

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 7, 2015 - April 6, 2016

Respectfully Submitted By

A handwritten signature in blue ink, appearing to read "Donald J. Fletcher".

Donald J. Fletcher
Independent Reviewer
June 6, 2016

TABLE OF CONTENTS

I.	<u>EXECUTIVE SUMMARY.....</u>	<u>3</u>
II.	<u>SUMMARY OF COMPLIANCE:</u>	<u>8</u>
	Section III. Serving Individuals with ID/DD in the most integrated settings.....	8
	Section IV. Discharge Planning and Transition from Training Centers.....	20
	Section V. Quality and Risk Management.....	28
	Section VI. Independent Reviewer.....	35
	Section IX. Implementation.....	35
III.	<u>DISCUSSION OF COMPLIANCE FINDINGS.....</u>	<u>36</u>
	A. Methodology.....	36
	B. Compliance Findings.....	37
	1. <i>Providing Waivers</i>	37
	2. <i>Transition of Children from Nursing Homes and Large ICFs</i>	39
	3. <i>Individual and Family Support Program</i>	43
	4. <i>Case Management</i>	46
	5. <i>Crisis Services</i>	52
	6. <i>Behavioral Capacity</i>	59
	7. <i>Integrated Day Opportunities / Supported Employment</i>	61
	8. <i>Independent Living Options</i>	67
	9. <i>Licensing and Investigations</i>	69
IV.	<u>CONCLUSION.....</u>	<u>73</u>
V	<u>RECOMMENDATIONS.....</u>	<u>75</u>
VI.	<u>APPENDICES.....</u>	<u>78</u>
	A. Individual Review Study.....	79
	B. Individual and Family Support Program.....	89
	C. Case Management.....	108
	D. Crisis Services.....	128
	E. Integrated Day Activities and Supported Employment.....	166
	F. Independent Housing.....	196
	G. Licensing and Investigations.....	199
	H. List of Acronyms.....	211

I. EXECUTIVE SUMMARY

This is the Independent Reviewer's eighth 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 review period from October 7, 2015 to April 6, 2016.

The Independent Reviewer has previously described how the Commonwealth's Home and Community-Based Services (HCBS) waiver programs and its regulations impede compliance with the Agreement. For more than three years, the Commonwealth's primary strategy to come into compliance has been to redesign its HCBS waiver programs. The Commonwealth's goals for the redesign are "to provide for a flexible array of community-based options with a rate structure that supports the cost of new and existing services and provides incentives to providers for offering expanded integrated options." During this review period, Virginia's General Assembly approved the redesign and most of the funds sought for its implementation. This represents a positive and essential step in the Commonwealth's strategy. The Commonwealth also recognizes that it must revise its regulations to achieve compliance. These revisions, however, have not yet occurred.

Now, the Commonwealth can move forward with the next phase of its strategy to come into compliance: implementation of the redesigned HCBS waiver programs. Orchestrating the implementation is a very complex undertaking. Successful efforts will involve the coordination of multiple state agencies, hundreds of service providers and case managers, and thousands of individuals and families who depend on waiver-funded services for their every day well-being.

It is the considered opinion of the Independent Reviewer that the Commonwealth must develop significant new provider capacity to achieve its goals and compliance. It now has far too few service providers and qualified professionals with the expertise and experience to provide services to all individuals with intense needs or with Autism Spectrum Disorders or to provide services in integrated settings.

Since 2012, many of the Commonwealth's service providers have been engaged in implementing Agreement's provisions. These providers have made essential contributions to positive outcomes for members of the target population. During the interviews conducted throughout this review period, however, stakeholders at all levels and in all geographic areas, identified the lack of adequate provider capacity as a major concern.

The existing HCBS waiver programs created financial incentives to provide services for more individuals in larger congregate settings. Sufficient payment rates have not been available to provide community-based services for individuals with intense service needs or for individuals who live in their own homes or family homes. For example, low payment rates have resulted in too few nurses with the experience and expertise to meet the needs of all the children and adults with ID/DD waiver-funded services. To develop community-based services for individuals with intense needs who transition from Training Centers to live in the community, DBHDS has developed interim stopgap measures, "bridge funds" and "exceptional rate" allowances, to supplement the inadequate HCBS waiver payment rates. The lack of adequate provider capacity, however, remains a major impediment to the development of the services and supports, and the systems that are needed by

Virginians and that are required by the Agreement and by the Center for Medicare and Medicaid Services' (CMS) "final rule" which governs HCBS waiver programs.

The Commonwealth has begun several initiatives to increase provider capacity. It successfully utilized a Request for Proposal (RFP) process to solicit bids and competition to develop new homes for four or fewer disabled housemates who transitioned from living in Training Centers. Other Commonwealth initiatives include:

- supporting the conversion of day support programs in segregated congregate centers to integrated community activities;
- developing more integrated residential and day activities options and building additional behavioral support capacity in southwest Virginia for at least sixty individual, and
- expanding the number of qualified behavioral support professional staff in several areas of the Commonwealth and on the REACH crisis services teams.

These are very positive initiatives. However, the Independent Reviewer has concluded that the currently planned initiatives should be considered only initial steps toward meeting the need. During interviews, program staff and their managers, as well as case managers and their supervisors, concurred that much more provider capacity is needed. From the Independent Reviewer's own professional experience, a strong provider system is the key element in the development of support services that meet the needs of individuals who live in their own or family homes.

During this review period, the individual services review exploratory study found that children with ID/DD are being raised in medical facilities rather than in the most integrated settings appropriate to meet their needs. These children rarely experience interactions with typical children of their age. The study found that institutional settings typically plan to discharge the children when the institutions will no longer be paid to support them rather than when they are ready for discharge to a more appropriate community-based setting.

The implementation of the Commonwealth's redesigned HCBS waiver programs is the first major restructuring of the service system since Virginia joined the CMS program in the early 1990s. The redesign of the HCBS waiver programs has included changes to:

- eligibility criteria,
- service definitions and expectations,
- payment rates,
- service limits, and
- cost caps.

Management of the transitions required by the redesigned waiver programs will involve the coordination of many elements of the system undergoing simultaneous change. Service providers will restructure their program and business models to work effectively under the redesigned waiver programs. The DBHDS and DMAS managers of the HCBS waiver programs will restructure administrative and data management processes. Administrative changes will occur in record keeping, program documentation and reporting, data management, billing and computer systems.

Case managers, the hub of the system for individuals and families, will be at the center of many of the changes. They will need to develop new expertise and knowledge to incorporate these changes

into discussions and service planning with individuals, their families and services providers. There is a broad consensus that a major investment in building the knowledge and expertise of case managers is critical. For example, to offer independent community living options, case managers will require new or expanded knowledge and understanding of the local housing market, the landlords who are willing to partner, and the service providers who can arrange for dependable wrap-around services for individuals who will live in their own homes.

Some of Virginia's service providers are already involved in major change initiatives. These initiatives include the development of a statewide crisis service system for children and adults; the expansion of supported employment opportunities; the creation of integrated day programs; the development of capacity to serve more individuals with intense needs; and the provision of wrap-around services to support individuals with ID/DD who live in their own of their family homes.

Service providers will not only change program and business models, they will also change the human resource policies and practices required to deliver such models. Staff training, staff supervision, staff turnover, emergency back-up, and quality assurance will take on more critical dimensions when the individuals served live in sites throughout a community, rather than in clustered group settings.

The Commonwealth's redesigned waiver programs and improved payment rates will encourage and facilitate changes. These transitions, however, will take time. They also will involve identifying and resolving the obstacles, and the inevitable unanticipated consequences, that result when complex systems are modified.

It is the Independent Reviewer's considered opinion that a well functioning quality improvement program is essential for every program and for every service during periods of significant change. Through quality improvement programs program and service managers monitor whether the implementation of planned change achieves the desired results. If not, in the next phase of the quality improvement program cycle managers decide what additional steps are needed to achieve the desired outcomes. Through quality improvement program managers identify obstacles early in the change process, determine how to address and resolve them, continue to monitor results, implement refinements, and enforce needed corrective actions.

At the regional and state levels, an effective Quality and Risk Management system is always important, but is especially so during periods of significant change. The Commonwealth continues to build its Quality and Risk Management system. It has taken a major step forward by creating its Data Warehouse. This is a connect-the-dots system. It allows information from disparate sources to be merged and analyzed. The data reports that now are possible provide the Commonwealth with improved ability to identify trends and patterns by service type, by provider, and by Region. The overall effort to build an effective Quality and Risk Management system at DBHDS, however, continues to be impeded by its regulations. The Commonwealth reports that it has drafted revisions and is reviewing them now to ensure that the revised regulations will allow the Commonwealth to comply with the requirements of the Agreement.

During this review period, the Commonwealth and DOJ have successfully negotiated outcome-timelines for several categories of provisions of the Agreement, which lacked specificity, due dates and measurable outcomes. The categories are: Integrated Day Activities and Supported Employment and Crisis Services for Children and Adults. The parties are currently negotiating

outcome timelines for Quality, Individuals in Nursing Facilities and ICFs, Individuals with Complex Medical and Behavioral Needs, and Integrated Housing Options.

During the eighth review period, it was determined that the Commonwealth has not made significant progress on the Agreement's provisions related to providing more integrated day and residential programs for individuals in the community. However, the Commonwealth's staff and stakeholders have engaged in concerted and collaborative efforts. They have planned and implemented initiatives and made important progress in several areas.

During this review period, the Commonwealth:

- improved real time reporting of incidents;
- provided rental subsidies to allow many more individuals to live in their own apartments;
- established a data warehouse, a foundational element in its quality management system;
- reached out to individuals with DD, other than ID, to help connect them to crisis services;
- made significant progress developing a crisis service system for children; and
- collected reliable point-in-time data for all individuals with ID/DD in supported employment.

These successes have not all resulted in determinations of compliance, but they are accomplishments of key milestones. Significantly, between October 13, 2011 and April 11, 2016, the Commonwealth helped 552 individuals transition to live in the community from its Training Centers. The census of the Training Centers decreased during this period to 376 residents.

In summary, during the eighth review period, the Independent Reviewer determined the Commonwealth to be in compliance, substantial compliance or non-compliance with the provisions listed below.

Maintained Ratings of Compliance:

- created HCBS waiver slots;
- increased frequency of case management and licensing oversight;
- implemented discharge planning and transition services for individuals residing in Training Centers;
- developed elements of a statewide crisis services system for adults with intellectual and developmental disabilities;
- responded on-site and on time to crises (mobile crisis teams);
- developed and updated Virginia's Plan to increase Independent Living; and
- offered choices of service providers.

Gained Ratings of Compliance:

- providers reported incidents within 24 hours;
- improved employment data collection;
- Regional Quality Councils reviewed employment targets; and
- facilitated increased access to subsidized independent living options.

Lost Rating of Substantial Compliance:

- inadequate community-based capacity to support individuals with intense behavioral needs
- stays in each Region's crisis stabilization program in excess of 30 days are not allowed

Retained Ratings of Non-Compliance:

- insufficient opportunities for individuals with ID/DD to live in most integrated settings;
- lack of discharge and transition plans for children to move from nursing facilities and large ICFs to community homes;
- lack of a statewide crisis service system for children and adolescents;
- lack of effective in-home mobile crisis supports;
- lack of integrated day activities and supported employment;
- insufficient number of subsidized community living opportunities; and
- an individual support planning process that is inadequately focused on helping individuals to learn new skills, to become more self-sufficient, and to become more integrated into their communities.

The following "Summary of Compliance" table provides a rating of compliance and an explanatory comment for each provision. The "Discussion of Compliance Findings" section includes additional information to explain the compliance ratings, as do the consultant reports, which are included in the Appendix. The Independent Reviewer's recommendations are included at the end of this report.

During the next review period, the Independent Reviewer will prioritize monitoring the status of the Commonwealth's compliance with the requirements of the Agreement in the following areas: Quality and Risk Management provisions (other than the case management, licensing, and provider training provisions); Supported Employment; Regional Support Teams; Safety in the Community; Mortality Review; and an Individual Services Review study of individuals discharged from Training Centers during Fiscal Year 2016 to live in community-based homes in Regions I, II and III.

Throughout the recent review period, the Commonwealth's staff have been accessible, forthright, and responsive. Attorneys from the Department of Justice gathered information that has been helpful to effective implementation of the Agreement. They continue to work collaboratively with the Commonwealth in negotiating outcomes and timelines for achieving the provisions of the Agreement. Overall, the willingness of both parties to openly and regularly discuss implementation issues and any concerns about progress towards shared goals has been important and productive. The involvement and contributions of the advocates and other stakeholders has been vitally important to the progress that the Commonwealth has made; their meaningful participation will continue to be critically necessary. The Independent Reviewer greatly appreciates the assistance that was generously given by the individuals at the center of this Agreement and their families, their case managers and their service providers. They produced documents, helped to arrange interviews with staff and family members, and facilitated site visits to homes and programs.

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 fifth, sixth, and seventh review periods are presented as: <i>6th period</i> <i>7th period</i> 8th period	Comments include examples to explain the ratings and status. The Findings Section and attached consultant reports include additional explanatory information.
III.C.1.a.i-v	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 ...	<i>Compliance</i> <i>Compliance</i> Compliance	The Commonwealth created 555 waiver slots during FY 2012 -2016, the minimum number required for individuals to transition from Training Centers. An additional 90 waiver slots, the minimum required for FY 2017, have been funded and await certification.
III.C.1.b.i-v	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)... v. In State Fiscal Year 2016, 275 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs.	<i>Non</i> <u><i>Compliance</i></u> <i>Non</i> <i>Compliance</i> Non Compliance	The Commonwealth created 1500 waiver slots between FY 2012 and FY 2016, 250 more than the 1250 required. An additional 300 slots, the minimum required for FY 2017, await certification. This meets the quantitative requirements of this provision. Its plan to transition children living in nursing facilities will be evident in the spring of 2017.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.1.c.i-v	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)... v. In State Fiscal Year 2016, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The Commonwealth created 600 waiver slots between FY 2012 and FY 2016 for individuals with DD, other than ID, 350 more than required. 275 slots, 250 more than the minimum required for FY 2017, await certification. The Commonwealth expects that results from implementing its plan to transition children living in nursing facilities will be evident in the tenth period.
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 2015, a minimum of 1000 individuals will be supported.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The Commonwealth met the quantitative requirement by supporting 2,084 individuals in FY 2016. The Commonwealth is redesigning its current IFSP, in part, because it does not include a comprehensive and coordinated set of strategies.
III.C.5.a	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	<u>Compliance</u> <i>Compliance</i> Compliance	□ 25 (100%) of the individuals reviewed in the case management study had case managers and had current Individual Support Plans. DBHDS reports that 88-89% of individuals received case management services.
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	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The substantive changes in the ISP process and the training of case managers have resulted in progress. The case management study, however, found a high

Settlement Agreement Reference	Provision	Rating	Comments
	are individualized, person-centered, and meet the individual’s needs.		level of discrepancies in 2 (50%) of the 4 CSBs studied. DBHDS monitoring confirms that 1 (25%) of the 4 CSBs has consistently performed below expected standards.
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.	<u>Non Compliance</u> <i>Non Compliance</i> 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.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	See comment regarding III.C.5.b.i.
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.	<u>Compliance</u> <i>Compliance</i> Compliance	The Independent Reviewer did not find evidence that case managers provided direct services, other than case management. The required term is included in the “FY 2016 CSB Performance Contract.” The case management study found that case managers had offered choices of providers.
III.C.5.d	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The DBHDS regulations and licensing monitoring protocols do not align with the Agreement’s requirements. The Commonwealth’s monitoring reviews have not identified discrepancies that were found during the case management study.

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.6.a.i-iii</u>	<p>The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall:</p> <p>i. Provide timely and accessible support ...</p> <p>ii. Provide services focused on crisis prevention and proactive planning ...</p> <p>iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual ...</p>	<p><u>Non Compliance</u> <i>Non Compliance</i></p> <p>Non Compliance</p>	<p>The Commonwealth has developed the required elements of a crisis system for adults with ID/DD. DBHDS is still developing its statewide children's crisis system. Additional funds are available in FY 2017. New initiatives to further improve crisis services will occur during the next six months. DBHDS expects to achieve compliance for children's crisis services in the tenth review period.</p>
<u>III.C.6.b.i.A</u>	<p>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.</p>	<p><u>Compliance</u> <i>Compliance</i></p> <p>Compliance</p>	<p>CSB Emergency Services are utilized for adults with ID/DD. REACH hotlines are operated 24 hours per day, 7 days per week for adults with ID/DD.</p>
<u>III.C.6.b.i.B</u>	<p>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.</p>	<p><u>Compliance</u> <i>Compliance</i></p> <p>Compliance</p>	<p>REACH continues to train CSB ES staff. DBHDS has developed a standardized curriculum. New ES staff and case managers were required to be trained. Now all such staff are so required.</p>
<u>III.C.6.b.ii.A.</u>	<p>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.</p>	<p><u>Compliance</u> <i>Non Compliance</i></p> <p>Non Compliance</p>	<p>The Commonwealth's training program was previously found to be inadequate for team members to respond with effective assessments or good quality in-home supports in many cases. DBHDS has not provided information that demonstrates compliance.</p>

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.6.b.ii.B</u>	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.	<u>Compliance</u> <i>Non Compliance</i> Non Compliance	REACH programs did not provide effective prevention plans, treatment strategies, or in-home supports. Although DBHDS now requires crisis prevention plans to be completed for every individual referred, these are not being completed consistently.
<u>III.C.6.b.ii.C</u>	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with ID/DD comes into contact with law enforcement.	<u>Compliance</u> <i>Compliance</i> Compliance	During the review period, REACH trained law enforcement personnel in all five Regions. In total, 395 police were trained during the eighth review period. This is an increase over the 339 and 224 trained during the sixth and seventh periods. DBHDS is contracting with an Autism organization to train police during the next period.
<u>III.C.6.b.ii.D</u>	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	<u>Compliance</u> <i>Compliance</i> Compliance	REACH Mobile crisis teams are available around the clock and respond at off-hours adults with ID/DD.
<u>III.C.6.b.ii.E</u>	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	<u>Compliance</u> <i>Compliance</i> Compliance	All Regions provided adults with ID/DD with more than an average of three days in-home support services during the second half of the review period.
<u>III.C.6.b.ii.G</u>	By June 30, 2013, the Commonwealth shall have at least two mobile crisis teams in each Region that shall respond to on-site crises within two hours.	<u>Non Compliance</u> <i>Compliance</i> Compliance	The Commonwealth did not create new teams. Instead, it added staff to the existing REACH crisis teams, which achieved responses within the required time for □ 529 (95.7%) of 553

Settlement Agreement Reference	Provision	Rating	Comments
			calls. Late crisis calls generally involved minor amounts of time.
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 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.	<u>Non Compliance</u> Compliance	The Commonwealth reported average response times within one hour in urban areas and within two hours in rural areas. See comment immediately above.
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	<u>Compliance</u> Compliance	All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults with ID/DD.
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.	<u>Compliance</u> Compliance	For adults with ID/DD admitted to the programs, crisis stabilization programs continue to be used as a last resort. For these individuals, teams attempted to resolve crises and avoid out-of-home placements.
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.	<u>Compliance</u> <u>Substantial Compliance</u> Non Compliance	There are credible reports of stays that exceed 30 days in <u>each</u> Region's program. These are explicitly not allowed.
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.	<u>Substantial Compliance</u> <u>Substantial Compliance</u> 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.	<u>Compliance</u> 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.	<u>Compliance</u> <i>Non Compliance</i> Non Compliance	The Commonwealth has not determined whether it is necessary to develop additional “crisis stabilization programs” for <u>adults</u> with ID/DD in each Region. Stakeholders in each Region report a lack of availability and access to crisis stabilization services for adults.
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.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	This is an overarching provision. Compliance will not be achieved until the sub-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 <u>must be developed and discussed at least annually</u> through a person centered planning process and included in the ISP.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The case management study found that discussions of employment occurred for a sample of 23 adults. Most discussions, however, did not involve the development of goals toward employment. The ISP teams subsequently recommended Day Support services for 22 (96%) of the adults. Most were not offered regular integrated activities or activities that engage in seeking employment.
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.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The Commonwealth developed a plan for Supported Employment. Its written plan to increase integrated day activities is not comprehensive. It lacks plans to provide guidance re: building CE into the ISP process,

Settlement Agreement Reference	Provision	Rating	Comments
			training case managers, and an assessment of the extent additional provider capacity may be needed.
<u>III.C.7.b.i.A.</u>	Provide regional training on the Employment First policy and strategies through the Commonwealth.	<u>Compliance</u> <i>Compliance</i> Compliance	DBHDS continued to provide regional training on the Employment First policy and strategies. Trainings were provided to service providers, family members, CSB staff, advocates, provider staff and transition teachers and supervisors.
<u>III.C.7.b.i.</u> <u>B.1.</u>	Establish, for individuals receiving services <i>through the HCBS waivers</i> , annual baseline information regarding:		The Commonwealth has significantly improved its method of collecting data. Data reported include a 93% return rate from ESO providers and 100% from DARS. 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.
<u>III.C.7.b.i.</u> <u>B.1.a.</u>	The number of individuals who are receiving supported employment.	<u>Non Compliance</u> <i>Non Compliance</i> Compliance	See answer for <u>III.C.7.b.i.B.1.</u>
<u>III.C.7.b.i.</u> <u>B.1.b.</u>	The length of time individuals maintain employment in integrated work settings.	<u>Non Compliance</u> <i>Non Compliance</i> Compliance	See answer for <u>III.C.7.b.i.B.1.</u>
<u>III.C.7.b.i.</u> <u>B.1.c.</u>	Amount of earnings from supported employment;	<u>Non Compliance</u> <i>Non Compliance</i> Compliance	See answer for <u>III.C.7.b.i.B.1.</u>
<u>III.C.7.b.i.</u> <u>B.1.d.</u>	The number of individuals in pre-vocational services.	<u>Compliance</u> <i>Compliance</i> Compliance	See answer for <u>III.C.7.b.i.B.1.</u>
<u>III.C.7.b.i.</u> <u>B.1.e.</u>	The length-of-time individuals remain in pre-vocational services.	<u>Compliance</u> <i>Compliance</i> Compliance	See answer for <u>III.C.7.b.i.B.1.</u>

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.7.b.i.</u> <u>B.2.a.</u>	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The Commonwealth has set, and compliance is rated based on, the targets being set to meaningfully increase the number of individuals receiving services <i>through the waivers</i> and on making substantial progress toward achieving the targets. There has been very little progress. The 7/1/14 baseline number for Individual Supported Employment was 204. As of 12/31/15, there were 211 individuals employed in ISE.
<u>III.C.7.b.i.</u> <u>B.2.b</u>	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	(Compliance) <i>Non Compliance</i> Compliance	The Commonwealth has improved data collection. Its goal that 85% of individuals will hold their jobs for at least twelve months has been exceeded. 88% have worked at their job for one year or more in ISE and 91% have held their jobs for one year or more in GSE.
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.	<u>Compliance</u> <i>Non Compliance</i> Compliance	The RQCs met during the first two quarters of FY 2106. They consulted with the DBHDS Employment staff, both members of the SELN. The RQCs reviewed quarterly the number of individuals employed and the number who remain in integrated employment for twelve months.

Settlement Agreement Reference	Provision	Rating	Comments
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.	<u>Compliance</u> <i>Non Compliance</i> Compliance	The RQCs reviewed the employment targets and the State’s progress for FY 2015. The RQCs 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.	<u>Compliance</u> <i>Non Compliance</i>	A review found that DMAS /Logisticare do not know whether transportation services for the target population are of good quality. Several sources indicate a higher level of complaints from this population.
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.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The Commonwealth will not revise its guidelines until after implementing its redesigned waivers. The existing guidelines (“Just the Facts”) do not include information regarding how and where to apply and how to obtain services for individuals / families who are on the waitlists or for others seeking services.
III.D.1.	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	This is an overarching provision of the Agreement related to serving individuals in the most integrated setting. The need for more settings of four or fewer, especially for individuals with intense needs, will not be resolved until implementation of the redesigned waivers.

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.D.2.</u>	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.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The Commonwealth facilitated an impressive additional 91 adults to live in homes of their own. This is 6% of the goal to provide 1,523 more adults their own home by 2021. To achieve compliance requires sustaining a higher rate of facilitating adults to move into their own homes.
<u>III.D.3.</u>	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.	<u>Non Compliance</u> <i>Non Compliance</i> Compliance	The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies to an additional 91 individuals.
<u>III.D.3.a.</u>	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 ...	<u>Compliance</u> <i>Compliance</i> Compliance	A DBHDS housing service coordinator developed and updated the plan with these representatives and with others.
<u>III.D.3.b.i-ii</u>	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.	<u>Compliance</u> <i>Compliance</i> Compliance	The Commonwealth estimated the number of individuals who would choose independent living options through FY 2015. It again revised its Housing Plan with new strategies and recommendations.

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.D.4</u>	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.	<u>Compliance</u> <i>Compliance</i> Compliance	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds have now been provided permanent rental assistance.
<u>III.D.5</u>	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.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	Documents reviewed did not indicate that the family-to-family and peer programs were active and creating pairings for individuals served in sponsored homes or congregate settings.
<u>III.D.6</u>	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).	<u>Compliance</u> <i>Non Compliance</i> Non Compliance	Individuals were placed in settings of five or more, in nursing facilities or in ICFs without the review of the CRC or the Regional Support Teams.
<u>III.D.7</u>	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 ...	<u>Compliance</u> <i>Compliance</i> 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.
<u>III.E.1</u>	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 ...	<u>Compliance</u> <i>Compliance</i> Compliance	Community Resource Consultants (CRCs) are located in and are members of the Regional Support Team in each Region and are utilized for these functions.

Settlement Agreement Reference	Provision	Rating	Comments
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.	<u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	PSTs did not submit some referrals as required. Individuals moved to settings of five or more, to nursing facilities or to ICFs, without the CRCs submitting referrals, or submitting with sufficient lead-time for the RSTs to fulfill their responsibilities or to utilize their authority.
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).	<u>Compliance</u> <i>Compliance</i> Compliance	DBHDS established the RSTs, which meet monthly. The CRCs refer cases to the RSTs regularly.
IV	Discharge Planning and Transition	Compliance ratings for the fifth, sixth, seventh and 8th review periods are presented as: (5 th period) <u>6th period</u> 7 th period 8th period	Note: The Independent Reviewer gathered information about individuals who transitioned from Training Centers and rated compliance during the 5th and 7th review periods. He will do so again during the 9th review period. The comments 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) <i>Compliance</i>	The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It made subsequent improvements in response to concerns the IR identified.

Settlement Agreement Reference	Provision	Rating	Comments
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) <i>Non Compliance</i>	The Commonwealth has not implemented its strategy to come into compliance. Most integrated residential and day options are often not available for individuals with intense needs.
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) <i>Compliance</i>	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 documented.
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, well being, 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) <i>Non Compliance</i>	Discharge plan goals did not include measurable outcomes that lead to skill development and increased self-sufficiency. The Commonwealth acknowledges its inability to provide integrated day services until it implements its redesigned waivers.
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) <i>Compliance</i>	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision and that the discharge plans are well documented. DBHDS tracks and reports that all residents of Training Centers have 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) <i>Compliance</i>	The documentation of information provided was present in the discharge records □ for 75 (91.5%) of the 82 individuals studied during three review periods.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	(Compliance) <i>Compliance</i>	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) <i>Compliance</i>	□ for 50 (98.0%) of 51 individuals studied during the fifth and seventh review period, the discharge records included these assessments.
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) <i>Compliance</i>	The PSTs select and list specific providers that can 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) <i>Compliance</i>	The CIMs and Regional Support Teams document barriers on the data collection sheet.
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	(Compliance) <i>Compliance</i>	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) <i>Compliance</i>	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) <i>Non Compliance</i>	The Individual Services Review Study found that the discharge plans lacked recommendations for how individuals can be best served. They did not include skill development to increase self-sufficiency or integrated day opportunities. DBHDS is implementing improvements.
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) <i>Compliance</i>	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) <i>Compliance</i>	The Individual Services Review studies during the fifth and seventh review periods found that □ 52 (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) <i>Compliance</i>	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.	(Non Compliance) <i>Non Compliance</i>	Reviews found that of the individuals studied □ 11 (45.8%) of 24 individuals and their ARs did not have an opportunity to speak with individuals currently living in their communities and their family members. DBHDS sent packets of information to ARs. Of 61 referrals at CVTC and NVTC, one family and two peer mentor pairings occurred.
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) <i>Compliance</i>	PST's and case managers assisted individuals and their Authorized Representative. Providers were identified and engaged; and provider staff were trained in support plan protocols that were transferred to the community.

Settlement Agreement Reference	Provision	Rating	Comments
<u>IV.B.11.</u>	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) <i>Compliance</i>	During the fifth and seventh review periods, the reviews found that □ 48 (92.3%) of 52 individuals /Authorized Representatives who transitioned from Training Centers were provided with information regarding community options.
<u>IV.B.11.a.</u>	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) <i>Compliance</i>	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.
<u>IV.B.11.b.</u>	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) <i>Compliance</i>	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.14	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.	(Non Compliance) <i>Non Compliance</i>	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) <i>Compliance</i>	The Independent Reviewer found that the residential provider staff for □ 51 (98.1%) of 52 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) <i>Compliance</i>	During the fifth and seventh period, the Independent Reviewer found that □ 49 (94.2%) of 52 individuals 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.	(Non Compliance) <u>Compliance</u> <i>Compliance</i>	The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions. □ for 52 (100%) individuals PMM visits occurred. The monitors had been trained and utilized monitoring checklists. During the sixth review period, the Commonwealth completed a look-behind process with a significant sample size. 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) <i>Compliance</i>	The Individual Services Review studies during the third, fifth and seventh review periods found that □ for 52 (96.3%) of 54 individuals, 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.	(Non Compliance) <i>Non Compliance</i>	The Individual Review studies found that essential supports were not in place prior to discharge for 8 (28.6%) of 28 individuals in the fifth and for 3 (12.5%) of 24 individuals in the seventh review periods. For the fifty-two individuals in the two groups: □ 8 (15.4%) did not have out-of-home day opportunities identified or provided, □ 3 (5.8%) did not have

Settlement Agreement Reference	Provision	Rating	Comments
			behavioral or medical supports identified or provided.
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) <i>Compliance</i>	The discharge records reviewed in the third and fifth review periods indicated that individuals 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) <i>Compliance</i>	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) <i>Compliance</i>	Community Integration Managers 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) <i>Compliance</i>	CIMs have reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals.

Settlement Agreement Reference	Provision	Rating	Comments
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.	(Non Compliance) <i>Non Compliance</i>	The Commonwealth has created five Regional Support Teams. All RSTs are operating and receiving referrals. The Independent Reviewer found, during the seventh period, that □ for 0 (0.0%) of 12 individuals referred to the RST, there was sufficient time to work with the PST and CIM to resolve identified barriers.
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) <i>Compliance</i>	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 fifth, sixth, and seventh review periods are presented as: <i>(5th period)</i> <i>6th period</i> <i>7th period</i> 8th period	For the Quality provisions without due dates, the Independent Reviewer prioritized monitoring, gathered information, and determined compliance during the 5th and 7th review periods. He will do so again during the 9th review period. The comments below are from the period when the 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) <i>Non Compliance</i>	This is an overarching provision of the Agreement. Compliance will not be achieved until the sub-provisions in the Quality section are determined to be in compliance.

