely on a review of documents, data and reports developed by REACH and

DBHDS. The consultant, from a targeted cohort of those served by REACH during the review period randomly selected the names of the individuals in the study.

The study that was conducted during the fourteenth review period includes thirty children and thirty adults. The focus of the study was to review the effectiveness of the REACH programs and community behavioral, psychiatric, and program supports to de-escalate and prevent crises; to stabilize individuals who experience crises that may result in hospitalization; and to provide successful in and out-of-home supports that assist the individuals to retain their community residential settings at the time of the crisis or post-hospitalization. The study, its results and conclusions are presented in Attachment 1.

SECTION 5: ELEMENTS OF THE CRISIS RESPONSE SYSTEM

6.b. The Crisis system shall include the following components:
i. A. Crisis Point of Entry
The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about and referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week and staffed with clinical professionals who are able to assess crises by phone and assist the caller in identifying and connecting with local services. Where necessary, the crisis hotline will dispatch at least one mobile crisis team member who is adequately trained to address the crisis.

The REACH programs in all Regions continue to be available 24 hours each day and to respond onsite to crises. DBHDS reported that there were 2,258 calls during Year 4, compared to 1677 calls during Year 3, 1348 calls to REACH during Year 2; and 280 calls in Year 1. In Year 4, 20% of the 2,258 calls were received on weekends or holidays, which is the same percentage of weekend/holiday calls that were received in Year 3 but an increase in the number and percentages from Years 1 and 2 when 10% and 13% respectively were received on weekends or holidays. In Year 4, nine (9%) of the calls were received between 11PM and 7AM, and 45% between 3PM and 11PM. The remainder of the calls was received from 7AM-3PM (46%). These data do not specify the calls that were received after 5PM because the calls are reported by the three REACH program shift hours. The data cannot be directly compared to Years 2 and 3 because of a change to the time periods used to report. The types of call are reviewed in greater detail earlier in this report.

Conclusion: REACH is available 24 hours a day, 7 days a week to respond to crisis calls. The number and percentage of calls during non-daytime hours Monday through Friday, and on holidays and weekends are consistent after increasing in Year 3.

B. By June 30, 2012 the Commonwealth shall train CSB Emergency personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.

The Regions' REACH staff continues to train CSB ES staff and to report on this quarterly. During Year 3 all five Regions provided training to CSB ES staff. The total ES staff trained during this review period was 297, compared to 347, 153 and 189 ES staff trained respectively in Years 1, 2, and 3. All ES staff are required to complete an online module about REACH when they are hired.

Conclusion: It remains difficult to draw a conclusion from the data provided since the number of ES personnel who have not been previously trained about REACH has not been reported. Overall, however, all REACH programs continue to provide this training.

ii. Mobile Crisis Teams

A. Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services support and treatment to de-escalate crises without removing individuals from their current placement whenever possible.

REACH leaders in Regions III, IV and V developed a training program to provide similar training for their staff that is used by these Regions REACH teams and by REACH in Region II. DBHDS has reviewed and approved the curriculum for use across the three Regions, as reported previously. The DBHDS standards for the REACH programs require comprehensive staff training consistent with set expectations for the topics, which is to be provided within 30, 60 and 120 days of hire. REACH staff must complete and pass an objective comprehension test. Ongoing training is required and each REACH staff must have clinical supervision, shadowing, observation, and must conduct a case presentation and receive feedback from a licensed clinician on their development of Crisis Education and Prevention Plans. DBHDS lead staff conduct semi-annual reviews of the REACH programs. One of the topics reviewed is the training of both new and tenured REACH staff. The review team also confirms that all staff who are required to be licensed or certified have maintained their licenses and certifications. The results of the Qualitative REACH evaluations are shared with this independent consultant. All REACH programs fully meet the training requirements established by DBHDS in Year 4.

REACH staff is involved in a growing number of responses to crisis calls. REACH staff responded to 1,063 crisis calls in Year 1; 1574 crisis calls in Year 2; 1904 crisis calls in Year 3; and 2222 crisis calls in Year 4. This trend represents a significant increase in workload since these crisis calls all require onsite responses. From the data in the Quarterly Reports, REACH services are providing preventative support services for a significant percentage of adults with IDD who are referred. These data are depicted in Table 15.

Of individuals who receive REACH mobile crisis services, approximately three out of four are maintained in their home settings. This information, which is detailed in Table 10 In Year 4, as in Year 3, shows that 76% maintained their residential setting and 7% moved to a new appropriate community setting, compared to 6% in Year 3. These are similar percentages to those reported for Years 1 and 2. A small percentage each year, ranging from 5% to 7%, which was the lowest in Years 3 and 4, are hospitalized after receiving mobile crisis supports.

While the information above is positive, a relatively small percentage of the individuals who were screened returned home with mobile crisis support or were diverted to a crisis stabilization home (i.e. CTH) The percentages of individuals who used mobile crisis support at the time of the crisis was 16% in Year 1 and 13% in each of Years 2 and 3, and back to 16% in Year 4. The percentages of the adults using the CTH at the time of the crisis was 9% in Years 1 and 2, reduced to 7% in Year 3, and further reduced to 5% in Year 4. In Year 1 25% of the individuals screened for a crisis used either mobile crisis supports or the CTH, while only 21% on the individuals screened in Year 4 used either or both of these REACH services. At the same time the number of adults who were hospitalized at the time of the crisis assessment increased dramatically from 210 in Year 1; to 515 in Year 2; to 595 in Year 3; and significantly again in Year 4 when 808 individuals were hospitalized at the time of the crisis assessment. This continued increase in the number of hospitalizations over four annual review periods is deeply concerning. In light of this alarming increase in the number of hospitalizations, it is more concerning that the CTH in particular appears to be underutilized as a diversion for hospitalizations.

Response Time- In all five Regions in Year 4, the REACH staff responded onsite within the required **average** response times. In fact, all Regions except Region I and the rural section of Region II have an average response time of 66 minutes or less in all quarters of Year 4. Both of the urban Regions (II and IV) have average response times ranging from 42 minutes to 51 minutes. Region I responds on average between 64-88 minutes and in the rural portion of Region I, the mobile teams responded onsite between 79 and 104 minutes across the four quarters in Year 4.

DBHDS has designated Regions I, III and V, as rural. A section of Region II was designated rural two years ago when the regional boundaries changed. The "rural" designation requires these Regions to respond onsite to crisis calls within two hours. In Year 4, Regions I, III and IV responded on-time 100%, 94%, and 97% of the time, respectively. The rural section of Region II responded on time only 74% of the time. Region IV, an urban region, which is expected to respond onsite within one hour, met this expectation 93% of the time during Year 4. Region II had the most significant difficulty responding to calls within the one-hour expected timeframe in its urban area, but is improving from a percentage of 62% in Year 1, 60% in Year 2, to 79% of on-time responses in Year 3 and 77% in Year 4. DBHDS reports the reasons for delays as traffic; weather conditions; and ES' informing REACH staff that it does not need to respond.

Starting in Year 3, DBHDS has reported response time broken down into 30-minute intervals. This is useful information as it helps to determine how many of the calls can be responded to fairly quickly. While the Agreement requires a one or two-hour response time, depending on urban or rural designation, these expectations may not be sufficient for REACH staff to respond on site in time to participate fully in the crisis screening or to ensure the screening is conducted at the individual's home.

During this review period REACH staff responded onsite to crisis calls within 30 minutes for 17% of the calls; within 31-60 minutes for 44% of the calls; within 61-90 minutes for 22% of the calls; and within 91-120 minutes for 13% of the calls. The remaining calls (3%) were not responded to within the required two-hour timeframe. When responding to a crisis in a family's home, the consequence of responding in more than thirty minutes is that the crisis may not have been stabilized there and the individual may be in route to the hospital to be screened by the CSB ES staff.

Overall, the Commonwealth's timely onsite response rate was 93% with 2073 of the 2221 calls responded to within the expected one- or two-hour timeframes. This compares consistently to Years 1, 2, and 3. This achievement is particularly noteworthy because 316 more calls required a face-to-face on-site response during Year 4 compared to Year 3. The need for onsite crisis response has more than doubled since Year 1 when 1001 individuals required a face-to-face assessment.

Conclusion: Many more screenings are being completed with REACH staff involved. REACH has provided mobile crisis support to more individuals each year. The number increased from 170, to 200, 243, to 352 adults in Years 1, 2, 3, and 4 respectively. There was also an increase in the percentage of individuals who were screened and who retained their settings with mobile crisis support, which was up to 16% of all individuals screened from 13% for Years 2 and 3. Mobile crisis support seems effective when it can be provided, but it may be beneficial to more individuals. Its availability and use has not reduced the number of individuals who were hospitalized. All Regions meet the training requirements for the REACH staff, as established by DBHDS. Screenings occur on time 93% of the time with 61% occurring within one hour in this reporting period. However only 33% of the crisis assessments occur in the individual's home or day program location. This percentage is consistent with the percentage of crisis responses in a community setting for adults in the qualitative study.

B. Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.

The REACH teams continue to provide response, crisis intervention and crisis planning services. DBHDS reported that REACH provided these services to 1,024 individuals in Year 3 compared with 1,301 and 941 individuals in Years 1 and 2, respectively. This number has reduced significantly in Year 4 when 785 adults used either Mobile Crisis Supports or the CTH. Note that these totals are not an "unduplicated count". Each individual is counted twice if they receive both mobile crisis supports and crisis stabilization services. They are also counted again when they use one service a second time. These totals represent the sum of the number of individuals who received: Mobile Crisis Support; Crisis Stabilization-CTH; Crisis Step Down-CTH or Planned Prevention-CTH. Each year since Year 1, the use of mobile crisis supports by all REACH participants (not just at the time of the crisis assessment) has declined through Year 3 and remained at that same number in Year 4, and has declined for the number who used the CTH program overall. The decrease in Year 4 of the use of both crisis services is 23% compared to the utilization in Year 3. This is depicted in Table 15. It is concerning that far more individuals are screened and that the number of hospitalizations for adults continues to increase yet the number who receive Mobile Crisis Supports or the CTH is declining.

Table 15
Number of Adults Using Mobile Supports and the CTH Program

Year	Mobile Crisis Supports	CTH	Total
1	641	660	1,301
2	543	532	1,075
3	486	538	1,024
4	487	298	785

In light of the decreases over the four years of the prime crisis services offered by REACH it seemed important to further analyze the use of REACH resources. REACH Programs also provide prevention services after an individual completes Mobile Crisis Supports, is discharged from the CTH, or initially if prevention support is more appropriate.

Prevention consists of regular check-ins with the individuals and their families, recommendations for linkages, and refreshers on the components of the Crisis Education and Prevention Plan (CEPP). DBHDS presents data that summarizes the number of hours of both Mobile Crisis Supports and Prevention each REACH Program provides. Mobile Crisis Support hours increased dramatically between Years 1 and 2 but have dropped significantly in both Years 3 and 4 to fewer hours than the number of hours provided in Year 1. Prevention hours were the highest in Year 3 (22,803 hours) but have decreased in Year 4 by 2,023 hours (9%). The total hours of both mobile support and prevention have decreased since Year 1. Table 16 depicts these data.

Table 16 *Number of Hours of Mobile Support and Crisis Prevention Support*			
Year	**Mobile Crisis Supports**	**Crisis Prevention**	**Total**
1	6,477	22.297	28,774
2	11,573	13,908	25,481
3	4,844	22,803	27,647
4	4.907	20,780	25,687

Conclusion: The use of the three types of crisis supports that REACH provides has declined between Years 1 and 4. During the same time period the number of crisis calls, number of referrals, and the number of crisis assessments have all increased significantly. The assessments increased from 1001 to 2222 and the number of adults with co-occurring conditions who are admitted for a psychiatric hospitalization has increased from 397 in Year 1 to 887 in Year 4, an increase of 123%.

Service Elements of REACH-REACH provides various service elements within both the CTH and Mobile Crisis Support services. These include: evaluation, crisis education/prevention planning (CEPP), crisis consultation, and provider training.

The DBHDS standards for REACH programs require that all individuals receive both an evaluation and crisis prevention follow-up services. All individuals must also have a Crisis Education Prevention Plan (CEPP), if they do not already have a current one at the time of referral. DBHDS reports on the number of individuals who receive these interventions by service category.

DBHDS reports that all of the REACH programs provided these required services to the majority of individuals using the mobile supports or the CTH. This is the highest level of compliance in this area in any review period. DBHDS reported the following rates of adherence to its requirements during Year 4: 90% of evaluations were completed; 75% of CEPPs; 100% of consultations; and 76% of provider trainings. For this particular review period Regions I, III and IV were most consistently delivering these service elements to individuals who received either mobile crisis support or used the CTH.
Table 17 summarizes this information over the three years below:

Table 17 *Adults Receiving REACH Service Elements*					
Year	**Number of Adults**	**Evaluation**	**CEPP**	**Consultation**	**Provider Training**
1	1,301	679	838	908	689
2	941	714	558	700	507
3	1,024	963	860	981	910
4	929	838	697	929	706

Conclusion: The Adult REACH Programs continue to complete the service elements and to provide consultation for100% of the adults. However, overall the Regions achieved a lower percentage of completed evaluations, CEPPs and particularly provider training in Year 4 compared to Year 3. Completion of these service elements was 100% for Regions I, II, III and IV for completing evaluations and providing the consultation, which is the follow-up service. Region V provided consultations for 403 individuals but only completed 313 evaluations. Region V also had the fewest CEPPs done in Year 4. Two hundred one (201) CEPPs were completed for 403 individuals. Regions I, II and IV completed CEPPs for 94%-100% of all the individuals they served, whereas Region II completed the CEPPs for 86% of the individuals the program served.

C. Mobile crisis team members adequately trained to address the crisis shall work with law enforcement personnel to respond if an individual comes into contact with law enforcement

The local REACH teams continue to train police officers through the Crisis Intervention Training (CIT) program. During Year 4, REACH teams trained a total of 734 police officers compared to 743 officers trained in Year 3, 659 police officers trained in Year 2 and 727 officers trained in the Year 1. This training for law enforcement was provided in all Regions except Region I. Regions II and V provided the training to the highest number of officers accounting for 71% of the law enforcement personnel trained by REACH staff in Year 4. Both Regions II and V trained the highest number of police officers in Year 3 as well.

DBHDS has partnered with the Department of Criminal Justice Services, the Virginia Board of People with Disabilities and Niagara University to develop comprehensive training for law enforcement. The focus of the training is disability awareness. This training initiative is detailed in an earlier section of this report.

Conclusion: REACH staff continues to train law enforcement personnel. The lack of such training in Region I is concerning and should be monitored. The Commonwealth's plan to enhance training for law enforcement personnel is essential. Police officers respond to many of the crises involving individuals with IDD and have the authority to issue an Emergency Custody Order (ECO) that initiates a pre-screening for potential hospitalization.

D. Mobile crisis teams shall be available 24 hours, 7 days per week to respond on-site to crises.

As reported earlier in Section 5, the REACH Mobile crisis teams are available around the clock and respond on-site, including during off-hours. There were 2222 mobile crisis assessments completed in Year 4 compared to 1904 mobile assessments completed in Year 3, which is a significant increase compared to the 1574 assessments conducted in Year 2, and the 1063 mobile assessments performed during Year 1. During Year 4 REACH staff responded onsite to the vast majority of crisis calls that they received.

The location where the crisis assessment occurs is very important. The SA establishes the expectation that Commonwealth's crisis system should be available to conduct crises assessments in the individual's home, day program or other community location. During Year 4 2,222 crisis assessments were conducted involving REACH staff. Only 730 (33%) were conducted in the individual's home or day program, whereas the CSB ES staff conducted total of 1,425 (64%) assessments at out -of-home locations, i.e. the CSB office or hospital. In Year 4 we see both the highest number and highest percentage of assessments being conducted at the hospital or CSB/ES. The percentage of assessments conducted in the family home, residence or day program was highest in Year 1 at 44% of all assessments. It has decreased to 33% in Year 4. It is positive that the hospital screeners are more routinely informing REACH of hospital screenings, but it is very concerning that the CSB's not implemented the requirements of the Agreement, and instead have maintained its pre-Settlement Agreement approach to conducting assessments after individuals are removed from their homes to the CSB ES or hospital.

In Year 4, 33% of the of the crisis assessments were conducted in the individuals' homes, day programs, or other community locations, which is comparable to the 37% and 36% performed in these locations in Years 3 and 2, respectively. The percentage is significantly less than the 48% of assessments that were conducted in these settings in Year 1. Over 60% of initial assessments in Year 3 occurred at either a hospital/ER setting which increased further, to 64%, in Year 4. This increase in out-of-home locations for the initial assessments is an indication that CSB ES screeners informed REACH programs of a greater number of screenings for potential hospital admission. It is also an indication of a lessening of REACH's opportunities to de-escalate and stabilize crises within the individual's home, which would allow the individual to remain in his or her home setting. The steadily increasing number of out-of-home assessments and hospital admissions over the four years is concerning. Removing individuals from their homes to conduct crisis assessments is contrary to the requirements of the Agreement and doing so contributes to an increase in the number of individuals with IDD admitted to psychiatric facilities.