Settlement Agreement Reference	Provision	Rating	Comments
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) <i>Non Compliance</i>	The Commonwealth has improved its draft list of risk triggers by including risks of harm in addition to harm that has occurred. It has not completed or implemented the lists and draft annual risk assessment. It has not changed regulations to allow collection of required data.
V.C.2	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	(Non Compliance) <i>Non Compliance</i> Compliance	DBHDS implemented a web-based incident reporting system. Providers now report 90% of incidents within one day of the event.
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) <i>Non Compliance</i> Non Compliance	The Commonwealth established a reporting and investigative process. The DBHDS Office of Human Rights (OHR) investigations do not align with the requirements of the Agreement.
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) <i>Non Compliance</i>	The Commonwealth has completed some training modules. Other progress has been made with root cause analysis and training on risk assessment. Available trainings are incomplete, not adequate to ensure reliability, and not competency based.
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)	(Non Compliance) <i>Non Compliance</i>	A Mortality Review Committee (MRC) completed reviews of unexpected and unexplained deaths. Recommendations occurred and some positive systemic steps have been taken to reduce mortalities. The MRC

Settlement Agreement Reference	Provision	Rating	Comments
	<p>medical records, including physician case notes and nurses 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.</p>		<p>did not include a member independent of the State; most mortality reviews were not completed in 90 days; and a quality improvement assessment has not been completed to determine whether initiatives have addressed problems or to determine other actions to reduce mortality rates.</p>
V.C.6	<p>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.</p>	<p>(Non Compliance) <i>Non Compliance</i></p>	<p>DBHDS cannot effectively use available mechanisms to sanction providers, beyond use of Corrective Action Plans. DBHDS reports that provisional licenses are being issued for repeat offenders.</p>
V.D.1	<p>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.</p>	<p>(Non Compliance) <i>Non Compliance</i></p>	<p>This is an overarching provision requiring effective quality improvement processes at the local and State levels. Compliance will not be achieved until the quality improvement sub-provisions are in compliance. The lack of consistently collected, complete and reliable data has not allowed effective review at the local and State levels. Only limited analysis occurred.</p>
V.D.2.a-d	<p>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.</p>	<p>(Non Compliance) <i>Non Compliance</i></p>	<p>The Commonwealth has taken steps to improve collection and use of data, to develop reports and to share data among staff and divisions. Implementation of the Data Warehouse is an important</p>

Settlement Agreement Reference	Provision	Rating	Comments
			accomplishment. Significant work remains to increase and organize the data and to ensure its reliability.
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) <i>Non Compliance</i>	The Commonwealth began collecting data in FY 2012. Data collection for some measures began June 30, 2014. For other measures, it has not begun. Case management and ISP data are not complete or reliable. Data about individuals with DD services and private ICFs are not included.
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) <i>Non Compliance</i>	This is an overarching provision. It will be in non-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) <i>Non Compliance</i>	The RQCs had limited and unreliable data. The RQCs completed limited analysis and discussion of trends or recommendations.
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.	(Non Compliance) <u>Compliance</u> <i>Compliance</i>	The five Regional Quality Councils now 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) <i>Non Compliance</i>	The RQCs met quarterly and had limited discussion of trends. Data available were not complete or reliable. The DBHDS Quality Improvement

Settlement Agreement Reference	Provision	Rating	Comments
			Committee directed the RQCs work.
V.D.6	At least annually, the Commonwealth shall report publically, 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) <i>Non Compliance</i>	The Commonwealth has begun to compile and has posted on its website: information toward creating and publicly reporting.
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) <i>Non Compliance</i>	The Commonwealth has surveyed all CSBs and will survey a sample of providers to ascertain a baseline regarding existing quality improvement practices. It has targeted 12/31/2015 to set clear expectations about QI processes for providers.
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) <i>Non Compliance</i>	The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS plans to require reporting through the risk management and provider QI programs.
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) <i>Non Compliance</i>	The Commonwealth began to implement the QSR process. It plans to use the results to improve quality of services on the provider, CSB, and system wide levels and to provide technical assistance.
<u>V.F.1</u>	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) <u>Compliance</u> <i>Compliance</i> Compliance	The case management study found that 24 (96%) of the 25 were in compliance with the required frequency of visits. DBHDS has identified data that frequency and type of case manager visit are inconsistent and, in some CSBs, consistently below target.

Settlement Agreement Reference	Provision	Rating	Comments
<u>V.F.2</u>	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) <u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The case management study found that 19 (83%) of 23 individuals reviewed were recommended for day support programs. They were not offered services in integrated settings appropriate to their needs. Of these 19, 3(15.8%) were not offered services consistent with the individuals' strengths and preferences.
<u>V.F.3.a-f</u>	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) <i>Compliance</i> Compliance	The case management study found that 24 (96%) of the 25 were in compliance with the required frequency of visits. All received monthly face-to-face meetings as required. In the ISR study the case managers of the 3 (100%) children who were eligible for enhanced case management were visited at the required frequency.
<u>V.F.4</u>	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) <i>Non Compliance</i> 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.
<u>V.F.5</u>	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) <u>Non Compliance</u> <i>Non Compliance</i> 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, including case manager contacts.

Settlement Agreement Reference	Provision	Rating	Comments
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) <u>Compliance</u> <i>Compliance</i>	The Commonwealth developed the curriculum with training modules that include the principles of self-determination.
V.G.1	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	(Compliance) <i>Compliance</i> Compliance	DBHDS completed 434 unannounced licensing inspection visits between 4/1/15 and 9/30/15.
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) <i>Compliance</i> Compliance	DBHDS has maintained a licensing inspection process with more frequent inspections.
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) <i>Non Compliance</i> Non Compliance	The DBHDS Licensing regulations and protocol do not align with the Agreement's specific requirements.
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) <i>Non Compliance</i>	The Commonwealth has not created a plan to: <input type="checkbox"/> develop the curriculum to train staff in the required elements of service for the individuals.
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) <i>Non Compliance</i>	Same as V.E.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) <i>Non Compliance</i>	The Commonwealth has worked to modify the Quality Service Review process to meet the requirements of the Agreement. Compliance will be achieved when results are used to improve quality.

Settlement Agreement Reference	Provision	Rating	Comments
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) <i>Non Compliance</i>	Same comment as V.I.1. immediately above.
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) <i>Non Compliance</i>	Same comment as V.I.1.
V.I.4	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	(Non Compliance) <i>Non Compliance</i>	Same comment as V.I.1.
VI	Independent Reviewer		
<u>VI.D.</u>	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 Intervenor's counsel.	(Compliance) <u>Compliance</u> <i>Compliance</i> Compliance	The DHBDS 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		
<u>IX.C.</u>	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented ...	(Non Compliance) <u>Non Compliance</u> <i>Non Compliance</i> Non Compliance	The Independent Reviewer has determined that the Commonwealth did not maintain sufficient records to document proper implementation of the provisions including: monitoring mechanism for case management, records of who is receiving enhanced case management, and crisis services.

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 in several ways:

- by reviewing data and documentation produced by the Commonwealth in response to requests by the Independent Reviewer, independent consultants, and the Department of Justice (DOJ);
- by discussing progress and challenges in regularly scheduled parties' meetings and in work sessions with Commonwealth officials;
- by examining and evaluating documentation of supports provided to individuals and their families;
- by interviewing individuals and/or their families, providers, and other stakeholders; and
- by visiting sites, including individuals' homes, nursing facilities and large ICF/IDDs, community-based crisis, residential, day and other programs.

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

- Transition of Children from Nursing Homes and Large ICFs (Individual Services Review);
- Individual and Family Support Program;
- Case Management;
- Crisis Services for Children and Adults;
- Behavioral Supports Capacity;
- Integrated Day Opportunities / Supported Employment;
- Independent Living Options; and
- Licensing and Investigations.

Seven independent consultants were retained to conduct the reviews and evaluations of these areas. For each study the Commonwealth was requested to provide all records that document that the related requirements of the Agreement are being properly implemented. Information that is not provided by the Commonwealth for the studies is not considered in the findings, conclusions, and determinations of compliance.

For the eighth time, the Independent Reviewer utilized his Individual Services Review study process and Monitoring Questionnaire to evaluate the status of services for a selected sample of individuals. By utilizing the same questions over several review periods, for different subgroups and in different geographic areas, the Independent Reviewer has identified findings that include positive outcomes, and areas of concern. By reviewing these findings, the Independent Reviewer has identified and reported themes.

For this report, the Individual Services Review study was focused on the status of discharge planning and transition services for children who reside in large facilities and of services for "like" children who live in community-based settings. Twenty-five children were selected randomly from the list of children with ID or DD diagnoses. Eighteen of these children reside at one of four facilities: the Commonwealth's two largest nursing facilities and two largest Intermediate Care Facilities for children with ID/DD. Seven "like" children, who had lived in large facilities or who were diverted from admission and who receive community-based ID waiver funded services were also included in the

review. All twenty-five children live in three of Virginia's five Health Planning Regions: Region II (northern Virginia), Region IV (greater Capitol area), or Region V (Virginia peninsula).

This was an exploratory study. The selected sample was not large enough to provide sufficient confidence that the findings will generalize to all similarly situated children. However, the randomly selected sample is sufficient to identify positive outcomes and areas of concern for further study.

The other studies completed by the Independent Reviewer's consultants for this report examined the status of the Commonwealth's compliance with specific prioritized provisions that were targeted for review and evaluation. The Independent Reviewer shared the planned scope, methodology, site visits, document review, and interviews with the Commonwealth and requested its suggested refinements. The Independent Reviewer also asked the Commonwealth to provide the measurable outcomes that it has established and to identify the records that it maintains to demonstrate proper implementation of the provisions that are the focus of each study.

The Independent Reviewer's consultants then 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 of individuals served and other stakeholders. To determine the ratings of compliance, the Independent Reviewer considered information provided prior to April 30, 2016. This included the findings and conclusions from the consultant's topical studies, the Individual Services Review study, 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 included in the Appendix.

Most of the provisions in the Discharge Planning and Transition and the Quality and Risk Management sections of the Agreement were closely studied during the fifth and the seventh review periods. The compliance ratings for many provisions in these sections were not expected to change substantially during the eighth review period. They will be studied during the ninth review period. The Independent Reviewer will rate compliance in his next Report to the Court.

Finally, as required, the Independent Reviewer submitted this Report to the parties in draft form for their comments. The Independent Reviewer considered any comments before finalizing and submitting this eighth Report to the Court.

B. Compliance Findings

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

The U.S. Center for Medicare and Medicaid Services operates the Home- and Community-Based 1915(c) waiver program. The funding from the Home- and Community-Based Services (HCBS) waiver provides support services in the community as an alternative to receiving services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Individuals with ID/DD may receive HCBS waiver-funded services once they are awarded a waiver slot. The Commonwealth joined the HCBS waiver program in the early 1990s.

The Commonwealth had created a total of 2455 new waiver slots, 400 more than were required by the Agreement, prior to this reporting period. During its recent session, the General Assembly approved an additional 200 waiver slots to be awarded to individuals with DD, other than ID, prior to the end of Fiscal Year 2016. The Commonwealth created these additional waiver slots as part of the redesign of its HCBS waiver programs. Under the existing program, the Commonwealth has awarded waiver slots for individuals with DD, other than ID, based on chronology, i.e. when an individual's name was added to the waitlist, rather than on the intensity of the individual's needs. By creating the additional 200 waiver slots during Fiscal Year 2016, the next 200 individuals, those closest to the front of the chronological wait list, will be awarded slots soon. The Commonwealth's switch to a policy of awarding slots based on intensity, as part of the redesigned HCBS waiver, which will be effective on July 1, 2016, might otherwise have deprived these 200 individuals from receiving waiver slots after they have waited for many years.

The Commonwealth creates HCBS waiver slots to enable individuals with ID/DD to receive waiver-funded services in the community. Waiver-funded services allow some individuals to continue to live in their communities. They also allow children and adults to transition from living in nursing facilities and publicly and privately operated large Intermediate Care Facilities (ICFs). Training Centers are large state-operated ICFs. Significantly, between October 13, 2011 and April 11, 2016, the Commonwealth helped 552 individuals transition to live in the community from the Training Centers. The census in the Training Centers had decreased to 376 residents.

The Independent Reviewer's Individual Services Review Studies have consistently found that waiver slots provide individuals and families with critical supports that significantly improve their quality of life. For these individuals, access to waiver-funded services is vital to their good health, personal growth, safety, and for the prevention of unnecessary institutionalization. That said, the Commonwealth's existing HCBS waiver programs have been confusing and difficult to manage for families, especially for those who receive in-home services. The waiver program definitions and rates have also created financial incentives for service providers to develop large congregate day and residential settings that perpetuated grouping individuals with ID/DD together and separating them from their communities, rather than meeting their needs in the most appropriate integrated setting. The Commonwealth's goals in redesigning its wavier programs are "to provide for a flexible array of community-based options with a rate structure that supports the cost of new and existing services and provides incentives to providers for offering expanded integrated options." The Commonwealth also anticipates that these incentives will result in community-based program options that decrease demand for crisis intervention and institutional level care.

The Commonwealth is in compliance with *Section III.C.1.a.i-v.*

2. Discharge Planning for Children Living in Nursing Facilities and Large ICFs

DBHDS has begun to implement a plan to facilitate the transition of children with ID/DD who live in nursing facilities to integrated community-based settings. A plan for children who have similar needs, but live in large ICFs, has not been completed. The Commonwealth reports that the initiatives underway for children who reside in institutional settings are currently specific to each individual's setting. It is exploring steps to merge these initiatives into a more comprehensive and cohesive single set of strategies. In its responses to the Independent Reviewer's recommendation in the previous Report to the Court, the Commonwealth has committed to:

- identify all children with ID/DD who are in the process of being admitted to or who currently reside in institutional settings,
- determine their service needs, and
- assist with the development of and transition to community-based settings with needed support services.

DBHDS has established a structure to screen children suspected of having an intellectual or developmental disability prior to admission to a nursing facility. To ensure that appropriate services are offered in the most integrated setting, DBHDS now maintains a single point of entry to nursing facilities. As reported previously, the Commonwealth has prioritized diverting children away from admissions to nursing facilities to alternative community-based services that meet their needs. DBHDS performs the Preadmission Screening and Resident Review (PASRR), a federal requirement applicable to all individuals *referred to* nursing facilities who are suspected of having an ID or DD. The PASRR helps to ensure that children are not inappropriately placed in nursing homes. In addition, DBHDS has initiated a Resident Review process for all identified individuals *currently in* nursing facilities. Through the Resident Review process, DBHDS:

- determines whether the nursing facility admission remains appropriate based on medical/nursing needs and the functional limitations of the individual,
- identifies barriers to discharge from the nursing facility, and
- identifies services and supports that the individual needs to transition to the community.

It is the intent of the Agreement that individuals with HCBS waiver slots will be offered community-based supports of good quality, which are designed to promote skill development, self-sufficiency and community integration. To overcome barriers to discharge and to access needed community-based supports, DBHDS has implemented a new process to connect each child with the appropriate Community Services Board (CSB) and to facilitate a referral to the Regional Support Team (RST), if needed. The Commonwealth reports that it has completed 396 PASRR II reviews and 360 Resident Reviews of children and adults with ID/DD.

The Commonwealth and the DOJ are working together to develop, by June 30, 2016, outcome timelines with performance indicators to address the issues of children living in long-term nursing facilities and large private ICFs. As of March 9, 2016, the Commonwealth reported that forty-nine children under age twenty-two with ID/DD were long-term residents of nursing facilities. The Independent Reviewer has not verified that this number captures all the children living in such facilities. The Commonwealth projects that implementation of its plans to transition children from

nursing facilities and large ICFs will be evident during the spring of 2017, which is during the tenth review period.

A. Individual Services Review Study: Children in nursing facilities and larger ICFs and “like” children living in community settings.

During the eighth review period, the Independent Reviewer designed an exploratory Individual Services Review Study to learn about the services provided to children with ID/DD who live in nursing facilities and large ICFs and the services to children with similar needs who live in the community. The Commonwealth provided a December 31, 2015, list of the 301 children (under age 22) who had received Medicaid-funded services while living in such facilities. Stakeholders assert that the list provided does not include other children with DD who also live at these or similar institutions, but are not listed because the facilities bill the Commonwealth for the provision of medical services and do not indicate that the children have a DD diagnosis.

The Independent Reviewer randomly selected four to six children at each of the four largest facilities in the Commonwealth; two are nursing facilities and two are large ICFs. A total of eighteen children were selected from the 196 children with ID/DD living in these four facilities. These facilities are located in three of Virginia’s five Health Planning Regions (II - northern Virginia, IV - greater Capitol area, and V - Virginia peninsula). Seven children with similar needs were selected who live in homes; four live with their families and three live in group-homes. All seven of these children have ID waiver-funded services in these same three Regions.

The sample size of eighteen out of 196 children living in four facilities and seven out of an unknown number of children with similar needs who live in community-based settings is too small to give a sufficient degree of confidence that the study’s findings will generalize to all similarly situated children. The sample size is sufficient, however, to identify positive outcomes and areas of concern, which should be studied further.

Although there were individual exceptions, the study found the themes listed below:

1. The families supporting their children with disabilities at home were very committed to ensuring that they would grow up as part of their family and their community.

These four families were each struggling to secure needed services. These included behavior supports; in-home nursing and personal care staff assistance; and needed safety and sensory equipment. Requests for the equipment had been repeatedly denied.

2. The eighteen children who live in medical facilities received health care assessments, examinations and monitoring more frequently as ordered by a physician. These occurred less frequently for the seven children who live in community homes.

Examples are below. See Appendix A for further details of positive outcomes and areas of concern.

Health Care item	Large facilities	Community homes
There was a current clinical assessment, if ordered by a physician.	100%	73.7%
Clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) were implemented or staff were actively engaged in scheduling appointments.	98.6%	52.0%
Examinations and lab work were completed as ordered by a physician	92.3%	87.5%
The individual's provider monitored health care per the physicians' orders, and clinical professionals monitored side effects if the individual received psychotropic medications	97.6%	75.0%

3. The children living in facilities had virtually no opportunities to interact with similar age children who did not have disabilities or for community integration.

The children who lived in community homes had more, but still too few, such opportunities. The children living in facilities rarely left the institutional settings, except for attendance at school. When they went into the community, they did so as part of a group of children, all of whom had disabilities. Almost all children in the study attended schools, or sections of schools, that were segregated from children without disabilities. For the children living in community homes, the lack of available integrated after school activities, nursing services, positive behavioral supports, and other services significantly limited the community integration opportunities. Neither group of children had Individual Support Plans/Plans of Care with measurable outcome goals that promoted the development of skills to increase self-sufficiency or that led to increased opportunities for integration.

4. There was a lack of discharge planning for the children who were living in private institutional settings.

Without effective discharge planning, these children were not offered “services ... provided in the most integrated setting appropriate to meet their needs.” Without active discharge and transition planning, these children will not make progress toward achieving the Agreement’s goals of community integration and self-determination. Although there were exceptions, the discharge date for most children living in the large facilities was the day before they turned age twenty-one; the day before the facility would no longer be paid to support the child.

5. Children living in the community with waiver slots lacked adequate services.

Case Managers for the children living at home and those living in group-homes were not able to resolve the issues associated with inadequate services. Examples of the inadequate services that were not resolved, included the inability to secure needed behavioral supports, in-home nursing services, personal care staff, nutritional assessments, and needed safety and sensory equipment.

6. Children living in both large facilities and community homes lacked available and accessible behavioral support services that meet their needs.

The Study found that there were inadequate behavior supports available and in place for the children who lived in the large facilities and for the children who lived in community homes. In both settings, there were weaknesses found in the monitoring of the side effects and health consequences of psychotropic medications.

7. Children living in the community homes were not able to access crisis services or out-of-home crisis stabilization programs in each Region.

The Agreement required that these services be in place as of July 1, 2012, so that all individuals with an ID or DD diagnosis who experience crises are provided timely and accessible supports directed at resolving the crisis and at preventing the removal of the individual from his or her home. It also required that by July, 1, 2013, the Commonwealth develop an additional crisis stabilization program *in each Region* as determined necessary ... to meet the needs of the children and adults *in that Region*. These programs provide a community-based, out-of-home last option alternative to institutionalization.

Although these positive outcomes and areas of concern will not generalize to all children who live in large facilities or in community homes, they are consistent with findings from previous Individual Services Review Studies.

The Independent Reviewer has provided the Individual Services Review reports to the Commonwealth so that it will examine the issues identified for each individual. The Independent Reviewer has asked the Commonwealth to share the reports with each individual's direct service provider(s) and case manager and, by September 30, 2016, to provide updates on the actions taken and the results in regards to the issues identified for each.

Selected tables with the Individual Services Review Study's findings are attached (Appendix A). The Independent Reviewer has separated findings from the Study into tables focusing on positive outcomes and areas of concern. The findings from the Study are also cited in the comments in the Summary of Compliance table. Some comments cite patterns from multiple Studies.

Conclusion: From Fiscal Year 2012 through Fiscal Year 2016, the Commonwealth created 1500 waiver slots for individuals with ID and 600 waiver slots for individuals with DD, other than ID. The Commonwealth created these slots to provide services in the most integrated setting appropriate to the individuals' needs and to prevent the institutionalization of individuals in the target population. The Commonwealth also created slots to transition children who live in nursing facilities and privately operated large ICFs to community-based settings.

During these five Fiscal Years, the Commonwealth created 600 more slots than the Agreement requires. The Commonwealth has met the quantitative requirements for these provisions. Through this review period, however, the Commonwealth has not developed or implemented a plan to transition individuals under 22 years of age from large ICFs and has not implemented its transition plans for children living in nursing facilities.

The Commonwealth, therefore, is in non-compliance with *Section III.C.1.b.i.-v.* and *III.C.1.c.i.-v.*

3. Individual and Family Support Program

Following an independent study one year ago, the Independent Reviewer determined that the Commonwealth's Individual and Family Support Program (IFSP) 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 Agreement. DBHDS reported that it had established a task force to redesign the program to address the issues that contributed to a determination of non-compliance. DBHDS informed the Independent Reviewer that its redesigned IFSP would not be in place during this review period. With that caveat in mind, during this review period, the Independent Reviewer retained the same independent consultant to determine:

- whether the Commonwealth's existing IFSP had achieved the quantitative measure of compliance by supporting 1000 individuals/families during Fiscal Year 2016,
- whether the Commonwealth had made changes to improve the functioning of the existing IFSP, and
- whether the Commonwealth's plan to redesign the model of the program, if implemented effectively, could lead to a determination of compliance.

During the last year, DBHDS has engaged in many activities to enhance the effective operation of its current IFSP funding process and to redesign its approach to provide a comprehensive and coordinated set of strategies. It has engaged the New Individual and Family Design Advisory Committee (NIDAC) while completing much of the redesign work.

A. Current IFSP Funding Process

DBHDS made changes to the IFSP for the Fiscal Year 2016 funding period. These changes were based on the lessons learned from previous funding periods, from internal discussions and from stakeholder feedback. As a result of its analysis, DBHDS:

- reduced the maximum amount for funding per person from \$3,000 to \$1,000 (this step ensured that available funds would be provided for more individuals);
- reverted to one application and funding period, such had existed during the first two years of the Program;
- hired two temporary staff to assist with managing the flow of IFSP applications, decisions and issuance of funds; and
- streamlined the IFSP application form, and
- updated the IFSP Guidelines in August 2015 to reflect these changes.

In addition, a line was added to the application for an applicant e-mail address. This allowed IFSP staff to communicate more effectively with families regarding their applications; and

Overall, these modifications alleviated the backlogs that had occurred in previous funding periods. As of March 31, 2016, DBHDS was still accepting applications. It had not found it necessary to deny any applications due to funding constraints. These results reflected significant program improvements in timeliness and responsiveness and, therefore, much less stakeholder frustration. During the first nine months of Fiscal Year 2016, DBHDS provided funds to support 2,084

individuals and families. This was significantly more than the 1000 that the Agreement requires, however, funding awards provided were substantially less than in previous years.

B. Re-Design of the IFSP

Since the independent consultant's previous report on the status of the IFSP, DBHDS has continued to engage stakeholders in the planning for the IFSP re-design. DBHDS responded, in part, to that report's recommendation to implement a formalized and ongoing avenue for stakeholder input to help to guide the evolution of the IFSP. As part of its redesign process, DBHDS formed an advisory committee (i.e. NIDAC). Stakeholder participation was solicited from individuals on waitlists and their families. Representatives from advocacy organizations, although not voting members, attended and participated in the discussions. It was commendable that DBHDS had engaged stakeholders in its efforts to re-design its IFSP.

DBHDS charged the NIDAC planning workgroup with providing assistance with an IFSP design that would place significant decision-making power in the hands of the individuals and families being served. NIDAC was to provide feedback for DBHDS to consider as it developed a viable work plan for creating a comprehensive and coordinated family support system. The planning effort included three meetings of NIDAC between July and October 2015 and a meeting in March 2016. DBHDS provided, and the participants reviewed, information about individual and family support programs that were organized around the principle of an individual- and family-led regional organizational structure. (In other states, this approach involved creating regional non-profit organizations.) DBHDS also tapped the Service Corps of Retired Executives (SCORE) to bring in experienced business people to advise NIDAC members on the process of incorporating and operating 501(c)(3) organizations. All those interviewed considered the participation of SCORE representatives as very helpful to the process.

DBHDS presented a proposed program model to the planning workgroup. The model would place significant decision-making authority in the hands of the individuals and families being served. New nonprofit regional organizations would be established with governing boards whose membership would be at least a majority of individuals and families eligible to be served by the IFSP. These local organizations would have decision-making authority over the distribution of the IFSP funds by establishing the criteria for funding awards. Other roles would include working within their communities to coordinate other existing resources and developing additional financial and in-kind support. The Governor requested funding from the General Assembly for five new positions to facilitate the work of these proposed regional organizations. Being empowered with decision-making authority is consistent with the principles of individual and family support and has been successful in other states' programs. In March, the NIDAC learned that the General Assembly had approved only one of the five positions that were planned to support the five regional organizations. DBHDS presented NIDAC with two options for moving forward. After considering the reduction in planned staff, NIDAC ultimately identified two additional alternatives to consider. One option would use a portion of the IFSP funds, which have been used solely for direct support of individuals and families, to cover the cost of the administrative positions that the General Assembly decided not to fund.

During the consultant's review, many NIDAC members, advocacy representatives and other stakeholders expressed two concerns with the current plans. First, the regional individual- and family-run organizations, as envisioned, would have responsibilities for fund raising and

coordinating supports in addition to establishing policies related to the use of individual and family support funds. Many expressed concern that their available time and energies were often consumed with managing their own and their family members' extraordinary needs. Second, many questioned whether it would be more effective for Virginia to use existing nonprofit agencies to host the proposed regional organizations, rather than creating new regional organizations.

At this time, however, despite the IFSP planning efforts underway, a determination as to the likelihood of compliance with the qualitative requirements of the Agreement is not possible. The Commonwealth has not yet laid out a clear plan that is likely to lead to compliance with any of these requirements. The Commonwealth's proposed design still lacks specificity. The plan has been presented largely in very broad strokes. The plan also lacks significant stakeholder support. The planning process itself, while commendable in its intent, has not been as robust as necessary to achieve a well laid out plan. Many critical details have not yet been addressed. Most NIDAC members and interested attendees who were interviewed also expressed opinions that supported this finding. At the time of this study, the planning process was still ongoing.

Overall, the new IFSP, as currently planned, does not include adequate design or program evaluation strategies to be able to achieve the overall goal of a comprehensive and coordinated set of strategies. These strategies must be formulated 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.

The IFSP planning process has not yet resulted in the development of a comprehensive strategic plan. The planning process has not been sufficiently robust. NIDAC members participated in only three meetings before they were expected to decide on the individual and family support program model. DBHDS has made a sincere effort to expand its stakeholder engagement in this initiative. The concerns and skepticism expressed by stakeholders, however, have not been adequately addressed.

C. Individuals Who Are Most At Risk Of Institutionalization

The planning process for the IFSP has not yet addressed the Commonwealth's previous single criterion determination that those "most at-risk for institutionalization" included *every individual on* the HCBS waitlists. This broad definition is consistent with one of the primary tenets of the traditional individual and family support programs. This tenet emphasizes that all individuals with intellectual and developmental disabilities and their families need and deserve supports; they should not have to prove they are somehow more deserving than someone else. As reported previously, most families expressed a level of discomfort with receiving financial supports while knowing that others had much more intense needs.

DBHDS has since drafted a proposed revision to the Administrative Code that would expand the single criterion definition. The draft criterion, which has not yet been formally submitted, has been rewritten to include *every individual who is eligible to be on* the HCBS waiver waitlists. DBHDS staff opine that including all individuals who are eligible might slow the rate of growth of the number of individuals who are on the waitlists. Some believe that the requirement to be on the waitlist to receive IFSP funds was a factor that contributed to the rapid growth of the waitlists. As noted in the 2015 study, the "DD" waitlist grew forty-three percent, from 1,300 to 1,885, between June 2013

and April 2015. According to DBHDS staff, this waitlist has continued to grow at a pace of about forty new people per month. It was not yet clear how the overall waiver re-design would impact the size and growth rate of the waiver waitlists.

The NIDAC re-design proceedings have not yet addressed the “most at risk of institutionalization” definition. Nor was the process for making this determination discussed at the stakeholder meetings. As previously recommended, this fundamental element of the IFSP should be examined, through a truly inclusive strategic planning process, including weighing its potential impact and benefits. While it is not always possible to predict unexpected outcomes, a careful strategic planning process should fully address proposed rule changes prior to promulgation.

The Independent Reviewer commends DBHDS for its efforts to re-evaluate its approach to individual and family supports and for making interim programmatic modifications. These changes eased the application flow and the funding logjams from previous years.

The Commonwealth is in non-compliance with the qualitative requirements of Section III.C.2, as defined in Section II.D. The Commonwealth fulfilled the quantitative requirement to support at least 1000 individuals during 2016.

In summary, in order to develop a useful quality improvement system for the Individual and Family Support Program, it will be necessary for DBHDS to develop a set of both outcome and performance indicators that will allow it to determine whether or not a goal is achieved and then to analyze why or why not. DBHDS should construct its data collection methodologies with this in mind.

4. *Case Management*

Case management is the hub of the service system for individuals and families. It is their most important single resource, especially when assessments, additional service or changes in their services and supports are warranted.

It is the case manager who assembles the Individual Support Team to develop the support plan for the individual; to assist the individual and family to gain access to needed services; and to monitor service delivery and to make service changes as needed. The central importance of the case manager to the individual and family, and to the Commonwealth’s ability to achieve the goals of the Settlement Agreement, is the reason the Agreement includes provisions to ensure that:

- case managers do not have a conflict of interest;
- individuals and families have a choice of, and can change, case managers;
- case managers observe and assess whether each individual’s support services are properly implemented, address risks, are in the most integrated setting appropriate to the individual’s needs, report and document any identified concern, and, as necessary, assemble the ISP team to address the concern and to document its resolution;
- there is a licensing process that assesses the adequacy of individualized supports; and
- the Commonwealth establishes a mechanism to monitor the delivery of case management services to ensure that they comply with performance standards.

The Independent Reviewer retained a team of independent consultants to evaluate the Commonwealth's compliance with the case management provisions. This study also included the review of status of compliance with the provisions that govern how the Commonwealth monitors case management to ensure compliance with regulatory and quality standards. The independent consultants' report *Case Management and Licensing Requirements* is attached at Appendix C.

A. Case Management

In February 2016, the Office of Licensure Services (OLS) revised its *Office Protocol*, which guides Licensing Specialists in their conduct of the overall work of Licensing. The latest version continues the improvements to the 2015 version, vis-à-vis areas to be assessed (*Section V.D.3*) and monthly follow-up on Corrective Action Plans (CAPs) until conditions are corrected.

DBHDS is in non-compliance with the requirements of *Section V.F.2*. This determination is based on three cases where Employment First was not effectively implemented; evidence that several case managers were not sufficiently trained and did not have access to needed specialized consultation; evidence that case managers were not adequately monitored for Agreement requirements; and evidence that four CSBs were not submitting data to DBHDS regarding the performance of their case managers.

B. Case Management Availability and Face-to-Face Meetings:

The Independent Reviewer's consultants found that the Commonwealth's Data Dashboard is a viable accountability tool for tracking the delivery of case management services. That is, the data gathered details of the number, the type, and the frequency of visits, but not the quality of the case management services. There continues to be concerns with the reliability of data provided by CSBs. The Individual Services Review Study also found that seven individuals (100%) who were randomly selected had an ISP and had documentation of the required face-to-face case management review.

Therefore, the Commonwealth is in compliance with the requirements of *Sections V.F.1.* and *V.F.3.* This rating is based on the findings of the twenty-five cases reviewed in this study and multiple Individual Services Review studies, all of which indicated that the frequency and type of required visits had been achieved. The DBHDS data regarding frequency of face-to-face visits indicates that these visits may not be occurring with the frequency required. These data, however, have previously been found to be under-reported and unreliable. The frequency of visits should be carefully reviewed in the next independent study to verify that visits occur at the required frequency.

C. Case Management Effectiveness

The independent consultants completed a discrepancy analysis of the effectiveness of case management services for twenty-five individuals. Twenty-one of the individuals were receiving ID waiver funded services. Four were receiving DD waiver funded services. The sample size of four (10%) of the forty CSBs is not sufficient to give a high degree of confidence that the study's findings will generalize to all CSBs. The 10% sample size is sufficient, however, to identify positive outcomes and areas of concern, which should be studied further.

The consultants conducted a discrepancy analysis of the services for randomly selected cases in four CSBs' catchment areas. (The methodology and details of the study are attached to this report at Appendix C.) The findings of the analysis were based on a review of the case records, case manager

interviews, face-to-face individual interviews, including caregivers and Authorized Representatives, as feasible or as appropriate. The discrepancy analysis found that rates of discrepancies suggested that the effectiveness of case management services in two of the four CSBs (50%) warrant further examination to determine the systemic deficiencies and the corrective actions that are needed. One CSB has been below DBHDS performance targets for multiple consecutive quarters.

The Agreement lists three major functions of case management: assembling teams, assisting individuals in accessing services and needed supports, and monitoring implementation of the ISP and making changes as needed. In this sample, the consultants observed that when events or changes suggested that substantive modifications were needed to the Individual Service Plan, case managers were generally hesitant to assemble team members in between annual meetings. This reluctance appeared to stem from logistical inconvenience for participants and the lack of enthusiasm for ‘one more meeting.’ This finding is consistent with the findings of previous Individual Services Review studies.

The consultants found the following four most frequent challenges to case management effectiveness:

- ensuring that ISP outcomes are changed when necessary;
- ensuring that needed referrals are made in a timely and complete manner;
- ensuring that all essential supports are included in the ISP; and
- ensuring that the individual is supported to access needed services.

The independent consultants found that at each CSB case management performance has been monitored as follows:

- HCBS Waiver program audits for DMAS;
- DBHDS Internal Auditors’ Operational Reviews; and
- local CSB supervisory monitoring strategy or tool.

The HCBS Waiver program audits include a paper review only. DBHDS reports that the Internal Auditors’ Operational Reviews occur only an average of once every eight to nine years for all CSBs. (Four to five of the forty CSBs are reviewed annually.) The consultants determined that the local CSB supervisory monitoring tools vary in frequency of administration. These local CSB tools do not examine in a uniform manner the content of case management actions for timeliness or for quality. The consultants concluded that local CSB supervisory auditing does not appear to consistently identify or to address cases with deficiencies. The consultants also identified that cases with deficiencies were present in each CSB.

The consultants also found evidence of improved case management effectiveness. The discrepancy analysis found positive indicators in two of the four CSBs (50%) and for the four individuals receiving DD waiver funded services. The consultants determined that the frequency of discrepancies in these cases “represent very close to acceptable rates of difference from the desired outcomes, based on differing caseload sizes, length of service of case managers, etc.”

The Commonwealth’s efforts to improve the effectiveness of case management and the individual service planning process has resulted in progress toward achieving compliance with the requirements of III.C.5.b. The presence of discrepancies in this sample of cases, however, is such that one entire CSB is not meeting measurable target cut-offs. Since two of the four selected CSBs

(50%) are experiencing frequent quality performance problems, it is likely that many other CSBs may also be experiencing similar performance problems delivering case management services.

If two of the four selected CSBs (50%) are experiencing frequent quality performance problems, then approximately twenty (50%) of the CSBs statewide may be experiencing similar performance problems delivering case management services. The Data Dashboard reports indicate that one of these two CSBs has been 'below target' and has had problems reaching the DBHDS's target of eighty-five percent on its July-August-Sept-Oct 2015 reporting cycle measurements of face-to-face case management.

The Commonwealth is in compliance with the requirements of *Section III.C.5.a*. Each individual had a case manager and a current ISP. The Individual Services Review study found that all seven individuals who received ID waiver-funded services had a case manager and a current ISP.

DBHDS is in non-compliance with the requirements of *Section III.C.5.b.i-iii*. However, the case management study found that progress has been made. The study found discrepancies in a significant percent of the cases reviewed in two of the four CSBs studied (50%). The discrepancies included case managers not doing the following when needed: changing ISP outcomes; making referrals; listing all essential supports in the ISP; and supporting the individual to access needed services. The sample of cases reviewed indicated that an entire CSB is not meeting performance target cut-offs.

DBHDS is in compliance with the requirements of *Section III.C.5.c*. The documentation reviewed and responses to inquiries indicated that case managers had offered choices of providers.

DBHDS is in non-compliance with the requirements of *Section III.C.5.d*. The Commonwealth does not have an effective mechanism to monitor compliance with performance standards for case management. The Operational Reviews occur an average of only once every eight to nine years for each CSB. The OLS effort to tighten scrutiny of CSB case management has been terminated.

The Commonwealth is in non-compliance with *Section IX.C*. It does not maintain sufficient records to demonstrate that the provisions of the Agreement are being properly implemented.

D. Least Restrictive

Of the twenty-five individuals whose services were reviewed in the case management study, fifteen individuals did not live with their families. Eleven of fifteen individuals (73%) lived in settings of five or more individuals with a disability. Only one individual had a CRC referral package on file with the Regional Support Team. A second individual, who had moved to a setting with five or more individuals within the last year, did not have a CRC referral package on file with the Regional Support Team. The remaining nine individuals had been placed in their residential settings more than eighteen months ago, prior to when the Regional Support Team process became fully functional. None of these individuals had been referred to the RST subsequently, after the process became fully operational, to determine whether the obstacles to a more integrated setting had been identified and could be resolved and whether a more integrated setting was available to be offered.

The consultants' reviews found that for twenty-one of the twenty-five individuals' records (84%) that case managers had provided education about less restrictive services. The case managers for each of

the eleven individuals who lived in settings of five or more individuals had discussed less restrictive options with them and their Authorized Representatives.

DBHDS is in non-compliance with the requirements of *Section III.D.1*. It does not serve individuals in the most integrated setting appropriate to their needs. The Commonwealth is commended for discussing with the Regional Quality Councils the barriers to individuals living in the most integrated settings and the very large need for group home settings of four or fewer, especially for individuals with intense needs and in some geographic areas. There is broad agreement that achieving compliance with this overarching provision will not occur under the existing waiver programs because the rate structure could not support the cost of four-bed homes.

DBHDS is not in compliance with the requirements of *Section III.D.6*. The case management study found that the Regional Support Teams were not used to determine the obstacles to living in a more integrated setting for the eleven individuals who lived in settings with five or more individuals. The Individual Services Review study found that of the two individuals who were moved to community-based settings of five or more individuals since the Regional Support Team were in place, only one had been referred to them.

DBHDS is in compliance with the requirements of *Section III.D. 7*. Case managers continued to offer education about less restrictive community options on at least an annual basis to individuals living outside their own or their family home.

E. A Mechanism To Monitor Compliance With Performance Standards

The DBHDS Licensing regulations align generally with the case management expectations in the Agreement. They do not align specifically as to the case management expectations detailed in the Agreement regarding regular face to face meetings with the individual being served; enhanced visit frequency; identifying risks to the individual; offering choice among providers; assembling professionals and non-professionals who provide supports, etc. DBHDS takes the position that other non-licensing mechanisms of quality improvement address these issues. These other mechanisms include the DBHDS HCBS Waiver program audits and the DBHDS Internal Auditors' Operational Reviews, which are described above. The Quality Service Reviews (QSR), which were being conducted during this review period, will be an additional monitoring mechanism. Since beginning to conduct the QSR's in 2015, DBHDS has discontinued its use of the OLS *Supports Efficiency Checklist*, which it had initiated as a nine-month pilot program to tighten scrutiny of case management effectiveness. DBHDS also discontinued its '360 degree' quality improvement process, which its quality management division had implemented to improve case management effectiveness.

In addition, the OLS *Guidance for Selected Licensing Requirements* (February 2015) details the evidence expected by Licensing for compliance with its regulations governing case management. These requirements, however, appear to be solely reliant on case manager interviews and documentation review. This approach overlooks an examination of individual needs, supports, and outcomes. For example, 12VAC35-105-675 requires that: "The provider shall review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment ...The provider shall update the goals, objectives and strategies contained in the ISP, if indicated, and implement any updates made." This regulation generally includes the case manager, but when OLS reviews only the case management record, and not the experience and status of the individual,

there is no way to specifically test the case manager's fulfillment of the requirement "...to make timely additional referrals, service changes, and amendments to the plans as needed (Section III.C.5.b)."

During 2015, there were more than 100 investigations/inquiries into complaints about sixteen CSBs. Only one of these investigations resulted in a corrective action plan. The implication is that, in a review of 100 case management records, no documentation deficiencies were identified. Based on the independent consultants' study at least two of four CSBs (50%) performed significantly below DBHDS performance targets (20 - 23% discrepancies), specifically on case management performance items. These performance concerns should have resulted in one or more OLS citations for case management.

The Internal Auditors' Operational Reviews specific to case management align with the Agreement. Only a few Operational Reviews are conducted in a year (five were issued in 2015). Given the rate at which the quality of case management services can improve or decline and the frequency of change in case management practice (e.g. a new ISP was rolled out before two of these reviews and after three of these reviews), an Operational Review on an average of every eight or nine years can only be a supplement to the needed and required case management monitoring function.

The Quality Service Review (QSR) templates for the *Support Coordinator Interview* and the *Support Coordinator Record Review* align generally with Agreement domains (V.D.3). These templates should help surface case management issues at the CSB level. The challenge will be to reliably assess case manager performance and then to translate shortcomings identified in QSRs into formal follow-up and corrective actions by OLS or some other entity. The Agreement requires that the product of these Reviews be used to "improve practice and the quality of services." The consultant studies have found (and OLS's experience confirms) that many problematic providers will ignore or give short shrift to this type of feedback unless they are held to a plan of action and specific follow-up.

OLS does not regularly compile the results of its licensing reviews into a report on trends related to compliance patterns across CSBs. The Data Warehouse capability that now exists within DBHDS gives OLS a tremendous ability to assess the health of the system vis-à-vis CSB performance.

The Commonwealth is in non-compliance with *Section III.C.5.d.*, the requirement to have a mechanism to monitor CSB compliance with performance standards.

DBHDS is in non-compliance with the requirements of *Section III.V.F.4.* DBHDS does not yet have evidence at the policy level that it has reliable mechanism(s) to assess CSB compliance with their performance standards regarding case manager contacts. For October 2015, four CSBs (25%) did not report data on the number, type and frequency of contacts. Only sixteen of the twenty-one names (76.2%) provided for the case management study were correctly identified as having received enhanced case management.

5. *Crisis services*

The Independent Reviewer has prioritized monitoring the development of the required statewide Crisis Services system during each of the eight review periods. For Virginians with a diagnosis of ID or DD a quality crisis services system is essential to prevent unnecessary institutionalization; this is the central purpose of the Agreement. During this review period, the Independent Reviewer engaged an expert consultant to complete a review of the status of crisis services development for children and the effectiveness of crisis services for adults with ID/DD.

The Agreement requires the Commonwealth to:

- develop a statewide crisis system for individuals with ID/DD;
- 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 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.

During this review period, the Independent Reviewer engaged an expert consultant to review the status of crisis services in order to answer the following questions:

- Has the Commonwealth sustained previously achieved compliance with its elements of its statewide crisis system for adults with ID?
- Has the development of crisis services for children achieved the planned milestones?
- Has the Commonwealth actively reached out to children and adults with DD, other than ID, to their families, and to their community organizations?
- What is the status of implementation of the recommendations included in the Independent Reviewer and independent consultants' previous reports to the Court?

The Commonwealth developed crisis services for adults first. That development was a major undertaking. The crisis system was developed in collaboration with the CSB, which served individuals with ID, but not necessarily adults with DD, other than ID. To recognize the Commonwealth's accomplishments of funding and developing the elements of the crisis service system, the Independent Reviewer has determined compliance with the elements of the statewide crisis services solely on the services for adults with ID. For the overarching crisis service system provisions, the Independent Reviewer has determined compliance based on whether the Commonwealth is providing an effective crisis service system for both children and adults who have a diagnosis of either ID or DD, other than ID.

The Commonwealth began developing its crisis services system for children well after the June 30, 2012 due dates in the Agreement. By December 2016, the Commonwealth now projects that mobile crisis teams for children will provide on-site mobile crisis team responses twenty-four hours per day, seven days a week, within one or two hours, as required in all Regions of the Commonwealth. A timely response to crisis calls is an essential precursor to providing crisis intervention services.

Therefore, during the tenth review period, a year from now, the Independent Reviewer will begin to determine compliance for all the crisis services' provisions, based on their availability and effectiveness, for the entire target population of children and adults with either ID or DD, other than ID.

A. The Status Of Crisis Services To Serve Children And Adolescents

DBHDS established the following timelines for achieving the developmental milestones of its statewide Children's Crisis Service System:

- a single point of entry in each region is in effect by July 2015;
- a data system and data collection are implemented by July 2015; and
- all crisis calls are responded to within defined standards 60% of the time by December 2015, 80% by July 2016, and 95% by December 2016.

The number of reported referrals to children's crisis service programs increased from 97 to 108 from the first half of the review period through its second half. The pattern of times of day and days of the week for reported referral calls, however, is similar to the pattern for the established adult crisis programs. The number of referrals ranged dramatically between Regions, from forty-three in one Region to seven in another. This number of referrals does not include information from two Regions' REACH programs. Each was unable to report the number of referrals during one half of the review period. In addition, other Regions' referral data did not align between reports. These statewide data, therefore, cannot be considered complete or reliable.

Of the referrals reported, a significantly higher percentage (88%) have been children with DD, other than ID, compared with 12% of the referrals for adult crisis services. DBHDS gives credit for reaching a higher percentage of children than adults with DD, other than ID, to direct referrals from schools and referrals from the families of students who were made aware by their schools of the availability of crisis supports. All outreach by the REACH programs to the schools will positively impact the knowledge of families of students with any intellectual or developmental disability.

The REACH mobile crisis staff responded onsite within the average required response times required by the Agreement. Response time data were not provided for the first half of the review period. For the second half, however, only two of sixty-four (3.1%) onsite responses were later than the standard of one hour in Regions II and IV and of two hours in Regions I, III and V. The data reported were incomplete. The required responses varied disproportionately between Regions. One Region reported that there were no crisis calls for three months. Two Regions reported always arriving within the required response time, but there were inconsistencies in the data. Region I's crisis system for children is not organized to respond to crisis calls after normal working hours and on weekends.

Mobile Crisis Services for Children

During this review period, mobile crisis services for children served an increased number of children. The number increased 11.3% from 97 served during the first half of the review period to 108 during the second half. The data indicate that a higher percentage of these children returned to their homes after receiving crisis services and did not need further crisis supports. This may be an indication of increased program effectiveness. During the second half of the review period, four Regions reported providing more than the required average of three days of support per child. The crisis education prevention plans (CEPP), which are required for all children served, were not provided to some

children. Data were incomplete for the first half of the review period. One Region was not able to report what types of services it had provided.

Crisis Stabilization Programs/Crisis Therapeutic Homes for Children

The Children's REACH programs do not have crisis stabilization homes, now called crisis therapeutic homes (CTHs), in any of the Regions. Such programs are required by the Agreement. DBHDS plans to issue an RFP by May 1, 2016 to develop community-based, out-of-home crisis respite services during Fiscal Year 2017. During the Fall of 2016, the Commonwealth plans to determine the capacity that it will need to provide children and adolescents with community-based "last resort" alternatives to avoid unnecessary institutionalization.

DBHDS has developed seven performance criteria for its expectations for the statewide Children's Crisis Services system. Data reporting will begin during the next review period. DBHDS projects that the regional programs will meet expectations as of December 2016, during the tenth review period.

Preventing Unnecessary Institutionalization of Children

The REACH staff participated in pre-admission screenings for twenty-six of the sixty-three children with ID/DD (41.3%) who were known to have been admitted to psychiatric hospitals during the reporting period. This increased percentage reflects REACH being better informed of the potential admissions. REACH was not notified of the preadmission process for thirty-seven of the psychiatric admissions (58.7%). The Commonwealth acknowledges that it is not aware when children and adolescents with ID/DD are screened for admission to private psychiatric facilities, how many are admitted, the length of their stays, or their disposition when discharged. The Commonwealth cannot fulfill the Agreement's central purpose of preventing unnecessary institutionalization when it is not notified of potential admissions to public and private psychiatric facilities. The impact of not being notified and of not being able to prevent unnecessary institutionalization was highlighted by the Office of the State Inspector General's (OSIG) recent investigation of conditions at Virginia's only state operated psychiatric facility for children and adolescents. The OSIG reported that, "children and adolescents with ID/DD and ASD (Autism Spectrum Disorders) are the fastest growing specialty population being admitted to the Commonwealth Center for Children and Adolescents, accounting for approximately 27% of the total admissions."

B. Crisis Services for Adults

Outreach and Services To Adults With DD, Other Than ID, And The DD Community

On January 12, 2016, DBHDS sent a letter to all individuals, who are either receiving DD waiver-funded services or are on the waitlist, and their families. DBHDS reported that this letter and the actions described below are parts of DBHDS's implementation of a plan to reach out to individuals with DD, their families, providers and the broader community serving individuals with DD, other than ID. The letter:

- explained the availability of REACH crisis services for children;
- provided an internet link to REACH information on the DBHDS website; and
- described how to access REACH services in each Region.

DD Case Managers are now receiving training and information regarding REACH services. CSB Emergency Services staff have received training to help them understand that REACH services are also a resource for individuals with DD. REACH staff have presented at statewide and local conferences to educate families and providers. DBHDS has enhanced its communication with state-operated and private mental health hospitals. DBHDS continues to work with other partners including Commonwealth Autism Service, Virginia Autism Center for Excellence and the Arc of Virginia to help distribute information about the REACH Programs.

During this review period, there was a significant increase in the percentage of individuals served who had DD, other than ID. In previous periods, only five percent of those served had DD, other than ID. During the first half of this review period this increased to ten percent of all served. During the second half of the review period, thirteen percent of the individuals served had DD, other than ID

Mobile Crisis Team Availability

REACH Mobile crisis teams were again found to be available and to respond twenty-four hours per day, seven days per week. All Regions' mobile crisis teams coordinate with CSB hotlines.

Sufficient Number Of Mobile Crisis Teams To Provide Timely On-Site Response To Crisis Calls

To increase capacity to provide timely response, staff have been added to the existing REACH Teams; new teams were not created. The added staff have resulted in sufficient capacity to provide onsite crisis responses for adults within the one and two hour requirements. Regions II and IV are urban areas and, therefore, must respond to crisis calls within one hour. Across all Regions, the mobile crisis teams arrived onsite within the required times for 529 of the 553 responses (93.7%).

The Commonwealth is in compliance with *Sections III.C.6.b.ii.G. and III.C.6.b.ii.H.*

Availability of In-home Supports

The five Regional REACH programs vary in the number of individuals who receive in-home services and in the total number of days of community-based crisis services that are provided. For the reporting period, the average number of days of provided in-home support exceeded three days. Each Region provided an average of three days or more during the second half of the period.

The Commonwealth is in compliance with *Sections III.C.6.b.ii.D. and III.C.6.b.ii.E.*

Effectiveness of Mobile Crisis Team Services

As reported previously, the Commonwealth has developed a comprehensive training program for mobile crisis staff. The training program includes a process to reinforce learning through supervision, team meeting discussions and peer review. The Independent Reviewer's qualitative review during the previous reporting period found that the mobile crisis services provided, however, were considered not effective. More expertise was required for effective support of individuals who are at risk of institutionalization. That review also found that REACH staff had not assisted individuals' support teams to identify and to secure the resources needed (e.g., providers with expertise in co-occurring conditions; behavioral support services; counseling, etc.). The REACH

teams had not provided Crisis Education Prevention Plans (CEPP) for many of the individuals who were studied.

At that time, DBHDS established the following standards to improve the quality of REACH crisis services for adults:

- increased educational and experience qualifications for crisis services staff;
- mobile crisis services staff will join the CSB ES staff for all on-site assessments;
- the provision of Crisis Education Prevention Plans and preventive follow-up services; and
- crisis staff to follow all individuals admitted to psychiatric hospitals.

The study during this review period found that two Regions had consistently implemented the standards that all individuals receive both Crisis Education Prevention Planning (CEPP) and crisis prevention follow up services. Two other Regions, however, did not provide CEPPs to many individuals. One Region provided prevention follow-up services to only ten percent of its participants. Another Region's REACH crisis services did not provide prevention follow-up services.

From the data provided during this review period, it appears that REACH services for adults are providing improved prevention support. During this reporting period, eighty-four percent of the individuals who received mobile crisis services maintained their residential setting. Another five percent of the individuals moved to a new appropriate community setting. Another four percent used out-of-home crisis stabilization services, but their final dispositions were not reported.

DBHDS reported completing case studies and quality reviews of the crisis services provided during this review period. The Commonwealth did not provide the results of these quarterly quality reviews to the Independent Reviewer's consultant for consideration. Without qualitative data available, it is not possible to determine the effectiveness of the services and supports provided and not possible to determine that compliance has been achieved.

The Commonwealth is in non-compliance with *Sections III.C.6.b.ii.A. and B.*

REACH Training of CSB Emergency Services staff, case managers and other stakeholders

The crisis services staff of the five regional REACH programs provided training to more than 2,000 individuals during this review period. The Regions continue to train CSB Emergency Services staff and to report on this quarterly. The Commonwealth reported that 101 Emergency Services staff were trained statewide. This is a significant increase from the two previous reporting periods. The REACH training is in addition to all new Emergency Services staff completing the standardized on-line curriculum. Previously, DBHDS required that all new case managers and CSB Emergency Services staff receive training using the DBHDS on-line material. On March 4, 2016, DBHDS required that all existing staff be trained by June 4, 2016, and that all newly hired staff be trained within thirty days of being hired.

During the review period, REACH provided training to 395 law enforcement officers. This is an increase over the 332 and 224 officers who were trained during the previous two reporting periods. DBHDS has made additional information available to law enforcement departments through its website. It has also retained Commonwealth Autism to provide more comprehensive training directly

to law enforcement personnel in the future. The independent consultant's study did not assess the effectiveness of the mobile crisis teams' work with law enforcement personnel.

The amount of training that REACH provided during this period is impressive. There are, however, significant disparities in the trainings provided between Regions. For example, in one Region 96.8% (121 of 125) individuals trained were hospital staff. Although 307 family and other caregivers received training statewide, one Region did not train any caregivers. Two Regions trained far fewer law enforcement officers.

The Commonwealth remains in compliance with *Sections III.C.6.b.i.B. and III.C.6.b.ii.C.*

Crisis Stabilization Programs

All five Regions continue to provide out-of-home crisis stabilization programs (which DBHDS calls Crisis Therapeutic Homes) for adults, as required. During the eighth review period, these programs:

- complied with the Agreement's prescribed purposes: to provide a short-term alternative and "last resort" option to avoid unnecessary institutionalization;
- served individuals with more significant needs by eliminating previous exclusions due to homelessness or for medical and physical care needs; and
- provided needed crisis stabilization services for 297 adults with ID/DD.

DBHDS eliminated the requirement that only individuals with a confirmed discharge plan could be served. It is also positive that the crisis stabilization programs are used for planned respite for individuals who are at risk of crises and to facilitate the return of individuals from psychiatric hospitalizations to the community. In each Region, the policy to allow individuals without a home address to be served has resulted in at least one or more individuals to remain longer than the Agreement's explicit limit of thirty-day stays. The reasons for longer stays appear to be inadequate community-based provider capacity to support individuals with challenging behaviors and the lack of residential services under the existing DD waiver program. Stays of more than thirty days, which are longer than needed to stabilize the crisis, undermines the previously reported effectiveness and the programs' availability for other individuals who are in crisis. The Commonwealth has not provided information for this review of the specific number and lengths of stay that exceeded thirty days, although, this information was requested in the consultant's previous report and specifically not allowed by the Agreement.

One Region will soon move its Crisis Stabilization program to a community-based setting. Another Region's program has seven beds. This is one more than is allowed by the Agreement, but the bed is rarely used. This Region is implementing a plan to develop a new crisis stabilization home that will comply with the six-bed maximum. The new home will be available during the next review period.

There are waiting lists for access to all of the crisis stabilization homes. Case managers and stakeholders report that referrals to these programs are not made for individuals who need them because of the lack of availability. The Region with the longest waiting list for its Crisis Therapeutic Home has individuals remaining longer than the maximum allowed thirty-day stays; these extended stays are for individuals who do not have an alternative home setting.

To regain a rating of compliance, the Commonwealth must limit the use of its crisis stabilization homes to planned respite to prevent crises and to stabilize individuals in crisis. These program settings for not designed as emergency housing of individuals who are homeless.

Despite the waiting lists and feedback from case managers regarding unmet needs, the Commonwealth has not yet determined whether additional crisis stabilization programs are necessary *in each Region* to meet the needs of the individuals who are eligible for crisis services *in that Region*.

During the tenth review period, the Independent Reviewer will determine compliance for crisis stabilization provisions based on whether the Commonwealth has effectively implemented the crisis stabilization services for children and adolescents.

In summary, the elements of a statewide crisis service system are in place for adults with ID. The REACH programs for adults are now serving a significantly increased number of Individuals with DD, other than ID. For adults, a Crisis Stabilization program operates in each region and complies with the Agreement's prescribed purposes: to provide a short-term alternative and "last resort option" to avoid unnecessary institutionalization. Compelling evidence indicates that the capacity of these services is not sufficient for adults. The Commonwealth has determined that the existing Crisis Stabilization programs are not sufficient to meet the needs of the target population. It has not yet determined, however, whether additional capacity is needed *in each Region* to meet the needs of the target population *in that Region*. It has not, therefore, developed an additional Crisis Stabilization program in each Region. For children, the Crisis Stabilization programs, have not yet been developed. The Commonwealth has made considerable progress during the past year with the development of the other elements of crisis services programs for children. The Commonwealth has not yet, however, demonstrated that these elements are in place and fully functioning for children with ID or DD. Referral and call data indicate that DBHDS's outreach to individuals, families and the DD community has informed them of the availability of the REACH crisis services. Children and adolescents are using and benefitting from these services. The REACH performance data that demonstrate whether the crisis services elements are fully functioning for children and adolescents, however, are incomplete and inconsistent.

Overall, the REACH teams are directly responding to crises more often. They are providing mobile supports and they are offering the Community Therapeutic Home programs to adults for crisis stabilization, prevention, and transitions from hospitals. Most individuals with whom REACH is involved are supported to stay in their existing setting.

The Commonwealth's records and data that are available cannot substantiate that services are sufficient to prevent unnecessary hospitalizations. Nearly twenty percent of adults and children who were referred to REACH were hospitalized after the initial mobile crisis assessment. The data do not include sufficient information as to whether all of these admissions were clinically necessary or whether children and adults remained hospitalized past when they were ready for discharge due to a lack of sufficient, appropriate and effective community resources. The Office of the State Inspector General (OSIG) has recently completed two reports regarding the admission to state operated psychiatric facilities of individuals with ID/DD and co-occurring behavioral health conditions. Both reports found a substantial increase in the number of individuals with ID/DD admitted. During 2015, there was an eighty-one percent increase in the admission of adults with ID/DD, including Autism Spectrum Disorders, to state operated adult psychiatric institutions and to the Hiram Davis Medical Center. During 2015, fifty-five children with these diagnoses were admitted to

Commonwealth's only state operated psychiatric facility for children. Both reports found that these facilities do not have the capacity to adequately protect, or to provide needed services, to these members of the target population. For individuals with ID/DD receiving services in these facilities, the OSIG also reported:

- a lack of needed specialized services,
- many disadvantages to providing services in these settings, and
- the inability to discharge when individuals are ready due to limited community-based capacity to support these individuals.

Therefore, in summary, based on the above findings, it has been determined that the Commonwealth is:

- in non-compliance with *Section III.C.6.a.i-iii.*;
- in compliance with *Section III.C.6.b.iii.A., B., and F.*;
- in substantial compliance with *Section III.C.6.b.iii.D.*; and
- in non-compliance with *Section III.C.6.b.iii.C. and G.*

The independent consultant's report (Appendix D) includes a detailed description of the review process, the information gathered, findings, analysis, conclusions and recommendations.

6. Behavioral Capacity

During this period, the Independent Reviewer's consultant studied the sufficiency of the Commonwealth's behavioral support services for individuals with ID/DD. In her previous qualitative review of the REACH crisis services, she reported that the temporary crisis services provided by REACH could be effective only if they are part of a continuum of effective community based supports and services for individuals with co-occurring conditions or intense behaviors. DBHDS acknowledges that the Commonwealth does not have the capacity to meet these individuals' needs and reported that it is taking the steps described below.

On July 15, 2015, the Commonwealth issued an RFP to develop residential homes and other community-based services for at least sixty individuals with ID/DD and intense behaviors and/or mental health issues. This new capacity will be targeted to meet the needs of fifty-five individuals who have these needs and who will be transitioning from the Southwest Virginia Training Center (SWVTC). DBHDS estimates that 200 more individuals with similar needs also live in Region III. It appears clear, therefore, that the additional capacity to serve "at least sixty individuals" will not be sufficient to meet the needs of the 255 individuals that DBHDS estimates need these services in the region. For the individuals with behavioral challenges who will be served, DBHDS expects to develop a comprehensive set of services and supports that include:

- residential and day services appropriate to individual needs;
- in-home crisis supports and out-of-home crisis stabilization;
- step-down crisis stabilization from mental health facilities, large ICFs, and jails;
- cross-system crisis prevention and intervention planning; and
- specialized staff.

Staff will include Board Certified Behavior Analysts (BCBAs) and certified Behavioral Support Professionals (BSPs). In response to the RFP, DBHDS expected to make awards to the selected provider during this eighth review period, but had not done so as of April 29, 2016. DBHDS has funding available and is considering issuing a similar RFP during Fiscal Year 2017 to develop additional capacity to provide needed behavioral support services in Region II.

DBHDS has implemented initiatives to expand the number of staff who are certified BSPs in Region III and throughout the regional REACH programs statewide. A BSP training program is scheduled to begin in May 2016 for twenty-two professional staff. Changes have been made in the structure of the program to increase the percentage of staff who will complete the training and become certified. BSP training has been funded for the staff of the REACH Children and Adult crisis service programs. To attract more BCBA trained professionals to serve individuals with ID or DD who have behavioral challenges and who experience crises, the Commonwealth redesigned waiver programs have established a higher differential pay rate for BCBAs. DBHDS defined behavioral support competencies for direct support and clinical staff. These were issued in August 2015. Competencies are defined for two levels of staff: qualified DD professionals and behavior interventionists. There is an extensive list of competencies to assist staff to more successfully plan, assess, and deliver support services for individuals with behavioral challenges.

The Commonwealth's community-based service system needs to develop significant additional capacity for the entire crisis support system to be effective and responsive and to meet the needs of individuals with intense behavioral needs. The Commonwealth does not have sufficient community-based crisis stabilization service capacity to meet the needs of the target population in the Regions.

The Commonwealth is in non-compliance with *Section III.C.6.b.iii.E*

Focus group participants expressed concerns about the limited capacity throughout the service system. The areas of limited capacity include the insufficient number of Crisis Stabilization programs; the woeful lack of behavioral support professionals; and the shortage of residential, day, and respite providers. Participants expressed dissatisfaction with psychiatric hospital services that are available to individuals with ID/DD. Many participants reported that these facilities have little expertise to address the unique needs of either adults or children with ID/DD. Due to the lack of available capacity, children frequently are admitted to psychiatric hospitals far away from their families and natural support networks. The OSIG reported that at the eleven percent of the adults who were ready but waiting for discharge from state operated psychiatric facilities had ID/DD.

While REACH crisis services were often complimented for specific work in Region III, participants in the two focus groups, and others who were interviewed, openly acknowledge both the fragmentation of the system for children and the lack of adequate resources for both children and adults who experience crises. Their experiences with and opinions about the existing crisis services echo those of the OSIG's recent report:

“Virginia lacks a system of adequate community-based services and supports, and appropriate settings to serve children and adolescents with ID, DD, ASD and forensic involvement. Until adequate programs are operational in the community, CCCA will continue to face challenges with bed capacity and possession of the staffing and programmatic resources necessary to provide quality services to diverse populations.”