In Year 3, and for the first time, more individuals were assessed at provider locations than at family homes. This trend continued in Year 4. REACH responded to 421 crisis calls at either residential or day provider locations and 285 crisis calls at family homes in Year 3 and to 443 at either a residential or day location and 287 at the family of individual's home in Year 4. This is an indication of the value that the providers place on the REACH programs to assist their staff when crises occur. However, it may also be an indication of the provider community's lack of clinical and behavioral expertise to address significant behavioral

challenges that some adults present. The fact more families call REACH each year to respond to a crisis at their home is an indication of the knowledge families have about the program. Table 18 compares the location of crisis assessments across the four years.

Table 18
Location of Crisis Assessment

Year	Home	Residential	Day	Hospital	CSB/ES	Other	Total
1	222	219	37	385	43	48	**1006**
2	235	280	44	826	107	51	**1568**
3	285	364	57	946	195	62	**1909**
4	287	401	42	1245	180	67	**2222**

DBHDS reports the number of crisis responses that involve law enforcement personnel. Law enforcement was involved in 590 of 1099 of the crisis calls during this reporting period, FY19 Q2 and FY19 Q3, which represents 54% of the crisis calls received by REACH Programs. It is difficult to draw any conclusions without knowing about the dispositions when law enforcement is involved. If an ambulance is called to transport someone to the hospital, law enforcement is routinely involved to assist with the response and to assure everyone's safety. Families may also call 911 during a crisis with a family member. It is beneficial that REACH participates in CIT training for law enforcement officers so the officers are better prepared to address the crisis situation involving someone with IDD. The trend of referrals being made primarily during normal business hours continues. REACH received a total of 2258 in Year 4. Four hundred fifty-three (20%)of these calls were received on weekends or holidays, which is comparable to the percentage of calls on these days in Year 3, when the Regions received 1020 calls (45%) between 3-11 PM and 196 calls (9%) between 11PM and 7 AM. Forty-six percent (1042) of all of the calls were made during the normal workday hours, which are reported now as 7AM – 3PM.

Conclusion: REACH staff responds appropriately to all crisis calls onsite and are available all days of the week and times of the day. However, fewer crisis calls were responded to in community settings in Year 4.

E. Mobile crisis teams shall provide crisis support for a period of up to three days, with the possibility of 3 additional days

DBHDS collects and reports data on the amount of time that REACH devotes to a particular individual. REACH is expected to provide up to three days of mobile crisis support on average for adults. Every Region did provide at least an average of three days in Year 4. The days ranged from 1-18 days. Region III continues to average the most days throughout the year, averaging over twelve days in all but one quarter.

Conclusion: REACH is providing the amount of mobile crisis support required.

G. By June 30, 2013 the Commonwealth shall have at least two mobile crisis teams in each region to response to on-site crises within two hours
H. By June 30, 2014 the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond on site to crises as follows: in urban areas, within one-hour, and in rural areas, within two hours, as measured by the average annual response time.

Regions have not created new teams, but added staff to the existing teams. The added staff has resulted in sufficient capacity to provide the needed crisis responses within the one and two hours as required, with the exception of Region II as noted previously. Regions II and IV are urban areas and are expected to respond to each crisis call within one-hour.

REACH responded onsite to all of the 2222 crisis calls in Year 4 with the exception of seven calls. Five of these calls were in Region I and due to severe weather. The Region participated in the screenings by telephone. The other two calls that were not responded to in-person occurred in Region V and were the result of misinformation from the ES pre-screeners. REACH responded to 2073 of the 2221 (93%) crisis calls within the required time periods (one hour in Regions that DBHDS has designated as urban, and two hours in Regions that it designated as rural). The on-time percentages have been either 93% or 92% for all four years.

***Conclusion*:** The REACH programs overall have maintained an on-time response rate of 93% in Year 4. All regions met or exceeded the average response time requirement for urban and rural areas.

iii. Crisis Stabilization programs
A. Crisis stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services.
B. Crisis stabilization programs shall be used as a last resort. The state shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement, and if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.
C. If an individual receives crisis stabilization services in a community-based placement instead of a crisis stabilization unit, the individual may be given the option of remaining in placement if the provider is willing to serve the individual and the provider can meet the needs of the individual as determined by the provider and the individual's case manager.
D. Crisis stabilization programs shall have no more than 6 beds and length of stay shall not exceed 30 days.
G. By June 30, 2013 the Commonwealth shall develop an additional crisis stabilization program in each region as determined to meet the needs of the target population in that region.

All Regions have a crisis stabilization program for adults that provide both emergency and planned prevention. All crisis stabilization programs are community-based and have six beds available.

The Crisis Stabilization Program continues to provide both crisis stabilization and planned crisis prevention as the Commonwealth intended in its design of these programs. All Regions also use the CTH programs for individuals as a step-down setting after discharges from psychiatric hospitals. Overall use of the CTH has decreased over the past four years. However, utilization in Year 4 was 298 visits. After a low of 398 visits in Year 2 utilization increased to 538 visits in Year 3. This is currently substantially less than the 660 visits in Year 1. This longer stays in the CTHs is one contributing factor. DBHDS includes data about the capacity and utilization of the CTH beds for all of the Regions. None of the Regions were at full capacity in any quarter of Year 4. The ranges of bed capacity used across the five regions for Year 4 are:

Region 1: 49%-95%, with three quarters under 63%
Region II: 15%-86% with three quarters under 58%
Region III; 58%-82% with three quarters ***over*** 71%
Region IV: 31%-71% with three quarters under 49%
Region V: 25%-47%

The decreased use of the CTHs is particularly troubling when occurring at a time of increased hospital admissions. This concern is supported by the data that the CTH have used for fewer individuals as well as a smaller percentage of all individuals using the CTHs for stabilization after a crisis. The numbers of individuals using the CTHs for stabilization dropped from 321 in Year 1, to 173 in Year 3, a number slightly higher than the 145 individuals who used the CTHs for crisis stabilization in Year 2. Only 109 individuals in Year 4 used it for stabilization. It is positive that more individuals are able to use the CTHs as a step-down from hospitalization. The use of the CTHs for this purpose has dramatically increased since Year 1 when only one adult used it for this reason. By Year 3, 129 individuals left hospitals for the CTHs, which represented 24% of the individuals who use the CTH. In Year 4, 119 individuals used the CTH for step-down but this number represents 40% of the individuals using the CTH.

The use of the CTH for prevention has dropped from 303 adults in Year 1 to only 48 adults in Year 4. No evidence was found that this decline resulted from those in crisis having fewer needs for crisis stabilization or prevention. It is unknown whether this decline is because of fewer requests, and if so whether fewer requests occur because of longer stays for those admitted to the CTHs and unavailability of beds, or fewer available staff. Regardless, it appears that these programs are not being offered or provided as intended and as practiced by REACH in previous years.

Table 19 describes the various uses of the Crisis Stabilization Programs **(**CTH's) over the past three years.

Table 19 *Use of the CTH*						
Year	**Stabilization**	**Prevention**	**Step Down**	**Readmission**	**Visits**	**Total Individuals**
1	321 (49%)	303 (46%)	1 (0%)	35 (5%)	660	**625**
2	145 (36%)	149 (37%)	84 (21%)	20 (5%)	398	**378**
3	173 (32%)	181 (34%)	129 (24%)	55 (10%)	538	**483**
4	109(37%)	48 (16%)	119 (40%)	22 (7%)	298	**276**

The decline in the use of CTH does not appear to be the result of declining needs. Use of the CTHs still more often as a resource for stabilization and step-down may be appropriate. The use of the CTH to prevent a crisis is part of many individuals' crisis prevention plans. It is not known from the data whether the individuals who were re-admitted for step-down purposes had been re-hospitalized. These would be valuable data to keep and to analyze for future reviews. During Year 1, the CTHs were used more equally for stabilization and prevention purposes. However, the increased use of the CTH as an appropriate step-down program for individuals who are ready to be discharged from psychiatric hospitals has changed this ratio during the subsequent years.

Table 20, Utilization of the CTH in Average Day Ranges, depicts the average lengths-of-stay at the CTH's for each purpose. The range for each describes the difference in the average lengths-of-stay across all five Regions. The goal, and the Agreement requirement, of the REACH CTH program is that no stays are for longer than thirty days.

The Crisis Stabilization Programs (CTHs) were designed to offer short-term alternatives to institutionalization with stays greater than thirty days not being allowed. The premise of capping the length-of-stay is that the setting is most effective as a short-term crisis service. The averages show the range for the five Region's CTHs for each year. DBHDS does not report on the number of stays longer than thirty days or the duration of these visits. The average lengths- of- stay is only over thirty days in Region II for step-down (44.75) and for stabilization (41), and in Region III for stabilization (37.25). However, these are the averages. DBHDS does not report how many actual stays were longer than thirty days in duration.

Maintaining shorter stays of no more than thirty consecutive days is helpful to REACH participants as a whole. When the number of days particular individuals stay exceeds the thirty days that are allowed, other individuals are precluded from using the CTH for crisis stabilization or prevention.

Table 20 *Utilization of Crisis Stabilization Programs (CTH) Average Day Ranges*				
Type of Use	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Stabilization	12-21	14-42	19-35	19-37
Prevention	4-11.5	4.5-12	5-26	3.5-14
Step-down	N/A	19-39	16-36	21.5-67

DBHDS does not report the length of the actual stays in the Crisis Stabilization Programs (CTHs). It will be helpful going forward to have information about the number of stays greater than thirty days and the reasons for the prolonged use of the CTH program. These extended stays are expected to occur far less frequently once the DBHDS transition homes are opened.

Conclusion: The CTHs will be more readily available for more individuals if the programs are able to achieve lengths-of-stay in accordance with the requirement of the Agreement. DBHDS has not yet been able to open the two transition homes for adults that it had planned; one is planned to serve individuals in Regions I and II, and the other individuals in Regions III, IV, and V. DBHDS now anticipates opening one of these settings by July 2019. The other will be ready at the same time but is needed for the Children's CTH in Region IV because the home intended for the Children's CTH has experienced construction delays. These settings will add to the Commonwealth's capacity to respond by providing therapeutic alternative residences that can support individuals who need stays of more than thirty days for crisis stabilization to make a positive transition to a new permanent residence.

DBHDS reports on the waiting lists for each Region's Crisis Stabilization Program's beds. Fifteen individuals were on the waiting list in this review period, FY19 Q2 and Q3. Only Regions I and II had a waiting list in FY19 Q2 and only Region I in FY19 Q3. Yet we found six individuals in the qualitative study who were referred to REACH in one month of FY19 Q2 who could have been diverted from the hospitalization, but there was no REACH CTH bed available. These individuals lived in Regions III, IV and V.

Conclusion: DBHDS does not have sufficient capacity in its five Crisis Stabilization Programs. Individuals with IDD, who could have been diverted from hospitalization or who were ready for discharge, continued to be institutionalized as a result of a lack of available beds in the existing Crisis Stabilization (CTH). Evidence that supports this concern was found in the qualitative study completed for the thirty selected adults in this review period who were referred for crisis services. The Regional REACH teams all acknowledged that it might have been possible to divert a few of the individuals who were hospitalized if the CTH had an available bed. We found that six (37.5%) of the sixteen adults who were hospitalized could have been diverted if a CTH bed had been available. It continues to be apparent that the numbers reported on the Waiting Lists do not fully reflect the number of individuals who could have been diverted from a hospital admission if a CTH opening was available.

It is evident from these data that the Crisis Stabilization Programs (CTHs) are not improving their ability to be a source of short-term crisis stabilization, intervention and prevention as required by the Agreement as evidenced by longer average stays and fewer individuals having the opportunity to use the CTH Program. Fewer individuals were able to use the CTH for crisis prevention. The ability of families to use this out-of-home support may assist them in being able to support their adult child for a longer period of time in their family home. It is important that its use for prevention and for re-admission returns to a more substantial number of adults. It is concerning that fewer adults overall were able to use the CTH in Years 3 and 4 than were able to use the CTH option in Year 1. There were many more individuals in crisis and admitted to, and discharged from, psychiatric facilities. The lack of available CTH capacity appears to be a contributing factor to the increase in the number of psychiatric hospitalization.

DBHDS has planned and secured funding to develop two transition homes for adults who require extended stays. Each planned home will be able to serve up to six individuals at one-time. DBHDS plans to serve individuals who are in need of up to six months of supports in a temporary residential setting. One home will serve Regions I and II. The other home will serve Regions III, IV and V. DBHDS plans to open only one of the transition homes by July 2019. This is a twelve-month delay over the anticipated opening that DBHDS reported in the eleventh review period. It is unfortunate the opening is delayed and the second home has no projected opening date at this time. These homes will be a critical component to the crisis service system. They should allow more individuals to be diverted, or stepped down, from hospitalization. Having an additional source for individuals who need a temporary residential setting will lessen the pressure on the existing CTHs, which have been the only residential resource for out-of-home diversion.

The REACH program continues to provide and to offer community–based mobile crisis support as the first option when appropriate and available. Timely mobile crisis support was provided to 487 adults in Year 4, compared to 486 individuals in Year 3, compared to 543 individuals during Year 2, and to 641 individuals in Year 1. The decrease in the numbers served in Years 3 and 4 is concerning.

There is no indication that DBHDS utilized any other community placements for crisis stabilization during the reporting period for individuals who could not remain in their home setting. Thirty-six individuals were supported in the Mental Health Crisis Stabilization program, compared to twenty-seven, thirty-three and seven respectively in the previous three years. The REACH teams preferred approach is to provide supports needed to stabilize individuals who are in crisis, so they are able to continue to live in their own homes.

The Settlement Agreement requires DBHDS to determine if individuals in the target population require additional crisis stabilization programs. The addition of transition homes will help the Commonwealth address the transitional housing needs of individuals in the target population who otherwise would need an extended stay at the CTH until a permanent alternative residence is developed or located. The addition of these new homes will benefit individuals and are expected to allow other aspects of the service system to

function more as designed and intended. I believe that DBHDS's determination to open transition homes to address the needs of adults in crisis who need a longer transition period is an important step toward addressing this requirement. The utilization data over the next few review periods will help determine whether two transition homes are sufficient.

SECTION 6: SUMMARY

The Commonwealth of Virginia continues to make progress in some areas to implement a statewide crisis system for individuals with I/DD. There has been no progress in providing assessments before individuals are removed from their homes. During Year 4 the REACH Children's and Adult Program continued to experience an increased number of referrals and needed crisis assessments, while providing mobile crisis supports to fewer individuals. The CTH program is used increasingly for step-down and readmissions but its use for stabilization and prevention, while up slightly from Year 2, is decreased significantly from Year 1 utilization rates. REACH adult and children's programs were engaged in continuing to train case managers, ES and hospital staff, providers and law enforcement officers, although the number of stakeholders varies across regions.

The Children's REACH program is fulfilling many requirements, but this does not yet include out-of-home crisis stabilization programs for use as a last alternative to children being admitted to institutions, including psychiatric hospitals.

The decrease in the use of mobile crisis supports for both children and adults and the CTH for adults is concerning and may be attributed to a lack of staffing. This concern is similar to the concern expressed in Year 3. I asked DBHDS for a staffing summary for the REACH community services of the adult and children programs for FY19. Last year DBHDS provided this information as well. The REACH programs for adults have now been combined with the programs for children in all Regions, except Region I. REACH employs clinicians for leadership responsibilities; Coordinators; in-home crisis workers; and CTH staff. The number of positions assigned to the CTH programs all include the CTH Managers. Table 21 below portrays the total number of positions in each Region:

Table 21
REACH Program Staff Positions

Region	***Clinical***	***Coordinator***	***In-Home***	***CTH***	***Total***
I	*8*	*15*	*7*	*23*	*53*
II	*10*	*21*	*8*	*20*	*59*
III	*16*	*8*	*11*	*27*	*62*
IV	*18*	*16*	*19*	*18*	*71*
V	*11*	*11*	*10*	*20*	*52*
Total	*63*	*71*	*55*	*108*	*297*
Average	***12.6***	***14.2***	***10.1***	***21.6***	***59.4***

The significant staffing variations between Region is curious. The positions assigned to the CTH vary from a low of eighteen positions in Region IV to a high of twenty-seven positions in Region III although all CTHs offer six beds for stabilization. Region V has by far the highest number of calls and referrals; yet, the Region has an overall below average number of Coordinators or In-home crisis staff.