The Commonwealth is in non-compliance with *Section III.C.6.b.iii.G*.

7. *Integrated Day Opportunities and Supported Employment*

A. Integrated Day Opportunities

The Agreement seeks to provide services in the most integrated setting appropriate to meet the needs of those served. The Commonwealth's system of waiver-funded day services largely governs how and where adults with ID waiver-funded services live their days, at least their weekdays. The structure and expectations of day services ultimately determine whether what these individuals do is meaningful; whether they have the opportunities to seek work; and whether they have regular opportunities to interact with non-disabled individuals in their communities. This is why the overarching requirement of the day services section of the Agreement is:

“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.”

The Commonwealth recognizes that the service definitions and pay rates of its existing HCBS waiver programs created strong incentives to provide day services in larger congregate centers rather than to provide more integrated opportunities. After three years of planning, the General Assembly has approved the redesign of Virginia's Home and Community-Based Services waiver programs. The substantial changes requested of the General Assembly were designed, in part, to help the Commonwealth to come into compliance with the Agreement and with the Center for Medicare and Medicaid Services' *Final Rule* for HCBS ID/DD waiver programs.

During this review period, with rare exceptions, the providers of HCBS waiver-funded programs still did not offer integrated day activities to individuals who are not employed.

B. The Employment First Policy

The Commonwealth has maintained its membership in the national State Employment Leadership Network (SELN). It issued an Employment First Policy in 2012. The Commonwealth included a term in the CSB performance contract that requires application of this policy. DBHDS has an Employment Services Coordinator position, which was filled from the beginning of the Agreement until January 2016. DBHDS is currently recruiting to fill the position.

The Agreement requires the Commonwealth to ensure that individuals in the target population are offered employment as the first day service option. The Agreement and the policy require that:

“Employment goals are developed and discussed at least annually through a person-centered process and included in the ISP.”

The independent consultant found that in a small sample of ISPs reviewed “there was no indication that CSBs are in compliance ... regarding employment planning for members of the target population or with the requirement to include employment related or readiness goals.”

The independent consultant who completed the case management study found that the discussions of employment had occurred for a randomly selected sample of twenty-three adults, but rarely

included the discussion of goals toward employment. The ISP teams for these adults subsequently recommended Day Support services for twenty-two of the adults (96%). None were offered regular integrated activities or activities that engage them in seeking employment services. These recommendations are consistent with perpetuating a day service system in which individuals with ID and DD are congregated in large groups and served in segregated rather than integrated settings.

The Commonwealth and the CSBs are not meeting the requirement to have employment goals included in the employment discussion during the individual planning process.

The Commonwealth is in non-compliance with *Section III.C.7.b*.

C. The Employment Implementation Plan

The Employment First Plan for FY2016-2018 was revised on December 29, 2015. The revisions to the plan lack specificity, do not report progress toward reaching the earlier plan's goals, do not include the action plan for implementation, and do not include the involvement of the Regional Quality Councils.

D. Integrated Day Activity Plan

The Agreement required the Commonwealth to develop an implementation plan, by September 6, 2012, to increase integrated day opportunities. The Commonwealth submitted an Employment First Plan, not a plan to increase day services in integrated settings for individuals in the target population who were not employed. The Independent Reviewer directed DBHDS to develop a plan by March 31, 2014. The Independent Reviewer asked the Commonwealth to describe its approach to create integrated day activity capacity throughout its provider community and to ensure that individuals in the target population will be able to participate in these integrated activities as the foundation of their day services. During the current review period, DBHDS submitted the revised "Community Engagement Plan FY2016-FY2018" on December 29, 2015.

The Commonwealth has planned and implemented some steps that should lead to increased integrated day opportunities including supported employment. The Commonwealth's redesigned HCBS waiver programs include a definition for integrated day activities, which DBHDS now refers to as Community Engagement. DBHDS has also added new service definitions related to providing integrated day services. Each includes a service definition, a list of allowable activities, and pay rates. The definitions are clear and the allowable activities are extensive. This effort should, over time, further the availability and success of integrated day activities. DBHDS has created the Community Engagement Advisory Group (CEAG) with broad stakeholder membership to provide advice regarding how to increase integrated day activities.

With the input of the Community Engagement Advisory Group, DBHDS drafted a comprehensive Community Inclusion Policy. This policy sets the direction and clarifies the values of community inclusion for all individuals with ID/DD, regardless of the severity of their disability. The policy promotes the use of natural supports and opportunities at naturally occurring times rather than to limit activities to weekdays and daytimes. This policy, if effectively and broadly implemented, should lead to an increase in integrated day services and to positive outcomes for individuals.

The DBHDS and the CEAG have developed a robust definition of Integrated Day Activities, which it now calls Community Engagement. These definitions are used to describe this service type in the redesigned HCBS waiver program. This definition of integrated day activities assures that the activities are meaningful. It also assures activities are available at times so an individual will be able to have an active, community-based daily routine. Integrated Day Activities will include community education or training and recreation and volunteer activities. The definition is outcome focused. Integrated day activities must be offered in the community, facilitate the development of meaningful relationships with typical individuals, and facilitate community inclusion. Transportation, which is included, will be a key element to successfully offering these services. The Independent Reviewer commends DBHDS for developing this comprehensive definition of integrated day activities.

The plan to develop integrated day activities, however, is not a sufficiently comprehensive implementation plan. The written plan lacks essential elements. Community Engagement is a newly defined service in the redesigned HCBS waiver programs. For individuals to be provided such services they must be included in the individual's ISP. Case managers will assemble the ISP team members to develop the ISP. Yet, the plan did not describe training for case managers. The development of an ISP requires a person-centered planning process. The plan did not include specifics about how to build community engagement into the person-centered planning process. The existing providers of day services typically offer day support programs in large congregate centers. Many providers have invested financially in these large buildings and have created a human resource structure to provide services in them. The plan did not include an assessment to determine the additional provider capacity that will be needed or the action steps to reach out to existing day service providers. It did not include a description of efforts to build provider capacity; it projects that incentives to provide the integrated day services will be developed in July of 2017. The Commonwealth states that, although its written plan does not describe these activities, that many of the elements that are not described are being, and will be, addressed. The Commonwealth did not provide this additional information to the independent consultant during her review. This information is not, therefore, included in the consultant's report, and was generally not included in determining the status of the Commonwealth's planning and implementation efforts.

Several initiatives to shift day services toward integrated activities are well underway:

- Pay rates have been developed for community engagement, community coaching, and community guides. They have been approved to be effective on July 1, 2016.
- DBHDS issued an RFP for Community Engagement on July 9, 2015, to assist two providers serving at least 100 individuals to convert from center-based programs to Community Engagement. The grants were to be awarded by the end of the review period, but the awards have been delayed.
- Some provider agencies report having started to increase community-integrated activities for individuals who are currently in the center-based programs.
- Providers have identified areas where there is momentum that will further the development of Community Engagement services and that will address the obstacles that need to be resolved. These providers have applauded the responsiveness of DBHDS staff and the quality of the support that these staff have provided.

The plan has established objectives in several areas. The CEAG is to work with Regions to identify additional providers of Community Engagement by March 31, 2016 and to work with stakeholders

to determine how to create incentives by July 1, 2017. Fact sheets have been developed for providers, families and individuals concerning the general importance of Community Engagement. The CEAG is scheduled to develop a training curriculum, detailing how to involve individuals in Community Engagement, by June 1, 2016. The CEAG plans to collect information on best practices and to identify these practices for providers.

Some of the actions needed to implement goals are on track; some are partially on track; and some have not yet been implemented. The timelines for completing these actions range from June 30, 2016 to June 30, 2017. As of April 19, 2016, the Employment First Advisory Group has drafted quality outcome measures.

At this time, although there are promising initiatives underway, the Commonwealth remains in non-compliance with *Sections III.C.7.a. and III.C.7.b.i.*

E. Training

DBHDS continued to provide education to other state agencies. In this quarter, the Department's staff provided technical assistance to DMAS staff and formal training to DARS and DBHDS staff about currently allowable employment services under the HCBS waivers.

DBHDS also provided regional training on the Employment First policy and strategies. During the first half of this review period, DBHDS trained 165 family members, CSB staff, advocates, provider staff, transition teachers and supervisors. During the second half of the review period, DBHDS provided regional training to five new potential providers and technical assistance to four service providers. The training sub-group of the Employment First Advisory Group (formerly, and as described in the Agreement, the SELN Advisory Group) had drafted training materials for case managers and had developed a fact sheet on workplace assistance.

DBHDS is in compliance with *Section III.C.7.b.i.A.*

F. Data Collection

DBHDS worked with the SELN and in partnership with the Virginia Department for Aging and Rehabilitative Services (DARS) to refine its approach to data collection. The Commonwealth made progress collecting data by gathering it from Employment Service Organizations (ESOs) and DARS. It also gathered more detailed data about individuals who are employed and who are in sheltered work. The Commonwealth has vastly improved its data collection since October 2014. The Commonwealth acknowledged that the data reported during earlier review periods, prior to the spring of 2015, had been faulty and incomplete. Since beginning to collect these data, the response rate from ESOs has increased from forty-four percent in October 2014 to ninety-three percent in December 2015. Data to be gathered were expanded to include information about members of the target population who receive employment services funded by DARS. It is helpful that DBHDS has been able to increase the accuracy and comprehensiveness of the employment data regarding the number of individuals with disabilities who are employed.

The data collected showed a substantial increase in certain areas. This change is understood to be a result of earlier incomplete and faulty data.

The Commonwealth has continued to obtain more comprehensive data. In its semi-annual report on employment, the Commonwealth included statewide data and analysis, goal setting for Individual Employment, summaries, and recommendations. These data are from points in time in June 2015 and in December 2015, respectively. While representing points in time, these reports can be compared on a semi-annual basis. Such comparisons over multiple years allow stakeholders and reviewers to note trends in progress or areas of regression or stagnation.

G. Average length of time at current job

The Commonwealth's December 2015 report is the first in which detailed information is reported distinctly for Individual Supported Employment, Group Supported Employment, and Sheltered Work. The average length of time for individuals with ID at their current jobs through Individual Supported Employment is six years, with a range of zero to thirty-two years. Individuals with DD in Individual Supported Employment worked an average of three years. Further details are included in the independent consultant's report (Appendix E).

The Commonwealth expects that eighty-five percent of individuals will hold their jobs for at least twelve months. The Commonwealth has exceeded this expectation. Eight-eight percent of the individuals have worked at their jobs for one year or more in Individual Supported Employment and ninety-one percent of the individuals have held their jobs for one year or more in Group Supported Employment.

H. Earnings from Supported Employment

DBHDS collected information regarding wages and earnings (see Appendix E, pages 180-182 for details). Its data reflect information from ninety-three percent of all providers and eighty-nine percent of the providers who offer HCBS waiver funded services. The collected information also includes all of the data from DARS. This is significantly improved from previous data collection. DBHDS can now report on earnings and on the length of time individuals have been employed. It is positive that more individuals were employed in December 2015 than were in June 2015. There were 272 additional individuals engaged in Individual Supported Employment. Fewer individuals received Group Supported Employment. The sum total of individuals in supported employment increased by one hundred and fifty-four individuals.

It is very positive to have data that include all individuals with ID and DD who are employed, rather than data that are limited to only those individuals who are employed using HCBS waiver funded services. DBHDS now has more accurate information related to employment about both the ID and DD populations. It is encouraging that more individuals are employed and earning wages. However, it is a concern that more individuals are receiving pre-vocational services, which are typically provided in large congregate settings and which typically do not include regular activities in integrated community settings.

DBHDS is in compliance with *Section III.C.7.b.i.B.1.a, b, c, d, and e*

I. Setting and Achieving Employment Targets

The Commonwealth continues to use the goals it developed in March 2014 for the number of individuals who will be receiving Individual Supported Employment *through HCBS waiver-funded services*. The Commonwealth established a baseline of 204 individuals in Individual Supported Employment as of July 1, 2014. At that time, there were 677 individuals receiving waiver-funded Group Supported Employment. On December 31, 2015, the Commonwealth reported that 211 individuals who were receiving HCBS waiver-funded services were employed in Individual Supported Employment. (ISE) The number of individuals employed in ISE was approximately thirty-seven percent (37.1%) of the Commonwealth's target of 568 individuals as of July 1, 2015 and less than twenty-three percent (22.6%) of the target of 932 that was set for July 1, 2016.

The Commonwealth has revised its overall target for employment to include all of the eligible individuals with ID or DD and all of the employment options available through either DBHDS or DARS. To establish its target, DBHDS used the national average that twenty-five percent of individuals with ID and DD participate in employment services. By using the national average, the Commonwealth has significantly increased the overall targets for this larger group from 1661 to 3660 individuals by Fiscal Year 2019. The Commonwealth is on track to reach this target. As of December 2015, 3036 individuals are in either Independent Supported Employment or Group Supported Employment.

J. Individuals in Supported Employment

The Commonwealth's current goal is for eighty-five percent of the total number of individuals who are in Independent Supported Employment to remain employed for twelve or more months. As noted earlier, the Commonwealth has surpassed this expectation. Because the Commonwealth could not previously report accurately, it is not possible to know whether exceeding this target reflects recent progress.

The Commonwealth is falling far short of its employment targets for the number of individuals who receive HCBS waiver-funded services. It is making significant progress towards its targets for employment that includes all individuals with ID/DD who are receiving DARS and other funding sources.

Building the capacity of service providers will be critical to the success of meeting these targets. Provider capacity seems especially critical in Regions I, III and IV. These Regions, especially Region III, still provide a preponderance of services in large sheltered work congregate settings.

The Commonwealth is in non-compliance with *Section III.C.7.b.i.B.2.a* and is in compliance with *Section III.C.7.b.i.B.2.b*.

K. Regional Quality Councils

The Regional Quality Councils (RQCs) met quarterly during the first half of Fiscal Year 2016. The five RQCs each reviewed the number of individuals to be employed in 2015 and the length of time individuals maintained employment. The RQC's also reviewed the state's achievement in reaching these targets and the targets for Fiscal Years 2016 to 2019. The RQCs were also informed of the supplemental targets set for individuals' ISP teams to discuss employment options and to set

employment goals. All five Regions discussed the targets for the number of individuals employed and the barriers. All RQCs voted in favor of the multi-year target plan.

After Fiscal Year 2015 ended the five RQCs reviewed the number of individuals who are employed, the employment data regarding the target to maintain employment for twelve months, and the employment targets for future years. They voted to maintain the existing targets.

DBHDS is in compliance with *Sections III.C.7.c or III.C.7.d*

8. Community Living Options

The Independent Reviewer retained the same independent consultant who previously reviewed the status of Virginia's *Plan to Increase Independent Living Options* in November of 2013 and again in November of 2014. This consultant's previous reports are in the Appendices of the Individual Reviewer's third and fifth Reports to the Court. These Reports are posted under the Settlement Agreement tab of the DBHDS website.

The Commonwealth has again made significant progress with some of its housing initiatives. During this review period, there was progress documented in the desired outcome of providing individuals with a "home of one's own" with needed supports and services in place. Eighteen months ago, the Commonwealth was "making changes in its systems to move toward ..." providing subsidized housing. At that time, the changes primarily involved work on readiness activities and aspirational goals that might offer actual subsidized housing in two to three years. Since July of 2015, ninety-one more adults with ID/DD are now living in their own homes with rental assistance and are receiving in-home support services. In addition, the Commonwealth is commended for providing permanent rental assistance vouchers to the individuals who had previously received temporary rental assistance through the Commonwealth's Rental Choice VA program.

The consultant's review found that the Commonwealth had achieved positive outcomes. With an increase of ninety-one individuals living in their own homes, the Commonwealth is now supporting 434 target population members to live in homes of their own. The Commonwealth is ahead of its milestone goal that 393 adults in the I/DD system would be living in independent housing by June 2016. In addition, the Commonwealth has already exceeded its goal to create 126 new independent housing options by June 2017. This was achieved because of the ability and willingness of Virginia's Housing Development Authority (VDHA) and local Public Housing Authorities to designate 200 rent subsidies to provide housing options for the target population within an up-and-running state program. The VDHA also made adjustments to the Low Income Housing Tax Credit Program (LIHTC) to provide incentives for developers to offer subsidized rental units to individuals with ID/DD. DBHDS projects that these incentives contributed to developers being awarded tax credits for specific projects. These projects have the capability of yielding forty to seventy-five units, some of which will be ADA accessible for individuals with mobility impairments, in two to three years.

The Commonwealth has also begun several initiatives that will likely improve its ability to increase the pace at which it will be able to provide future independent living options. These include creating Housing Specialists for each Region, providing flexible funding to help individuals obtain and maintain housing; issuing an RFP to develop three model approaches, and providing on-line and training resources for case managers.

During the consultant's review of the status of the housing plan, he met with state housing and service officials and with local housing and service advocates. In almost every discussion, these officials and stakeholders identified the limited existing provider capacity to provide scattered site support services as a key systemic obstacle. Without this concern being addressed and resolved, most questioned the Commonwealth's ability to achieve future independent housing goals.

It is the consultant's and the Independent Reviewer's opinion that a strong provider system is the key element in the development of an array of integrated scattered site residential options. The Commonwealth has facilitated an additional ninety-one individuals to live in independent housing during the past nine months. This represents impressive progress, now reaching 434 individuals. The Commonwealth's goal is that 1,866 adults in the ID/DD system will live in homes of their own. This goal was established by applying the current national average for the number of adults with I/DD who live in their own homes, which is approximately ten percent of individuals with I/DD identified by state I/DD agencies. There were 343 adults with ID/DD living in such housing when the initiatives began. Through March 2016, the Commonwealth had facilitated ninety-one additional adults with a home of their own. This is 6.0% of the goal of an additional 1523 required to reach the goal of 1,866 adults with a subsidized home of their own by June 2021. Accomplishing this goal will require independent housing to be provided to an additional twenty-four individuals during each of the next sixty months compared with providing fewer than ten per month during the previous year.

There appears to be a consensus that, as DBHDS and the CSBs move to rapidly expand the independent housing program, the most significant barriers to progress will be the limited existing capacity of Virginia's service providers and the knowledge and preparation of case managers. Providing quality scattered site supports requires that providers develop and implement new program and business models. Staff turnover, staff training, staff supervision, emergency back up, and quality assurance take on more critical dimensions when the individuals served live in scattered sites. The development of new and additional provider capacity is critical to the Commonwealth's ability to sustain progress. The extent of the organizational changes that are needed, however, is more akin to developing a new industry to support scattered site housing for people with intellectual and developmental disabilities. The Commonwealth's HCBS waiver has provided incentives to provide congregate residential settings for individuals with average needs. As a result, while there are hundreds of ID and DD providers, there is a significant shortage of providers who serve individuals with intense medical and behavioral needs and service providers who provide supports to individuals in integrated settings.

The central role of the case manager is the second significant obstacle to sustaining an increased rate of providing independent housing. The case managers are very familiar with the historic and current default option of referring adults with ID to congregate residential options. In certain parts of Virginia, there is also good familiarity with the sponsored home option. To facilitate an adult with ID to live in his or her own home requires that case managers develop a new understanding of the providers that can "wrap services around" an individual who does not live in a provider owned group home. The service components to support an individual in independent housing are different from those required in congregate residential programs. In addition to arranging wrap around services, case managers will also need to understand both the local housing market and the landlords who are willing to partner with the program.

DBHDS has collaborated effectively with sister state agencies and with other organizations to achieve significant progress. With the commitment of the Commonwealth's housing agencies to set aside immediately available housing vouchers for members of the target population, DBHDS's housing team has facilitated coordination with local housing officials, landlords, in-home service providers, and case managers to coordinate the availability of subsidized housing with needed support services. The Commonwealth has successfully facilitated new subsidized housing and provided permanent rental assistance for those who participated in the one-time funded Rental Choice program.

The Independent Reviewer commends the Commonwealth for the achievement of the initial six percent of its independent housing outcome goal. The Commonwealth has taken steps, and has planned additional steps, that will likely increase the rate it facilitates the provision of independent housing units. To achieve compliance and accomplish its Independent Community Living Options goals, the Commonwealth must demonstrate that it can reach and maintain a higher pace of facilitating adults to move into homes of their own with rent subsidies and with needed supports. This will require that the Commonwealth address and resolve the current systemic obstacles to progress. These include provider capacity and case management, and doing so under the redesigned HCBS waivers.

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

The Commonwealth is in non-compliance with *Section III.D.2.*

9. Licensing and Investigations

The Commonwealth's primary system for regulating the conduct of service provider agencies is the Offices of Licensure Services (OLS) and Human Rights (OHR). The effective functioning of OLS and OHR in accordance with the requirements of the Agreement, therefore, is critical to the goal of improving the lives of people with intellectual and developmental disabilities in Virginia. The OLS system is also the primary compliance mechanism for Community Service Board (CSB) performance under their contracts with the Commonwealth for the Case Management function. To accomplish the case management monitoring responsibilities outlined in the Agreement, however, DBHDS implemented supplemental non-licensing strategies.

An independent consultant was retained to study the licensing and investigation provisions of the Agreement. The consultant's review assessed the quality of OHR and provider investigations of allegations of abuse and neglect and the effectiveness of the relationship between OLS and OHR. These two Offices operate in tandem to identify and address abuse and neglect. The review also assessed the coordination between DBHDS and DSS/APS/CPS (Department of Social Services/Adult Protective Services/Child Protective Services) when APS/CPS investigates allegations of abuse and neglect of individuals who live in settings funded by DBHDS. The review also evaluated DBHDS licensing and other strategies to ensure that case management services are of good quality, meet individuals' needs, and help each individual achieve positive outcomes.

DBHDS has taken a significant step forward in its development of a Data Warehouse, a central repository of data and data analytics from one or more disparate sources. Evidence of the capabilities of the Data Warehouse is present in data reports received for this review of OLS/OHR review.

A. Provider Licensing

DBHDS licensing regulations align generally, but not specifically, with the expectations in the Agreement. The DBHDS licensing protocols (checklists) align generally with the licensing regulations. Licensing Specialists interview staff and clients to assess both whether actual services have been provided and whether the expectations of the licensing regulations and the Agreement have been achieved. The interview process, however, is still unstructured. The lack of structure to these interviews leads to wide variation in what Licensing Specialists examine.

OLS revised its *Office Protocol*, which guides Licensing Specialists in their conduct of the overall work of Licensing, during this review period. The revised protocol continues the improvements to the 2015 version, in terms of the areas to be assessed (*Section V.D.3*) and the required monthly follow-up on Corrective Action Plans (CAPs) until the cited conditions are corrected.

OLS has completed a number of other improvement initiatives. It completed a business-mapping process, implemented enhanced training opportunities, and generated analytics from the Data Warehouse. OLS revised and streamlined its complaint process with the addition of a fillable form suitable for emailing in to DBHDS (although it is difficult to find on the webpage). During 2015, twenty-one ID provider agencies had officially closed one or more licensed but underused or underperforming sites.

OLS sustained its practice of providing increased frequency of unannounced and more frequent licensing inspections.

The review of a sample of ad hoc OLS investigations suggests that Licensing Specialists give appropriate attention to detail and to fact gathering. Investigations that reveal regulatory compliance problems may evolve into Corrective Action Plan requirements of the provider. If so, Licensing Specialists verify and follow-up within forty-five days. In a study of case management services, the independent consultant found that too few investigations find regulatory violations (e.g. 100 reviews of case management records without identifying even one documentation deficiency).

During 2015, OLS placed only one ID provider on provisional status. This is fewer than the seven placed on provisional status in 2014. Further, one provider, who had been placed on provisional status for six months in 2014, received critical reviews in December 2015 and in January 2016 for a number of repeat citations. This provider was also cited for “systemic non-compliance.” As of March 2016, this provider was not placed on provisional status and further sanctions had not been applied. Another service provider, already on provisional status, was cited for numerous financial irregularities (e.g. issuing checks for staff payroll while knowingly having insufficient funds, etc.). There were no additional consequences beyond another CAP. This provider was removed from provisional status soon after these citations, but was subsequently cited for repeat violations. Following these latter citations, this provider was not placed on provisional status, was not otherwise sanctioned, and is not listed on the roster of “closed” agencies. Individuals with ID/DD are put at increased risk when providers are not required to correct deficiencies.

Although OLS has not regularly compiled the results of licensing reviews, reported trends or analyzed patterns across providers, it now has access to the information to do so. Information to complete such reports is now accessible through the Data Warehouse. Detecting and reporting patterns and frequencies in the results of licensing reviews across Regions, agencies and services will

help ensure that system improvements are discovered. It will also become a continuing source of information for the identification of needed guidance instructions, alerts, trainings, etc.

B. Rules and Regulations for Licensing Providers

The Independent Reviewer has reported frequently that where the Commonwealth's Licensing regulations do not align specifically with the Agreement, they impede its ability to comply with many provisions of the Agreement. The Independent Reviewer reported in his second Report to the Court that the Commonwealth's:

“regulations are reported to set low standards, to be broadly written, to be too vague to be effectively enforced, and to have not kept up with changes in the field of practice.”

The Commonwealth has acknowledged the need to revise its regulations to comply with the Agreement. The Independent Reviewer's consultant reviewed the draft revisions, which DBHDS proposed in June 11, 2015. The Commonwealth reports that it is revising these draft regulations further to ensure that the revisions address all issues associated with the effective implementation of the Quality and Risk Management provisions of the Agreement.

As reported previously and as detailed in the consultant's attached report (Appendix G), OLS appears to have the necessary regulatory tools to require improvements among substandard providers and to eliminate substandard providers who have demonstrated an inability or refusal to improve their services. The use of provisional status with only one provider and the notable and continued failure to use the other half dozen sanction tools suggest that an increased emphasis on the enforcement of regulations is necessary.

Based on this review of OLS, DBHDS does not have evidence at the policy level that OLS is identifying systemic patterns of compliance problems with the Agreement, including its “data and assessments” across the eight domains at Section V.D.3.

The Commonwealth continues to be in compliance with *Section V.G.1. and 2.*
The Commonwealth is in non-compliance with the requirements of *Section V.G.3.*

C. Abuse and Neglect Investigations

OHR receives all initial reports of abuse or neglect in community settings through the CHRIS (Computerized Human Rights Information System) electronic incident reporting system. OHR then triages what type of investigation of abuse and neglect is warranted. DBHDS expects investigation of all substantive allegations. Some incidents may be forwarded to OLS for their investigation or for a joint investigation. Providers complete the largest share of these investigations. OHR reviews these investigations to confirm details and to identify if any components are missing before closing the reports. Summaries of the provider investigations are then entered into the Abuse Allegation Report (AAR) database. This electronic AAR database is not always complete. OHR has implemented quality improvements. Resources and additional strategies have been established. These include assignment of a quality improvement staffer who will audit both the electronic AAR database and samples of provider reports. These changes hold promise to positively impact OHR records. OHR is currently dependent on the quality of the AAR database to identify needed systemic

improvements. The usefulness of the AAR database is also dependent on the integrity of providers for the content of investigation reports and for the extent of the investigations.

The Independent Reviewer's consultant reviewed twenty-seven investigation reports that were jointly completed by OLS and OHR in 2015. The consultant found that OHR may forward incidents to OLS for investigation of allegations of abuse and neglect. OLS is authorized by Virginia's statute to determine violations of regulations and to require that providers implement Corrective Action Plans. The independent consultant found an apparently effective collaboration between OLS and OHR at the field and at the policy level.

OHR added a new quarterly sampling process to its *Protocols, Procedures and Practices Manual*. Through this process, OHR and OHR field staff will "look behind" a ten percent sample of closed provider investigations. OHR will compare their timeliness and content to OHR expectations. OHR expects that this "look behind" review process will identify areas where training or follow-up assistance is warranted in order to improve the investigative results that providers report to OHR. This is a positive quality improvement step for OHR. This step should result in actions taken that improve outcomes.

OLS cited twenty ID providers during 2015 for "late reporting" (i.e. longer than 24 hours); six of these providers (30%) had been cited for "late reporting" during the previous three years. Beyond Corrective Action Plans, there appear to have been no enforcement actions taken as a result of these repeat citations. However, the Independent Reviewer has found an improvement in timely reporting through his review of CHRIS reports for individuals who have moved from Training Centers. In addition, during FY 2014, fifty-eight provider agencies were cited for late reporting, suggesting a systemic improvement in timely reporting. DBHDS monitors and reports on the timeline for submissions. DBHDS documented that service providers submitted ninety percent of CHRIS reports within the requisite twenty-four hours following a reportable incident.

The consultant's review determined that the investigation linkages between DBHDS and DSS appear healthy and continuous. DSS Adult/Child Protective Services accepted forty-seven investigations from OLS/OHR. Providers are consistently reminded by OLS and OHR to fulfill their obligations to report all incidents of potential abuse or neglect to DSS Adult or Child Protective Services. Communication was found to have occurred between these entities. A lack of communication, although it may occur in some individual cases, does not appear to be a systemic issue affecting the functioning of DBHDS.

Some OLS investigations of the deaths have not been completed in a timely manner and have not always included a review of the ISP and the case manager's notes. This indicates that death reviews may be incomplete and may overlook significant events surrounding an individual's death.

DBHDS has significantly improved timely reporting through its CHRIS electronic web-based incident reporting system.

DBHDS is in compliance with *Section V.C.2*.

DBHDS is moving toward, but remains in non-compliance with the investigational requirements at *Section V.C.3*. Progress is evident in improved timely reporting and in OLS monitoring implementation of CAPs. OLS investigations (except investigations into the deaths of individuals

who have moved from Training Centers) have also shown improved attention to detail, fact gathering and the development of related Corrective Action Plans. However, OLS is still not taking appropriate follow-up actions when a provider fails to implement Corrective Action Plans.

DBHDS has achieved compliance with *Section V.C.2.* regarding “timely reporting.”

DBHDS is in non-compliance with the requirements of *Section V.C.6.* to “take appropriate action” when action is needed beyond Corrective Action Plans.

IV. CONCLUSION

The Independent Reviewer reported previously to the Court that the Commonwealth would remain in non-compliance with many of the core provisions of the Agreement until it:

- effectively implemented its primary strategy to come into compliance and
- revised its regulations to align specifically with the requirements of the Agreement.

The Commonwealth’s primary strategy is the redesign of its HCBS waiver programs. During this review period, the General Assembly approved the redesigned HCBS waiver programs and most of the additional funds requested to implement the redesign. Implementation is an immense undertaking. It will require broad systemic, service and program changes. It will also require the development of new provider capacity and program development throughout the state.

The Commonwealth recognizes that revisions to its regulations are required. Revisions are needed to make further progress toward achieving compliance with many of the Agreement’s provisions. These include provisions related to quality management, risk management, data to assess and improve quality, quality improvement programs, provider investigations, competency-based training, case management, and licensing. These areas are central to achieving the overarching quality and risk management systems and the quality outcomes described in the Agreement. Well functioning quality and risk management systems and programs are especially critical during periods of change. Beginning in the next review period and continuing for at least the next two years, new programs will be developed, recently developed programs will be refined, and existing programs will be restructured to operate in accordance with the redesigned HCBS waiver programs and to achieve compliance with the provisions of the Agreement. It is essential that the Commonwealth revise its regulations as soon as possible, so that they align specifically with the requirements of the Agreement. Doing so will allow the Commonwealth and providers, throughout the period of implementation of the redesigned waiver program, to collect data, to identify and to address areas of concern, unintended consequences and risks of harm.

It is the considered opinion of the Independent Reviewer that the Commonwealth has far too few service providers and qualified professionals available to meet the needs of the target population. Almost all stakeholders, at all levels of the system and in all geographic areas, identify the lack of adequate provider capacity as a major obstacle. The Commonwealth needs to significantly increase the number of providers with the expertise and experience to provide services to individuals with intense behavioral and medical needs, to individuals with Autism Spectrum Disorders, or to provide such services in integrated settings. The Commonwealth recognizes the need to build new provider capacity and to facilitate the conversion of existing provider capacity. It has taken important steps, and plans to take additional steps, to develop additional capacity to serve individuals with intense

behavioral and those with medical needs in the community. The planned initiative will also expand its ability to serve individuals in community-based living arrangements and day activity programs in integrated settings. These plans, however, are currently targeted to specific geographic areas and to only a small percent of the current providers. Building sufficient provider capacity is one of the Commonwealth's most significant challenges as it implements the redesigned waiver programs.