At the time of this study, however, every Region had staff vacancies in each category. This was true in Year 3 as well, when there was a 25% vacancy rate. Overall, the REACH programs are operating with sixty-one out of 297 REACH positions being vacant, a statewide vacancy rate of 20%.

The vacancies in each Region are as follows:
Region 1:4 (7.5%%) similar to Year 3
Region II: 14 (24%), a decrease from Year 3
Region III: 10 (14.5%%) a decrease from Year 3
Region IV: 2 (28%) an increase from Year 3
Region V: 4 (27%) an increase from Year 3

All of the vacancies include in-home mobile support staff and coordinators. REACH Coordinators may also provide in-home support and are responsible to develop CEPPs. Region II has ten of twenty-one Coordinators vacant. Both Regions IV and V have significant numbers of both Coordinator and in-home worker positions vacant. While there is an overall vacancy rate of 20%, the vacancy rate is 30% statewide for the Coordinator position. Regions III and IV had significant vacancies in the CTH program at the time DBHDS reported staff vacancies to this consultant. Region II had seven of twenty-seven CTH positions vacant and Region IV had eight of eighteen CTH positions vacant.

Functioning effectively with an overall vacancy rate of 20% is extremely difficult and can be highly taxing on managers and on the current staff. With such a high number of positions being vacant, managers often must cut back on the quantity of services being provided. It is reasonable to conclude that the high number of staff vacancies is a significant contributing factor to the REACH programs' decrease in the number of individuals for whom in-home mobile support and CTH services were provided, and, therefore to the increase in hospitalization. I recommend that DBHDS begin reporting on all staffing in the REACH programs in the fifteenth reporting period and efforts that are being made to reduce the vacancy rate.

The Commonwealth now has better data regarding individuals admitted to psychiatric hospitals and the involvement of REACH, which occurs when the individuals are known to them. However, the number of individuals admitted to hospitals has continued to increase; and the data are not available to determine whether more of these individuals could have been diverted if the appropriate community resources, including sufficient CTHs and transition homes, were available. Hospital and CSB ES staff may more regularly inform REACH staff of crisis screenings, in light of the increased number of pre-screenings in Year 4. REACH is involved

with far more hospitalizations of individuals with IDD reported in Year 4. DBHDS and REACH should analyze the increase in hospitalizations and determine what corrective actions can be taken to achieve the planned, expected and desired outcomes of the development of crisis services, as well as the linkages between hospitals and CSB ES programs of REACH crisis services. Completing initial assessments in the individuals' homes and before they are removed to a hospital location, is critical to achieving the desired outcomes for these individuals.

The number of individuals hospitalized and the reduction in the overall provision of mobile supports and the CTH program is very concerning. However, it is heartening that for the first time there were fewer children hospitalized than in previous reporting periods.
The qualitative review study of a small sample of individuals found that REACH had consistently responded to crises and had maintained contact with individuals during their hospitalizations. Many of these individuals, however, particularly the adults, may have been able to be diverted. Also, the rural locations of some of the screenings may preclude timely involvement of REACH staff in the prescreening, unless REACH staff is deployed differently. This appears particularly problematic in Region III from data learned during the last two qualitative studies.

REACH staff develops and implements plans and provides families with links to community resources. REACH data indicate that the majority of those who did participate in REACH services generally had their needs for short-term crisis intervention and family training met. Both children and adults used mobile crisis supports in 74% of the study sample of individual cases.

DBHDS has put significant effort into increasing the number of behavioral specialists. It must still be determined, however, whether the plans underway will provide sufficient capacity to meet the existing level of need. One finding of the study is that too few individuals who need a BSP have access to one. Very few of either the children or adults who could benefit from a behaviorist had one: 33% of the adults and 15% of the children were engaged with a behaviorist. Overall 58% of children and adults who need a behaviorist do not have access to one. DBHDS's efforts to develop residential providers, which can support individuals with co-occurring conditions, have not yet been sufficient. Developing a sufficient number of residential providers that are competent to support individuals with intense behavioral needs will be critical to the system's success in reducing unnecessary hospitalizations and transitioning individuals in a timely way from crisis stabilization and psychiatric hospitalizations to community-based settings. I recommend DBHDS provide written reports regarding these efforts and the outcomes in future reporting periods. The outcome of the qualitative study evidences the work that is needed in this area. While 73% of the children had providers that could meet their needs, only 50% of the adults had providers with the necessary expertise to address their mental health diagnoses or behavioral challenges. Overall 62% of the individuals in the sample had adequate support from providers.

ATTACHMENTS:

Attachment 1: Summary of the Qualitative Study of sixty REACH Participants
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Attachment 2 Individual Summary for each child and adult included in the selected sample has been provided (underseal) to the Parties.

ATTACHMENT 1:

SUMMARY OF THE QUALITATIVE STUDY OF SIXTY REACH PARTICIPANTS

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Section I Introduction

The status of the Commonwealth's progress was studied for the provisions that are detailed in Sections III.C.6.b.ii.B, and III.C.6.b.ii.E, of the Settlement Agreement for the fourteenth review period. The Expert Reviewer will review progress toward compliance. Findings, conclusions, and any recommendations or suggestions will be reported to the Independent Reviewer to assist in his determination of compliance.

As part of the review during this review period the Expert Reviewer completed a qualitative study including sixty individuals referred to REACH during the review period. This qualitative study is to complement the review of the data reports submitted by DBHDS. The study will inform the determinations made by the Independent Reviewer regarding the Commonwealth's success meeting the provisions of the SA related to developing and implementing crisis services for individuals with IDD and behavioral challenges or who have mental health diagnoses.

For the fourteenth period review, a qualitative study of the REACH delivery of community-based crisis services for sixty individuals with I/DD in Regions III, IV and V who were referred to REACH was conducted. This study includes a review of the effectiveness of the REACH programs and community behavioral, psychiatric and psychological supports to de-escalate and prevent crises; to stabilize individuals who experience a crisis; and to provide successful in-home and out-of-home supports, including community linkages for ongoing services and supports, that assist individuals to retain their community residential settings.

Section II Methodology

The qualitative study includes a review the records of sixty children and adults who received REACH services during FY19Q2. DBHDS produced the list of all children and adults who received REACH services between 10/1/18 and 12/31/18 from Regions III, IV and V. The study includes individuals who were psychiatrically hospitalized and those whose crises were managed with community support. To create a stratified sample for this study, I then randomly selected sixty children and adults with I/DD who were served by REACH in the three identified Regions who were referred to REACH between 11/1/18 and 11/30/18. The review also includes interviews with REACH staff and individuals' Case Managers.

There were a total of ninety-three individuals who were referred during the defined time period. Table 1 portrays the age groups and regional affiliation of these individuals. The sample included 89% of the individuals referred to REACH in Region III; 53% of the individuals referred to REACH in Region IV; and 67% of the individuals referred to REACH in Region V, in the time period noted. Overall, the sample includes 50% of the adults, 91% of the children, and 65% of the all referred in the three Regions between 11/1/18 and 11/30/18. See Table A below

Table A *Individuals Receiving REACH Services 11/1/18 and 11/30/18 Sample Selection*					
Region	**Adults Referred** 11/1/18-11/30/18	**Children Referred** 11/1/18-11/30/18	**Adults Selected**	**Children Selected**	**Total in Sample**
III	12	7	10	7	17
IV	29	18	10	15	25
V	19	8	10	8	18
Total	60	33	30	30	60

DBHDS was asked to produce the following documentation for each of the selected individuals: REACH records; Individual Service Plan (ISP) and behavioral support plans, if applicable; and Names and contact information of the Case Manager (CM) and REACH Coordinators

DBHDS produced all of the REACH records and all contact information. DBHDS shared ISPs for all individuals who had these plans. Very few individuals in the sample worked with a Behaviorist so only a few behavioral plans could be shared.

All three REACH teams were interviewed. The REACH teams in Regions III, IV, and V have each combined responsibilities into one cross-trained team for the provision of crisis services for both children and adults. We interviewed REACH team members in person after we were able to review the records. All teams were very helpful and we appreciate the time they gave to produce all of the needed records and to answer questions.

DBHDS provided the contact information for the CMs and all were contacted. Those who responded were interviewed by telephone. In total, fifteen CMs were interviewed, twelve for adults, and three for children.

Section III Summary of Findings

This report is based on the review of thirty adults and thirty children, the sixty individuals in the selected sample. The purpose of the record review and the interviews was to analyze the Commonwealth's efforts to provide crisis intervention and prevention services that help avoid hospitalization and maintain the community settings for individuals who experienced a crisis; determine if REACH responds to crises in a timely way, completes required plans, and coordinates effectively with families, providers and CMs; and determine if the community system offers the necessary community supports these individuals need in addition to REACH to stay in their residences. The analysis included a review of REACH's crisis response; the timeliness and location of the crisis response; if hospitalization was avoided as a result; if diversion was possible but not attained due to a lack of community resources; the provision of in-home mobile supports; the use of the CTH; the development of the crisis plan; the development of community linkages for the individual; the availability of psychiatrists and behaviorists; the provider capacity; and whether the individual retained his provider.

Thirty-seven (62%) of the individuals lived with their families including twenty-six of the children (87%) and eleven (37%) of the adults. Two of the children lived with foster families and two were in residential settings. Two adults lived independently. One adult was in jail. The other sixteen adults lived with providers although in four of the cases the provider was an Assisted Living Facility (ALF). Nineteen of the thirty adults were on one of the HCBS Waivers. Many of the remaining adults were on a waiting list for waiver services. Only three children were on a waiver. Twenty-six of the individuals had a CM, including eighteen adults and eight children.

Individual Plans (IP): IPs were provided by DBHDS for thirty of the sixty individuals in the study. Everyone in waiver programs (22) has an IP and some others on the waiting list or receiving mental health services had IPs. The IP gives a greater sense of the individual needs. However, it was telling that very few of the IPs include specific information on the serious behaviors some of these individuals present, nor are the behaviors or mental health concerns addressed in the plans. The Plans, also do not always reflect the input of providers or REACH.

REACH Crisis Response: The vast majority of the initial calls in this review period were placed during an active crisis resulting from behavioral actions that involved physical aggression, property destruction, and/or extreme self-injurious behavior including suicide ideation or threats. The Police were involved with twenty-eight (47%) of the sixty individuals, including fourteen children and fourteen adults. It is evident that the police and REACH staff work closely together on the scene of these crises.

Where the pre-screening occurred: Sixteen (27%) of the individuals in the study experienced a crisis response at their home or day program, including ten adults and six children. REACH and/or the police were able to stabilize the situations at home without necessitating a hospital screening, which is significant. Forty-four (73%) of the individuals experienced a hospital pre-screening at the ES or hospital, although for some REACH responded to a subsequent call at the individual's home. The Commonwealth, in establishing crisis intervention and prevention services, envisioned that its statewide crisis system would respond to a crisis at the home or relevant community setting. We know from past reports that ES screeners do not respond to an individual at their home and often REACH is not contacted until the individual is in route to, or at the hospital. In all sixteen situations when REACH did respond in the home, the crisis was stabilized there. However, this is a small percentage of the population in the study for this period.

Most of the pre-screenings were completed at the ES or hospital. For the children, twenty-four of the thirty crisis responses occurred at the ES or hospital. Of these pre-screenings thirteen (59%) resulted in a hospitalization and nine (41%) were diverted from a hospitalization. For the adults, twenty of the pre-screenings occurred at the ES or hospital. Of these pre-screenings, fifteen (75%) resulted in a hospitalization and five (25%) were diverted from a hospitalization. It is far more likely for an individual, especially an adult, to be hospitalized once he or she has been removed from the home setting. If the Commonwealth is to reduce the unnecessary hospitalization of children and adults with IDD, its statewide crisis system must respond while the individual is still at home, as it committed to do in the Agreement. As its crisis system is currently structured, it is unlikely that the number of individuals for whom a crisis is responded and stabilized at home, will increase until CSB ES staff is mobile and responds with REACH staff to the home.

REACH response to the crisis: REACH responded directly to all but three of the adults and participated in the screening. The REACH teams responded timely for 100% of the children and 90% of the adults, for an average of 93%. In the case of one child, REACH was in route to the hospital but the parents took the child home. All three of the adults without a response from REACH were in Region III. REACH was not notified of one of the pre-screenings. In the other two cases, REACH did not respond because the ES screener told the worker not to come due to a TDO being issued. Region III reports this is sometimes the case because of the distance between the REACH program and the pre-screening locations. REACH indicates a staff goes if the family needs their assistance. However, if the individual is a new referral, REACH is relying on an ES worker's perception of the family's need. The REACH protocol, however, is that REACH will attend all pre-screenings. This expectation should be clarified to determine if not attending when a TDO is already issued meets the DBHDS requirement.

REACH's response times for fifty-six (93%) of the sixty calls were well within the established guidelines. There were two calls for adults that were not responded to at all in Region III, as noted above, and. the third case in Region III was due to REACH not being notified of the pre-screening. One call in Region IV that was responded to 45 minutes late

Hospitalizations: A total of thirty-one (52%) individuals were hospitalized; fifteen children and sixteen adults. Twenty-eight (48%) of the individuals were diverted from hospitalization. One child was not in jeopardy of hospitalization. REACH provided hospital support for eleven (73%) of the fifteen children whose families accepted REACH services and for thirteen (81%) of the sixteen adults who accepted REACH support, for an average of 80% who received REACH support while in the hospital who accepted REACH involvement.

Children are generally hospitalized for short stays at the Commonwealth Center for Children and Adolescents (CCCA). In the sample reviewed, the adults who were hospitalized often experienced multiple hospitalizations; some of which were for long periods of time. Two adults were still hospitalized in early April when we met with the REACH teams. One who had multiple hospitalizations spent a total of 119 days hospitalized in 2018 and could have been diverted during this review period if a CTH bed was available. Another adult experienced three hospitalizations in 2018, the longest of which was for 132 days.

Hospitalizations Avoided: Hospitalization was avoided for 29 individuals (48%) including 15 children and 14 adults (including one child not in jeopardy of being hospitalized). It appears that hospitalizations could have been diverted for nine (29%) of the thirty-one individuals who were hospitalized. Other hospital stays might have been shortened if an adult crisis stabilization (CTH) bed was available or the children's CTHs were open. While a number of children in this study were hospitalized due to suicide or homicidal ideation, and therefore hospitalization was necessary, the REACH teams all report many hospitalizations for children generally served by REACH could be diverted with available CTH capacity. One REACH Director estimated this might reduce as many as 60% of the children's hospitalizations that would otherwise occur. It will be valuable to determine if there is a reduction in hospitalizations for children once the children's CTHs are in full operation, the frequency with which the CTHs are offered and

available, and whether twelve beds statewide are sufficient to divert children from unnecessary hospitalizations.

Accepted REACH: Forty-five families (76%) accepted REACH and 14 families (23%) refused REACH mobile supports upon initial contact or after a brief period of time. One adult was not eligible for REACH services. Those who refused included ten children and four adults. Two of the adults who refused REACH services lived in ALFs and two lived with their families. Eight families of children refused REACH, some who believed they had sufficient supports including community-based crisis supports. The other two children were represented by DSS. DSS did not accept REACH services for either child.

Utilization of Mobile Supports: REACH provided in-home mobile supports to sixteen adults and seventeen children, thirty-three (73%) of the forty-five, who accepted services. REACH also continued with many of the individuals and families, providing prevention services. In the majority of situations, the days of support provided exceeded the three days that are routinely planned after a crisis. The use of mobile supports has helped sustain many of these individuals.

The mobile support days only include the actual face-to-face interventions by REACH staff with the individual. It does not include the time of observation to develop the Crisis Stabilization Plans and the Crisis Education and Prevention Plans (CEPP); time spent training parents or staff; phone consultation with the individual or family; or the time arranging linkages or consulting with the team. Much of the in-home mobile support is focused on activities to help stabilize the individual; build rapport and trust; identify triggers to behaviors; develop coping strategies; and build self-esteem.

REACH develops goals for individuals receiving mobile supports. Not all plans include measurable objectives or REACH staff do not necessarily write progress notes toward achieving the outcomes. Documentation of plans, goals and progress notes is excellent in REACH Team in Region IV, but can be improved in both REACH Teams in Regions III and V. In some cases, there were no notes summarizing the entire period of time that REACH was involved with the individual. While the REACH progress notes have become less therapeutic and more descriptive of the actual crisis service provided, the records maintained do not consistently include what REACH staff review, when their reviews are done, what adjustments are made and how staff are measuring success or failure related to their approach to providing in-home mobile supports. Because the plans frequently do not use measurable objectives, it is not possible to reliably track individuals' progress toward achieving the plan goals. Region IV can be used as the model that best meets the expectations of the REACH guidelines.