Two recent studies by the Office of the State Inspector General underscored the consequences of the lack of adequate community-based services for individual with behavioral needs. These studies documented increased admissions of children and adults with intellectual and developmental disabilities to state operated psychiatric facilities. The OSIG reports include descriptions of the disadvantages of individual with ID/DD receiving services in these facilities and that many individuals who are ready for discharge from them cannot be transitioned to community-based services because needed programs are not available.

During the eighth review period, the Commonwealth through its lead agencies, DBHDS and DMAS, and their sister agencies has maintained compliance with provisions that it had previously achieved. It received a new rating of compliance with requirement for timely reporting of incidents by providers, for improved employment data collection and review, and for facilitating access to subsidized independent living options. It lost a compliance rating as a result of the first qualitative review of the Commonwealth's capacity to meet the needs of individuals with intense behavioral needs and for stays in its Crisis Stabilization programs in each Region that exceed the thirty-day maximum allowed. It continued to be in non-compliance with many provisions. These include discharge planning and transition of children from private institutional settings (nursing facilities and large ICF/IDDs), the lack of sufficient community integration opportunities in day services and living options, the lack of ISPs that promote skill development and increased self sufficiency, the lack of sufficient community-based Crisis Stabilization programs for adults and children in each region, and the lack of a fully functioning statewide crisis services system for children.

The Commonwealth and the Department of Justice have successfully negotiated four outcome timelines provisions, which, as written in the Agreement, lacked specificity, measurable outcomes and due dates. The categories are: Integrated Day Activities, Supported Employment, and Crisis Services for Children and Adults. The parties are currently negotiating outcome timelines for several additional topic areas of the Agreement. These included children who are now being raised in nursing facilities and large Intermediate Care Facilities, Quality and Risk Management, integrated housing, and supports for individuals with intense behavioral and medical needs.

The Commonwealth's leaders are pleased to have the opportunity to begin implementation of its redesigned HCBS waiver programs during the upcoming ninth review period. Furthermore, they express strong commitment to the implementation of new services, of system reforms, and of initiatives to develop the capacity needed to achieve compliance. To achieve desired outcomes, the Commonwealth must coordinate and manage a major system reform. A immense effort will be required at all levels of the system and in all geographic areas. The Commonwealth's regulations should be revised as soon as possible. Only with a fully developed quality and risk management system will the Commonwealth fulfill the requirements of the Agreement and its promises to all Virginians, especially those with intellectual and developmental disabilities and their families.

V. RECOMMENDATIONS

The Independent Reviewer's recommendations to the Commonwealth 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, 2016. The Commonwealth should also consider the recommendations and suggestions included in the consultants' reports included in the Appendix. The Independent Reviewer will study the implementation and impact of these recommendations during the tenth review period (October 7, 2016 –April 6, 2017).

Transition of Children from Nursing Facilities and Large ICFs

1. The Commonwealth should ensure that the CSB case manager, Community Resource Consultant, and Regional Support Teams are involved
 - before the non-emergency long-term admission of a child or adult with ID/DD to a nursing facility, large ICF, or other medical care facility, and
 - during each individual's stay to actively participate in the development of discharge and transitions plans to integrated settings that are appropriate to meet the individual and consistent with the individual's/Authorized Representative's informed choice.

The Commonwealth's process should ensure the identification, documentation, and resolution of barriers to placements in appropriate integrated community-based setting.

Individual and Family Supports Program

2. The Commonwealth should develop an overall strategic plan, with a clear vision and mission, for its individual and family supports program. The basis of the strategic plan should be a thorough assessment of needs, resources, and opportunities. The Commonwealth should develop the plan with individuals and families, who will be at the center of comprehensiveness and coordination. The plan should include indicators of expected performance and outcomes related to access, comprehensiveness and coordination of individual and family supports.

Case Management

2. DBHDS staff should evaluate and supplement the orientation and training of CSB and private case managers in order to effectively implement the redesigned waiver programs. Case managers should be taught: to assist individuals and families to understand new service models and to recommend providers who are willing, able, and available to provide integrated day activities, integrated housing, and wrap-around services for in-home and independent community living options.
3. DBHDS should enhance its systems to monitor and to improve CSB case management performance to ensure compliance with the Commonwealth's standards and with the requirements of the Agreement. The monitoring methods used should include tools so that the Commonwealth can hold CSBs and private case managers accountable for acceptable performance. For the CSB supervisory record audits, DBHDS should establish standards and a model tool that address timeliness, format, and quality of content.

4. The Commonwealth should develop measurable criteria for the ISP goals related to Health and Well Being, Community Inclusion, Skill Development, and Choice and Self-determination.

Crisis Services and Behavioral Capacity

5. The Commonwealth should assess and determine the need for additional crisis stabilization programs for children and for adults *in each Region*. The Commonwealth should report quarterly to the Independent Reviewer the number of individuals whose stays exceeded the Agreement's 30-day stay maximum. Discharge planning should begin upon admission for any individual admitted without an identified place of residence for discharge. The Commonwealth should provide to the Independent Reviewer a discharge record and a current discharge and transition plan within two weeks for any individual whose stay exceeds 30 days. The discharge plan should document the barriers, including the availability of emergency housing, that prevents the individual from timely transition to an integrated setting appropriate to the individual's needs.
6. The Commonwealth should establish statewide expectations for the REACH crisis services training of family members, other caregivers, and law enforcement officers. DBHDS should report how it monitors this training, including that conducted for all CSB Case Managers, Emergency Services staff and REACH staff who complete and pass the required training.
7. DBHDS should report the findings of its quarterly crisis services qualitative reviews and its analysis of whether the Commonwealth's performance indicators for the qualitative aspects of this provisions have been achieved.
8. DBHDS should assess and determine the need to develop additional community-based provider capacity to deliver needed behavioral support services in each Region. This assessment should include the capacity and geographic distribution needed to prevent unnecessary admissions of children and adults to both public and private psychiatric facilities. It should also determine the capacity needed to ensure that individuals with ID/DD, including Autism Spectrum Disorders, are able to be discharged to integrated community-based settings when they are ready to transition to the community. The behavioral supports should be available to provide needed in-home support and community residential options throughout all five Regions, and should meet accepted professional standards and the Commonwealth's behavioral competencies.

Integrated Day Activities

9. The Commonwealth should establish baseline data, develop targets for the number and distribution of providers, and performance indicators for the provisions of Integrated Day Activities. The Commonwealth should implement a statewide training plan with the assistance of the Community Engagement Advisory Group.

Supported Employment

10. The Commonwealth should require all Employment Service Organizations to provide employment data for the individuals with ID/DD whom these organizations support.
11. The Commonwealth should establish performance indicators for the effective implementation of its Employment First Policy by CSBs. These indicators should allow the determination of whether “employment services and goals were *developed and discussed* at least annually through a person-centered planning process and included in ISPs”. The Commonwealth should identify how it will ensure that CSB’s consistently submit reliable data that will allow the Commonwealth to determine whether the qualitative aspects of the Employment First Policy are being effectively implemented.

Provider Capacity

12. DBHDS should assess, determine the need for, and identify the priority program and clinical areas for further development of provider capacity. The Commonwealth should specifically determine the additional provider capacity needed to serve individuals with intense medical needs and to provide such services in integrated settings including in-home services.

Licensing and Investigations

13. The Commonwealth should create a supplement to the Office of Licensure Services case management checklist to operationalize the expectations of the Agreement. This supplement should be outcome-focused (versus documentation-focused) and specifically include probes of: identifying risks to the individual, offering choice among providers, assembling professionals and non-professionals who provide supports, monitoring to make timely referrals (especially regarding changes in health status), and modifying the ISP when needed.

I. APPENDICES

- A. INDIVIDUAL SERVICES REVIEWS**
- B. INDIVIDUAL AND FAMILY SUPPORT PROGRAM**
- C. CASE MANAGEMENT**
- D. CRISIS SERVICES REQUIREMENTS**
- E. INTEGRATED DAY ACTIVITIES - SUPPORTED EMPLOYMENT**
- F. INDEPENDENT HOUSING**
- G. LICENSING AND INVESTIGATIONS**
- H. LIST OF ACRPONYMS**

APPENDIX A.

INDIVIDUAL SERVICES REVIEWS

October 7, 2015 - April 6, 2016

Completed by:

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Demographic Information

Sex	n	%
Male	17	68.0%
Female	8	32.0%

Age ranges	n	%
Under 3	3	12.0%
3 to 6	1	4.0%
7 to 12	3	12.0%
13 to 18	14	56.0%
19 to 21	4	16.0%

Levels of Mobility	n	%
Carried by adult	1	4.0%
Crawls	1	4.0%
Walks without support	8	32.0%
Walks with support	4	16.0%
Total assistance with walking	0	0.0%
Uses wheelchair	11	44.0%
Confined to bed	0	0.0%

Relationship with Authorized Representative	n	%
Parent or Sibling	22	91.7%
Public Guardian	2	8.3%

Type of Residence	n	%
Own/family home	4	16.0%
Sponsored home	0	0.0%
Supported apartment	0	0.0%
Group home	3	12.0%
Psychiatric facility	0	0.0%
Nursing facility	10	40.0%
Rehabilitation facility	0	0.0%
Large ICF/ID	8	32.0%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	3	12.0%
Limited spoken language, needs some staff support	1	4.0%
Communication device	0	0.0%
Gestures	7	28.0%
Vocalizations	11	44.0%
Facial expressions	3	12.0%
Other	0	0.0%

Individual Support Plan - POSITIVE OUTCOMES								
Individual Support Plan	Large Facility Sample				Community Home Sample			
Item	n	Y	N	CND	n	Y	N	CND
Is the Individual's Support Plan/Plan of Care/ Individual Program Plan current?	18	100%	0.0%	0.0%	7	100%	0.0%	0.0%
Is there evidence of person-centered (i.e. individualized) planning in the development of the Individual's Support Plan/Plan of Care/Individual Program Plan?	18	100%	0.0%	0.0%	7	85.7%	14.3%	0.0%
Is the support staff present, knowledgeable and able to assist the individual to use the adaptive equipment?	17	100%	0.0%	0.0%	3	100%	0.0%	0.0%
Is the individual receiving supports/specialized services identified in his/her Individual Support Plan/Plan of Care/Individual Program Plan?								
Medical	18	100%	0.0%	0.0%	7	100%	0.0%	0.0%
Psychiatry	4	100%	0.0%	0.0%	4	100%	0.0%	0.0%
Is there evidence the family or support person has been trained on the desired outcome and support activities of the Individual's Support Plan/Plan of Care/Individual Program Plan?	18	100%	0.0%	0.0%	7	100%	0.0%	0.0%
If a Residential provider's home, nursing home or ICF/IID, is residential staff able to describe the individual's likes and dislikes?	18	94.4%	5.6%	0.0%	3	100%	0.0%	0.0%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	18	100%	0.0%	0.0%	2	100%	0.0%	0.0%

Individual Support Plan - AREAS OF CONCERN								
Individual Support Plan	Large Facility Sample				Community Home Sample			
Item	n	Y	N	CND	n	Y	N	CND
d. If an ICF/IID or nursing home placement, is there evidence of discharge planning?	18	5.6%	94.4%	0.0%	0			
Does the Individual's Support Plan/Plan of Care/Individual Program Plan have specific and measurable outcomes and support activities?	18	5.6%	94.4%	0.0%	7	14.3%	85.7%	0.0%
Is the individual receiving supports/specialized services identified in his/her Individual Support Plan/Plan of Care/Individual Program Plan?								
Dental	16	75.0%	25.0%	0.0%	7	71.4%	28.6%	0.0%
Behavioral Supports	8	62.5%	37.5%	0.0%	5	20.0%	80.0%	0.0%
INTEGRATION ITEMS								
Was it documented that the individual and, as applicable, his/her Authorized Representative, were facilitated to have conversations and meetings with individuals currently living in the community and their families?	18	0.0%	100%	0.0%	3	0.0%	100%	0.0%
If applicable, were employment goals and supports developed and discussed?	5	0.0%	100%	0.0%	3	0.0%	100%	0.0%
If no, were integrated day opportunities offered	5	0.0%	100%	0.0%	3	0.0%	100%	0.0%
Regardless of age, does typical day include regular integrated activities	17	0.0%	100%	0.0%	6	33.3%	66.7%	0.0%
Do you have ongoing opportunities to interact socially or build friendships with other individuals who are not paid to serve you?	17	17.6%	58.8%	23.5%	7	28.6%	28.6%	42.9%
If not living with your family, have you met your neighbors?	18	0.0%	100%	0.0%	4	50.0%	50.0%	0.0%
If not living with your family, do you have opportunities to meet your neighbors	18	0.0%	100%	0.0%	4	75.0%	25.0%	0.0%
If living in a congregate setting with a group of individuals with disabilities, do you go into the community <u>primarily</u> with your housemates as a group?	17	100%	0.0%	0.0%	3	100%	0.0%	0.0%

Individual Support Plan – AREAS OF CONCERN								
Individual Support Plan	Large Facility Sample				Community Home Sample			
Item	n	Y	N	CND	n	Y	N	CND
Do you belong to any community clubs or organizations?	17	0.0%	100%	0.0%	7	0.0%	100%	0.0%
Do you participate in integrated community volunteer activities?	17	0.0%	100%	0.0%	7	0.0%	100%	0.0%
Do you participate in integrated community recreational activities?	17	5.9%	94.1%	0.0%	7	14.3%	85.7%	0.0%
Do you participate in grocery shopping?	17	0.0%	100%	0.0%	7	57.1%	42.9%	0.0%
Do you participate in buying your clothes?	17	29.4%	70.6%	0.0%	7	42.9%	57.1%	0.0%
BEHAVIOR ITEMS								
Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others?	18	22.2%	77.8%	0.0%	7	71.4%	28.6%	0.0%
Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment?	18	5.6%	94.4%	0.0%	7	57.1%	42.9%	0.0%
Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, etc.)?	18	5.6%	94.4%	0.0%	7	42.9%	57.1%	0.0%
Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills?	18	0.0%	100.0%	0.0%	7	57.1%	42.9%	0.0%
Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence?	18	11.1%	88.9%	0.0%	7	57.1%	42.9%	0.0%
If Yes, is there a written plan to address the behavior?	2	50.0%	50.0%	0.0%	4	0.0%	100%	0.0%

Individual Support Plan - Comparisons								
Individual Support Plan	POSITIVE OUTCOMES				AREAS OF CONCERN			
	Large Facility Sample				Community Home Sample			
	Item	n	Y	N	CND	n	Y	N
Does the individual require adaptive equipment?	18	88.9%	11.1%	0.0%	7	57.1%	42.9%	0.0%
If yes, is the equipment available?	16	100%	0.0%		4	50.0%	50.0%	0.0%
If no, has it been ordered?	0				2	0.0%	50.0%	50.0%
If available, is the equipment in good repair and functioning properly?	16	100%	0.0%		4	75.0%	25.0%	0.0%
Is the individual receiving supports/specialized services identified in his/her Individual Support Plan/Plan of Care/Individual Program Plan?								
Residential	18	100%	0.0%	0.0%	7	71.4%	28.6%	0.0%
Health	18	100%	0.0%	0.0%	6	50.0%	50.0%	0.0%
Is the individual refusing any of the above supports?	18	0.0%	100%	0.0%	7	42.9%	57.1%	0.0%
If yes, is the team addressing this issue?	0				3	0.0%	100%	0.0%
Do you have problems with transportation?	18	0.0%	100%	0.0%	7	28.6%	71.4%	0.0%

Individual Support Plan - Comparisons								
Individual Support Plan	AREAS OF CONCERN				POSITIVE OUTCOMES			
	Large Facility Sample				Community Home Sample			
	Item	n	Y	N	CND	n	Y	N
Is the individual receiving supports/specialized services identified in his/her Individual Support Plan/Plan of Care/Individual Program Plan?								
Recreation	18	66.7%	33.3%	0.0%	7	100%	0.0%	0.0%
Is residential staff able to describe the individual's talents/contributions, preferences and weaknesses?	18	72.2%	27.8%	0.0%	3	100%	0.0%	0.0%
Within the last quarter, have you participated in community outings on a consistent weekly basis?	17	29.4%	70.6%	0.0%	7	85.7%	14.3%	0.0%

Health Care – POSITIVE OUTCOMES								
Health Care	Large Facility Sample				Community Home Sample			
Item	n	Y	N	CND	n	Y	N	CND
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	18	100%	0.0%	0.0%	7	100%	0.0%	0.0%
If ordered by a physician, was there a current physical therapy assessment?	16	100%	0.0%	0.0%	2	100%	0.0%	0.0%
If ordered by a physician, was there a current speech and language assessment?	11	100%	0.0%	0.0%	2	100%	0.0%	0.0%
Is lab work completed as ordered by the physician?	18	100%	0.0%	0.0%	2	100%	0.0%	0.0%
Does the provider monitor fluid intake, if applicable per the physician's orders?	18	100%	0.0%	0.0%	3	100%	0.0%	0.0%
Does the provider monitor food intake, if applicable per the physician's orders?	8	100%	0.0%	0.0%	2	100%	0.0%	0.0%
Does the provider monitor tube feedings, if applicable per the physician's orders?	12	100%	0.0%	0.0%	2	100%	0.0%	0.0%
Does the provider monitor seizures, if applicable per the physician's orders?	13	100%	0.0%	0.0%	2	100%	0.0%	0.0%
Does the provider monitor weight fluctuations, if applicable per the physician's orders?	18	100%	0.0%	0.0%	4	100%	0.0%	0.0%
Does the provider monitor bowel movements, if applicable per the physician's orders?	18	100%	0.0%	0.0%	3	100%	0.0%	0.0%

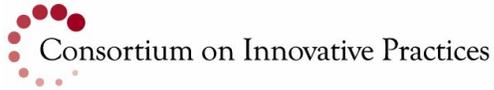
Health Care – AREAS OF CONCERN								
Health Care	Large Facility Sample				Community Home Sample			
Item	n	Y	N	CND	n	Y	N	CND
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	16	75.0%	25.0%	0.0%	7	71.4%	28.6%	0.0%
Are there needed assessments that were not recommended?	18	11.1%	88.9%	0.0%	7	57.1%	42.9%	0.0%
If ordered by a physician, was there a current nutritional assessment?	16	87.5%	12.5%	0.0%	2	0.0%	100%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	16	87.5%	12.5%	0.0%	5	60.0%	40.0%	0.0%
If the individual receive psychotropic medication?								
Is there documentation of the intended effects and side effects of the medication?	9	66.7%	33.3%	0.0%	4	50.0%	50.0%	0.0%
Is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	9	66.7%	33.3%	0.0%	4	50.0%	50.0%	0.0%
Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?	6	66.7%	33.3%	0.0%	3	33.3%	66.7%	0.0%
Is there documentation of the intended effects and side effects of the medication?	9	66.7%	33.3%	0.0%	4	50.0%	50.0%	0.0%

Health Care – Comparisons								
Health Care	Large Facility Sample				Community Home Sample			
	POSITIVE OUTCOMES				AREAS OF CONCERN			
Item	n	Y	N	CND	n	Y	N	CND
If ordered by a physician, was there a current occupational therapy assessment?	15	100%	0.0%	0.0%	3	66.7%	33.3%	0.0%
If ordered by a physician, was there a current psychological assessment?	7	100%	0.0%	0.0%	6	66.7%	33.3%	0.0%
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?								
OT	11	100%	0.0%	0.0%	4	75.0%	25.0%	0.0%
PT	12	91.7%	8.3%	0.0%	3	66.7%	33.3%	0.0%
Speech/Language	8	100%	0.0%	0.0%	4	75.0%	25.0%	0.0%
Nutrition	18	100%	0.0%	0.0%	4	25.0%	75.0%	0.0%
Psychology	8	100%	0.0%	0.0%	5	40.0%	60.0%	0.0%
Were the Attending or Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the Attending Physician or PCP?	18	100%	0.0%	0.0%	5	60.0%	40.0%	0.0%
Is there evidence of a nourishing and healthy diet?	18	100%	0.0%	0.0%	7	85.7%	14.3%	0.0%
If receiving psychotropic medication, do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	9	100%	0.0%	0.0%	4	25.0%	75.0%	0.0%
Is there any evidence of administering excessive or unnecessary medication(s), including psychotropic medication?	18	0.0%	100%	0.0%	7	14.3%	85.7%	0.0%

APPENDIX B.

INDIVIDUAL AND FAMILY SUPPORT PROGRAM

By: Rebecca Wright MSW, LCSW



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

INDIVIDUAL AND FAMILY SUPPORTS

By

Rebecca Wright, MSW, LCSW
Consortium on Innovative Practices

April 20, 2015

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 Independent Reviewer's sixth Report to the Court, dated June 6, 2015, found the Commonwealth had not met the qualitative requirements for the IFSP. 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. This reviewer documented in the IFSP study, included with the Independent Reviewer's sixth Report (June 6, 2015) that the Department of Behavioral Health and Developmental Services (DBHDS) had acknowledged its awareness of the issues that resulted in the non-compliance ratings. At that time, DBHDS reported that its Director of Administrative and Community Operations was leading a task force to address many of them. The sixth report included recommendations to DBHDS for its consideration as it developed strategies that may lead to compliance. These included:

1. Develop and implement a formalized and ongoing avenue for stakeholder input to help to guide the evolution of individual and family support program as a person- and family-centered comprehensive and coordinated set of strategies in the Commonwealth, and of the IFSP in particular as a part of that overall set of strategies.
2. An overall strategic plan for individual and family supports should be developed through an inclusive stakeholder planning process.
3. The definition of "most at risk for institutionalization" should be fully explored with stakeholders in the process of strategic planning.
4. The roles of case management should be examined. Expectations of case managers should be clearly defined as they relate to facilitating access to individual and family supports and to the IFSP in particular. Case managers should ensure coordination with other services and supports for individuals on the ID and IFSDD waiting lists.
5. DBHDS should develop and disseminate an individual- and family-friendly guide to the IFSP and the application process. The guide should provide a level of detail, accuracy and accessibility to be effectively used by individuals in the target population and their families to access the correct point of entry to needed services. The guide should be updated as programmatic modifications occur that might affect eligibility, dates, supports available, etc.

6. Guidelines that DBHDS publishes for families seeking services should be designed to assist individuals/families: who are not yet aware of how to seek HCBS waiver services, who have applied for services, and whose names are on waitlists. The DBHDS guidelines should also be for those who have been awarded a waiver slot and their families.
7. The Commonwealth should include the agencies that an individual/family is likely to contact initially when a child is first diagnosed with a significant disability or when an individual is new to the Commonwealth. These include agencies such as hospital neonatal intensive care units, pediatrician organizations, and public school special education programs.
8. DBHDS should identify indicators to adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports. It should also develop measures of the impact on the risk of institutionalization and the capacity for collection and analysis of the needed data.

For the Report to the Court, due June 6, 2016, the Independent Reviewer's monitoring priorities again included studying the Commonwealth's compliance with the qualitative aspects of its IFSP. DBHDS informed the Independent Reviewer that its IFSP would not be completed during this review period. This study, therefore, focused primarily on whether the IFSP under development is designed and planned to include requisite elements that address the related Agreement criteria. The study findings and recommendations from the Independent Reviewer's sixth Report, as outlined above, served as a basis for evaluating progress achieved since that time as well as the potential efficacy of the planned IFSP toward achieving future compliance. In addition, the study evaluated whether the Commonwealth has complied with the quantitative requirement to support a minimum of 1000 individuals during Fiscal Year 2016. This study also reports the substantive modifications that DBHDS has made to the current IFSP on an interim basis and any related outcomes.

Over the last year, DBHDS has engaged in a number of activities for the purposes of both enhancing its current IFSP funding process and re-designing its approach to providing a comprehensive and coordinated set of strategies, as the Settlement Agreement requires. Much of the latter work has been done under the auspices of the New Individual and Family Design Advisory Committee (NIDAC.) At this time, however, a determination as to the likelihood of compliance with the qualitative requirements of the Settlement Agreement is not yet possible. The Commonwealth had not yet laid out a clear plan that is likely to lead to compliance with any of these requirements. The Commonwealth's proposed design lacks specificity. The plan has been presented largely in very broad strokes. The plan still lacks significant stakeholder support. The planning process itself, while commendable in its intent, has not been as robust as necessary to achieve a well-laid out plan. Many critical details have not yet been addressed. Most NIDAC members and interested attendees who were interviewed also expressed opinions that supported this finding. At the time of this study, the planning process was still ongoing.

Overall, the new IFSP, as currently planned, does not include adequate design or program evaluation strategies to be able to achieve the overall goal of a comprehensive and coordinated set of strategies 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. The NIDAC planning workgroup that was charged to assist with this design was presented with a model that would place significant decision-making power in the hands of the individuals and families being served. The model utilizes regional organizations with advisory boards comprised of at least a majority of individuals and families being served. The primary roles of these regional organizations would be to set funding criteria, to work within their communities to coordinate other existing resources, and to develop additional financial and in-kind support. DBHDS has also requested funding above and beyond the IFSP allocation to provide for staffing for each region. At the time of this report, there remained many unresolved issues as to how this model would be implemented, and, to some extent, whether it would be an effective approach for Commonwealth. For example, while DBHDS staff indicated that the proposed regional organizations would make local decisions regarding criteria for determining who is “most at risk for institutionalization”. NIDAC members indicated that this responsibility had not yet been discussed.

It was commendable that DBHDS had engaged stakeholders in its efforts to re-design its IFSP. DBHDS staff are enthusiastic about the future of individual and family supports in the Commonwealth and are eager to put a more “family-friendly” model in place. While it is important to maintain momentum toward developing an approach that would achieve a comprehensive and coordinated set of strategies, a significant amount of work remains. DBHDS must continue to engage stakeholders in a broad and meaningful conversation about what approach will work well within Virginia’s service system and unique circumstances. There is no need to “reinvent the wheel,” as several DBHDS staff suggested. There is much to learn from the experiences of other states. DBHDS should be cautious, however, not to be over-reliant on other states’ experiences as a means for ensuring solutions for Virginia’s circumstances.

There were two themes that emerged from stakeholder interviews related to this point. In the first, NIDAC members almost universally expressed concern that individuals and families were being asked to take on additional responsibilities for fund-raising and coordination when their time and energies were so often consumed with managing their own and their family members extraordinary needs. The intent to empower individuals and families with decision-making authority is admirable. Being empowered with decision-making authority is consistent with the principles of individual and family support and has been successful in other programs. The question remains, however, whether the individuals and families in the Commonwealth believe that this approach will be effective for them in their circumstances or for Virginia’s. Many reported a second theme. Rather than creating new regional organizations, as was done in the

other states', would it be more effective for Virginia, to use existing nonprofit agencies to host the proposed regional organizations? DBHDS staff expressed strong negative opinions about whether such an approach was wise. Getting to the "right" answer will require a careful examination of the advantages and disadvantages.

Overall, additional planning and deliberation with stakeholders are needed to effectively address the requirements of the Settlement Agreement. DBHDS should continue a strategic planning process. It is important that this process results in a clear plan that addresses the requirements of the Settlement Agreement with goals, objectives and timelines as well as with a set of planned outcome and performance measurement indicators and data collection methodology.

I. PURPOSE OF THE REVIEW

The purpose of this review was to make a determination as to the compliance status of the qualitative requirements of the Settlement Agreement as they pertain to individual and family supports. These requirements 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.*

The study analyzed whether the design of the IFSP proposed by DBHDS and its implementation, in combination with other available individual and family supports, could be reasonably expected to fulfill the requirements of the Settlement Agreement. The analysis was based on the following ten criteria:

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? Will the process include prioritization criteria, for determining which individuals may be considered “most at risk of institutionalization,” 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? Will the plan include 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?

II. STUDY METHODOLOGY

In order to ascertain the status of compliance for each of the criteria, the study methodology included document review, DBHDS staff interviews, stakeholder interviews, and review and analysis of available data.

The document review process included requests made to DBHDS for any NIDAC minutes, reports and any other work product related to the design of the IFSP; any needs assessment, data or information used in the design of the IFSP; any strategic planning document(s) that define a set of milestones to be achieved toward statewide implementation and projected timeframes; a detailed description of the organizational structure of the proposed regional IFSP (e.g., membership, support staff, funding formula and mechanism, etc.); any finalized or draft policies and procedures; any finalized or draft versions of any indicators, tools, processes and/or any quality improvement strategies to be used to assess whether programmatic outcomes have achieved desired and expected outcomes; a description of DBHDS' strategy for formalized stakeholder input in the development and implementation of the planned IFSP and documentation of any related stakeholder input activities that have been held or are planned; and any work product related to the development and dissemination of the guidelines and other outreach strategies. A full list of documents reviewed may be found in Appendix A.

The data review included requests for data collected by DBHDS regarding the geographic distribution of IFSP funds; current Wait List data; other services and supports received by individuals and families making application for IFSP; applications made and applications funded by individuals living independently vs. applications made and applications funded by families; the categories of services and supports requested and funded; number of applications received, approved and denied; for denied applications, data regarding reasons for denial; number of applications pended and data regarding reasons for pended status; number of applications received, approved and denied; Draft Quarterly IFSP report for period ending 3/31/16. A complete list of data provided and reviewed is included in Appendix A.

The expert consultant interviewed DBHDS staff involved in the development, design of the IFSP, DBHDS staff responsible for day-to-day administration of the IFSP, and stakeholders participating in the NIDAC. The stakeholders included individuals and families as well as representatives of advocacy organizations and service organizations. To gain some assessment of broader stakeholder knowledge of the IFSP design under discussion, the expert consultant also completed group interviews with attendees at several Focus Group meetings that were held for the purpose of evaluating case management effectiveness. These meetings included case manager supervisors, - case managers and representatives of provider agencies, respectively. A full list of individuals interviewed is included in Appendix B.

III. FINDINGS

Over the last year, DBHDS has engaged in a number of activities to enhance its current IFSP funding process and to re-design its approach. The goal for the redesign activities is to provide a comprehensive and coordinated set of strategies, as the Settlement Agreement requires. To provide context for the compliance findings, these activities are summarized below.

Current IFSP Funding Process: DBHDS reported that it made changes to the FY 2016 funding period based on lessons learned during previous funding periods, internal discussions and stakeholder feedback. These changes included:

1. Reduced the maximum amount for funding per person from \$3,000 to \$1,000. This step ensured that available funds would be provided for more individuals.
2. Reverted back to one application and funding period, which had existed during the first two years of the IFSP Program.
3. Hired two temporary staff to assist with managing the flow of IFSP applications, decisions and issuance of funds.
4. Streamlined the IFSP application form. In addition, a line was added for an applicant e-mail address. This allowed IFSP staff to communicate more effectively with families regarding their applications.
5. Updated the IFSP Guidelines in August 2015 to reflect these changes.

Overall, the modifications that DBHDS made alleviated the backlogs that had occurred in previous funding periods. DBHDS was still accepting applications as of March 31, 2016, and had not found it necessary to deny any applications due to funding constraints. These results reflected significant improvements in timeliness and responsiveness, and therefore, much less stakeholder frustration with the program. DBHDS had served 2,084 individuals and families during FY 2016, through March 31, 2016.

IFSP Re-Design: Since this expert's previous report on the status of the IFSP, DBHDS has continued to engage stakeholders in the planning for the IFSP re-design. DBHDS responded, in part, to that report's recommendation to implement a formalized and ongoing avenue for stakeholder input to help to guide the evolution of the individual and family support program. DBHDS formed an advisory committee (i.e. NIDAC). Stakeholder participation was solicited from individuals on waitlists and their families. Representatives from advocacy organizations, although not voting members, attended and participated in the discussions. NIDAC was to provide feedback for DBHDS to consider as it developed a viable work plan for creating a comprehensive family support system for the Commonwealth.