CEPP: CEPP's were developed or updated for thirty-two of the individuals in the sample. REACH was not able to complete CEPPs for seventeen of the individuals who had either refused REACH services or discontinued services before a CEPP could be completed, were ineligible for REACH, or remained hospitalized. Overall, REACH completed 74% of the CEPPs for those in the sample for whom CEPPS could be done, but REACH only 38% were finalized. The Regions vary in their ability to complete CEPPS. The Region III REACH team completed 80% of the provisional CEPPs, but only finalized 11%. The Region IV REACH team does well completing the provisional and finalizing CEPPS with 84% and 76% completed respectively. The Region V

REACH team wrote provisional CEPPS for 57% of the individuals who needed a CEPP, and finalized them for only 8% . In Region V far more provisional CEPPs are completed for adults (7 of 9) than for children (1 of 5). The percentages for individuals in the sample vary from those found in the REACH quarterly reports for CEPPs.

CTH: Only five adults used the CTH, all successfully. This was the option that prevented hospitalization or was planned as a step-down that allowed the individual to leave the hospital sooner. Two additional individuals in Region IV were offered the CTH at the time of the crisis, but they chose not to use it. A few individuals were hospitalized, which may have well been avoided if a CTH bed had been available.

Linkages: One of REACH's primary focuses is to help individuals, families, CMs, and teams establish linkages with community services that will more comprehensively help individuals to stabilize and maintain this stability; retain their residential and day providers; be assisted to find employment; and access the medical and clinical supports they need to live successfully in the community. At the time of the crisis calls, linkages were already in place for nine of the individuals in the study; therefore, REACH did not pursue linkages for these individuals. However, upon discussion with REACH or the CM it seems some of these children and adults would benefit from a behaviorist; yet, at the time of service, this was not discussed.

REACH recommended, and in many cases arranged, community linkages for thirty-seven (73%) of the fifty-one individuals who needed them. These linkages included connection with CSBs and CMs; pursuit of waiver eligibility; DARS for employment support; day programs; outpatient therapy; family counseling; mental health support; neurologists; psychiatrists; in-home intensive supports; alternative schools; and behavioral specialists.

The Regions' REACH Teams' work to provide linkages varies, when connections to other services and supports are needed. Region III did not assist with linkages for four individuals in the study. Region V did not assist with linkages for nine individuals in the study. Region IV, which had the most individuals in the study, provided linkages for all of the children and adults who needed them.

Psychiatry: Thirty-seven individuals (64%) had a psychiatrist; psychiatric support was determined to be unnecessary for two adults. Of the twenty-one individuals without a psychiatrist who need one, eleven are adults and ten are children.

Behaviorist: In Virginia, behavioral support services, continues to be the least available and most needed support to assist individual and families who have co-occurring conditions and present behavioral challenges. Only ten individuals had a behaviorist: six adults and four children. A behaviorist is not recommended for another fifteen individuals. Thirty-five (58%) of the sixty individuals in the sample cannot access a behaviorist, but need behavioral support services. This remains a significant area of need in Virginia for individuals with I/DD and behavioral needs.

Case Manager: Twenty-six individuals, eighteen adults and eight children, had assigned CMs. We were able to interview three of the children's CMs and thirteen of the adult's CMs. Ten of the CMs (38%) did not respond to a request to be interviewed. Each CM was asked about the individual's current status; how helpful REACH was; what training REACH provided; how REACH communicated with the CM and the family; and if the individual needed a behaviorist.

Of the three Region IV CMs with children on their caseloads, two were very positive about their experiences with REACH's responsiveness, communication, helpfulness, and training. One reported the family was dissatisfied and the CM found the REACH Team's communication inconsistent. The four CMs interviewed for adults, all from Region IV, were all extremely positive about all of the REACH staff's communication and services. Three of these adults used the CTH. All CMs believed the CTH greatly assisted the individuals to stabilize and were very supportive to the families. The CMs valued the CTH staff for their training and transition work.

Four CMs for adults in Region III were interviewed. Two were very positive about REACH services and their interactions with the REACH staff. One individual had used the Region III CTH. The CM found the CTH staff "wonderful". The CTH staff provided significant training to the new GH staff and was in contact with the CM weekly. One CM found REACH unhelpful; it did not assist the CM with linkages and communication and follow through was reported to be poor. The CM felt the REACH staff made excuses not to meet with her and gave the wrong information about the status of the individual while in the hospital. The fourth CM interviewed found REACH very helpful during the crisis in this reporting period although not helpful for this family in the past. The CM convinced the family to try REACH again because the CM thought the previous experience was based on the competency of one particular REACH staff. The CM's other experiences with REACH were good and, in this crisis, REACH had excellent communication with her and with the family. The CM reports the CTH is an excellent resource.

Four CMs were interviewed in Region V. One reported the individual had an excellent experience with REACH, but that REACH frustrated the CM. There was a lack of communication and REACH did not share the CEPP. The CM learned from the individual served what REACH had provided as mobile crisis support. The second CM also reported REACH provided positive assistance to the individual and the GH staff; however, REACH did not communicate with her. She only received the CEPP recently and the GH shared it with her. She reports that her previous experiences with REACH were better in terms of communication. The third CM who was interviewed also reported better communication in the past. This time REACH didn't communicate at all and never shared the CEPP. She is not aware of any training of the GH staff. The fourth CM who was interviewed shares the frustration of poor communication by REACH staff. She reports it was non-existent with her and sporadic with GH staff. She did think the training REACH provided to the GH staff was useful.

CMs were also interviewed in the fall of 2018. At that time the feedback from the CMs was more generally positive across the three Regions involved at that time (I, IV, and V). It appears the negative comments in Region III may be related to one or two specific staff. Region V may need to focus more attention on its communication and coordination with CMs. It is noteworthy that CMs generally find the communication and interaction with CTH staff to be consistently responsive and helpful.

Provider Capacity: The two tables that follow this narrative summary include information about the number of individuals who have a provider who meets their needs and how many individuals retained their residential setting at the time of the crisis. Forty-six (77%) of the individuals, twenty-five children and twenty-one adults, retained their setting including. Children who left home went to residential treatment facilities or group settings. One adult remains hospitalized, but the other adults transitioned to group homes or sponsored homes, which are better resourced to meet their needs. As in previous studies, after the crisis occurred, a number of group homes or sponsored homes would not allow the adult to return to his/her previous home.

This review found that thirty-seven (62%) of the individuals, twenty-two children and fifteen adults, had providers who could substantially meet their needs. This was determined by the following factors: multiple hospitalizations; a lack of behavioral support including psychiatric care that reduced crises; and families and individuals who are not on the waiver so do not have the range of supports they or their families need to help them continue to be stable and experience a quality of life.

Not all providers were willing to accept training from REACH, follow the CEPP or accept recommendations for linkages or improvements in the structure and expectations of the day programs. The competency of provider staff and the capacity to effectively support individuals with significant behaviors remains a challenge for the Commonwealth to successfully maintain individuals with I/DD and either behavioral or mental health challenges in their communities.

REACH Program Impressions: Overall REACH is accomplishing the intended goals of stabilization via mobile supports and use of the CTH program, when it is available and accessed. The CTH was surprisingly underutilized in this sample. This is concerning because the CTHs are very effective when used. This underutilization is consistent with the data in the Year 4 DBHDS Crisis Services reports. Hospitalization is not being diverted for significant portion of the individuals who could have had their crises stabilized in the community if stabilization beds had been available and utilized. In other cases, individuals who may need stabilization in a hospital experience longer stays than are necessary because a step-down bed is not available or because a new service provider had to be secured and trained.

REACH generally responds to crises in a timely manner and provides extensive mobile in-home supports. REACH continues to support its participants by providing prevention support after mobile crisis support is no longer needed. REACH works effectively with CMs, generally, and takes the responsibility to arrange community linkages seriously. The feedback from CMs this reporting period is less consistently positive about the overall quality of REACH Teams' communication. The extensive cross systems work, necessary in a few of the cases in the selected sample, was exceptionally well done and had very positive results. Individuals in this sample did, in some cases, experience multiple hospitalizations and eleven of the adults (37%) in the sample are not yet able to access waiver-funded services, which increases the likelihood that crises will recur in their lives.

The success of REACH could be more consistent, and with less frequent recidivisms participants, if a behaviorist were in place for all who displayed that need. It is understood that the lack of resources in this profession is a national issue. Virginia needs to evaluate its efforts to increase the number of behaviorists and determine if its efforts need to be enhanced.

Introduction to Tables 2 and 3: The results of the study are presented in the following two tables. For greater ease in reviewing the data, separate tables are presented for children and adults. The columns reflect the areas of REACH responsibilities to respond to crises and provide supports. These include the crisis plan; the number of hospitalizations; the availability of behaviorists and psychiatrists; and the adequacy of providers.

Table B *Findings for Adults Referred for REACH Services 11/1-11/30/18*									
IND	**REACH@Screen**	**Response On Time**	**Hospital Diverted**	**Could have been diverted w/R**	**Hospitalized**	**Hospital Support**	**Screening Location**	**Mobile Support**	**CTH**
01 (III)	YES	YES	YES	N/A	NO	N/A	ES/HOSP	NO	NO
2 (III)	NO (12)	NO	NO	NO	YES	YES	ES/HOSP	N/A	N/A
3 (III)	YES	YES	NO	YES	YES	YES	ES/HOSP	N/A	N/A
4 (III)	YES (2)	YES	NO	NO	YES	NO	ES/HOSP	YES	NO
5 (III)	NO	NO	NO	YES	YES	NO	ES/HOSP	NO	NO
6 (III)	YES	YES	NO	NO	YES	YES	ES/HOSP	NO	NO
7 (III)	NO	NO	NO	YES	YES	YES	ES/HOSP	YES	NO
8 (III)	YES	YES	NO	YES	YES	YES	ES/HOSP	NO	YES
9 (III)	YES	YES	YES	N/A	NO	NO	ES/HOSP	N/A	N/A
10 (III)	YES	YES	NO(9)	NO	YES	YES	ES/HOSP	YES	YES
11 (IV)	YES	YES	YES(3)	N/A	NO	N/A	HOME	YES	YES
12 (IV)	YES (4)	NO (8)	NO	NO	YES	YES	ES/HOSP	N/A	N/A
13 (IV)	YES (5)	YES	YES	N/A	NO	N/A	ES/HOSP	YES	YES
14 (IV)	YES	YES	YES	N/A	NO	N/A	HOME	YES	NO
15 (IV)	YES (6)	YES	YES	N/A	NO	N/A	ES/HOSP	N/A	NO
16 (IV)	YES	YES	YES	N/A	NO	NO	ES/HOSP	NO	NO
17 (IV)	YES	YES	NO	YES	YES	YES	ES/HOSP	YES	NO
18 (IV)	YES	YES	NO	NO	YES	YES	HOME	YES	NO
19 (IV)	YES	YES	NO	NO	YES	YES	ES/HOSP	N/A	N/A
20 (IV)	YES	YES	NO(10)	NO	YES	YES	ES/HOSP	N/A	N/A
21 (V)	YES	YES	NO	NO	YES	N/A	ES/HOSP	N/A	N/A
22 (V)	YES	YES	YES	N/A	NO	N/A	DAY	YES	NO
23 (V)	YES	YES	YES	N/A	NO	N/A	HOME	YES	NO
24 (V)	YES	YES	YES	N/A	NO	N/A	HOME	YES	NO
25 (V)	YES(7)	YES	NO	YES	YES	YES	ES/HOSP	YES	NO
26 (V)	YES	YES	YES	N/A	NO	N/A	HOME	YES	NO
27 (V)	YES(11)	YES	N/A	N/A	N/A	N/A	HOME	YES	NO
28 (V)	YES	YES	YES	N/A	NO	N/A	HOME	YES	NO
29 (V)	YES	YES	NO	NO	YES	YES	ES/HOSP	YES	NO
30 (V)	YES	YES	YES	N/A	NO	N/A	HOME	NO	YES
% MET	**90%**	**86%**	**43%**	**37.50%**	**53%**	**81%**	**33%**	**73%**	**22%**

Table B *Findings for Adults Referred for REACH Services 11/1-11/30/18*									
IND	**CEPP***	**CEPP/in 45 Days***	**Linkages**	**Psychiatry**	**BSP**	**Provider Meets Need**	**Kept Provider**	**Residence****	**CM**
01 (III)	NO	NO	NO	NO	NO	NO	NO	UNKNOWN	YES
2 (III)	N/A	N/A	N/A	NO	NO	UNKNOWN	YES	FAM	NO
3 (III)	N/A	N/A	N/A	NO	NO	NO	NO	GH	YES
4 (III)	YES	YES	NO	YES	NO	NO	YES	FAM	YES
5 (III)	N/A	N/A	N/A	NO	N/A	NO	NO	ALF	NO
6 (III)	YES	NO	NO	NO	NO	NO	NO	FAM	NO
7 (III)	YES	NO	YES	YES	NO	YES	YES	SH	YES
8 (III)	YES	NO	YES	YES	YES	NO	NO	FAM	YES
9 (III)	N/A	N/A	N/A	N/A	N/A	YES	YES	SH	NO
10 (III)	YES	NO	YES	YES	YES	NO	NO	GH	YES
11 (IV)	YES	YES	YES	YES	YES	NO	NO	SH	YES
12 (IV)	YES	YES	YES	YES	N/A	NO	YES	FAM	YES
13 (IV)	YES	YES	YES	YES	YES	YES	YES	FAM/SH	YES
14 (IV)	YES	YES	YES	YES	N/A	YES	YES	FAM	YES
15 (IV)	N/A	N/A	N/A	NO	N/A	NO	YES	ALF	NO
16 (IV)	NO	NO	YES	YES	N/A	YES	YES	GH	NO
17 (IV)	YES	YES	YES	YES	NO	YES	YES	GH	YES
18 (IV)	YES	NO	YES	YES	NO	YES	YES	FAM	NO
19 (IV)	N/A	N/A	N/A	YES	N/A	NO	NO	ALF	NO
20 (IV)	N/A	N/A	YES	YES	N/A	YES	YES	ALF	NO
21 (V)	N/A	N/A	YES	NO	N/A	NO	YES	IND	NO
22 (V)	YES	NO	YES	YES	N/A	YES	YES	GH	YES
23 (V)	YES	NO	N/A	N/A	N/A	YES	YES	IND	YES
24 (V)	YES	NO	NO	YES	NO	YES	YES	GH	YES
25 (V)	YES	YES	NO	NO	N/A	NO	YES	FAM/SH	NO
26 (V)	YES	N/A	YES	YES	YES	YES	YES	GH	YES
27 (V)	YES	NO	YES	YES	NO	YES	YES	GH	YES
28 (V)	NO	NO	NO	NO	NO	YES	YES	GH	NO
29 (V)	NO	NO	NO	NO	NO	YES	YES	FAM	YES
30 (V)	YES	NO	YES	NO	YES	NO	NO	FAM	YES
% MET	**82%**	**32%**	**70%**	**61%**	**33%**	**50%**	**70%**		**60%**

* CEPP is N/A for individuals who refused REACH services or not participating after the crisis was stabilized
** Residences are individual (IND), family (FAM), group home (GH), sponsored home (SH) and assisted living facility (ALF)

1. The individual did not return to the community in RIII but is in the process of being transferred to RIV.
2. The individual had four hospitalizations in the reporting period. REACH responded to only two face to face.
3. He stayed one night in the hospital because he refused to leave. He went to the CTH the next day.
4. Multiple screenings in the review period. He was diverted only once to substance abuse rehabilitation.
5. Multiple screenings in the review period. He was admitted to the CTH regularly to divert hospital admission.
6. These screenings and diversion were prior to the reporting period but included in the documents. Then he refused REACH in this reporting period.
7. REACH attended one screening. REACH was not notified of the second screening.
8. REACH responded once within the 60 minute requirement. The other time REACH arrived in one hour and 45 minutes
9. REACH involvement resulted in one diversion prior to admit in November.
10. Not eligible for REACH services.
11. Individual was found dead by REACH clinician when responding to crisis call at group home.
12. REACH was not called for the screening.

Table C *Findings for Children Referred for REACH Services 11/1/18-11/30/18*								
IND	**REACH @Screen**	**Response On Time**	**Screen Location**	**Hospital Diverted**	**Could have been diverted w/R**	**Hospitalized**	**Hospital Support**	**Mobile Support**
01 (III)	YES	YES	ES/HOSPITAL	NO	NO	YES	YES	N/A
02 (III)	YES	YES	ES/HOSPITAL	YES	N/A	NO	N/A	N/A
03 (III)	YES	YES	SCHOOL	YES	N/A	NO	N/A	NO
04 (III)	YES	YES	ES/HOSPITAL	NO	NO	YES	YES	N/A
05 (III)	YES	YES	ES/HOSPITAL	NO	NO	YES	YES	N/A
06 (III)	YES	YES	ES/HOSPITAL	YES	N/A	NO	N/A	YES
07 (III)	YES	YES	ES/HOSPITAL	NO	YES	YES	YES	YES
08 (IV)	YES	YES	HOME	YES	N/A	NO	N/A	YES
9 (IV)	YES	YES	HOME	YES	N/A	NO	N/A	YES
10 (IV)	YES	YES	ES/HOSPITAL	NO	YES	YES	YES	NO
11 (IV)	YES	YES	ES/HOSPITAL	NO	YES	YES	YES	NO
12 (IV)	YES	YES	ES/HOSPITAL	NO	NO	YES	YES	NO
13 (IV)	YES	YES	HOME	N/A	N/A	NO	N/A	YES
14 (IV)	NO	YES	HOME/HOSPITAL(1)	NO	NO	YES	NO	YES
15 (IV)	YES	YES	ES/HOSPITAL	NO	NO	YES	YES	YES
16 (IV)	YES	YES	ES/HOSPITAL	YES	N/A	NO	N/A	YES
17 (IV)	YES	YES	ES/HOSPITAL	YES	N/A	NO	N/A	YES
18 (IV)	YES	YES	ES/HOSPITAL	YES	N/A	NO	N/A	YES
19 (IV)	YES	YES	ES/HOSPITAL	NO	NO	YES	NO (6)	YES
20 (IV)	YES	YES	HOME/HOSPITAL(1)	NO	NO	YES	YES	N/A
21 (IV)	YES	YES	ES/HOSPITAL	NO	NO	YES	NO	N/A
22 (IV)	YES	YES	ES/HOSPITAL	NO	NO	YES	YES	N/A
23 (V)	YES	YES	HOME	YES	N/A	NO	N/A	YES
24 (V)	YES	YES	HOME	YES	N/A	NO	N/A	YES
25 (V)	YES	YES	ES/HOSPITAL	NO	NO	YES	NO	N/A
26 (V)	YES	YES	ES/HOSPITAL	YES	N/A	NO	N/A	NO(2)
27 (V)	YES	YES	ES/HOSPITAL	YES	N/A	NO	N/A	YES(3)
28 (V)	YES	YES	ES/HOSPITAL	NO	NO	YES	YES	YES(4)
29 (V)	NO(5)	YES	ES/HOSPITAL	YES	N/A	NO	N/A	YES
30 (V)	YES	YES	ES/HOSPITAL	YES	N/A	NO	N/A	YES
% MET	**93%**	**100%**	**20%**	**48%**	**20.00%**	**50%**	**73%**	**74%**

IND	CEPP*	CEPP w/in 45 days*	Linkages	Psychiatry	BSP	Provider Meets Need	Retained Setting
01 (III)	YES	N/A	NO	NO	NO	NO	NO
02 (III)	N/A	N/A	YES	YES	N/A	YES	YES
03 (III)	NO	NO	YES	NO	NO	YES	YES
04 (III)	N/A	N/A	N/A	NO	NO	YES	YES
05 (III)	N/A	N/A	N/A	NO	NO	NO	NO
06 (III)	YES	NO	YES	YES	NO	YES	YES
07 (III)	YES	NO	YES	YES	NO	YES	YES
08 (IV)	YES	YES	YES	YES	NO	NO	NO
9 (IV)	YES	YES	YES	YES	YES	YES	YES
10 (IV)	N/A	N/A	YES	YES	NO	NO	NO
11 (IV)	NO	N/A	NO	NO	NO	NO	YES
12 (IV)	YES	YES	YES	NO	NO	NO	YES
13 (IV)	YES	YES	YES	YES	NO	YES	YES
14 (IV)	NO	N/A	YES	YES	NO	NO	YES
15 (IV)	YES	NO	YES	YES	NO	YES	YES
16 (IV)	YES	YES	YES	YES	YES	YES	YES
17 (IV)	YES	YES	YES	NO	YES	YES	YES
18 (IV)	YES	YES	YES	YES	N/A	YES	YES
19 (IV)	YES	YES	YES	YES	YES	YES	YES
20 (IV)	YES	NO	YES	YES	N/A	YES	YES
21 (IV)	N/A	N/A	YES	YES	NO	YES	YES
22 (IV)	N/A	N/A	YES	YES	NO	YES	YES
23 (V)	YES(3)	N/A	YES	YES	NO	YES	YES
24 (V)	NO	NO	YES	YES	NO	YES	YES
25 (V)	N/A	N/A	NO	NO	NO	NO	NO
26 (V)	NO	NO	NO	NO	NO	YES	YES
27 (V)	N/A	N/A	NO	YES	NO	YES	YES
28 (V)	N/A	N/A	NO	YES	NO	YES	YES
29 (V)	NO	NO	YES	YES	NO	YES	YES
30 (V)	NO	NO	NO	NO	NO	YES	YES
% MET	**67%**	**47%**	**75%**	**67%**	**15%**	**73%**	**83%**

* CEPPs marked N/A are a result of families refusing REACH initially or not participating after the crisis was stabilized.

1. One screening at home another screening at the hospital.
2. A stabilization plan was said to be developed but was not produced. No documentation that it was presented.
3. Only one prevention visit took place.
4. Documentation shows two visits as prevention type.
5. Arrived at hospital within allotted time but parent had already left with child per discharge.
6. CCCA did not respond to REACH contact during these hospitalizations

APPENDIX E.

INDIVIDUALS AND FAMILY SUPPORT PROGRAMS,
PUBLISHING GUIDELINES, AND
PEER TO PEER AND FAMILY TO FAMILY PROGRAMS

Completed by:

Rebecca Wright MSW, LICSW

Report to the Independent Reviewer
United States v. Commonwealth of Virginia

INDIVIDUAL AND FAMILY SUPPORTS

By

Rebecca Wright, MSW, LICSW
Consortium on Innovative Practices

May 10, 2019

I. EXECUTIVE SUMMARY

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to create an Individual and Family Support program (hereinafter IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. The related provisions are as follows:

> **Section II.D:** *Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C.*
> *The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.*
> **Section III.C.2:** *The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization…*
> **Section III.C.8.b:** *The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.*
> ***Section III.D.5.*** *Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.*
> ***Section IV.B.9.b.*** *…The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.*

The Independent Reviewer's sixth, eighth and twelfth Reports to the Court, dated June 6, 2015, and June 6, 2016, and June 13, 2018, respectively, found the Commonwealth had met the pertinent quantitative requirements by providing IFSP monetary grants to at least 1,000 individuals and/or families, but had not met the qualitative requirements. He reported that 1) the Commonwealth's individual and family support program did not include a comprehensive and coordinated set of strategies to ensure access to person and family-centered resources and supports, as required by the program's definition in Section II.D. and 2) the Commonwealth's determination of who is most at risk of institutionalization was based on a single very broad criterion and did not prioritize between individuals on the urgent and non-urgent waitlists or those with greater or more urgent needs.

The twelfth Report to the Court documented the Commonwealth's devotion of appreciable resources and effort in the area of individual and family supports, resulting in considerable strides in planning for an IFSP to address the provisions of the Settlement Agreement. These included developing an IFSP Strategic Plan; creating an IFSP Community Coordination Program; organizing an IFSP State Council and Regional Councils as forums for informing stakeholders about the IFSP and obtaining their input; continuing to develop enhancements to the IFSP Funding Program; and undertaking an initiative for a family-to-family and peer-to-peer mentoring program. Some of these efforts were still in the preliminary planning or early implementation stages at that time, but had good potential for moving the Commonwealth toward compliance. DBHDS still needed to focus additional attention on several areas, including the following: the definition of who would be considered "most at risk for institutionalization" for the purposes of the individual and family support program; considering how case management options available to individuals on the waitlist could be integrated as a part of a comprehensive set of individual and family support strategies; notification regarding the availability of individual and family supports to individuals and families; and, identifying indicators to assess performance and outcomes of the IFSP, including the development of capacity for the collection and the analysis of the needed data.

For the 14th Report to the Court, due in June 2019, the Independent Reviewer's monitoring priorities again included studying compliance with the qualitative aspects of the IFSP, focusing on the progress the Commonwealth has made since the last study. The study also reports on whether the Commonwealth has complied with the quantitative requirement to support a minimum of 1000 individuals for Fiscal Year 2018.

Concurrent with this 14th study period, the Court required the Parties to provide it with an agreed list of all provisions of the decree with which the Commonwealth has complied and which provisions remained in dispute, including statements in measurable terms of what the Commonwealth would have to do to fully comply with the decree. Pursuant to this order, for individuals who have moved from Training Centers, the Parties agreed the Commonwealth had complied with Section IV.B.9.b.

The Parties disagreed on the remaining provisions related to IFSP and each submitted proposed compliance indicators for those. While the respective proposed indicators from the parties were not identical, they all appeared to be closely aligned to the focus areas identified in this consultant's IFSP report from the 12th Review Period. At the time of this report, final compliance indicators were still pending, but it would be reasonable to expect that they will continue to have the same focus. In that vein, the report for this study period presents findings within the context of the those focus areas and references the Parties' respective proposed indicators.

For each focus area, this 14th period study found DBHDS continued to make progress, but had not yet finalized development and/or implementation of the strategies intended to bring them into compliance. As it may facilitate the Department's ongoing work in these focus areas, this report also attempts to identify a minimum set of finalized policies, procedures, instructions, protocols and/or tools that will be needed for the Independent Reviewer to formulate future compliance recommendations.

II. STUDY METHODOLOGY

The study methodology included document review, DBHDS staff interviews, stakeholder interviews, and review and analysis of available data. A full list of documents and data reviewed may be found in Appendix A. A full list of individuals interviewed is included in Appendix B.

In preceding IFSP studies, and in the absence of specific, measurable compliance indicators, the Independent Reviewer had relied upon the following set of thirteen criteria to guide the analysis:

1. Will the design of the planned IFSP and other family supports to be provided under the Agreement result in a set of strategies that can be considered comprehensive in nature?
2. Will the planned design for individual and family supports to be provided under the Agreement result in coordination with other services and supports for which a family or individual may be eligible?
3. Will the planned design for individual and family supports adequately facilitate access to person-centered and family-centered resources, supports, services and other assistance?
4. Will the design of the planned IFSP provide a clear and sound definition of "most at risk of institutionalization," including whether the definition has been refined to reflect the priority of supports to those at greatest risk?
5. Will the design of the planned IFSP provide a clear and logical process for determining which individuals may be considered "most at risk of institutionalization?" for determining? Will the process include prioritization criteria, and, if so, whether the process and prioritization criteria will be implemented in a manner that is designed to address the risks of individuals who are most at risk of institutionalization?
6. Will the design of the planned IFSP define a performance and outcome measurement strategy, which includes the methodology for data collection and record maintenance that are sufficient to determine whether the planned IFSP fulfills the Commonwealth's obligations under the Agreement?
7. Will the design of the planned IFSP include sufficient strategies to publish guidelines that are sufficient, in terms of detail, accuracy and accessibility? Will they guide individuals with developmental disabilities and their families, to an available and correct point of entry to access services?
8. Will the design of the planned IFSP include sufficient strategies to publish IFSP guidelines as required and update them as needed and at least annually?
9. Will the design of the planned IFSP include sufficient strategies to undertake appropriate outreach and dissemination processes to ensure individuals and families will have access to the guidelines on a timely basis?
10. Will the design of the planned IFSP include sufficient strategies to provide appropriate agencies with the guidelines on a timely basis?
11. Will the proposed design and early implementation of the family-to-family and peer programs support the facilitation of opportunities for individuals and families to receive options for community placements, services and supports?
12. Does the Commonwealth's annual individual service planning process document an offer of family-to-family and peer-to-peer meetings and discussions to facilitate community placement consistent with the individual's informed choice?

13. Does the Commonwealth offer families and/or individuals who may be considering different types of residential settings an opportunity to have discussions with families and/or individuals who have had such residential experiences; and if the family and/or individual expresses an interest, does the Commonwealth facilitate such family-to-family or peer-to-peer discussions?

Concurrent with this study period, however, the Court had ordered a hearing on April 23 and 24, 2019, for which one of the stated outcomes was to state in precise measurable terms what the Commonwealth must do to comply with each remaining provision of the decree. Further, the Court required the Parties to provide it with an agreed list of all provisions of the decree with which the Commonwealth has complied and which provisions remained in dispute, including statements in measurable terms of what the Commonwealth would have to do to comply with the decree.

Pursuant to this order, the Parties agreed the Commonwealth had complied with Section IV.B.9. b. The Parties disagreed on the remaining provisions related to IFSP and each submitted proposed compliance indicators for those. While the respective proposed indicators from the Parties were not identical, they all appeared to be closely aligned to the focus areas identified in this consultant's IFSP report from the 12th Review Period, including the following: 1) the definition of who would be considered "most at risk for institutionalization" for the purposes of the individual and family support program; 2) considering how case management options available to individuals on the waitlist could be integrated as a part of a comprehensive set of individual and family support strategies; 3) notification regarding the availability of individual and family supports to individuals and families; and, 4) identifying indicators to assess performance and outcomes of the IFSP, including the development of capacity for the collection and the analysis of the needed data.

At the time of this report, final compliance indicators were still pending, but it would be reasonable to expect that they will continue to have the same focus. In that vein, the report for this study period will present findings within the context of those focus areas as well as reference the Parties' respective proposed indicators.

The Court also indicated during the hearing that the Commonwealth would need to produce the policies, procedures, instructions, protocols and/or tools it would use to operationalize and sustain the system improvements; further, that these documents would be used by the Independent Reviewer to formulate further compliance recommendations to the Court. To facilitate this process, this report attempts to identify a minimum set of policies, procedures, instructions, protocols and/or tools that would likely be needed for review.

III. FINDINGS

Section II.D

Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C.
The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.

Previous reviews have used the following criteria to evaluate compliance with this section:

- Will the design of the planned IFSP and other family supports to be provided under the Agreement result in a set of strategies that can be considered comprehensive in nature?
- Will the planned design for individual and family supports to be provided under the Agreement result in coordination with other services and supports for which a family or individual may be eligible?
- Will the planned design for individual and family supports adequately facilitate access to person-centered and family-centered resources, supports, services and other assistance?

At the time of the 12th period review, and based upon the above criteria, the Independent Reviewer found DBHDS had made good progress toward the development and coordination of community resources for individuals and families as well as toward ensuring stakeholder involvement. The IFSP study further found DBHDS needed to examine the role of case management (or support coordination, as it is also known) in ensuring access to and coordination of individual and family supports that might be available outside of the waiver. In conjunction with its waiver re-design process, DBHDS had issued emergency regulations, providing that individuals on the waitlist "may" receive case management services. The criteria through which individuals and families have access to case management were not formalized in policy or standardized processes and not well-publicized. The IFSP State Plan did not address the role of case management. DBHDS and the IFSP State Council needed to take this issue under advisement and address how case management options for individuals on the waitlist would be clarified and shared with everyone on the waitlist, and to further consider/envision how such options could contribute to a comprehensive and coordinated set of strategies. The Independent Reviewer recommended that DBHDS should clearly define expectations of case management options available to individuals on the waitlist, as these related to facilitating access to the IFSP

Funding Program as well as to the broader array of individual and family supports for which they might be eligible**.**

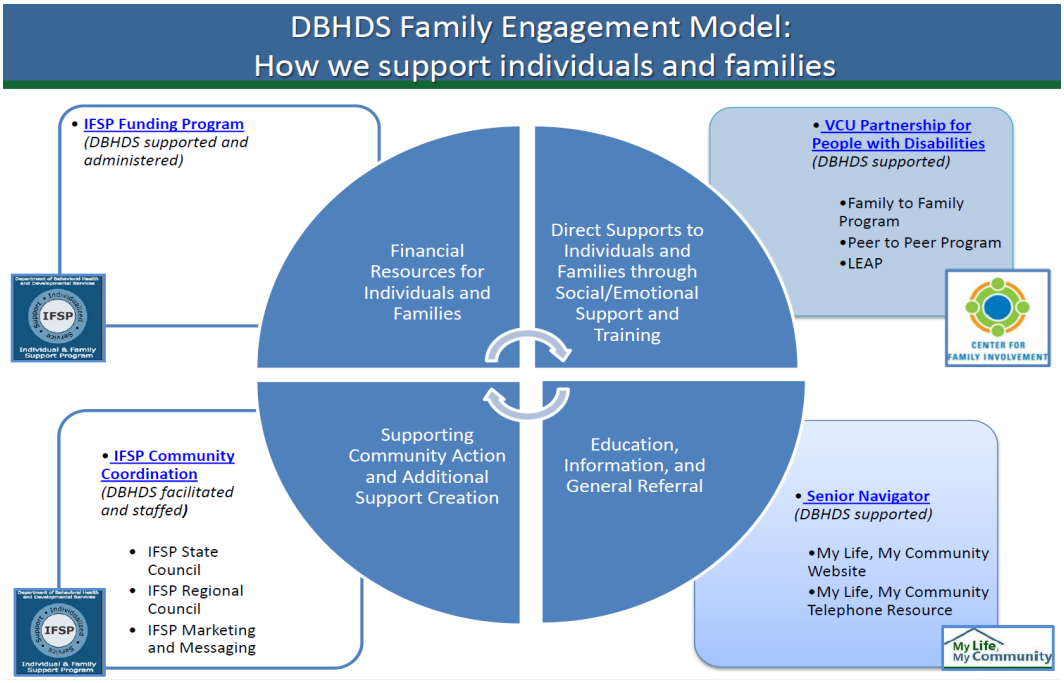
14th Review Period Findings

The Parties have proposed the following remaining compliance indicators:

US	Commonwealth
Establish, based on the emergency regulations that provided case management to individuals on the waiting list, final standards for providing case management services to individuals not in the Medicaid waiver along with guidelines for accessing these services	Eligibility guidelines for IFSP programs and other supports and services such as case management for individuals on the waiver waitlist are published on the My Life, My Community website.