The first NIDAC meeting was held in July 2015. Meetings in August and October 2015 followed it. The group had met once this far in 2016, on March 23. Attendance has been somewhat sporadic among members. Participants have been provided with information about individual and family support programs in other states that were organized around the principle of an individual- and family-led regional organizational structure. Specifically, these states included Alabama, Indiana, North Carolina and Tennessee. NIDAC proceedings included review of the various models. This included a presentation from a representative of the North Carolina program. DBHDS also tapped the Service Corps of Retired Executives (SCORE) to bring in experienced business people to advise NIDAC members on the process of incorporating and operating 501(c)(3) organizations. All those interviewed considered the participation of SCORE representatives as very helpful to the process.

DBHDS presented a proposed program model to the planning workgroup. The model would place significant decision-making authority in the hands of the individuals and families being served. Nonprofit regional organizations with governing boards whose membership would be at least a majority of individuals and families eligible to be served by the IFSP. The primary roles of these regional organizations would be to set funding criteria, to work within their communities to coordinate other existing resources and to develop additional financial and in-kind support. The development of a related statewide organization was also discussed. A statewide organization would either provide a venue for the regional organizations to come together or a strong centralized entity that would set key policies and oversee activities. DBHDS proposed and the Governor requested funding from the General Assembly for five new positions to facilitate the work of these regional organizations.

At the March 23, 2016 meeting, the NIDAC membership was asked to decide whether to move forward with either a decentralized or a centralized model. The membership reviewed a list of pros and cons that had been compiled by a smaller group of the members, with the assistance of SCORE. DBHDS reported that only one of the five requested staff positions had not been approved by the General Assembly. Given concerns expressed in the ensuing discussion, DBHDS suggested a third option, "pass-through". This third option would include five staff to be hired by DBHDS, one to work in each region. It would not include initiating the formal development of the regional entities, at least for some undetermined period of time. A job description for these positions had not yet been developed, but it was envisioned the staff would both manage applications regionally and work to develop local resources. The advantage of this approach was described as being able to start very quickly. In the end, however, the NIDAC membership agreed upon a fourth option. This option would involve beginning with the "pass through" approach, and then transition to the centralized model over the next year. This option would require a portion of the IFSP allocation to fund the positions in each region. It remains uncertain whether this option is feasible because DBHDS staff indicated that it was not yet clear whether it would be possible to use IFSP funds to support these positions.

Before and after the March 23, 2016, meeting, the NIDAC members and the representatives of advocacy organizations who attended the NIDAC planning meetings, expressed considerable concerns. Most expressed the opinion that the planning process did not provide for enough time to thoroughly explore and consider the options being considered. Many of the NIDAC members were not thoroughly familiar with the Settlement Agreement requirements for the Individual and Family Support Program. A major theme of concern expressed by the NIDAC members was whether families and individuals would want to take on additional responsibilities for fund-raising and coordination in their respective regions. Their time and energies are so often consumed with managing their own extraordinary needs and/or those of their family members. The second theme was whether it made more sense, for Virginia, to use existing nonprofit agencies to host the proposed regional entities rather than to create new ones as occurred in the other states' models.

Compliance Findings for 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.

Compliance Finding: DBHDS is not yet in compliance with this section.

Compliance Indicators:

- 1. Will the design and implementation of the IFSP and other individual and family supports provided under the Agreement result in a set of strategies that can be considered comprehensive in nature?**

This consultant's 2015 study noted that funding through the IFSP should be viewed as only one component of a comprehensive individual and family support program. Additional components include: other financial resources, peer supports, family to family support, information and referral, etc. At that time, there were few concrete strategies in the design of the IFSP to complement, or to coordinate with, other available supports. A needs assessment of individual and family supports available statewide had not been completed. Goals, objectives and timelines had not been developed to ensure the required comprehensive and coordinated set of strategies.

The previous report recommended that an overall strategic plan for individual and family supports should be developed through an inclusive stakeholder planning process.

As described above, the NIDAC planning process has not been sufficiently robust or inclusive. The path forward has been painted for the most part in broad strokes. Based on interviews with DBHDS staff and stakeholders and on the review of planning documentation reviewed, the primary responsibility in the re-designed IFSP would lie with the five regional organizations that would be developed. These regional organizations would be charged with ensuring a comprehensive set of strategies, with coordinating with other services and supports, and with facilitating access. They would also be charged with developing additional resources in their communities beyond the IFSP funding. This responsibility is only described in a broad and generalized statement of intent at this point. Additional planning and deliberation is needed. This is particularly important because the stakeholders interviewed frequently expressed reservations about the ability or willingness of individuals and families to take on this task.

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?

Previous findings indicated that, from a systemic perspective, coordination with other services and supports had not yet been fully realized for individuals on HCBS waitlists and their families. In particular, the role of case management in facilitating this access and coordination of these supports had not been adequately examined. Facilitation of this sort remains a critical element to a comprehensive and coordinated system. To date, the planning process has not addressed how the regional organizational structure would facilitate access to and coordination with case managers. The regional entities, however, would be charged with the responsibility for coordinating individual and family supports with other supports and services. Additional planning and deliberation are needed.

The previous study found that the existing IFSP staffing resources were not sufficient to support the identification of other available resources and the coordination with other agencies for each applicant. Since then, DBHDS hired two temporary staff to assist with managing the flow of IFSP applications, decisions and issuance of funds. This step, however, did not increase capacity to coordinate with other services and supports for which a family or individual may be eligible. It remains unclear how the proposed state and regional organizations might utilize staffing in this regard. A final decision had not been made regarding the availability of staff positions. A single staff position was approved in the most recent budget. A job description, however, have not yet been developed. In the best of circumstances, a single staff person per region will not meet the need to assist individuals and their families on the waitlists to identify and to access other services and supports for which they 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?

The previous study found that systemic coordination of person-centered and family-centered resources, supports and services was not available to individuals on the waitlists and their families. This was due to a number of factors. These include a lack of case management involvement as well as other design and implementation aspects of the IFSP.

The proposed state and regional IFSP organizations would have responsibility for coordination and access, as described in IFSP re-design documentation and in staff interviews. As described above, this does not appear to be feasible. The resources have not yet been identified to support the IFSP, to adequately facilitate access to person-centered and family-centered resources, supports, services and other assistance. The proposed re-design does envision that the regional non-profit organizations will develop local resources and linkages. This is only a broad and generalized statement of intent. The NIDAC stakeholders expressed doubts about whether this aspect of the role of the local organizations was feasible or even desirable. Additional planning and deliberation is needed in this area.

The previous study found the number of IFSP applications and the average request amount had grown as individuals and families had become more aware of the program. When combined with other design features, this had led to increased denials, a lack of timeliness, and an overall increased level of frustration with the program. Changes made during the current FY 2016 funding period have been very effective in addressing these issues. The changes have eliminated denials in this round and have greatly enhanced the timeliness of DBHDS' responsiveness. Through March 31, 2016, there had been 2,084 applications approved and a total of \$1,964,620 distributed. These included 975 approvals from individuals/families on the Urgent waitlist, 570 from the Non-Urgent waitlist, and 539 from the IFSDD waitlist. DBHDS was still working to ensure individuals and families were aware of ongoing funds availability and actively encouraging new applications.

Compliance Findings for 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...

Compliance Finding: DBHDS is not yet in compliance with this section.

Compliance Indicators:

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?

As reported in the 2015 study, DBHDS determined the broadest possible definition of those “most at risk for institutionalization”. Every person who is on either the ID or IFSDD waiver waitlist was determined to be “most at-risk for institutionalization”. This definition made every individual on a waiver wait list eligible to receive a monetary award under the IFSP. This broad definition is consistent with one of the primary tenets of the traditional individual and family support programs that all individuals with intellectual and developmental disabilities and their families need and deserve supports. They should not have to prove they are somehow more deserving than someone else. While most stakeholders appeared at that time to agree with this general principle, the philosophical and practical bases for the Commonwealth’s determination decision had not been well documented or communicated. Stakeholders, the individuals and families who might apply for IFSP funds, did not have ongoing input in the discussion. As reported previously, most expressed a level of discomfort with receiving financial supports knowing that others had much more intense needs. The 2015 study recommended that the definition of “most at risk for institutionalization” be fully explored with stakeholders in the process of strategic planning, including whether it reflected the priority of supports to those at greatest risk. This has not yet occurred.

DBHDS had drafted a proposed revision to the Administrative Code that would expand the definition to include anyone who is eligible for the ID or IFSDD waiver waitlist, but this had not yet been formally submitted. For purposes of the IFSP, this rule revision could potentially remove a barrier for individuals and families who are eligible for a waitlist, but who would prefer not to enroll. It is not clear whether “eligibility” for the wait list alone would remove an extra step in the application process and, as eligibility determination would still be needed to access individual and family support funding.

If implemented, revising this eligibility criterion might slow the rate of growth in that waitlist. Some believe that the requirement to being on the waitlist was a prerequisite to receive IFSP funds was a factor that contributed to rapid growth of the waitlists. As noted in the 2015 study, the DD waitlist grew 43%, from 1,300 to 1,885, between June 2013 and April 2015. According to DBHDS staff, the waitlist has continued to grow at a pace of about 40 new people per month. It was not yet clear how the overall waiver re-design would impact the size and growth rate of waiver waitlists.

The NIDAC re-design proceedings have not yet addressed the “most at risk of institutionalization” definition. Nor was this determination discussed at the stakeholder meetings. This fundamental element of the IFSP should be examined, as previously recommended, through a truly inclusive strategic planning process, including weighing its potential impact and benefits. While it is not always possible to predict unexpected outcomes, a careful strategic planning process should fully address proposed rule changes prior to promulgation.

5. Will the design of the planned IFSP provide a clear and logical process, including prioritization criteria, for determining which individuals may be considered “most at risk of institutionalization,” 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?

As reported in the 2015 study, the Administrative Code related to the IFSP (§37.2-203) and the IFSP Guidelines, updated February 2014, did not provide any prioritization criteria for determining which individuals may be most at risk for institutionalization beyond the requirement for being on either the ID or IFSDD waiver waitlist. No assessment of the level of need or the current status as it relates to imminent risk of institutionalization was completed in the application review process. Instead, the Code and Guidelines stipulated only that applications submitted by individuals and families will be considered on a first come-first served basis. At that time, there was an almost universal uneasiness among stakeholder interviewees as to whether the design of the IFSP, particularly with a first come-first served approach, may be inherently unfair to those who need it the most. , DBHDS has drafted a proposed revision to the Administrative Code that would remove the first come-first served requirement, however, this change has not yet been approved. This could be a very positive step, but there must be an alternative methodology to prioritize how limited funding will be distributed.

The NIDAC re-design proceedings had not yet addressed any “most at risk of institutionalization” prioritization criteria. According to interviews with IFSP staff, and the documentation reviewed, DBHDS anticipates that the regional organizations will have some leeway to make local decisions in this area, but this remains undefined. It has also not yet been

determined what authority the planned statewide organization will have or how that authority will be shared with regional organizations. A draft of proposed administrative rule changes indicated only that the “council(s), in consultation with the department, will develop and post criteria for providing supports through the Family Support Program.” Some NIDAC members interviewed questioned whether allowing prioritization criteria to vary from region to region would create additional inequities. A methodology has not yet been defined to identify whether such potential inequities may, in fact, occur or what minimum standards may apply to safeguard against them.

DBHDS had made some modifications to its current IFSP processes to ease the funding backlogs, to improve timely responses and to make it possible to serve more individuals. These included reducing the maximum amount for funding per person from \$3,000 to \$1,000, thereby ensuring that funds would be available for more individuals. The application period also reverted back to one on-going funding period.

6. 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 2015 study, DBHDS has not developed outcome, performance or satisfaction indicators. No data were collected that related to IFSP performance, impact or satisfaction. The study recommended that DBHDS identify indicators to adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports. Recommendations were also made to determine the impact on the risk of institutionalization and to develop capacity for collection and analysis of the needed data. This current review found that the NIDAC re-design proceedings had not yet addressed a performance and outcome measurement strategy. DBHDS staff reported that performance and outcome indicators had not yet been developed.

DBHDS did distribute a baseline satisfaction survey in June 2015 to all applicants from the second funding period of 2015. A follow-up survey is scheduled for June 2016. Survey responses were received from 233 people. Of these, 57.41% indicated they were very satisfied or satisfied, while a 34.26% were dissatisfied or very dissatisfied. There was no analysis provided as to the reasons for the satisfaction vs. dissatisfaction. Such an analysis might have been very useful when determining needed program quality improvement. DBHDS did collect comments from individual respondents. Common themes included the need for additional funding, the need for timeliness in reviewing applications and responding to applicants and their families, and issues with the application process. A review of the comments for this study found concerns about funding prioritization were reported with some frequency. In order to develop a useful quality

improvement system for individual and family support, it will be necessary for DBHDS to develop a set of both outcome and performance indicators that will allow it to determine not only whether a goal is achieved, but also to allow it to analyze why or why not. As it works to complete a follow-up survey and/or additional satisfaction evaluations, DBHDS should construct its data collection methodologies with that in mind.

DBHDS continues to use a database that has been functional since late CY2014. This allows the IFSP office to present some data related to disbursement of the IFSP funds. These data, however, have not yet been analyzed to any significant degree for quality improvement. The IFSP program staff are currently working with DBHDS's IT staff to ensure the database will accommodate regional data and to convert it to a web-based platform.

Compliance Findings for 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.

Compliance Finding: DBHDS is not yet in compliance with this section.

Compliance Indicators:

- 7. Will the design of the planned IFSP include sufficient strategies to publish guidelines that are sufficient, in terms of detail, accuracy and accessibility to the population, to be effectively used to direct individuals in the target population to the 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, 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?**

As described above, DBHDS made some modifications to its IFSP guidelines in August 2015 to clarify changes made to the funding process. This was a positive step. Otherwise, DBHDS further acknowledged that the Indicators 7, 8, 9 and 10 had not yet been addressed in the ongoing re-design planning process. As with other requirements and indicators, sufficient information and documentation were not yet available to assess whether the design of the planned IFSP included

sufficient strategies to undertake appropriate outreach and dissemination processes. These processes include, but are not limited to, publishing guidelines. Given the uncertainties surrounding the eventual IFSP structure, there was not yet a clear plan that described the various roles and responsibilities related to outreach and dissemination among DBHDS, a centralized state organization and/or regional councils.

V. CONCLUSIONS AND RECOMMENDATIONS

DBHDS is to be commended for its efforts to re-evaluate its approach to individual and family supports. It is also commended for making interim programmatic changes that eased the application flow and funding logjams from previous years.

The following recommendations are offered as steps toward achieving compliance with the individual and family support requirements of the Settlement Agreement. Some of these recommendations remain the same as those included in the previous report.

1. An overall strategic plan for individual and family supports should be developed. An effective strategic plan will include a clear vision and mission that is developed with a broad stakeholder consensus. It should be based on a thorough assessment of needs and of resources, and include clear goals and objectives. It should also include a work plan, just as the stated purpose of the NIDAC indicated that it was created to achieve. While DBHDS is eager to move forward with a new approach, it will be worth the time it takes to develop a detailed plan.
2. DBHDS should identify indicators needed to adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports, and its impact on the risk of institutionalization. DBHDS should develop the capacity for the collection and the analysis of the needed data. Such indicators must reflect the broader definition of comprehensiveness and coordination. In order to develop a useful quality improvement system for individual and family support, it will be necessary for DBHDS to develop a set of both outcome and performance indicators that will allow it to determine not only whether a goal is achieved or not, but also allow it to analyze why or why not. DBHDS should construct its data collection methodologies with that in mind.

Additional suggestions the Commonwealth may wish to consider as it moves forward with this initiative include:

1. Several stakeholders interviewed suggested that an experienced facilitator/planner be engaged to help guide the IFSP planning process. This may be a worthwhile path to consider in terms of both expediting the development of a comprehensive plan and of engaging stakeholders in a frank and fully objective conversation about what will work best for Virginia.

APPENDIX A: DOCUMENTS/DATA REVIEWED

1. Indiana Individual and Family Support Code
2. Tennessee Selections from Family Support Guidelines 2015
3. Letter for 7-16 stakeholders meeting
4. NIDAC members contact information sheet January 2016
5. NIDAC members contact information sheet January 2016
6. Minutes from NIDAC Meeting 07 16 2015
7. NIDAC Minutes 8 19 2015
8. NIDAC Meeting Minutes 10.5.2015
9. IFSP NIDAC Meeting PowerPoint October 5th 2015
10. Introduction letter to NIDAC from Besty MacMichael from North Carolina September 2015
11. First In Families Overview
12. North Carolina First In Families Statewide Aggregate Report 2014-2015 Q4 and EOY
13. Draft-Proposal for the New Design of Virginia's IFSP Beginning FY 2017 2 5 16
14. Ch230 Draft Emergency IFSP Regulations 1-23
15. Report on the progress of the New Design of the IFSP February 2016
16. Introduction to survey letter June 2015
17. Improvements made for existing IFSP Program
18. DBHDS IFSP Family Stakeholders Meeting PowerPoint July 16 2015
19. June 2015 IFSP Survey Results
20. Individual and Family Support Program Data through March 31st 2015 FY 2016 (003)
21. NIDAC Minutes from Meeting on March 23rd (2016)
22. Individual and Family Support Program Guidelines Updated August 15, 2015
23. DDS FY 2016 IFSP Application August 2015
24. DDS FY2016 DIRECTIONS for IFSP application

APPENDIX B: INTERVIEWS & STAKEHOLDER INPUT

1. Peggy Balak, DBHDS DOJ Settlement Agreement Advisor
2. Beverly Rollins, DBHDS Director of Administrative and Community Operations
3. Jae Benz, DBHDS Senior DD Administrative & Policy Analyst
4. Bob Villa, DBHDS IFSP Program Manager
5. Roxie Lyons, DBHDS IFSP Staff
6. Sandra Brown, DBHDS IFSP Staff
7. Sam Pinero, DBHDS DD Program Manager
8. *Candace Kuhn, Parent
9. *Lily Kuhn, Self-Advocate
10. *Nita Williams, Parent
11. *Geoffrey Federmeier, Parent
12. *Joy Spenser, Parent
13. *Deborah Hunley, Parent
14. *Jackie Hampton, Parent
15. Jamie Liban, Arc of Virginia
16. ‡Dana Yarbrough, Partnership for People with Disabilities, Family to Family, Parent

* NIDAC member

‡ Participated in NIDAC proceedings

Other Stakeholder Input:

1. Case Manager Focus Group
2. CSB Supervisors and ID/DD Directors Focus Group
3. Residential and Day Program Managers Focus Group

APPENDIX C

CASE MANAGEMENT REQUIREMENTS

by: Ric Zaharia, Ph.D.



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

Case Management
Requirements

By

Ric Zaharia, Ph.D.
&
Rebecca Wright, MSW, LCSW

April 30, 2016

Introduction

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement (SA) requested a follow-up to our October 2014 review of the Case Management requirements of the Agreement. This review was based on onsite interviews, document reviews and focus groups to assess key indicators and progress towards compliance. The documents reviewed included those provided by the Commonwealth that it determined demonstrated its progress toward achieving compliance.

For this review we focused on four CSBs (Community Service Boards) from three Health Planning Regions. The Independent Reviewer selected these CSBs based on regional representation and size of the general population. For each CSB, the review included: a) a qualitative review of a selected sample of at least six individual records with case manager interviews, and b) a follow-up assessment of the six individual's well-being via a face-to-face visit and interviews with caregivers and authorized representatives (ARs), where appropriate or feasible.

Our approach yielded a sample of twenty-five (25) cases, with a subsample of twenty-one (21) cases from the ID (Intellectual Disabilities) Waiver. The sub-sample cases were selected from a list of individuals who the Commonwealth reported were receiving CSB 'enhanced case management'. The 'enhanced case management' criterion for the selection of individuals for this study was prioritized because such cases require greater scrutiny and more intensive monitoring by case managers. The lists of individuals provided, however, had not been recently updated and were not all current. Changes in their eligibility for enhanced case management status since when the list was previously updated resulted in only sixteen (1) of the twenty-one (21) individuals from the ID Waiver receiving enhanced case management services at the time of our review.

This review did include one of the six individuals who were selected for the sample in each of the CSBs from the DD (Developmental Disabilities) Waiver and who were receiving DD case management services. The DD Wavier case management program is to be integrated with the CSBs as part of The Commonwealth's HCBS Waiver redesign plan. If approved, the integration of separate ID and DD case management systems is planned for implementation during Fiscal Year 2017.

We then conducted a discrepancy analysis to determine what 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 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 evaluation of the individual, their situation and other data (minor differences were discounted, since we were examining only significant differences that impact the individual's well being).*

We also evaluated whether there are needed assessments that had not been requested and whether the requirements of the Settlement Agreement have been met. We utilized an adapted version of the Department's voluntary Enhanced Case Management monitoring tool (July 2013) to conduct our assessment. The adaptations were made so that our evaluation was more comprehensive and covered all relevant requirements of the Settlement. The adaptations included queries from the focused studies completed by other consultants to the Independent Reviewer and from the Individual Service Review studies.

We also conducted Services Effectiveness focus groups in three CSBs during our visit. One focus group included case managers. A second focus group included CSB case management supervisors, ID Directors, etc. The third focus group included residential and day staff managers from the CSB area. We invited representatives from DD agencies to attend each group.

The design of these focus groups was in collaboration with the Virginia Association of Community Services Boards (VACSB) in order to enlist their support in recruiting the relevant agency staff, with DBHDS in order to provide sanction to the effort, and with advocacy groups to ensure family and individual representation. We invited ten to sixteen (10-16) staff for each group, expecting five to eight (5-8) staff would actually attend. The Services Effectiveness theme of each focus group was, “What is working and what is not working for individuals in getting the services and supports they need?”

The onsite work involved in this project extended from February 21 until March 4, 2016. The Compliance Table on the following page recaps our conclusions about DBHDS success at complying with the selected elements of the Settlement Agreement.

Compliance Table

SA Section	Settlement Agreement Language	Rating	Page
III.C.5.a Case Management	<i>The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.</i>	Compliance	7
III.C.5.b Case Management	<i>b. For the purposes of this agreement, case management shall mean: 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; 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.</i>	Non-Compliance	7
III.C.5.c Case Management	<i>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 the provision of such services.</i>	Compliance	7
III.C.5.d Case Management	<i>The Commonwealth shall establish a mechanism to monitor compliance with performance standards.</i>	Non-compliance	7
Section III.D.1 Community Living Options	<i>1. The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.</i>	Non-Compliance	9
Section III.D.2 Community Living Options	<i>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.</i>	Not Determined	9
Section III.D.6 Community Living Options	<i>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.</i>	Non-compliance	9
Section III.D.7 Community Living Options	<i>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.</i>	Compliance	9
Section III.C.7.a Case Management	<i>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.</i>	Non-Compliance	11
Section III.C.7.b Case Management	<i>.....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.</i>	Non-Compliance	11
Section V.A.	<i>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)...</i>	Non-Compliance	11
V.F.1 Case Management	<i>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.</i>	Compliance	11
V.F.2 Case Management	<i>2. At these face-to-face meetings, the case manager shall...</i>	Non-Compliance	11
V.F.3 Case Management	<i>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</i>	Compliance	12
V.F.4 Case Management	<i>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.</i>	Non-Compliance	12
V.F.5 Observation & Assessment	<i>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.</i>	Non-Compliance	14
Section IX.C Implementation	<i>Requires that there be “...sufficient records to document that the requirements of the Agreement are being properly implemented...”</i>	Non-Compliance	14

1. Case Management Effectiveness

Settlement Requirement:

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.

Methodology:

- Reviewed ‘Commissioner’s Data Dashboard’;
- Reviewed case management monitoring at the CSB level;
- Reviewed completed performance evaluations of CSBs from 2015, including reports from the Office of Licensing Services (OLS) and the Internal Auditor.
- Conducted discrepancy analyses of 25 randomly selected cases in four CSBs based on a review of the case record, case manager interview, face-to-face individual interviews, including caregivers, ARs as feasible or as appropriate.

Findings:

The authors conducted discrepancy audits of twenty-five (25) cases over a two-week period in February and March 2016. The Independent Reviewer selected a diverse sample of four CSBs based on population size and regional representation. The questions from the Case Management Review Tool that we used are included as part of Attachment A.

Sixteen (64%) of the twenty-five cases reviewed received enhanced case management. Fifteen (60%) were males. The average age in the sample was 39 years with a range of 15-67 years; twenty-three (92%) were over age eighteen. Eleven (73%) of the fifteen individuals who were not living with their families lived in settings of five or more.

The SA lists three major functions of case management: assembling teams, assisting individuals in accessing services and needed supports, and monitoring implementation of the ISP and making changes as needed. We observed in this sample, when events or changes suggested substantive changes were needed to the ISP, that case managers were generally hesitant to assemble team members in between annual meetings. This reluctance appeared to stem from logistical inconvenience and the lack of enthusiasm for ‘one more meeting’.

Our discrepancy analysis, in fact, suggested that the top four challenges faced by case managers were:

Changed ISP outcomes when needed	(Item #29, 14 discrepancies)
Made needed referrals	(Item #30, 13 discrepancies)
Listed all needed, essential supports in ISP	(Item #3, 11 discrepancies)
Supported the individual to access needed services	(Item #15, 11 discrepancies)

The DBHDS Data Dashboard uses a compliance rating to compare performance. Using the Dashboard approach, we compared the four CSB’s cases and the DD Waiver cases along the DBHDS continuum of ‘meeting targets’ (for this table set at 90%), ‘approaching targets’ (for this table set at 80-89%), and ‘below target’ (79% or less). Table 1 displays the results using the total number of non-discrepancy ratings for all the individuals (numerator) against the total number of all items across individuals for that CSB (denominator). We regard the variations among the top three ratings (Region I, II, and DD Waiver) as minor and believe they represent very close to acceptable rates of difference from the desired outcome, based on differing caseload sizes, length of service of case managers, etc. Two (50%) of the four CSBs, however, warrant further examination by DBHDS to determine the systemic deficiencies and the needed corrective actions.

Table 1
Compliance Rates Based on Discrepancy Analyses

Area	70%	80%	90%	100%
DD Waiver 87%				
Region II CSB 87%				
Region I CSB 90%				
Region IVa CSB 77%				
Region IVb CSB 80%				

5% below target
 approaching target
 meet/exceeds target

When we inquired whether case managers offered a choice among service providers, we found 100% compliance with this expectation.

We verified by observation and documentation that each CSB has its own locally developed monitoring strategy or tool, participates in the Department’s HCBS Waiver program audits of case management services, and undergoes Operational Reviews as scheduled (four to five CSBs are completed annually; an average of once every 8-9 years). Local monitoring tools vary in frequency of administration and whether the content of case management actions are examined for timeliness or quality. Local supervisory auditing does not appear (based on documentation that was provided for our review) to consistently identify or address cases with deficiencies, which we identified as present in each CSB.

The DBHDS Office of Licensing Service's (OLS's) efforts to tighten its scrutiny of case management services using the *Supports Efficiency Checklist* (see our separate assessment of OLS case management reviews) was terminated last year with the implementation of the Quality Service Reviews, which are currently being conducted by a national consulting firm.

Conclusions

DBHDS is in compliance with the requirements of III.C.5.a. Each individual had a case manager and a current ISP.

DBHDS has made progress toward achieving compliance with the requirements of III.C.5.b. The presence of discrepancies in this sample of cases, however, is such that an entire CSB is not meeting target cut-offs. If two (50%) of the four selected CSBs are experiencing frequent quality performance problems, then 20 +/- (50%) of the CSBs statewide may be experiencing similar performance problems delivering case management services. The Data Dashboard reports indicate that one of these two CSBs has been 'below target' and had problems reaching the DBHDSs target of 85% on its July-August-Sept-Oct 2015 reporting cycle measurements of face-to-face case management.

DBHDS is in compliance with the requirements of III.C.5.c. The documentation reviewed and responses to inquiries indicated that case managers had offered choices of providers.

DBHDS is not in compliance with the requirements of III.C.5.d, a mechanism to monitor compliance with performance standards for case management. The Operational Reviews occur an average of only once every eight to nine years for each CSB and the OLS effort to tighten scrutiny of CSB case management has been terminated. Consequently, Section IX.C. also remains out of compliance

Recommendations to achieve compliance:

DBHDS should establish standards and a model tool for the CSB supervisory record audits. The standards should address timeliness, format, and quality of content. The *Case Management Performance Checks for CSBs* tool that is used in the Operational Reviews is an example of a good starting place. In its model tool DBHDS should consider outlining steps to follow to correct individual case manager performance and systemic causes of discrepancies.

DBHDS should continue planned case management training efforts.

DBHDS should enhance its systems to monitor and to improve CSB case management performance to ensure compliance with the Commonwealth's standards and the requirements of the Settlement Agreement. The monitoring methods that are used should include tools so that CSB's can be held accountable for acceptable performance.

Suggestions for Departmental consideration:

DBHDS/OLS should consider convening a case management supervisory group to discuss how case management performance can be better measured and to establish the parameters of enhanced scrutiny of case management requirements.

2. Least Restrictive

Settlement Requirement:

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.*
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).*

Methodology:

- Evaluated at least six randomly selected cases in each of four CSBs from three (60%) of Virginia's five Health Planning Regions, as identified by the Independent Reviewer. The review included case record review, case manager interview, face-to-face individual interviews, including caregivers, ARs, etc., as appropriate.
- Examined referrals on file with Community Resource Consultant/Regional Support Team (CRC/RST) for the individuals included in the review.

Findings:

Among the eleven individuals who live in settings of five or more, only one had a CRC referral package on file with the RST. A second individual who had moved to a setting with five or more within the last year did not have a CRC referral package on file with the RST. The remaining nine individuals had been placed in their residential settings more than eighteen (18) months ago, prior to when the RST process became fully functioning. None had been subsequently referred to the RST, after they became fully operational, to determine whether the obstacles to a more integrated setting had been identified and could be resolved and whether a more integrated setting was available to be offered.

When we examined whether case managers had provided education about less restrictive services (Item #14), we found discrepancies in four (16%) in the twenty-five cases; in other words for 84% of the cases this expectation was fulfilled. The case managers for each of the eleven individuals living in settings with five or more individuals had discussed less restrictive options with them/AR.

We observed only one case in the sample where we would challenge the decision to not refer an individual for housing subsidies or provide information about housing assistance. However, this one case is not sufficient to make a judgment about this provision.

Conclusions

DBHDS is not in compliance with the requirements of III.D.1., serving individuals in the most integrated setting.

DBHDS compliance with the requirements of III.D.2., is not determined from this project.

DBHDS is not in compliance with the requirements of III.D.6., a review by the RST.

DBHDS is in compliance with the requirements of III.D.7.

Recommendations to achieve compliance:

DBHDS should substantially increase the availability of providers (including private sector case management) to ensure the reality of choice and the availability of more integrated settings. The free exercise of choice is often constricted by the lack of options.

3. Case Management Services

Settlement Requirement:

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.*

Methodology:

- Reviewed ‘Commissioner’s Data Dashboard’;
- Reviewed case management monitoring at the CSB level;
- Reviewed completed performance evaluations of CSBs from the previous year, including OLS and Internal Auditor reports;
- Evaluate at least six randomly selected cases in each of four CSBs; review will include case record review, case manager interview, face-to-face individual interviews, including caregivers, ARs, etc., as appropriate.

Findings:

During the development of the list of cases for this study, CSBs reported to DBHDS that their database had not been updated. This resulted in some individuals who were correctly listed as receiving enhanced case management a year ago were no longer be receiving such enhanced services. As a result, only sixteen (76.2%) of the randomly selected sample of twenty-one (21) cases were still required to be receiving enhanced case management at the time of this study, although twenty-one individuals had received enhanced case management previously qualified when they did qualify. In consultation with the Independent Reviewer, the decision was made to proceed with six (29%) of the cases not receiving enhanced case management services. This decision was made because of the limited sample size in some CSBs. This decision resulted in the sample that was reviewed having a wider range of characteristics.

We found no appreciable difference in the compliance rate between the services provided for the individuals who received enhanced case management and those who received non-enhanced case management. We found that CSBs in some cases have approached the two groups comparably, often visiting those receiving non-enhanced case management at the same frequency. The study found that twenty-four (96%) of the twenty-five cases were in compliance with the required frequency of visits.