The findings below for this review period provide a summary of continued efforts by DBHDS to develop a comprehensive and coordinated set of individual and family support strategies, but with a highlighted focus on the provision of individual case management**.**

At a systemic level, DBHDS continued to coordinate the development and implementation of various IFSP-related programs and initiatives at a state level. Working with its network of IFSP State and Regional Councils, the conceptualization of what the IFSP will encompass continued to evolve and broaden in scope, with an emphasis on family engagement across four primary domains. As the figure below illustrates, DBHDS staff support and directly administer two domains: the IFSP Funding Program and the IFSP Community Coordination Program. Whereas, DBHDS supports, but administers through contracts with community partners, the initiatives in the two other domains: Virginia Commonwealth University (VCU) Partnership for People with Disabilities administers the family-to-family and peer-to-peer programs and Senior Navigator administers the My Life, My Community (MLMC) website.



Source: Individual and Family Support Program State and Regional Councils Meeting January 31 -February 1, 2019

- **IFSP Funding Program:** DBHDS continued the annual distribution of IFSP funding to eligible individuals and families. In FY 2018, this funding program approved 3,210 of 3,538 applications (91%) and distributed $3,150,945. This exceeded the requirement to serve at least 1,000 families or individuals in a year. DBHDS continued to expand upon its use of technology and social media such as You Tube to assist families in navigating the application and reporting requirements, but IFSP staff also continued to provide some face-to-face outreach and technical assistance to support family participation and access.

- **IFSP Community Coordination Program:** The Community Coordination program functioned as the hub for family engagement. One of its primary roles was to support the IFSP State and Regional Councils, comprised of families of individuals on the waitlist. The purpose of the State Council was to provide guidance to DBHDS that reflects the needs and desires of individuals and families across Virginia. The IFSP five Regional Councils, on the other hand, were envisioned as a liaison between the IFSP State Council and local efforts to increase services to individuals on the waitlist by identifying and/or developing local resources and sharing those with their communities. Each Regional Council had developed its own regional workplan to this effect and was experimenting with various strategies, including informational workshops and fairs, social media, coordination with local schools and organizations and personal contacts with individuals and family members. Per interview, IFSP staff was planning to develop a mini-grant program to communities to support implementation of IFSP goals and activities. As anticipated at the time of the previous review, DBHDS had also added another IFSP staff position to provide more hands-on logistical support for regional council activities and develop needed marketing, outreach and informational materials. This staff person was also expected to coordinate information internally at DBHDS and work with Senior Navigator to update articles and information featured on the MLMC website and the IFSP Regional Council pages. In addition to not having criteria to provide regarding access to case management services, the other major challenge relative to ensuring individuals and families are guided to the correct point for access to services is in the identification of individuals and families who have not yet been reached. DBHDS was aware of a need in this area and had some plans underway or pending to address it. For example, one of the objectives in the IFSP State Plan was to draft a strategy for sharing information with families based on their connectedness to resources. This would include aligning notifications of IFSP funds with communications to families upon entry to the waiver waitlist. Along that line, DBHDS reported IFSP staff would soon begin managing data entry and updating for the waitlist and believed this access to waitlist information would facilitate DBHDS to provide better direct outreach to all the target population.

- **VCU Partnership for People with Disabilities:** As reported at the time of the previous review, DBHDS continued to collaborate and invest resources with the Partnership for People with Disabilities to engage with individuals and families on behalf of the Department across a platform of programs, including the family-to-family network, which provided one-to-one emotional, informational and systems navigational support to families and the peer-to-peer mentoring network. It also administered the LEAP

(Leadership for Empowerment and Abuse Prevention) project, which provides training by people with disabilities for others with disabilities about prevention of abuse by establishing healthy relationships. In addition, the current DBHDS agreement with VCU called for its Regional Navigators to provide various organizational supports to the IFSP Regional Councils.

- **MLMC Website:** As previously reported, DBHDS had continued to collaborate with Senior Navigator to re-brand and expand upon the My Life My Community (MLMC) website to provide a centralized on-line portal for individuals and families to access relevant information about availability of community supports and services. DBHDS's initial plans included incorporating information about family supports, housing, and providers; links to other trusted resources, as well as to a searchable database that would be location specific. MLMC also had two devoted call-center staff with responsibilities to take calls from individuals and families. IFSP staff had provided training to MLMC call-center personnel so they were prepared to provide answers on a variety of commonly asked questions and provide referral information. IFSP staff continued to serve as back-up when call center personnel were not certain about the appropriate responses. In addition to fielding questions and requests for technical assistance on behalf of DBHDS throughout the most recent annual IFSP annual funding cycle, the on-line informational website had its "soft launch" at the end of March 2019 and was expected to be officially launched at the time of its review by the IFSP Councils in May 2019. IFSP staff and Senior Navigator personnel anticipated the content would continue to expand over time.

Waitlist Case Management: At the time of the 12th Review Period, DBHDS had issued emergency regulations in conjunction with the roll-out of its re-designed waivers. These regulations indicated individuals on the waiting list could receive, or be eligible for, individual case management services from the Community Services Boards (CSBs,); however, DBHDS had not clearly defined expectations for case management options available to individuals on the waitlist or widely shared information about those options with such individuals and their families. The regulations did not provide specificity about the circumstances under which individuals on the waiting list "may" receive case management services or provide guidance about how eligibility decisions would be made. The DBHDS publication, *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: The Basics October 2017 Sixth Edition*, informed readers that individuals on the waiver waitlist may be eligible for case management services, noting that there was the option for case management/support coordination that was not connected to waiver-funded services. It further indicated those interested should contact their local CSB to find out if they might be eligible for Medicaid-funded case management or for private-pay services on a sliding scale, but DBHDS had not promulgated any related standardized procedures for making such eligibility determinations, such as specific criteria or a uniform screening This continued to be the case for this review period.

As part of the Independent Reviewer's case management study for this review period, his experts probed the case management of individuals who were IDD eligible, who were wait-listed for Waiver services and who chose to receive targeted case management (TCM), which is available to all Medicaid eligible individuals, regardless of their access to a waiver slot. In interviews with

seventeen (17) case managers/supervisors, all acknowledged carrying a caseload of waitlisted individuals, but none could provide local guidance or policy to use in supporting them; all referenced targeted case management policies for their guidance, but these also failed to provide a clear process or uniform screening tool for making determinations about needs that might indicate eligibility for case management.

It will be essential for CSBs and case managers to be cognizant of the options for eligibility for case management for people on the waitlist and to apply standardized and equitable eligibility criteria for determining access. On April 12, 2019, DBHDS issued a web-based Development Disabilities Support Coordination Manual (https://sccmtraining.partnership.vcu.edu/supportcoordination/) which included information about case management for individuals on the waitlist. It indicated TCM services could be provided to:

1) a person who is a recipient of the DD Waiver;

2) a person with an intellectual disability on the waiting list for the DD Waiver who is eligible for Medicaid (in this instance the person may or may not be a recipient of one of the other Medicaid Waivers);

3) a person with a developmental disability on the waiting list for the DD Waiver who is eligible for Medicaid AND has a short-term special need (in this instance the person may or may not be a recipient of one of the other Medicaid Waivers); and,

4) a person with an intellectual disability **not** on the waiting list for the DD Waiver, who is eligible for Medicaid and targeted case management, but **not** DD Waiver (in this instance the person may or may not be a recipient of one of the other Medicaid Waivers.)

Still, the on-line manual did not provide any guidance for case managers or CSBs about what could qualify as a "short-term special need."

The previous report also found the IFSP State Plan did not yet address how to integrate these options into an overall comprehensive set of strategies or provide individuals and families with clear information about how to access case management. For the purposes of facilitating coordination and access for individuals on the waitlist and their families, these options for case management continued to have tremendous potential; however, DBHDS had still not fully formalized these criteria and processes in policy or procedure. For this review period, IFSP staff provided a working document entitled *Case Management Options for Individuals on the DD Waivers Waitlist Guidance Document for Development for Family Marketing on Case Management Eligibility Ver. 4/2019*, that included the following statement:

> "A special service need is one that requires linkage to and temporary monitoring of those supports and services identified in the ISP to address an individual's mental health, behavioral, or medical needs, or provide assistance related to an acute need that coincides with support coordination/case management allowable activities."

It was good the above-referenced document made some attempt define a "special service need" but further clarification and guidance continued to be needed. This information had not yet been disseminated to individuals on the waitlist or their families and DBHDS staff indicated that it

anticipated the primary methods for such dissemination would be on the MLMC website and included in an annual attestation process for waitlisted individuals (described further below.) DBHDS should ensure the needed clarifications, policies and procedures are made before dissemination occurs.

In order to inform the Independent Reviewer's future analysis of compliance, DBHDS should provide, at a minimum, the following documentation:

- Policy on case management options for individuals on the waitlist, including TCM for Medicaid eligible-individuals and other options for non-Medicaid eligible individuals;
- Policy/instruction defining "DD or ID active support coordination/case management service criteria" and "special service need" and any associated protocol to be used by CSBs both for making determinations of eligibility and for terminating services;
- Policy, instructions, protocols and instruments related to CSB monitoring of all individuals on the waitlist and any associated protocol; and,
- Guidelines for individuals on the waitlist and families regarding case management options and how to apply for them; instructions/protocols for dissemination and notification to individuals on the waitlist and all other impacted entities; and, evidence of dissemination and notification.

Section III.C.2.

> *The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization…*

Previous reviews have used the following criteria to evaluate compliance with this section:

- Will the design of the planned IFSP provide a clear and sound definition of "most at risk of institutionalization," including whether the definition has been refined to reflect the priority of supports to those at greatest risk?
- Will the design of the planned IFSP provide a clear and logical process for determining which individuals may be considered "most at risk of institutionalization?" for determining? Will the process include prioritization criteria, and, if so, whether the process and prioritization criteria will be implemented in a manner that is designed to address the risks of individuals who are most at risk of institutionalization?

At the time of the 12th period review, the Independent Reviewer found DBHDS had not yet made a clear determination about how to define those it considered to be "most at risk for institutionalization" for the purposes of the IFSP. The Department had drafted administrative rule changes to remove a statutory requirement to fulfill funding requests from individuals and families on a "first come-first served basis." The proposed rule changes also called for allowing DBHDS to define administratively "most in need" and any prioritization criteria, with the advice of the IFSP State Council. DBHDS also still needed to clarify whether its prioritization of the waiver waitlist into three priority levels of those considered to be "most in need" would also be

applicable to the IFSP Funding Program. The Independent Reviewer recommended that DBHDS continue to examine the definition of "most at risk for institutionalization," including whether the current prioritization of the waiver waitlist was, or should be, applicable to IFSP.

14th Review Period Findings

The Parties proposed the following compliance indicators:

US	Commonwealth
Examine the standards for prioritizing applicants to receive funding through the ISP to establish criteria for "most at risk for institutionalization" and to determine how the prioritization standards for the waiver waitlist should be applicable to IFSP	The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.

DBHDS had not yet determined how to address the "most at risk" criteria. Further, they had not submitted any proposed regulatory changes as previously indicated to address the first come-first served criteria, nor did they have a current plan to do so, citing as the barrier the Virginia Attorney General's concern about the potential for numerous appeals by IFSP applicants who did not receive funding.

DBHDS staff reported they had considered using the waiver waitlist priority status as defined in the emergency regulations, but did not feel it could be applied to IFSP without compromising programmatic flexibility. In interview, DBHDS staff were in the early stages of considering a plan for integrating the current first come-first served requirements with the waiver waitlist priority status through a system of triaging applications and blending financial assistance with other available supports. As conceptualized, this plan would rely on screening IFSP applications on a first come-first served basis, and then prioritizing the urgency of needs and channeling requests accordingly. For example, DBHDS might grant an entire funding request; alternatively, they might determine the request could be met with partial funding coupled with referral to another resource, or partial funding with an expectation the individual or family might bear some of the attendant cost.

This plan would also leverage and integrate other ongoing crisis intervention strategies to address most critical needs. DBHDS provided some examples of resources it could tap, as follows:

- DBHDS was collaborating with Virginia Commonwealth University Center for Family Involvement (VCU/CFI) to deploy a data collection and education strategy targeting individuals with DD who had been deemed to be most at-risk of institutionalization as evidenced by receipt of Crisis Services. Specifically, VCU/CFI staff would be trained by DBHDS to survey families of individuals who have received Crisis Services to obtain post-intervention satisfaction data. VCU/CFI would also then work with DBHDS to develop specific direct services strategies (e.g., information and referral) to be implemented specifically for families of individuals on the waitlist during the post-crisis survey process. This initiative was not yet fully in place.

- DBHDS had another resource at the state office level already in place to assess urgent circumstances for individuals with ID or DD and take needed actions. IFSP staff indicated they anticipated making referrals to this resource, the Critical and Complex Consultation Team, as applications warranted.

This approach to prioritization would represent a significant change to the current strategy, which for the most part amounted to a stipend in which almost all applicants received a set amount of funds (i.e., $1,000) on a first come-first served basis. DBHDS currently used its small IFSP staffing resources to complete reviews of applications to ensure they requested allowable supports and/or items and to otherwise verify applicants' compliance with program rules during prior funding periods. The potential new process would likely require additional IFSP staffing to expand the review of applications to weigh urgency of need, determine the amount of funding dollars for each request and/or where to channel those requests and, for those referred elsewhere, follow-up to ensure the supports had been received. DBHDS reported they had not yet fully evaluated how this conceptualized approach would play out. In addition, IFSP staff had not yet discussed these strategies with stakeholders, but were planning to engage the IFSP State Council in a related discussion at its next scheduled meeting in May 2019.

In order to inform the Independent Reviewer's future analysis of compliance for this focus area DBHDS should provide, at a minimum, the following documentation:

1. Policy defining criteria for "most at risk for institutionalization," including how the standards for the waiver waitlist are, or are not, applicable to the IFSP;
2. Policy and/or instruction describing or otherwise illustrating all components of the triage process, including any associated protocol and/or criteria used.
3. As other entities are involved in the implementation of this process, the agreements outlining the various responsibilities and any associated protocol;
4. Evidence of stakeholder participation in the development of and/or approval of these policies, procedures and protocol; and,
5. Evidence of dissemination to all impacted Parties.

Section III.C.8.b.

The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.

Previous reviews have used the following criteria to evaluate compliance with this section:

- Will the design of the planned IFSP include sufficient strategies to publish guidelines that are sufficient, in terms of detail, accuracy and accessibility? Will they guide individuals with developmental disabilities and their families, to an available and correct point of entry to access services?
- Will the design of the planned IFSP include sufficient strategies to publish IFSP guidelines as required and update them as needed and at least annually?
- Will the design of the planned IFSP include sufficient strategies to undertake appropriate outreach and dissemination processes to ensure individuals and families will have access to the guidelines on a timely basis?
- Will the design of the planned IFSP include sufficient strategies to provide appropriate agencies with the guidelines on a timely basis?

At the time of the 12th period review, and based upon the above criteria, the Independent Reviewer found that while DBHDS continued outreach efforts to those on the waiting list regarding the IFSP Funding Program, stakeholders still expressed concern that everyone on that list did not receive direct notification of the funding opportunity. Individuals and family members would have to know when, where and how to look for the on-line announcements to be able to participate; without that direct notification, there was concern that those who lacked a current and ongoing connection to the service system were those who were also least likely to be informed about available funding. Stakeholders viewed this as perpetuating a system in which people who had access to information and resources obtained additional access, by virtue of their ongoing connections, while others did not.

14th Review Period Findings

The Parties proposed the following remaining compliance indicators:

US	Commonwealth
Establish an on-going communication plan to ensure that all families receive information about the program frequently enough to stay aware of the program and to be knowledgeable about the benefits and the requirements to apply and enroll.	Upon being placed on the waiver waitlist, individuals are informed of their eligibility for IFSP funding and are informed annually thereafter. IFSP-funding availability announcements are provided to all individuals on the waiver waitlist.

The fourteenth review period's study found that DBHDS had continued to develop and implement a multi-pronged strategy for publishing and disseminating guidelines that could be effectively used to direct individuals in the target population to the correct point of entry to access services. One of the components of the overall communication plan was the MLMC website, as described above with regard to Section II.D. While the website initiative continued to be in a developmental stage at the time of this report, it held promise for promoting widespread availability of needed information.

DBHDS was also relying on the IFSP Regional Councils as local vehicles for information-sharing. With support from the DBHDS IFSP staff, the Regional Council members had been energetically engaged in various outreach, information-sharing and networking activities. These included attending, and piggy-backing on, meetings of other existing support groups and using their Facebook pages to disseminate information. For example, to address a barrier to ensuring adequate attendance at its meeting in its geographically large and rural region, one Regional Council had been experimenting with live-streaming educational presentations.

As documented in the previous report for the 12th Review Period, the primary remaining concern continued to be ensuring the dissemination of information and guidelines about the IFSP, and in particular for the funding program and case management options, to everyone on the waitlist. While DBHDS did not yet have the needed capacity in place to address this significant gap, it had developed a plan to ensure notification to everyone at the time of enrollment on the waitlist and at least annually thereafter. DBHDS was nearing completion of a project to verify, and maintain, in current contact for all individuals on the waiver waitlist in its Waiver Management System (WaMS). Using these data, DBHDS further planned to begin an annual attestation letter process in which all current waitlist enrollees would be contacted and asked to update the contact information. At the same time, DBHDS would provide information about the availability of IFSP supports, including the funding program and case management options. IFSP anticipated this process would be operational in Summer 2019

In order to inform the Independent Reviewer's future analysis of compliance for this focus area, DBHDS should provide, at a minimum, the following documentation:

1. Copy of the agreement with Senior Navigator, describing the responsibilities for ensuring the availability, currency and adequacy of guidelines and information, and any associated protocol;
2. Policy and procedure for maintaining and updating waiver waitlist data in WaMS, and any associated protocol;
3. Policy and procedure for the annual attestation letter process, including the plan for dissemination, copy of the letter and any other associated protocol;
4. If the annual attestation process did not coincide with the IFSP funding period, policy and procedure for ensuring individuals on the waitlist and their families received notification of each IFSP funding cycle with updated deadlines and other pertinent information so as to facilitate a timely application; and,
5. Evidence of implementation and dissemination.

Section III.D.5

Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.
*(**IV.B.9:** PSTs and the CSB case manager shall coordinate with the specific type of community providers identified in the discharge plan as providing appropriate community- based services for the individual, to provide individuals, their families, and, where applicable, their Authorized Representative with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family- to-family and peer programs to facilitate these opportunities.)*

Previous reviews have used the following criteria to evaluate compliance with this section:

- Does the Commonwealth's annual individual service planning process document an offer of family-to-family and peer-to-peer meetings and discussions to facilitate community placement consistent with the individual's informed choice?
  Does the Commonwealth offer families and/or individuals who may be considering different types of residential settings an opportunity to have discussions with families and/or individuals who have had such residential experiences; and if the family and/or individual expresses an interest, does the Commonwealth facilitate such family-to-family or peer-to-peer discussions?

At the time of the 12th Review Period, the Independent Reviewer found the proposed Memorandum of Agreement (MOA) were broadly stated and did not specify how the proposed program would interface with the annual individual service planning and informed choice processes, or how these interfaces might serve to increase the number of individuals and families who choose to participate. At that time, DBHDS staff indicated a more detailed workplan was to be developed once the contract was finalized.

The Parties proposed the following remaining compliance indicators:

US	Commonwealth
The Commonwealth, currently through a contract with the VCU Partnership for People with Disabilities, will track and report on outcomes with respect to the number of individuals on the waivers with whom the family-to-family and peer-to-peer supports have contact and the number who receive the service/support. At least 86% of those on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources. At least 95% of individuals being assigned a Community Living Waiver slot will be offered the opportunity to receive Family-to-Family or Peer Mentoring supports.	The findings of noncompliance with this provision relate solely to family-to- family and peer programs. The Commonwealth asserts that it will be in compliance with this provision of the Settlement Agreement when: 1. At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources. 2. The Virginia Choice Form is completed as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested. 3. The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to- family and the peer-to-peer supports have contact and the number who receive the service.

For this 14th review period, the Independent Reviewer requested materials including:

- Any finalized or draft policy, procedures, tools or protocols related to the family-to-family and peer programs;
- Any data collected regarding individuals and families who have participated in the family-to-family and peer programs, and any related analyses completed;
- Any data collected regarding programmatic outcomes of the family-to-family and peer programs, and any related analysis completed; and,
- Any draft or finalized versions of indicators, tools, processes and/or any quality improvement strategies to be used to assess programmatic outcomes as they relate to family-to-family and peer programs.

With the exception of copies of the MOA with VCU, DBHDS did not provide any of the documentation or materials specified above. The MOA also did not clearly specify the interfaces with the annual individual service planning and informed choice processes, as described during the 12th Review Period.

In order to inform the Independent Reviewer's future analysis of compliance for this focus area, DBHDS should provide, at a minimum, the following documentation:

1. Copy of the agreement with VCU, describing the responsibilities for ensuring the availability, currency and adequacy of family to family and peer to peer programs, and any associated protocol, including the interfaces with the annual individual service planning and informed choice processes;
2. Final policy and procedure describing the interfaces with the annual individual service planning and informed choice processes; **and,**
3. The performance and outcome indicators that need to be tracked to ensure program efficacy.

All Sections: Performance and Outcome Measurement

Previous reviews have used the following criterion to evaluate compliance in this area: Will the design of the planned IFSP define a performance and outcome measurement strategy, including data collection and record maintenance methodologies, sufficient to determine whether the planned IFSP fulfills the Commonwealth's obligations under the Agreement?

At the time of the 12th period review, the Independent Reviewer found DBHDS still needed to identify indicators to adequately assess performance and outcomes of the IFSP and to develop the capacity for the collection and the analysis of the needed data. At the least, the Department needed to develop indicators related to access, comprehensiveness and coordination of individual and family supports, the program's impact on the risk of institutionalization and individual and family satisfaction. DBHDS staff reported plans to begin this process in the near future. The Independent Reviewer recommended that DBHDS identify indicators needed to adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports, impact on the risk of institutionalization and individual and family satisfaction. The Independent Reviewer further recommended that DBHDS implement collection and analysis of these data in an expeditious manner to provide for data-based decisions about any additional policy and procedural decisions in this area.

14th Review Period Findings

The Parties had proposed the following compliance indicators:

US	Commonwealth
Establish a set of performance indicators and an annual review cycle to measure: • the performance and outcomes as set by the Commonwealth related to access, comprehensiveness and coordination of individual and family supports; • the impact on the risk of institutionalization; and, • individual and family satisfaction.	The IFSP State Plan includes a set of measurable program outcomes. An annual report is produced reviewing progress towards the outcomes.

DBHDS had updated the IFSP State Plan (revision date February 6, 2019) and identified a set of outcome targets for each of the short-term goals. These thoughtfully addressed some of the recommended measures such as access, as measured by individual and family levels of awareness of the IFSP, and individual and family satisfaction. Examples of outcome targets for access included that 80% of individuals on the waiver waiting list who were Priority One had been outreached for assistance, and that 90% of people on the waiver waiting list indicated awareness of IFSP and supports. The plan identified an outcome target for 80% of people completing an IFSP satisfaction survey to indicate high satisfaction with IFSP funding. Other identified targets focused on performance measures that appeared to address underlying desired outcomes. For example, a performance target included holding 80% of in-person funding outreach events to individuals with language barriers, limited technology and/or geographic areas with lower application rates, which might increase participation by underserved populations.

DHDS had data collection for some of the outcome targets, although it projected that many were to begin at later dates. It was positive that IFSP staff had developed a data collection matrix of its current efforts at data collection, which included both quantitative and qualitative measures and identified the data collection schedule (i.e., quarterly or annually.) Generally, this current set of data measured system outputs, such as the number of trained family navigators and the number and types of events where IFSP materials were presented, rather than outcomes, such as increased awareness or other results, for the individuals/families

Going forward, DBHDS will want to consider additional measures to assess impact on risk of institutionalization, the comprehensiveness of the IFSP, as it reflects the expressed needs of those it is designed to serve, and the degree and adequacy of coordination, both on a systemic and individual basis. DBHDS will also need to consider how it will integrate key IFSP measures into its overall Quality Improvement/Risk Management Framework. Per IFSP staff, the current Framework was still in its infancy, but it was the intent to integrate the IFSP State Plan outcomes as it was finalized.

IV. CONCLUSIONS AND RECOMMENDATIONS

The Independent Reviewer's reports for the 12th Review Period found DBHDS had made substantial progress toward meeting some of the individual and family support provisions of the Settlement Agreement and emphasized four areas that required additional development. For this 14th Review Period, DBHDS had continued to make some progress in each of these areas, as described above, but work was still needed in each, also as described above

1. DBHDS should clearly define expectations for case management options available to individuals on the waitlist, as those relate to facilitating access to the IFSP Funding Program as well as to the broader array of individual and family supports for which they might be eligible. This would include defining specific policy and procedure that would standardize the eligibility determination process across all CSBs. Further, DBHDS should ensure individuals on the waitlist and their families are informed about these options.

2. The definition of "most at risk for institutionalization" should continue to be examined as the requirement for IFSP funding. In the process, DBHDS should consider whether/how the current prioritization of the waiver waitlist is, or should be, applicable to IFSP. This process should be undertaken in a fully transparent communication process with stakeholders.

3. DBHDS should finalize and implement a process by which all individuals on the waitlist and their families receive timely announcements and information about the IFSP Funding Program and other available supports.

4. In its MOU with VCU, DBHDS should clearly specify the proposed interfaces between the VCU family to family and peer to peer programs and the annual individual service planning and informed choice processes;

5. DBHDS should finalize a set of indicators needed to adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports, impact on the risk of institutionalization and individual and family satisfaction. DBHDS should implement collection and analysis of these data in an expeditious manner. For purposes of sustainability, DBHDS should select and incorporate key measures into its overall Quality and Risk Management Framework as that is further developed, and,

6. DBHDS should provide the minimum documentation, as recommended throughout this report, needed to inform the Independent Reviewer's future analysis of compliance for each focus area.

ATTACHMENT A: DOCUMENTS/DATA REVIEWED

1. SC Manual Letter 4.12.19.pdf
2. Case Management Options for Individuals on the DD Waivers Waitlist Guidance Document for Development for Family Marketing on Case Management Eligibility Ver. 4/2019
3. Support Coordination Manual Developmental Disabilities (https://sccmtraining.partnership.vcu.edu/supportcoordination/)
4. IFSP Compliance Reports Draft 2/25/19
5. Updated Guidelines with FAQ for the IFSP August 2018
6. IFSP State Plan Updates 2-6-19
7. Senior Navigator Statistic October-December 2018
8. Sampling for IFSP Funds Revised 9-14-18
9. IFSP Regional Roster
10. Quick Tips for the FY 2018 IFSP Funding-Application
11. FY 2019 Individual & Family Support Program Application Portal User Guide
12. FY 2019 Maximizing Your Funds
13. IFSP-FY 2019 Training-Announcement-9-20-18
14. FY 2019 Receipts Procedure 1-2-19
15. Instructions for Uploading Receipts
16. FY 2019 Individual and Family Support Program Receipt Remittance Form
17. IFSP Go-Card Instructions (English-and-Spanish-ver.-2-20-18)
18. Sampling for IFSP Funds Revised 9-14-18
19. FY19 Audit Summary
20. Council Meeting Notes and associated materials, June 2018
21. Council Meeting Notes and associated materials, November 2018
22. Council Meeting Notes and associated materials, January 2019
23. My Life My Community Update_2Q FY19
24. IFSP Funding Applications New Applicants vs Repeat Applicant FY15-FY19
25. FY 2019 Training Recap
26. DMAS DD TCM Manual
27. Complex Case Consultation
28. Compliance Reports Requirements 2-25-19
29. Ch 5 Case Management and Wait List Eligibility Flowchart
30. Business Rules Compilation
31. 720-4671 MOA Partnership for People-revised 5-30-18
32. 720-4671, Contract No-Cost Extension Final Draft
33. Dear DD Waiver Waiting List Individual- Cover Form (Attestation Letter)
34. My Life My Community Virginia Stats 5.1.16 - 9.30.18
35. 190416 Overall # of provisions Status of Compliance
36. 190415 Agreed Compliance List
37. 190412 - US' Noncompliance Contentions submission Attachment A ECF 315-1
38. 190412 - Agreed Compliance List Submission Attachment A ECF 314-1
39. 2019.04.22 - Supplemental Agreed Compliance List ECF 323-3 Attachment C
40. 2019.04.22 - Supplemental Agreed Compliance List ECF 323-2 Attachment B
41. 2019.04.22 - Supplemental Agreed Compliance List ECF 323-1 Attachment A
42. 2019.04.22 - Supplemental Agreed Compliance List ECF 323
43. Commonwealth Compliance Contentions and Actions to Achieve Full Compliance

ATTACHMENT B: INTERVIEWS & STAKEHOLDER INPUT

1. Peggie Balak, DBHDS DOJ Settlement Agreement Advisor
2. Beverly Rollins, DBHDS Director of Administrative and Community Operations
3. Erika Haskins-Jones, DBHDS IFSP Coordinator
4. Carly DBHDS IFSP Staff
5. Roxie Lyons, DBHDS IFSP Staff
6. Nomi Sheets, Parent, IFSP Council Member
7. Lesley Harrop, Parent, IFSP Council Member
8. Deborah Green, Parent, IFSP Council Member
9. Allene Pack, Parent, IFSP Council Member
10. Jessica Neal, Parent, IFSP Council Member
11. Dana Yarbrough, Director, Center for Family Involvement, Virginia Commonwealth University Partnership for People with Disabilities, Parent
12. Katie Benhauser, Senior Navigator (My Life, My Community)
13. Charlottesville Family Support Group Meeting 4/12/19

APPENDIX F.

CHILDREN with IDD

in

NURSING FACILITIES AND PRIVATE NTERMEDIATE CARE FACILITIES

Completed by:

Ric Zaharia Ph.D.

Report to the Independent Reviewer
United States v. Commonwealth of Virginia

Children with IDD In Virginia Nursing Facilities and Private Intermediate Care Facilities

By

Ric Zaharia, Ph.D.

May 1, 2019

Executive Summary

The Independent Reviewer requested an off-site follow-up of the April 2017 review of DBHDS plans/efforts to reduce the numbers of children living in Nursing Facilities (NFs) and large, private Intermediate Care Facilities (ICFs), including transition and diversion efforts.

The Settlement Agreement requires at III.B.1, III.C.1.b-c, III.D.1, III.D.6 that the IDD target population, including those on wait list or who meet criteria for waitlist, will have dedicated waiver slots to prevent or transition from placement in an NF or ICF; placement will be in the most integrated setting consistent with informed choice and need and, if placed in an NF or 5+ facility, will be reviewed by the Community Resource Consultant and/or the Regional Support Team.

This review focused on an assessment of the documentation of the sample of children with intellectual and developmental disabilities (IDD), who were admitted during calendar 2018 to four facilities (two NFs and two private ICFs). The final sample size was 13. This sample allowed us to probe the impact of the Department's efforts since 2017 to divert and transition children from the four facilities.

DBHDS continues its efforts to divert children from unnecessary placement in the two NFs. DBHDS continues working well with one NF to return children to their families or home communities following rehabilitation. As found in a previous study, transitioning children home does not appear to function well with the second NF, where only two of the thirty-one children living at nf2 WERE returned to their communities.

DBHDS has also begun assessing and diverting children applying for ICF admission using the VIDES level of care determination assessment tool. Since the Commonwealth implemented the single point of entry process in mid-2018, two children have been assessed via VIDES and not admitted to an ICF.

The purpose of this study was to assess the Department's efforts to divert NF/ICF admissions and to facilitate the transition of children from living in institutions to living in the family home or in the most integrated community setting following an out-of-home placement in an NF/ICF. The former, the diversion of children from being placed in these types of institutions is largely in place and effective. The latter, the transitioning of children into more home and community-based settings, is in effect at three of the four facilities. One NF did not discharge any of its children in 2017 or 2018.

Methodology

- Identified children under age 18 who meet DD wait list criteria and were admitted to or were assessed for admission to NFs in 2018 or large private ICFs May- December, 2018;
- Reviewed the Commonwealth's processes and plans to transition children from NFs and ICFs to home- and community-based settings;
- Interviewed DBHDS staff regarding admission of children to NFs or large private ICFs.