The four reviewed DD cases had an average overall compliance rate of 87% with a range of 77-97%. This compares favorably with the overall compliance rate of 84% of the entire sample of twenty-five cases. We found a tendency among DD case managers to be more oriented to action, flexibility, advocacy, and natural supports. Individuals or ARs described DD case manager behavior that was timely and responsive (customer oriented), that articulated their needs and supports to others (ally and spokesperson), and that used community and existing community supports to meet individual needs (fixer). They are not well oriented to documentation systems, electronic health records, and the interdisciplinary nature of team conduct. We found that there is no established plan for the integration of DD case managers into the CSB service delivery system.

Based on the data submitted by CSBs on any given month only between ten and fifteen (25% - 38%) CSBs met the Data Dashboard targets set by DBHDS for the number, type, and frequency of case manager visits. These data indicate that for any given month between twenty-five and

thirty (63-75%) of CSBs are sub-par on this measure. The DBHDS data indicate that a significant number of individuals do not appear to receive the frequency or type of visit agreed to in the Settlement. Moreover, comparing Data Dashboard performance between October 2014 and October 2015, eighteen of nineteen (95%) underperforming CSBs currently are doing worse on frequency of face-to-face case management visits than they were a year ago. On in-home case management visits nine (53%) of seventeen underperforming CSBs are doing worse than they were a year ago. Most disturbing is that four (25%) CSBs did not report data for October 2015 on either of these measures.

The mitigation process that DBHDS recently adopted for quality improvement in case management data and measures looks promising. The outline of Operational Guidelines for a planned case management manual (expected October 2016) also looks like a positive step forward for the field. This tool will require organized tables of content, indexes, and electronic availability.

We identified several case managers who were not sufficiently trained. Case managers also did not have access to needed specialized consultation in making case management decisions related to individuals on their caseload with clinical complexity and intense needs.

Conclusions

DBHDS is not in compliance with the requirements of III.C.7.a., integrated day opportunities, including supported employment.

DBHDS is not in compliance with the requirements of III.C.7.b. because we believe three cases (13%) reflect on the lack of effective implementation of the Employment First initiative at the ISP Team level, particularly for individuals with more significant disabilities. Employment or “seeking” employment goals were also frequently not part of the employment discussions for the other cases reviewed.

DBHDS is not in compliance with V.A., all services are of good quality.

DBHDS is in compliance with the requirements of V.F.1.

DBHDS is not in compliance with the requirements of V.F.2. based on three cases where Employment First was not effectively implemented, several case managers who were not sufficiently trained and did not have access to needed specialized consultation, case managers not adequately monitored for SA requirements, and four CSBs not submitting data to DBHDS regarding the performance of their case managers.

DBHDS is in compliance with the requirements of V.F.3. This rating is based on the findings of the twenty-five cases reviewed in this study and multiple Individual Services Review studies, all of which indicated that the frequency of required visits had been achieved. The DBHDS data regarding frequency of face-to-face visits indicates that these visits may not be occurring with the frequency required. These data, however, have previously been found to be under-reported and unreliable. The frequency of visits should be carefully reviewed in the next independent study to verify that visits occur at the required frequency.

DBHDS is not currently in compliance with the requirements of V.F.4. DBHDS does not yet have evidence at the policy level that it has reliable mechanism/s to assess CSB compliance with their performance standards relative to case manager contacts.

Recommendations to achieve compliance:

DBHDS should substantially increase the availability of providers (including private sector case management) to ensure the reality of choice and the availability of more integrated settings. The planned expansion of a Health Supports Network and expanded resources for crisis services are positive steps forward.

DBHDS should require that CSBs achieving less than 50% on the case management Data Dashboard measures provide a 'data entry improvement plan'; CSBs achieving less than 90% should provide a 'case management performance improvement plan.'

Suggestions for Departmental consideration:

DBHDS should consider conducting an annual refresh of the enhanced case management database, above and beyond the monthly, voluntary 'survey monkey' update.

DBHDS should consider developing a transition plan and a communication plan for the successful assimilation of DD case managers into the CSB service delivery system. A successful assimilation will provide for optimal choice making for individuals and their AR's.

DBHDS should consider emphasizing case manager training by increasing training and human resources over the next year. The volume of training needed should be cross-walked with the availability of Community Resource Consultants who are expected to do the training and with central office planners who are expected to lead the design and implementation of new rounds of training.

DBHDS should also consider accelerating the work on the Case Management Manual to coincide with the planned merger of DD case managers into the ID waiver system.

DBHDS should consider adopting statewide the practice of Region 10. They have embedded action steps including convening team members and notifying involved parties, into the electronic boilerplate of the case manager note. This prompts the case manager not just to record, but to act when plan changes are warranted.

DBHDS should consider specialized competency certification above and beyond the basics for serving individuals with autism, with behavioral health challenges, with medical complications, etc.

DBHDS should consider offering training opportunities to providers of day support programs around meaningful, integrated day opportunities.

4. Observation & Assessment Database

Settlement Requirement:

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.*

Methodology:

- Reviewed 'Commissioner's Data Dashboard' as updated;
- Reviewed other observation and assessment databases and data collection tools;
- Reviewed twenty-one (21) Individual Service Plans and data reported to DBHDS regarding goals achievement, including interview with respective case managers.
- Reviewed training outline and PowerPoint for the new ISP (PC ISP April 2015).

Findings:

The five goals (Health and Well Being, Community Inclusion, Choice and Self Determination, Living Arrangement and Day Activity), which the Commonwealth selected to represent the key indicators of positive and negative outcomes, represent a good faith attempt to comply with the SA requirement at Section V.D.3. The Living Arrangement and Day Activity measures have some usefulness because of their criterion reference to 'stability'. However, as we have previously reported, a halo effect exists when case managers report on their own outcome data with no verification process or criterion reference. This effect is aggravated when implementation is unclear and left ambiguous, so that "professional" judgment replaces measurable criteria. The potential biased reporting that can result from the halo effect is more easily exaggerated when goals/outcomes are not written in measurable terms and when there are not baseline measures of skill levels, independence or integration.

In fact, we were generally disappointed with the quality of most of the 'measurable outcomes' throughout the ISPs. Using the most generous interpretation of compliance and crediting any element of measurement of any kind, we found 19% of the outcome measures as non-compliant on measurable outcomes. Even OLS's nine-month pilot of the *Supports Efficiency Checklist* showed a widespread conclusion of 'no verifiable data' at the provider level to support the 'measurable outcomes' on which they were working. The Commonwealth is in the first year of a new ISP process/format; hopefully measurable outcomes will improve in quality over time, since case managers will generate measurable outcomes consistently if they follow the guidance provided to them in their ISP training.

Many case managers understand that giving the "Met" rating meant 'Achieved', but most do not understand that the next step is to end that outcome (PC ISP Q&A, 6.15.15). These problems and the fact that most case managers admit their confusion about how to complete these goal questions, makes their reporting on the Data Dashboard non-functional.

The Living Arrangement measure, the Day Activity measure, the In-home measure, and the Face-to-Face visits have usefulness on the Data Dashboard because they are criterion referenced, are verifiable, and are therefore functional. However, the issue here is, as we have suggested before, the follow-up with the respective CSB. For the four CSBs that we reviewed for this project, the DBHDS Data Dashboard rated one CSB as consistently 'below target' for 3 consecutive months (July, August, September 2015), one CSB as consistently 'exceeded target' for the same three consecutive months, and the other two as 'approaching target' or 'below target' for the same 3 consecutive months.

DBHDS has made a huge leap forward in its development of a Data Warehouse, a central repository of data and data analysis from one or more different sources. The evidence of the capabilities of this new capacity is in data reports received for the OLS/OHR review project. Case management data managed through the Data Warehouse should also begin to produce information that is useful in meeting the expectations of the SA.

Conclusions

DBHDS is not currently in compliance with the requirements of V.F.5 and IX.C. DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to assess CSB compliance with their performance standards, including case manager contacts. DBHDS does not yet maintain sufficient records to demonstrate the proper implementation of these provisions.

Recommendations to achieve compliance:

Measurable criteria should be developed for the goals Health and Well Being, Community Inclusion, and Choice and Self-determination. For example, see the MH definition for employment on the data dashboard; not only is the terminology content useful but the goal itself lends itself to stretching the ID system to meet SA goals.

DBHDS should require that CSB's achieving less than 50% on all Data Dashboard measures provide a 'data entry improvement plan'; CSBs achieving less than 90% should provide a 'case management performance improvement plan.'

Suggestions for Departmental consideration:

DBHDS should consider requiring all DD managers and policy staff to undergo training in the Data Warehouse.

DBHDS may want to evaluate the wording used in the ISPs and in the ISP training: 'meaningful outcomes with measurable goals' may clarify matters for case managers.

5. Focus Group Observations

As a part of this review we held a series of three focus groups in February and March 2016. The theme of each focus group was “What is working and what is not working for individuals in getting the services and supports they need?” Focus groups were targeted respectively to 1) case managers, 2) CSB supervisors and ID/DD Directors and 3) residential and day program managers from one Region. Invitations were sent to twelve to sixteen (12-16) staff for each group, anticipating that six to eight (6-8) staff would be able to attend.

Each group was asked broad questions that were intended to stimulate open and frank discussion about the ability of the system to identify, arrange and then deliver the needed services to people with intellectual and developmental disabilities. In the focus group meetings, each two hours in length, discussion was both robust and far ranging. The proceedings for each are detailed below.

In keeping with focus group ground rules, which assured the freedom to speak openly, the findings are reported in the aggregate and in the form of relevant key themes that emerged. These themes were reviewed with the group at the conclusion of each meeting to assure they represented the discussion accurately.

Two themes were common across all focus groups and are presented here as context:

1. There was a general acknowledgement that the Commonwealth was in the midst of a vast systems change effort and that some time would be needed for some of these changes to play out before they would achieve desired results.
2. There was a great deal of uncertainty about the pending roll-out of the Waiver Re-Design and what that would mean for the system and for the role of case management, both for ID as well as DD populations.

The Residential and Day Program Managers Focus Group included five managers; DD managers of services were invited but none attended. The discussion was far-ranging and touched on many systemic issues that were not always obviously related to case management per se, but were conceptualized by the attendees as affecting the very foundation of systemic effectiveness.

Key Themes:

- The most frequent theme expressed by this group was the lack of system “agility” or ability to respond with appropriate speed to routine needs, much less emerging needs that are likely to become crises if unattended.
- The next most frequent theme was the lack of a clear path for accessing services that was also sufficiently streamlined.
- The system of case management was considered to be one key factor in this lack of agility.

Related concerns included:

- Case managers don’t have sufficient authority to take action and are not empowered to make decisions, but all service authorizations must flow through them. This was seen as creating a considerable bottleneck.
- Case managers were characterized as ‘receptionists, couriers or messengers’ who primarily made referrals. Their roles in planning and monitoring the delivery of services received little recognition by providers of service.

- Likewise, case managers were sometimes viewed as somewhat removed and not always as familiar with families of the people being served. There was a consensus that provider program managers and social workers were the “real” case managers. It was noted this was not universal and depended on the individual case manager to a degree. Some providers found regularly scheduled group meetings with case managers helpful.
- Case managers had varying levels of competence and the adequacy of training provided to them was questioned. There was concern many case managers were not well acquainted with various services and supports outside of those which are Medicaid-funded.
- Freedom of choice of case managers was described as an illusion as it appeared individuals were often steered in the direction of those with openings on their caseloads.
- Despite these concerns, there was also a consensus that the case management system was not broken. It was noted that the foundational relationship was good, but the functionality needed to be overhauled. In particular, there needed to be a much stronger focus on outcomes for individuals and adherence to performance measures for case managers. Privatization was seen as an option preferred by some.
- Meeting attendees overwhelmingly agreed that the systems of oversight and monitoring were duplicative and burdensome as were the requirements for documentation, resulting in a negative impact on the entire system of services as a whole. These requirements also specifically affected how case managers did their jobs, causing their time and attention to be focused more on paperwork than outcomes for people. It was recommended that the duplicity of oversight be eliminated and that one standardized system of documentation be implemented.

The Case Manager Focus Group included six ID case managers, serving individuals in both rural and urban settings; DD case managers were also invited but none attended.

Key Themes:

- Timeliness of services initiation varied fairly widely, depending on individuals’ geographic locations as well as the type of service sought. In particular, case managers indicated that initiation of residential services often took longer due in part to the need to explore residential options before making a selection. Delay of service initiation was related to the dearth of available residential options in their area. This was particularly true for those with more intense needs and for settings that were more integrated.
- The prior authorization process was also seen as a barrier to timely service initiation. The prior authorization process that was reported to be lengthy, to require considerable documentation, and to result in frequent denials.
- Freedom of choice of service providers was viewed as somewhat of an illusion where the provider base was particularly limited.
- Freedom of choice of case managers was also seen as somewhat illusory, particularly in the rural areas. Most, but not all, however, reported offering such choice if the individual expressed any dissatisfaction.

- There was a consensus that there were some safeguards in place toward offering conflict-free case management, but that complete separation of case management and service provision would be better.
- There was a lack of clarity about the purposes of the Regional Support Team (RST) and the Community Resource Coordinator (CRC). There were varied opinions of their usefulness as a resource at this time. The referral and application processes for these resources sometimes led to responses that were focused on whether a form was filled out correctly rather than on responsiveness to the situation that needed to be addressed. There was a general acknowledgement that these processes were fairly new and still evolving.
- Also viewed as new and evolving, the ISP process was generally seen in a favorable light and as much more person-centered. Case Managers indicated it was taking some additional time to prepare for a Shared Planning session, but it was generally agreed this was a worthwhile investment. Most reported that individuals being served liked the new process, although parents and guardians had not adjusted as well to the change and may need some additional outreach. Case managers also wished providers had more training in the process and suggested that such training be mandatory.
- Case Managers struggled with their lack of authority to address concerns with provider implementation of the ISP and related quality of care. Each case manager reported working to keep avenues open for bringing such issues to the attention of provider management staff. They called team meetings and engaged guardians, however, they did not feel that these efforts were always effective. When case managers were not able to resolve the situation by these means, then they relied on reporting to the DBHDS Office of Licensure Services or, when appropriate, Adult Protective Services.
- Caseload acuties and size, perennial issues for most systems, were also raised in the discussion but did not appear to be top concerns.
- Case Managers reported examples of creative and positive practices. Senior Case Manager position has been developed that provides oversight, training and technical assistance for rural case management staff. The Capacity Symposiums have been held in some areas that have present projected service needs data and real estate market information to potential new residential providers.

The CSB Supervisors and ID/DD Directors Focus Group included seven staff, including one representing an agency providing DD case management. Key Themes:

- The impact of limited resources on services effectiveness was the most frequently reported concern. Limited resources included the following:
 - There is limited waiver slot availability.
 - There is a lack of mental health and behavioral supports for individuals with ID. REACH Crisis Stabilization home has been a significant help as a step-down resource after psychiatric hospitalization. It is not equipped, however, for the severity of need in some cases. It also doesn't have sufficient capacity to meet the needs of the number of people who would benefit from the service. With the limited number of REACH staff per region, consultative services are also limited in availability. Supports related to the prescribing, use, and monitoring/adjusting of psychotropic medications were also reported as a need in several areas.

- More and more individuals served are requiring 24-hour nursing services and/or may receive enteral (tube) feedings. There is a lack of residential, day and in-home providers, however, who have the staff and experience to meet these needs. Focus Group attendees were very supportive of the concept of having regional nurse-consultants to assist providers and case managers to adequately monitor and address health care and medical needs.
- While OT, PT and Speech services are still ostensibly available as in-home waiver services and for therapeutic consults, these providers are increasingly scarce.
- The ISP process received mixed reviews. Participants reported that frequent and ongoing changes in the ISP process and ongoing modifications to each CSB's electronic health record. Both resulted in increased frustration and more work for case managers. The new process was seen as having potential, but additional training across the system was needed to make that potential a reality. There was also a cautionary note expressed that getting the details of the forms right should not take precedence over true person-centeredness.
- There was a consensus that case managers would benefit from additional training, particularly in facilitation skills to support the person-centered planning process. It was noted some such training has been provided.
- It was hoped that a formal roll-out plan for the integration of the currently separate ID and DD case management systems, including guidance documents, materials and instructions, would be forthcoming.
- The five major effectiveness measures built into the ISP were considered to be somewhat ambiguous. Training is needed to define not only their purpose, but a standardized process by which a case manager could better evaluate how well those measures were being met.
- The CSBs all had quality monitoring systems for case management quality and effectiveness that included varying levels of document review and trending; some also provided training based on the results of those trends. Each agency also had its own QA tools, but some felt it would be helpful to have a standardized tool for use statewide.
- The Commonwealth's monitoring of service provider quality was completed largely by DMAS and by the DBHDS Office of Licensing. Providers, however, could also be referred to Community Resource Consultants (CRC). With the growing number of providers there was concern that the current monitoring system might not be sufficient. It was recommended that at least there should be an increased number of CRCs.
- There was some discussion that not all providers of DD case management would choose to continue to offer that service under the Waiver Re-Design, but might choose to provide service facilitation instead. How this might impact the overall case management system remains to be seen.

Suggestions for Departmental consideration:

DBHDS should consider additional strategies to communicate change activities to the service delivery system, such as a Facebook page for "DBHDS Change" or email blasts to a DBHDS listserv to notify DBHDS users of activities that are underway. Current strategies are passive and represent communication that may be satisfactory during normal periods. More active approaches that allow interaction and the pushing of information out are warranted as the Department enters a period of Waiver redesign, rate changes, procedural modifications, etc.

DBHDS should consider welcoming the private case management sector into the larger ID system. DD case managers tend to be more oriented to action, to flexibility, to advocacy, and to the use of natural supports. Their weaknesses in documentation systems, electronic health records, and the interdisciplinary team process, can be overcome with training and technical assistance. The positive impacts of a private case management system as an alternative to the public case management systems are significant: more options for families and individuals, more outlets for the case management of challenging cases, and efficiencies in job performance.

Attachment A

Case management Review Tool Items	
1	Has the individual's Individual Support Plan/Plan of Care (ISP) been modified as necessary or in response to major events?
2	Does the ISP have specific and measurable outcomes?
3	Are all essential supports and services listed in the ISP?
4	Are there any changes in status to previously identified risks, (losing current housing, losing placement due to challenging behavioral needs)?
5	Any recent medical appointments, any changes in medications, or any concerns with physical health in past 3 months? Choking, constipation, falls, etc.?
6	Do any of these issues warrant convening a team meeting to consider changes to the ISP?
7	Any assessments completed in the past year?
8	If yes, were the results (risks, injuries, change in status) incorporated in the ISP by the team?
9	Any recent issues of safety, freedom from harm, abuse, use of seclusion or restraints?
10	If yes, were these addressed by the CM and the team?
11	Is the individual satisfied with major services?
12	If no, is action being implemented to resolve his/her concerns?
13	Does the individual have interests in any additional services, supports or activities?
14	Did the case manager/support coordinator provide information/ education to the individual or AR in the last ISP about less restrictive services?
15	Has the CM supported the individual in accessing needed services in the ISP?
16	Has the CM visited the individual as required during the past three months? (Every 30 days if enhanced CM, including one every other visit in their home, every 90 days if not enhanced.)
17	Was the individual offered choice among providers, including case managers, in the last annual ISP meeting?
18	Did the team discuss supported employment/employment services in the last annual ISP?
19	If yes, were employment goals and supports developed/updated and discussed in the last ISP?
20	If yes, did the case manager take necessary steps to support the individual towards employment?
21	Is the individual making progress on the employment goals in the ISP
22	Were there any behavioral crises or emergencies in the past year?
23	If yes, was the case manager involved and coordinating communication between provider, AR, REACH, individual?
24	If yes, did the case manager coordinate a team meeting?
25	If yes, did everyone attend who was needed?
26	Are supports and services consistent with the individual's choices, preferences, and with self-determination?
27	Is a team meeting needed? When it will occur?
28	If yes, will those attending include the most important individuals?
29	Are there any ISP outcome changes that are needed?
30	Any needed referrals?
31	Is the individual following a special diet?
32	Does the individual appear to need an assessment (or reassessment) for a special diet?
33	Does the individual require an adapted environment or equipment?
34	If yes, are these monitored and being implemented?
35	Are services and supports being provided in the most integrated setting appropriate to the individual's needs?
36	Are there goals/outcomes for which there is no progress and which the CM and the team have not attended to?
37	If appropriate, has the individual been provided referrals and support to acquire subsidized housing, rental assistance or bridge funding?

APPENDIX D

CRISIS SERVICES REQUIREMENTS

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 6, 2016

TABLE OF CONTENTS

Section 1: Overview of the Requirements- 2

Section 2: Purpose of the Review- 2

Section 3: Review Process- 3

Section 4: A Statewide Crisis System for Individuals with ID and DD- 4

Section 4A: Review of the Crisis Services Plan to Serve Children and Adolescents- 4

Section 4B: REACH Services for Adults- 13

Section 5: Elements of the Crisis Response System- 23

Section 6: Summary -32

Table 1: Total Referrals for Children-5

Table 2: Disposition at Time of the Crisis Assessment-8

Table 3: Disposition at the Completion of Mobile Supports- 8

Table 4: REACH Crisis Responses-13

Table 5: Outcomes for Individuals After the REACH Assessment-14

Table 6: Outcomes for Individuals Using REACH Services- 15

Table 7: CEPP and Crisis Prevention Follow Up-26

Table 8- Summary of Compliance -34

Appendix 1: Summary of Focus Groups in Region III-35

SECTION 1: OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the crisis services requirements of the Settlement Agreement. The review, which is for the time period 10/7/15-4/6/16, will determine the Commonwealth of Virginia's compliance with the following requirements: The Commonwealth shall:

- 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 potential crises, and
- provide 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.

This, the seventh review of crisis services and prevention, will focus on the recommendations made by the Independent Reviewer in his report of June 2015.

SECTION 2: PURPOSE OF THE REVIEW

This review will build off of the review completed in the fall of 2015 for the review period 4/7/15 through 10/6/15. It will also report on the status of the recommendations that the Independent Reviewer made in his last Report that resulted from the conclusions, findings and ratings of compliance of that review.

For this review, the ratings of compliance for the overarching crisis services provisions (III.C.6.a.i-iii) will be based on the status of development and operations of crisis services for children and adolescents as well as for adults. The remaining crisis services provisions will be rated based only on the crisis services for adults with ID/DD. The crisis services for children are being developed and refined. The Commonwealth does not expect its crisis services for children and adolescents with ID/DD to reach its performance milestones and compliance until after the next reporting period. The Independent Reviewer will begin including the crisis services for children into the reported compliance ratings for all crisis services provisions for the Report to the Court for the tenth reporting period.

The focus of this review will be on those areas that were determined previously not to be in compliance for adults, on all crisis services provisions for children, and on the Independent Reviewer's related recommendations. This focus will be on:

- The Commonwealth's ability to provide crisis prevention and intervention services to children with either intellectual or developmental disabilities, including providing out of home crisis stabilization services. The DBHDS was in the beginning phase of implementing these services across all five regions at the time of the review in the fall of 2015.

- The Commonwealth’s plan to reach out to law enforcement and criminal justice personnel to effectively work with individuals with intellectual and developmental disabilities to address crises and crisis intervention services to prevent unnecessary arrests or incarceration.
- A review of the DBHDS data for psychiatric hospitalizations for children and for adults
- The capacity of the system to provide the full range of behavioral supports that are needed by this population
- The quality of crisis services that individuals are receiving from the five regional REACH programs

SECTION 3: REVIEW PROCESS

The Expert Reviewer reviewed relevant documents and interviewed key administrative staff of DBHDS, REACH administrators and stakeholders to provide the data and information necessary to complete this review and to determine compliance with the requirements of the Settlement Agreement. The documents reviewed included those provided by the Commonwealth that it determined demonstrated its progress toward achieving compliance.

Document Reviewed:

1. State Children’s REACH Quarterly Report: IIFY16
2. State Children’s REACH Quarterly Report: IIFY16
3. State Adult REACH Quarterly Report: IIFY16
4. State Adult REACH Quarterly Report: IIFY16
5. Psychiatric Hospitalization Report for Adults: 7/1/14-6/30/15
6. Psychiatric Hospitalization Report for Children: 7/1/14-6/30/15
7. Scope of Work Design for Law Enforcement Training
8. DBHDS REACH Training Directive- 3/4/16
9. DBHDS Family Letter-1/12/16
10. DBHDS RFP to develop services for individuals with behavioral challenges and/or mental health needs- 7/15
11. Performance Indicators for Children’s Crisis Services
12. Behavioral Support Competencies for Direct Support Providers and Professionals in Virginia Supporting Individuals with Developmental Disabilities- 8/15
13. Letter from the disability Law Center of Virginia to Interim Commissioner Dr. Jack Barber- 3/24/16
14. Office of the State Inspector General Unannounced Inspection at Commonwealth Center for Children and Adolescents (CCCA)- 6/29/15

Interviews with DBHDS and REACH staff: I interviewed Heather Norton, Director, Community Support Services, Michele Ebright, Behavioral Psychologist, Lucy McClandish, Region III ID/D Director at New River Valley CSB, Denise Hall, REACH Director for Region III, Karen Adams, Assistant Director REACH Region III, James Vann, REACH Director Region I, and Amanda Cunningham, Children’s Coordinator REACH Region I. I also spoke with Jamie Liban, Executive Director of the Arc of Virginia, Shane Ashby, ID/D Director at Mt. Rogers CSB and the Director of Case Management there. I appreciate the time that everyone gave to contributing important information for this review.

Focus Groups: I conducted two focus groups in Region III, one in Marion and one in Roanoke. The focus groups included CSB Emergency Services staff, case managers, behaviorists, providers, parents and guardians. Advocates were invited but were unable to attend. The participants were very candid and provided a richer understanding of the crisis response system. I want to thank Lucy McClandish and Denise Hall for their efforts to coordinate these events and to arrange for suitable meeting space.

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 Settlement 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 in-home 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.*

A. Review Of The Status Of Crisis Services To Serve Children And Adolescents

DBHDS established timelines for the outcomes of the Children’s Crisis Service System. The department anticipates the following:

- A single point of entry in each region is in effect by July 2015
- A data system and data collection is implemented by July 2015
- All crisis calls are responded to within defined standards 60% of the time by December 2015
- All crisis calls are responded to within the defined standards 80% of the time by July 2016
- All crisis calls are responded to within defined standards 95% of the time by December 2016

The information provided below is from the two Children’s REACH Quarterly Reports that DBHDS provided for Quarters II and III FY16.

REACH Referrals- The Children’s REACH Programs received ninety-seven referrals in QII and 108 in QIII. In QII 43 (44%) of the 97 referrals were made in Region V. Of these, 33 (77%) of 43 were non-crises referrals. The number of referrals during QII in the other regions ranged from 11-17. There was an overall 11.3% increase in referrals, from 97 to 108, during QIII. During this third quarter, 39 (36%) of the 108 referrals occurred in Region I. Region II had the fewest referrals in both quarters, 12 and 7, respectively. The number and percentage of crisis versus non-crisis calls increased from 38 (39.2%) during QII to 70 (64.8%) in QIII. Families and CSB Case Managers are the primary source of referrals. CSB ES staff, schools, hospitals or other providers made fewer referrals.

Table 1 summarizes the referrals across both quarters.

Table 1: Total Children’s Referral Calls

Call Type	RI-QII	RI-QIII	RII-QII	RII-QIII	RIII-QII	RIII-QIII	RIV-QII	RIV-QIII	RV-QII	RV-QIII	Total
Crisis	11	28	2	0	11	19	4	12	10	11	108
Non-Crisis	0	11	10	7	6	2	10	4	33	14	151
Total	11	39	12	7	17	21	14	16	43	25	205

Time of Referral- REACH tracks the time and dates of referral calls. This is presented in a different chart and the numbers do not match the numbers in the Referral Breakdown by Type, which reflects the total referral activity. Region II, however, could not produce the data on time of call for QII. Region I cannot produce these data on time of call for QIII. Data are available for 187 of the referrals. This difference is not only caused by the lack of reporting by Regions I and II but because the other three regions data do not align for QII and the data for Regions III and V do not align for QIII. All of these regions report more calls in the Time of Referral Table than they report in the Referral Breakdown Table. Of the referral calls, 72% were received during normal work hours on Monday through Friday, whereas, 9% were received on weekends or holidays and 19% were received after 5PM on weekdays. This pattern of referral calls is a similar for adult with ID/DD. DBHDS needs to align its reports to be consistent and accurate.

Referrals for Individuals with ID and DD- The Children’s REACH Program is serving 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 and DD; and a developmental disability only. During QII 49 (46%) 46% of the individuals served had a developmental disability only. In QIII this increased to 64 (59%) of the individuals referred. The number of individuals served by disability type matched the total number of referrals in QIII. The number of individuals reported by disability groups in QII was nine more (106) than the number of referrals (97). Only 20% of children and adolescents served by REACH across the two quarters were reported to have an intellectual

disability only, compared to 88% for adults over the reporting period. DBHDS credits this difference between the referrals to the children's and adult programs in large part as a result of direct referrals from schools and schools making the families of students they serve aware of this crisis support. Since the schools serve both disability groups all outreach by the REACH programs to the schools will positively impact the knowledge of families of students with any intellectual or developmental disability.

Response Time- REACH staff responded to referrals that required an onsite response within the required time on average across all regions in both quarters. (*Note Region II did not report any crisis calls in QIII, only calls that were considered non-crisis.*) However, DBHDS did not report on actual response time for QII. Only two (3.1%) of sixty-four onsite responses were later than the standard of one hour in Regions II and IV and two hours in Regions I, III and V in QIII. This expectation has been met 97% of the time but only reflects half of the reporting period. Also Region I does not have the capacity to respond to calls for children after hours or on weekends. Region I relies instead on the ES staff within each CSB area to respond. This does not meet the expectations of the Settlement Agreement. DBHDS is working with this program and the regional CSBs to correct it.

Of interest is that most, but not all, regions respond onsite to every crisis call. Regions I and IV appear to respond to all crisis calls with an onsite response. It is somewhat difficult, however, to ascertain the actual number of crisis calls because the numbers on the Summary of Call Data and the Referral Breakdown by type do not match.

The location of the mobile assessments is also included in the data provided. The majority of the 104 assessments were done in family homes totaling 42 (40%). The next most common location for assessments was CSB ES settings where 29 (28%) were done. Twenty-six (25%) occurred in hospital/ER settings. Of note is that only one of these assessments by REACH was done at a CSB/ES in QII but that this increased to twenty-eight during QIII. This increase meant that CSB/ES locations surpassed hospitals/ERs as the second most common location for assessments during QIII.

The fact that twenty-six were conducted in hospital settings indicates that REACH is being notified more frequently of pre-admission screenings by CSB ES staff. DBHDS reports, however, that there were sixty-three admissions to psychiatric hospitals during the reporting period. Although, the crisis services requirements for children are intended to ensure services are provided in community-based settings, and to avoid unnecessary institutionalization for any child or adolescent with an ID or DD diagnosis, REACH programs were involved with fewer than half of the individuals who were admitted to psychiatric institutions. REACH was either only informed of, or only joined ES staff for 63 (41%) of these admissions. Without being notified, crisis stabilization services that are designed to provide a last resort alternative could not fulfill this responsibility.

Mobile Crisis Services- There were ninety-seven referrals in QII. Of these referrals, thirty-eight (39.2%) received mobile crisis services. In QIII this increased to seventy-eight (72.2%) of the 108 individuals who were referred received mobile crisis services. The number in QII matches the number of crisis calls. In QIII, seventy-eight were reported to have received crisis services

versus the seventy crisis calls received. QIII mobile crisis response data might include individuals who were already enrolled in REACH from a previous time period that required mobile crisis services.

DBHDS reports on the disposition at both the time of the crisis assessment and at the completion of the mobile support services. Of the individuals assessed by REACH 29 (21%) were hospitalized or placed in residential treatment at the conclusion of the assessment. More than half of the individuals were able to remain with their families without mobile supports and a total of 105 (77%) stayed home after the assessment, including the 34 (25%) whom needed mobile crisis support. This indicates that they may have been seeking preventative crisis support. Region IV is the only region that offered an out of home community-based crisis stabilization/last resort alternative for children with ID/DD.