Children in Private Nursing Facilities/Intermediate Care Facilities-IDD

Background

In his June 2016 Report to the Court, the Independent Reviewer concluded, among other things, that:

> *p.41- There was a lack of discharge planning for the children who were living in private institutional settings.*
>
> *p.42- The Commonwealth has not developed or implemented a plan to transition individuals under age 22 years of age from large ICFs and has not implemented its transition plans for children living in nursing facilities.*

DBHDS's plans for diverting admissions and transitioning of institutionalized children from ICFs included: a) establishing centralized tracking, b) establishing a single point of entry for ICFs, c) administering a Level Of Functioning tool (VIDES) for admission to ICFs, d) prioritizing discharge planning for 18-year-olds at ICFs, e) annual reviewing by DBHDS staff of individual Level of Care determinations using the DMAS Quality Review Tool, f) educating families on community-based options for institutionalized children, g) emphasizing the requirements for CSB referral to the RST/CRC process, h) educating ICF facility staff on community options, i) enhancing connections of CSBs with their institutionalized children, and j) implementing a post-move monitoring process for those discharged. There is evidence that most, if not all of these strategies, have been implemented by DBHDS.

A 'single point of entry' of IDD children into NFs was established at DBHDS several years ago; the Preadmission Screening and Resident Review (PASRR) federal requirement is now directed centrally at DBHDS; a 90-day individual Resident Review is also managed directly by DBHDS; CSB connections are formalized once a child is proposed for NF admission; family education is initiated post-admission for acute Nursing Facility services to ensure parents and guardians are aware of their options; a post-move monitoring process for children who are placed into community-based settings was also implemented.

Findings

DBHDS reports today that there is a census of 170 children in nursing and private ICF facilities (see Attachment A). This is a reduction from the 196 reported in 2015 but no change from our last study in 2018 (171).

All children with IDD, who were under age 18, who were admitted to one of the two NFs during 2018 or who were admitted to one of the two ICFs since May 2018, and who were known to DBHDS were identified. This study did not identify any other children with this profile at these facilities. We then reviewed their PASRR or VIDES documentation, as well as any available documentation supporting their admission. We concurrently requested the same information for those who were reviewed by VIDES but not admitted to one of the four facilities during 2018. This resulted in thirteen (13) children admitted to one of the four facilities.

Table 1
Admissions/Discharges

Facility Name	Facility Type	2017 IDD Admissions	2017 IDD Discharges	2018 IDD Admissions	2018 IDD Discharges
Children's Hospital	NF1	2	6	2	2
Illif	NF2	2	0	1	0
St. Mary's	ICF1 *	4	5	6	12
Holiday House	ICF2 *	3	4	4	4
	Total	**11**	**15**	**13**	**18**

*May – December 2018

Table 1 suggests that admission and discharge practices at the four facilities have not changed significantly in the past two years. The general trend of discharging more children than are admitted continues.

During CY2018 six (6) children were diverted from NFs. During the last half of CY2018 two (2) children were diverted from ICFs. Although several of these diversions were due to the absence of a confirmed IDD diagnosis, these latter children, if IDD eligible, are now being consistently referred to the Regional Support Team (RST) for review.

The administration of the VIDES level of care determination instrument by DBHDS staff began in May of 2018. Admission data indicates that of twelve (12) children referred for admission after DBHDS began administering the VIDES, ten (10) children were approved as eligible for admission and two (2) were diverted. This admissions cohort had an average age of 13 years with a range of 5-18 years old. The sample included seven (7) males and three (3) females. For four (4) of the ten (10) the absence of a waiver slot was cited as one factor in pursuing ICF admission in the RST documentation. In addition to the lack of available waiver slot, RST documents cited pressures resulting from the lack of, or inconsistent, home

nursing or behavioral supports as the most commonly stated reasons for admission of a child to an ICF.

Finally, it was reported and confirmed that NF2 graduated two (2) of their aging out individuals into their adult facility. A change in placement facility would seem to warrant a CSB generated person-centered plan, but apparently did not in these two cases.

The slot reservation strategy called for in the Settlement Agreement (*"dedicated waiver slots to prevent or transition from a placement in an NF or ICF")* remains vague and non-specific. As reported previously, CSB case managers and their supervisors have not been aware of the availability of waiver slots to prevent institutionalization. DBHDS reports that it has continued to educate and reinforce with CSBs the obligation to refer individuals to the RST prior to placement into nursing and intermediate care facilities. Although case managers at the CSBs probably continue to remain unaware of any reservation strategy, DBHDS staff report that IDD waivers and other services are available to those individuals who choose not to enter an ICF. It is unclear whether DBHDS has clearly and firmly articulated to CSBs the preference for the placement of children in home and community based settings.

Attachment A details the current point in time placement of children at the four children's facilities, two NFs and two ICFs. Since our last review, there have been few significant shifts in which CSBs utilize the ICF or NF facilities for children with IDD. As we have previously noted, one quarter of the CSBs, which are clustered in the Western and Southwestern Regions (Region I and III), do not have any children living in these four facilities. Whereas, the top CSBs that rely on these facilities (i.e. for the highest number of children with IDD to live, usually throughout their developing years) are clustered in Region V. They are #1 Virginia Beach, #2 Hampton - Newport News, #3 Norfolk, and #4 Chesapeake. This has been the case since 2018 and suggests 'placement by convenience' and/or tacit support for local businesses.

Recommendation:
DBHDS should establish a policy that eliminates the incentives for CSBs to have children placed in nursing and intermediate care facilities. DBHDS should award high users an additional number of waiver slots to transition and divert young children.

Suggestions for Departmental Consideration:
DBHDS should consider prioritizing transition planning for the youngest children (<10) placed in NF/ICFs. DBHDS should ensure that the Sponsored Residential family-like model is available and is being actively used for diverting and transitioning children away from congregate settings that are staffed with shift workers.

DBHDS should consider setting aside and publicize a percentage of allocated slots to prevent the long-term institutionalization of very young children (<10).

DBHDS should ensure that individuals 18-22 years old placed at NF2 receive person-centered planning about the future and their options for life in more integrated settings.

DBHDS should consider a policy direction to CSBs that indicates the Department's preference that young children should be raised by families or in family-like settings, where attachment and bonding with a continuous caregiver can occur, rather than in congregate settings with shift workers. (See the position of American Academy of Pediatrics at, Friedman, Kalichman & CCD, *Out of home placement for children and adolescents with disabilities*, Pediatrics, 2014, 134, 836 **and** the comparative research conducted on institutionalized versus fostered young children at Nelson, Fox, & Zeanah, Romania's Abandoned Children, Harvard University Press: Cambridge, 2014).

Summary

The goal of this study was to probe the Commonwealth's efforts to divert NF/ICF admissions and to facilitate the transition of children out of institutional placements to live in the family's home or, if that is not an immediate option, in the most integrated community setting.

DBHDS is effective at diverting children from unnecessary placement in the two identified NFs and at working with one NF to return children to their families or home communities. This latter mechanism, transitioning children home, does not yet function well with NF2, which discharged only two of the thirty-one children living at NF2 . With the single point of entry controls in place DBHDS is now able to ensure there are no inappropriate ICF admissions, but it's effectiveness at diverting ICF admissions may now depend on the availability of community-based settings that serve the specialized needs of those with medical or behavioral challenges.

Given the statutory Medicaid provision that admission to an ICF is a State Plan entitlement, DBHDS and DMAS have taken initial reasonable steps to ensure families understand their options and that admitted children always need facility level medical or active treatment, even though these institutions are not the best place for children to grow up. The parental right to having informed-choice and to choose facility-level care is the well-known institutional bias in Medicaid. Therefore, the Commonwealth's challenge now is to build out the community-based system components that serve individuals, including children, with specialized medical or behavioral challenges, and out-of-home family-like residential options for those who cannot live with their families. The Commonwealth should ensure an informed choice process that facilitates family consultation with other families whose children with similar needs have been successfully served in community-settings, including visits to family-like residential options if appropriate. Families should be fully informed and have true choices for their children. This choice must be as vigorous as to community options as it currently to institutional options.

Attachment A

Number of IDD Children from each CSB* - February 2019

		Nursing Facilities		Private ICF/IID		
	CSB**	NF1	NF2	ICF1	ICF2	TOTAL
Virginia Beach	1	0	0	16	7	23
Hampton Newport News	2	2	0	12	4	18
Norfolk	3	2	0	10	4	16
Chesapeake	4	0	0	11	1	12
Fairfax Falls Church	6	0	11	2	0	13
Portsmouth	7	0	0	11	1	12
Richmond BHA	8	9	0	0	0	9
Henrico	9	5	0	3	0	8
Western Tidewater	10	0	0	4	3	7
Prince Williams	11	0	5	1	1	7
Blue Ridge BH	12	1	1	3	1	6
Chesterfield	13	3	0	2	0	5
Middle Peninsula	14	0	2	3	0	5
District 19	15	1	1	2	0	4
Arlington	16	0	3	0	0	3
Rappahannock	17	2	0	0	1	3
Valley	18	0	1	0	0	1
Horizon BH	19	0	0	0	1	1
Northwestern	20	0	1	0	0	1
Colonial	21	0	0	0	2	2
Southside	22	1	0	1	0	2
Mt Rogers	23	0	0	2	0	2
Region 10	24	1	1	0	0	2
Alexandria	25	0	1	0	0	1
Goochland-Powhatan	26	1	0	0	0	1
Hanover	27	1	0	0	0	1
Loudon	28	0	1	0	0	1
Piedmont	29	0	0	1	0	1
Crossroads	30	0	0	0	0	0
Alleghany-Highlands	31	0	0	0	0	0
Cumberland Mountain	32	0	0	0	0	0
Danville-Pittsylvania	33	0	0	0	0	0
Dickenson BH	34	0	0	0	0	0
Eastern Shore	35	0	0	0	0	0
Harrisonburg-Rockingham	36	0	0	0	0	0
Highlands	37	0	0	0	0	0
New River Valley	38	0	0	0	0	0
Rappahannock-Rapidian	39	0	0	0	0	0
Rockbridge	40	0	0	0	0	0
Unassigned	-	0	3	0	0	3
	TOTAL	29	31	84	26	170

*CSB assignment often fluctuates based on family relocations

**Number assignment for 2019 does not correspond to numbers reported for March 2018

APPENDIX G.

INDEPENDENT HOUSING

Completed by:

Patrick Rafter

MEMORANDUM

Date: May 1, 2019

To: Donald Fletcher, independent Reviewer

From: Patrick Rafter, Housing Consultant

Re: Virginia Housing Plan Review

Subsequent to my review of *Virginia's Plan to Increase Independent Living Options* during the week of April 22, 2019, I am submitting a report of the Commonwealth's progress and recommendations for future consideration.

In addition to reviewing the Virginia Plan Update, and its Provider Data Summary: The State of the State, and supporting documents, I had clarifying discussions with the Department of Behavioral Health & Developmental Services (DBHDS) staff, providers and advocacy group representatives.

Development Continues Ahead of Schedule:

The DBHDS Independent Housing Outcomes Table shows 925 individuals in the Settlement Agreement population living in their own home as of March 2019. With a targeted goal of 796 living in their own home by the June 30, 2019, the end of Fiscal Year (FY) 2019, DBHDS continues to stay ahead (as it has since my review of May 2016) of its Outcome-Timeline schedule of providing independent community-based housing to 1866 individuals by the end of FY 2021.

It should be noted that the last two years of the proposed development schedule (FY 2020 & FY 2021) calls for a much more aggressive expansion with DBHDS having to almost double Independent Housing Options from the current number of 950 to the FY 2021 target of 1866.

Housing Related Issues:
Provider Capacity/Geographic Service Disparity:

In my May 2016 review, I noted that families/advocates expressed concerns regarding the lack of provider development in certain areas of the state. I also noted that the Commonwealth's vision of a supported housing program requires parallel developments of both housing and support resources. At that time, DBHDS staff acknowledged the existence of challenges in developing provider capacity and were in the early stages of developing approaches to enhance provider development.

I further noted in my November 2017 report, "*I would expect for a more detailed baseline measurement tool be developed which would clearly delineate areas and services around the Commonwealth that are struggling with capacity problems. The tool will assist in ascertaining the impact that proposed independent housing development activities are having in noted problem geographic areas. Once this aspect of reporting is firmed up, there will be a clearer and more comprehensive picture as to how the Commonwealth is responding to the provider development/geographic service disparity.*"

Since my review in 2017, DBHDS staff developed a comprehensive statewide baseline/ongoing evaluation of existing support services and targeted specific areas of the state that are struggling with producing needed supported independent housing. The first 6-month post baseline evaluation shows slight improvement, but this first evaluation period is probably too short to ascertain the productivity of DBHDS activities in this area.

While the provider development baseline and newly launched provider development activities show promise, the fact that DBHDS has yet to promulgate permanent regulations for the newly developed waiver is particularly problematic and creates a drag on needed provider development. DBHDS needs to advance its regulatory framework to support asking the provider community to assume a new business model. My discussions with providers indicates that until they have a clear picture of DBHDS expectations, they will be reluctant to develop the necessary new services to support individuals who choose to reside in one of the new independent community living options.

Recommendation: **Accessible Housing Development**
The housing subsidy program developed by the Commonwealth served to jump start the effort of providing independent community living options. It has been my experience that, given the scarcity of fully accessible accommodations in most communities, people utilizing wheel chairs (particularly motorized wheelchairs) or needing other environmental modifications often get "left behind" in congregate care facilities and in sponsored home opportunities. As DBHDS looks ahead in its long-term planning, I encourage it to anticipate this challenge and to facilitate the development of options specific to expanding housing opportunities for people using wheelchairs.

Recommendation: **Leveraging Support Packages**
The current focus on offering apartment living to single individuals as the primary path to independent community living limits the reach of housing opportunities. Living alone may also not be the preferred option for some of the individuals who would otherwise choose to live in more independent housing. Also, the option of offering apartment living to single individuals is viable only to those whose support needs can be met within the tight service limitations of the waiver. I encourage DBHDS to explore approaches that allow individuals with disabilities to choose to live together and "combine" their supports and rent subsidy budgets. This option, once introduced, will open the possibility for many more individuals to move into independent community living settings who would not otherwise have that choice.

Case Management: It was not within the defined scope of my review to analyze the DBHDS/CSB case management system, but I feel obligated to raise concerns since an effective case management system is critical for coordinating services for a successful independent community housing program.

In almost all my discussions over the last two years in Virginia, weakness in the current case management system, including the lack of effective long-range planning, were cited as a serious obstacle to helping more individuals with IDD to live in more independent living options and to develop more self-sufficiency. While DBHDS launched numerous activities to strengthened the existing system, anecdotal reporting by advocacy groups indicate the system is still marked by inconsistent implementation of policy/procedures and lack of accountability. The Commonwealth has been going through a major restructuring of its Developmental Disabilities (DD) service system. While the existing case management system responded in some areas, it may be time for a more comprehensive review of the existing structure. As one individual indicated to me, "we are perfectly aligned to meet the needs of 10 years ago".

As always, I appreciate the courtesies and assistance given to me by DBHDS staff during my review. I am available to answer questions they may have.

APPENDIX H.

LIST OF ACRONYMS

ADL	Activities of Daily Living
APS	Adult Protective Services
AR	Authorized Representative
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Professional
CAP	Corrective Action Plan
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CIT	Crisis Intervention Training
CL	Community Living (HCBS Waiver)
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTH	Crisis Therapeutic Home
CTT	Community Transition Team
CVTC	Central Virginia Training Center
DARS	Department of Rehabilitation and Aging Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disabilities
DDS	Division of Developmental Services, DBHDS
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice, United States
DS	Day Support Services
DSP	Direct Support Professional
DSS	Department of Social Services
ECM	Enhanced Case Management
EDCD	Elderly or Disabled with Consumer Directed Services
EFAG	Employment First Advisory Group
EPSDT	Early and Periodic Screening Diagnosis and Treatment
ES	Emergency Services (at the CSBs)
ESO	Employment Service Organization
FRC	Family Resource Consultant
GH	Group Home
GSE	Group Supported Employment
HCBS	Home- and Community-Based Services
HPR	Health Planning Region
HR/OHR	Office of Human Rights
HSN	Health Services Network
IADL	Individual Activities of Daily Living
ICF	Intermediate Care Facility

ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports ("DD" waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
ISR	Individual Services Review
LIHTC	Low Income Housing Tax Credit
MLMC	My Life My Community (website)
MOU	Memorandum of Understanding
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
PASSR	Preadmission Screening and Resident Review
PCR	Person Centered Review
PCP	Primary Care Physician
PHA	Public Housing Authority
POC	Plan of Care
PMM	Post-Move Monitoring
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
QMD	Quality Management Division
QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Services Review
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RFP	Request For Proposals
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
START	Systemic Therapeutic Assessment Respite and Treatment
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
VCU	Virginia Commonwealth University
VHDA	Virginia Housing and Development Agency