The report on the disposition for individuals at the completion of mobile crisis supports shows a significant increase in the number of children who were able to remain living in their home. It is positive that 96 (80%) of the 120 of children and adolescents remained living at their homes after receiving mobile crisis services and did not need further mobile crisis supports. An additional 13 (12%) remained living in their homes with the provision of additional crisis support services. Only eleven (9%) of the 120 of children who received REACH crisis services during the period reviewed were hospitalized for psychiatric support or placed in residential treatment at the end of mobile supports being provided. This may be evidence of the effectiveness of a newly established program. DBHDS should report on-what mobile supports continue at the end of mobile supports being completed and report this information in all future quarters.

Table 2 illustrates the disposition at the time of assessment across both quarters.

Table 3 illustrates the disposition at the end of mobile support services, only for QII.

This data was not reported in QIII.

Table 2: Disposition at the Time of Crisis Assessment- 10/1/15-3/31/16

Region	Psychiatric Admission	Residential Treatment	Community Crisis Unit	Home with Mobile Supports	Home without Mobile Supports	Total
I	3	1		9	38	51
II*	1	1		3	7	12
III	7			3	13	23
IV	4		4	15	7	30
V	12			4	6	22
Total	27	2	4	34	71	138

*Region II did not report this data in QIII.

Table 2 has data for only half of the review period

Table 3: Disposition at the Completion of Mobile Supports- 10/1/15-12/31/15

Region	Psychiatric Admission	Residential Treatment	Home with Mobile Supports	Home without Mobile Supports	Total
I	3	1	9	39	52
II	1	2	3	13	19
III	1		1	4	6
IV				24	24
V	3			16	19
Total	8	3	13	96	120

Number of Days of Mobile Support- REACH is expected to provide three days of mobile crisis support on average for children and adolescents. During QII three of the regions exceeded this threshold. Region II could not report and Region V provided an average of 2.3 days. During QIII the four regions that reported averaged between 4 and 6 days. All exceeded the three-day average. Region II can still not report this data.

The Children’s REACH program is sending clinicians to homes, schools and other settings where children spend most of their time. Doing this is to help children who exhibit challenging behaviors to develop and to practice coping skills and to help parents, teachers and other caregivers to work effectively with the individuals. The Children’s REACH programs have begun to report on the types of services offered to children who receive Mobile Crisis Support. The data reported, however, is not complete and, in some instances, appears to be incorrect. The data align with the other charts that show the numbers of children who have received mobile supports in only two regions (Regions III and IV). Region I reports two more children than appear in the other charts, Region II cannot report. Region V reports serving fourteen more children (11 compared to 25). Regions III reported that it provided all of types of services to all of the children who received mobile supports in QIII. The QII report on Children’s crisis services did not include this data element.

The mobile crisis support services include: comprehensive evaluation, crisis education prevention plan (CEPP), consultation, prevention follow-up, and family/provider training. The CEPP and prevention follow-up are required for all REACH participants. This service, however, was not provided to all individuals in Regions I, IV or V. Region II was not able to report what types of services it provided.

Training- Children’s REACH staff have provided extensive training during the reporting period. The following groups have been trained:

- Law Enforcement- 46
- CSB employees- 558
- Family members and residential staff- 132
- ES staff- 113
- Hospital staff- 11
- Other community partners- 117

During QIII Region V had a special training initiative for parents to address issues facing adolescents as they go through puberty. Region III led a series of systems change trainings that involved a total of 294 individuals that are not reflected in the totals above.

Crisis Stabilization Programs/Crisis Therapeutic Homes- The Children's REACH programs do not have crisis stabilization homes, now called crisis therapeutic homes (CTH) in any of the regions. Such programs are required by the Settlement Agreement, DBHDS plans to issue an RFP by May 1, 2016 to develop out-of-home crisis respite services during FY17. There is funding available to develop two homes, or to develop an alternative approach to crisis stabilization model, such as therapeutic host/sponsor homes. DBHDS is finishing its review of psychiatric hospitalizations for both children and adults with ID and DD. The staff plans to use these data to determine the capacity that will need for children and adolescents, and whether additional CTH's are needed for adults. DBHDS will provide this report to the Independent Reviewer and Expert Reviewer by the fall of 2016.

Psychiatric Admissions- DBHDS reports on a total of sixty-three psychiatric hospitalizations that were known to Children's REACH programs during the reporting period. Forty-eight (76.2%) of the sixty-three individuals returned home. Two of the children were placed in foster care, two were placed in congregate residential programs, six were admitted to residential treatment facilities, and five children continued to be hospitalized. Of those hospitalized, eleven (17%) of sixty-three were not able to return home or to be placed with community residential supports. The sixty-three is a significantly larger number than the thirty-five individuals that REACH reported being involved with who were admitted to psychiatric hospitals, as reported in Tables 2 and 3. This difference is an indication that the Children's REACH programs are not yet meeting all children and adolescents who are screened for admission to a psychiatric facility, and are not becoming involved with all children with ID/DD once they are admitted to psychiatric institutions. It would help these children avoid future unnecessary hospitalization for these children and their families to have the support of the REACH programs, especially once the children return to their families' homes or to foster care.

DBHDS provided raw data on the admissions of children and adolescents to psychiatric facilities that occurred between 7/1/14 and 6/30/15. This is prior to both the current review period and to the full implementation of Children's REACH services. It provides a baseline of information, however, to compare future psychiatric admissions data since the children's crisis services have been made available. All of the admissions were to the Commonwealth Center for Children and Adolescents (CCCA). It is the only state operated psychiatric facility available for children and adolescents in Virginia. DBHDS acknowledges that it does not have information regarding hospitalizations for children that occur in private psychiatric hospitals. This makes it impossible for the Commonwealth to know whether its services to help children avoid unnecessary institutionalizations are available and effective.

There were 134 children and adolescents admitted to the only state operated psychiatric facility for children during FY15. These Children ranged from 3 to 17 years of age. Of these children, twenty-five (18.7%) were ten years of age or younger at the time of admission. Forty-four (33.6%) of them were between the ages of 11-14. All the children had been discharged by 6/30/15. Twenty-seven (20.1%) of them had a stay longer than thirty days. Dispositions occurred as follows:

- *1 went to jail who was age 17*
- *31(23%) went to mental health treatment centers*
- *4 went to specialized foster care*
- *85(63%) returned home*

Of the individuals that were placed in residential treatment:

- *3 were 7 years old*
- *2 were 8 years old*
- *2 were 9 years old*
- *4 were 10 years old*

There is no information regarding the transition for any of the individuals that were placed in residential treatment. It is not possible, therefore, to determine whether these were short term or long-term placements.

The Virginia Office of the State Inspector General (OIG) issued a report dated 1/12/16 of an unannounced visit made to CCCA on 6/29/15. The purpose of the visit was to review the quality of the services, make policy and operational recommendations, and assess the impact of the Safety Net Law (37.2.809.1[B]). The review considered all children placed at CCCA, not just those with ID or DD. The State Inspector General made one major finding:

1. Virginia lacks a system of adequate community-based services and supports, and appropriate settings to serve children and adolescents with ID, DD, ASD and forensic involvement. Until adequate programs are operational in the community, CCCA will continue to face challenges with bed capacity and possession of the staffing and programmatic resources necessary to provide quality services to diverse populations.

The State Inspector General report includes the following two recommendations:

- 1. The General Assembly (GA) should approve funding for the development of community based children and adolescents treatment programs including crisis services, and integrate treatment for children and adolescents with co-occurring conditions and that are forensically involved. DBHDS should publish a plan with targeted outcomes, dates and responsible parties. The report does note that the GA provided \$4.5 million starting in FY13 and added \$4.65 million in FY16.*
- 2. DBHDS and the State Board of Behavioral Health and Developmental Disabilities in collaboration with CSBs and the Virginia Hospital and Healthcare Association should develop short term alternatives to settings for children and adolescents and these alternative settings should be fully funded and operational.*

The report notes “children and adolescents with ID/DD and ASD are the fastest growing specialty population being admitted to CCCA accounting for approximately 27% of the total admissions.” The OIG report also highlights that CCCA has difficulty meeting the needs of children who are medically complex. Of the overall population at CCCA,

twenty-five (25%) are readmitted within one year. The OIG reported that a similar number (63%) of children with ID/DD and the general population went home. A higher percent of children with ID/DD (23%) compared to the percent (17%) for the overall population went to residential treatment facilities.

The OIG report highlights the current need for Children's REACH services and supports; for the DBHDS's current efforts to develop community based therapeutic respite; and for the analysis of psychiatric admission data to determine the amount of out of home crisis support for children that will be needed. It is apparent that the two crisis therapeutic homes for children and adolescents that are planned and funded for FY17 will be insufficient. Children with ID and DD will not have community-based alternatives to institutionalization for up to fifteen months until these new services are available. It also points to the need for a broad range of community based treatment services for this population, of which REACH crisis prevention and stabilization services will only be a part.

The Commonwealth's federally required advocacy entity disAbility Law Center (dLC) sent a letter to Dr. Barber, Interim Commissioner DBHDS dated March 24, 2016. The staff of the dLC expresses their concerns about the inadequacies of the behavioral supports in the community to prevent unnecessary psychiatric hospitalizations and speak against the use of the Training Centers for temporary placements for individuals in crisis. They find the community fragmented in its responses to these individuals. While the dLC is concerned for all individuals with ID or DD that experience unnecessary hospitalizations, they are particularly concerned about the plight of children and adolescents. Their concerns echo those of the OIG, Focus Group attendees, and the Independent and Expert Reviewers.

Recommendations- DBHDS should respond to the State Inspector General's recommendations to develop a range of community-based supports for children with ID and DD. It should develop an implementation plan that includes the development of out of home crisis stabilization services and the expansion of community based behavioral supports. These supports should include sufficient capacity to provide needed in-home support and community residential options in all five regions. DBHDS should report how it plans to meet the needs of children for out-of-home crisis stabilization until the two homes are fully operational. It should also report what will be done to address the needs of individuals who cannot be supported with these twelve beds.

Performance Indicators for Children's Crisis Services- DBHDS has developed seven performance indicators for Children's REACH services. These include expectations for:

- a plan to track the use of crisis stabilization beds and the disposition of those served;
- the creation respite beds as a preventative strategy;
- quarterly reviews of the regional programs' adherence to standards and clinical reviews;
- annual quality reviews of psychiatric hospitalizations and the involvement of REACH crisis services programs;
- a retrospective review of psychiatric hospitalizations during FY15;
- the development and implementation of improvement plans to address identified areas of improvement; and
- data collection regarding individuals who come into contact with law enforcement.

DBHDS will report quarterly for the adherence to performance contracts and for clinical reviews. Data collection was scheduled to begin in January 2016. Data about law enforcement interaction was to be available for the quarter January through March 2016. This review was completed before these data were scheduled to be available. The remaining performance expectations will be reported between June and December 2016.

DBHDS did not provide information from the quarterly reviews of the five regional REACH programs. This will be useful information to have for future Expert Reviews including the clinical reviews of case studies. DBHDS did report the interaction with law enforcement for both children and adults. There were nine calls to the Children’s REACH programs that involved law enforcement during QIII. A total of seven children were involved. Two of the children were involved with law enforcement twice each. REACH programs were involved in all of these situations. Six of the calls were resolved so that the child remained in the community. Two children were admitted to the state operated CCCA. There are no data for one of the children.

B. Reach Services For Adults

REACH Referrals- the data from two quarters FY16 Quarter II (QII) and FY16 Quarter III (QIII) were reviewed for this study. Regions received a total of 383 referrals of adults with ID/DD during this period. This compared with a total of 353 during the previous review period. Region V continues to have the lowest number of the referrals, 44 referrals (11%). Region III accounts for 127 (33%) of the referrals. The Quarterly Reports do not specify how many individuals are served by REACH in a quarter. The data on dispositions of individuals who have used REACH services, however, can be extrapolated. REACH served 545 individuals during the period. As with referrals, more individuals were also served than in the previous reporting period.

Table 4- REACH Calls and Responses summarizes the call information. Overall only 551 (73%) of the 749 crisis calls received a face-to-face response. Regions I and IV responded with an on site face to face staff response to 100% of the crisis calls during QII. All regions, except Region V, responded with 100% on-site face-to-face responses to all crisis calls during QIII. Region V had the more of crisis calls (122) that the other regions during QIII. Region V, however, only responded to only 41 (33.6%) of them onsite. There was no explanation provided for this disparity. The majority of the calls, 68% during QII and 71% during QIII, were for non-crisis prevention or for a brief information consultation. This is an indication of the positive crisis prevention outcomes for some of the REACH crisis services.

Table 4- REACH Calls and Responses		
Calls	Quarter II	Quarter III
Total Calls	1097	1298
Crisis Calls	351	398
Face to Face Response	234	317
% of Crisis Calls w/ Direct Response	67%	80%

During this reporting period, Case Managers continued to make the highest number of referrals to REACH. Community Service Board ES staff combined with hospitals were the two next most frequent referral sources. Case Managers were the referring source for 22-74% and 32-83% of

the referrals in the two quarters respectively. In both quarters they are by far the primary referral source in Region V where there were no referrals made by the CSB ES programs. Emergency Services staff made between 13-24% of the referrals during QII statewide, but none came from Regions IV or V. During QIII between 6-24% of the referrals came from the CSB ES programs, but again no such referrals came for the CSB ES programs in Region V. DBHDS should learn how and whether REACH is appropriately involved in hospital screenings Region in V where so few or no referrals are made by these region's CSB ES programs. Region IV's ES staff make the referrals through the CM's so the referrals show up under Case Managers rather than ES staff.

Statewide crisis services were provided as follows during the reporting period:

- ✓ 299 adults received Crisis Stabilization/CTH services and 305 adults received Mobile Crisis Support
- ✓ 153 individuals served required crisis stabilization in the CTH program
- ✓ 149 individuals served in the CTHs received planned respite and crisis prevention support

Approximately the same number of individuals access mobile crisis support as access the crisis stabilization/CTH program.

The following two tables provide information on the first dispositions for individuals. Table 5 provides the dispositions after the individuals' initial assessments by REACH. Table 6 lists the dispositions after the individuals received either mobile or crisis stabilization/CTH services from REACH. In both cases the majority of individuals, a total of 753 (67%) retained their residential setting after the assessment. A higher percent (20%) of individuals were hospitalized after the assessment. A much smaller percent (6%) of the individuals who received REACH services were hospitalized.

No one needed continued mobile crisis support after receiving REACH services (Table 6), yet 84% of these individuals retained their setting. This is an indication of the effectiveness of REACH mobile supports and its CTH program.

Table 5- Outcomes for Individuals after the REACH assessment shows the outcome for individuals at the completion of the crisis assessment during the reporting period.

Table 5- Outcomes for Individuals after the REACH Assessment				
Outcome	QII	QIII	Total	%
Retain Setting	153	148	301	51%
Hospitalization: Psychiatric	45	76	121	20%
Hospitalization: Medical	2	4	6	1%
Jail	0	1	1	<1%
Crisis Stabilization (CTH)*	26	39	65	11%
Mobile Support	53	41	94	16%
New Group Home	1	2	3	<1%
Total	280	311	591	100%

* includes Community Crisis Stabilization Unit admissions

Table 6- Outcomes for Individuals using REACH Services shows the outcome for individuals supported by a REACH program during the reporting period.

Table 6- Outcomes for Individuals Using REACH Services				
Outcome	QII	QIII	Total	%
Retain Setting	243	209	452	84%
Hospitalization: Psychiatric	14	17	31	6%
Hospitalization: Medical	2	0	2	<1%
Jail	0	2	2	<1%
CTH	14	10	24	4%
New Residence	0	25	25	5%
Training Center	0	1	1	<1%
Other	0	1	1	<1%
Total	273	265	538	100%

Psychiatric hospitalizations-DBHDS provides an addendum to its quarterly report. The addendum reports additional data on the outcomes for individuals who are hospitalized as a result of the crisis. They also report whether these are new or active cases. DBHDS is to report whether these individuals eventually return home or whether an alternative placement needs to be located. A total of fifty-nine individuals who had contact with REACH were reported admitted to psychiatric hospitals in *Tables 5 and 6*. The addenda provide different data regarding psychiatric hospitalizations and the known dispositions. These data indicate that DBHDS is aware of 229 psychiatric hospitalizations of individuals with ID/DD. This is thirteen more than during the previous reporting period. The department notes that these data do not reflect, and that it does not know, the total number of individuals with ID/DD who are admitted to private psychiatric institutions.

The DBHDS report contains the known dispositions for more than the known number of individuals. This is confusing but may be the result of more than one admission for some individuals. In QII one region does not know the disposition of all of the individuals, while two regions report more dispositions than individuals. In QIII one region does not know the dispositions of all individuals and one region over reports. The following dispositions occurred:

- 62% of individuals retained the original placement or moved with family
- 14% remained hospitalized
- 9% used the REACH Crisis Stabilization/CTH
- 7% were able to move to a new appropriate community residential setting or to an Assisted Living Facility (ALF)
- 6% were in an "Other" category that included jail for 2 individuals and for short term respite situations
- <1% were placed at a Training Center

Outcomes were not positive or were only temporary for 31% of the individuals hospitalized. This is the first time that an individual's disposition when discharged from psychiatric hospital has been a Training Center.

This is not the total number of hospitalizations of individuals with ID and DD. There are data inconsistencies and there is not reporting from private hospitals.

DBHDS reports that the REACH program remains actively involved with all individuals who are hospitalized when they are aware of the hospitalization. The revised REACH standards require REACH to join the ES staff for every screening and stay involved with everyone who is hospitalized as a result of the screening. REACH staff participates in the admission, attends commitment hearings, attends treatment team meetings, visits, and consults with the treatment team. The data in the Quarterly Reports, however, for the individuals with whom REACH is involved, indicate that REACH is not involved with everyone who they know is hospitalized. There is a vastly larger number of individuals reported in the addenda with no indication or explanation of REACH involvement with the additional individuals who are hospitalized but who are not referred to in the body of the quarterly reports. The inconsistency in data reporting was raised in the last Expert Reviewer's report. The inconsistency, which continues, was not explained in either of the quarterly reports reviewed for this period. The inconsistency should be explained.

Recommendations: DBHDS should ensure that every individual with an ID/DD who REACH or DBHDS knows was admitted to a psychiatric hospital is engaged with REACH staff during their hospitalization.

Training-DBHDS requires all Case Managers and CSB Emergency Services staff to be trained about REACH Crisis Services. DBHDS is requiring all existing staff to be trained by June 4, 2016 and all newly hired staff to be trained within thirty days of hire. Chief Deputy Commissioner Kathy Drumwright sent correspondence to all Executive Directors, Developmental Disability Directors, and Emergency Services Directors on March 4, 2016 informing them of this requirement. The REACH module is available through the DBHDS Knowledge Center.

The quarterly reports for QII and QIII document that the REACH Adult Programs continue to provide extensive training to a range of stakeholders. The five regional REACH programs trained more than 2,000 individuals during the reporting period. This included:

- *Law Enforcement- 395*
- *CSB employees- 571*
- *ES staff-111*
- *Family and other caregivers-307*
- *Hospital staff-125*
- *Other community partners- 617*

The numbers of staff who were trained in various groups differ across the regions. Regions II and III trained the fewest law enforcement personnel. Region IV did not train any ES workers or family or other caregivers. Region V did not train any family or other caregivers. Region I's training of hospital staff accounted for 121 of the 125 who were trained.

Recommendations- The amount of training completed by REACH staff is impressive. It remains concerning, however, that the DBHDS does not establish expectations for training, report on, analyze, or explain the extreme variances across regions in some of the training by stakeholder groups. DBHDS now requires CSB Case Managers and ES staff to be trained. They use the DBHDS online material available. DBHDS has developed a new training initiative for law enforcement personnel, which is described later in this report. It would be helpful for DBHDS to establish statewide expectations for the training of family members and other caregivers.

Outreach to the DD Community- DBHDS is implementing a plan to reach out to individuals with DD, their families, providers, and the broader community serving individuals with DD, other than ID. DD Case Managers are now receiving training and information regarding REACH services. ES staff is trained to understand that REACH services are also a resource for individuals with DD. DBHDS reports that it has enhanced its communication with state-operated and private mental health hospitals. To educate families and providers REACH staff have presented at statewide and local conferences. DBHDS continues to work with other partners including Commonwealth Autism Service, Virginia Autism Center for Excellence, and the Arc of Virginia to help distribute information about the REACH Programs. This was a topic of the two focus groups that this reviewer conducted in Region III. DD Case Managers were invited but none attended possibly because attendance at such an event would not be billable for them.

The individuals who attended the Focus Groups did not generally differentiate between individuals with ID and those with DD, other than ID, in terms of access to appropriate behavioral supports. The exception is that the current list of DD waiver funded services does not include 24 hour supervised residential settings.

Heather Norton, Director of Community Support Services did send a letter on January 12, 2016 to all individuals, who are on the either DD waiver or the waiting list, and their families that explained the availability of REACH services. The letter provides a link to REACH information on the DBHDS website. This information is descriptive and provides information about accessing REACH services in all five regions.

Serving individuals with developmental disabilities-The REACH programs reported serving more individuals with DD, other than ID, than has been reported during past review periods. Sixteen individuals were served in QII, which represents 10% of the population. An even greater number was served in QIII: twenty-eight individuals with DD only. This represents 13% of the REACH population. The percentages of individuals with only a DD who have been served by REACH have been 5% or less in previous reporting periods. This appears to be evidence of greater outreach to the DD community. Ms. Norton's letter in January may have in part led to the increase during QIII.

Building Behavioral Capacity- I noted in the previous Crisis Services Requirements Report that REACH crisis services programs can only be effective if they are part of a continuum of community-based supports and services for individuals with co-occurring conditions or challenging behaviors. During the current review period and for this report, I reviewed the adequacy of existing behavioral supports to meet the needs of individuals in the target population.

On July 15, 2015 DBHDS issued a Request For Proposals (RFP) to develop residential homes for Individuals with ID/DD and Challenging Behaviors and/or Mental Health Issues. Responses were due on July 24, 2015. The RFP was developed to help the Commonwealth to build the capacity to effectively address the needs of individuals who demonstrate challenging behaviors and/or mental health issues. The new capacity is being specifically targeted to meet the needs of individuals who will be transitioning from the Southwest Virginia Training Center (SWVTC). DBHDS reports that approximately fifty-five individuals who live at the SWVTC have these needs. The RFP also includes an estimate of 200 more individuals with similar needs who also live in Region III. DBHDS seeks to select at least one provider, and up to three, who will develop community service options for the individuals moving from the SWVTC and to increase the community capacity in Region III for individuals that will need a similar service. DBHDS proposes the development of residential options that include small homes, sponsor homes, and supervised apartments. Homes will ideally serve no more than four individuals, although, an exception can be made to serve five individuals in one home. DBHDS is asking for the selected provider(s) to commit to giving preference to the following individuals transitioning over a ten-year period:

- *Residents of SWVTC*
- *Residents of other training centers*
- *Residents of mental health facilities*
- *Individuals who are incarcerated*
- *Residents of large ICF-IIDs or out-of-state facilities*
- *Individuals that would otherwise be placed in one of the options listed above*

DBHDS expects a comprehensive set of services and supports for individuals with behavioral challenges and/or mental health needs. These services and supports include: residential and day services appropriate to individual needs; in-home crisis supports and out-of-home crisis stabilization; step-down crisis stabilization from MH facilities, large ICFs, and jails; cross-system crisis prevention and intervention planning; and specialized staff. Staff will include BCBA's and certified Behavioral Support Professionals (BSPs).

DBHDS expects to have up to four residential settings developed by August 2016 to provide community-based residential support for individuals with challenging behaviors. DBHDS expected to make these awards before this review period ended but had not done so as of April 29, 2016. The funding is available and DBHDS plans to award funding to three or four providers. These providers will be able to partner with REACH programs, as needed. They are expected, however, to hire and train staff with greater levels of behavioral competencies who will effectively address the needs of its participants without relying on REACH crisis services. Since the awards have not been made, I was not able to review the provider proposals to understand how they propose to secure the services of BCBA's and BSPs.

DBHDS reports that providers in Region IV have a higher level of behavioral competency and capacity. This is supported to some extent by anecdotal information from Regions I and III. Some individuals who use the Region I and III crisis stabilization/CTH programs end up being referred to and accepted by waiver providers in the Region IV catchment area. DBHDS has funding to issue a similar RFP in Region II to develop these behavioral supports during FY17. The last phase of this provider capacity building initiative may be to develop similar capacity in Regions I and V.

DBHDS is expanding the number of staff who are qualified BSPs in Region III and throughout the REACH program statewide. In May 2016, Mt. Rogers is scheduled to start training and will offer it to twenty-two professionals. It was reported at both the Fall 2015 and Spring 2016 Focus Groups that very few individuals complete the training and become certified. This is in part due to the extensive plan that is required of, but not completed by most, trainees until after the classroom training is finished. Many find it difficult to complete this requirement while attending to the responsibilities of their current jobs. DBHDS is trying to address this by having the creation of the plan be incorporated into the training process. This will give participants more dedicated time to complete the plan. This change would also result in staff being certified based on their demonstrated knowledge when the training is completed. When the second phase of certification process occurs after the completion of the plan, then the staff will be certified and able to begin mentoring others.

DBHDS has funded BSP training for staff of the REACH Children's and Adult's Programs. It is expected that each REACH Coordinator and Navigator will be certified within two years. Training will begin for four staff of the REACH Region III program during the summer of 2016. Other regions will each send to the BSP certification training between two and four staff from either the adult or children's programs. REACH staff will be given sufficient time to have their portfolio/plans completed.

The Commonwealth has established a differential pay rate for BCBA's. The new pay rates that will take effect when the new HCBS waiver is implemented in July 2016. DBHDS believes that the higher pay rate will attract more BCBA's trained professionals to serve individuals with ID or DD who have behavioral challenges and experience crises.

DBHDS defined behavioral support competencies for direct support staff and for professionals. These were issued in August 2015. Competencies are defined for two levels for professionals: qualified DD professionals and behavior interventionists. There is an extensive list of competencies to assist staff to more successfully plan, assess and deliver support services for individuals with behavioral challenges. The document stresses the engagement of individuals with developmental disabilities participating in the individual service planning process. The department has also developed a Skill Competencies Professional Development Tracker to help providers monitor the professional development of staff working with people with ID and DD. It is to illustrate evolving skills, abilities, abilities and progress toward proficiency in each competency area. It is to be used by staff to gauge one's own progress, by supervisors to document professional development, or by organizations to document training and development offer professional opportunities. It tracks training received, the demonstration of skills implemented, and the determination of the proficiency. Proficiency is demonstrated by successfully completing college course work; conference and workshop attendance; involvement in professional

development activities; receiving coaching, mentoring or technical assistance by a skilled professional; observed practice of the skill area; and demonstration of the skill.

Interviews and Focus Groups in Region III- The Independent Reviewer asked me to focus part of this review to determine the Commonwealth's current capacity to meet the needs of individuals with behavioral challenges and to enhance our understanding of the Commonwealth's needs and efforts to building its capacity to meet the behavioral needs of the individuals served. The last review included a more specific analysis of services in Regions I and IV. That review included focus groups and a review of records of randomly selected individuals who had been admitted for psychiatric hospitalizations.

During March 2016, for this review, I conducted focus groups in Marion and Roanoke. I also met with and interviewed Region III REACH managers, the ID/DD Directors from Mt. Rogers and New River Valley CSBs, and the Case Management Director from Mt. Rogers. I also visited both the existing crisis stabilization home/ CTH and the new home under construction.

The Focus Groups were asked about the existing capacity of the community service system to support individuals with ID/DD; the quality of REACH services; the interface of REACH with both CSB Emergency Services (ES) staff and CSB case managers; and the recommendations that would improve the existing system. Case Managers, ES and hospital discharge screeners, CSB Directors, and parents attended. Attachment 1 includes information gathered through these discussions.

Twelve individuals attended including case managers, ES staff, parents, CSB administrators and disability rights professionals. They were asked to comment on the following issues:

- The existing elements of the community crisis services system
- The capacity of the crisis services system to address the needs of individuals with ID and DD
- The availability of behavioral supports, family support, residential services and day services for this population
- The responses to crises by ES and REACH staff and how they interface
- The coordination of REACH services and the individual's service planning team
- The ways in which the crisis system can be enhanced

The focus group participants expressed concerns were about the limited capacity of many aspects of the community service system. The areas of limited capacity to meet existing needs includes the insufficient number of crisis stabilization/CTH settings; the woeful lack of BCBA's and Professional Behavioral Specialists; the lack residential options in the DD waiver; and a shortage of residential and day providers that can effectively address behavioral challenges and co-occurring conditions. Both focus groups expressed dissatisfaction with the services at the psychiatric hospitalizations that are available to individuals with ID and DD. These facilities were reported to have little expertise to address the unique needs of individuals with ID or DD including adults and children. Children cannot remain close to home when they are admitted to hospitals that are often far away. REACH was often complimented for specific work. These comments support the findings of the Office of the Inspector General, the findings in this report, and the system building efforts of DBHDS. The Commonwealth's service system needs to develop significant additional capacity for the entire crisis support system to be effective and responsive and to meet the needs of individuals with behavioral challenges.

What were particularly heartening were the overwhelmingly positive comments and examples of experiences with the Region III Adult and Children's REACH programs. REACH is known for working in collaboration with the CSBs and service providers. The REACH programs were reported to communicate and coordinate well with Case Managers, to be responsive to ES staff requests for their participation in hospital screening, and with linking individuals and their families to community resources. No participants in the focus groups expressed any concerns about the REACH program's effectiveness or with the efforts of the REACH staff.

My interviews with the leaders of the Region III REACH program provided some insight about the positive reaction community stakeholders have about the REACH program. This is only one of two REACH programs in the state that serves both adults and children under the direction of one REACH Director. The other program is in Region IV. The REACH Coordinators in Region III are QMHPs with a four-year college degree and at least one year of clinical crisis experience. The program seeks to work with providers and schools as equal partners. Providers are generally receptive to REACH training and technical assistance. The Director uses a case study and peer review process to build staff's crisis planning and implementation abilities. The Assistant Director is a Master's Level behavioral professional. The program works collaboratively with the existing community system with a focus on prevention. The staff acknowledges the fragmentation of the system for children and the lack of adequate resources for both children and adults that experience crises. Region III has modeled its crisis service for children on those that have been successful for adults. The REACH program sponsored systems change training for the region within this reporting period.

Conclusions: The DBHDS is not in compliance with *Section III.C.6.a.i, or 6.a.ii or 6.a.iii*. The program elements are in place for adults with ID, now for those with DD but not fully for children with ID or DD. Data is not robust yet for children so these determinations cannot be made. The REACH teams are responding to crises directly more of the time, providing mobile supports, and offering the CTH program for crisis stabilization, prevention and transition from hospitals. Most individuals are supported to stay in their existing setting.

DBHDS is not in compliance with 6.a.iii. The data available cannot substantiate that services are sufficient to prevent unnecessary hospitalizations. Almost 20 % of adults and children referred to REACH were hospitalized after the initial mobile crisis assessment. The data does not include sufficient information as to whether all of these were clinically necessary or may have resulted in hospital stays past stabilization due to a lack of appropriate and effective community resources. When reviewing the other report for adults with psychiatric admissions, 32% had poor outcomes that did not include permanent effective supports and services in community settings.

The Commonwealth also needs to continue its systemic improvements if individuals are to stop experiencing multiple and unnecessary hospitalizations. REACH is one part of the system that provides a variety of temporary crisis supports. REACH must be complimented by a strong, well trained residential and day provider network that has expertise in providing effective mental health and behavioral supports; the availability of mental health community supports; the availability of behavioral support specialists; psychiatric settings with expertise in ID and DD; and effective discharge planning for individuals who are hospitalized or incarcerated.

DBHDS does not have a statewide crisis system in place for children and adolescents who experience a crisis since it does not have out of home crisis stabilization.

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 to crises. There were 410 calls to REACH reported in the data the DBHDS provided about the time of day referrals were made for this reporting period. This varies from the 383 referrals although the higher number of calls may reflect more calls from one individual. Only 18% of the calls were received outside of regular business hours. This continues the trend from previous reporting period. The type of call is reviewed in greater detail earlier in this report.

Conclusion: The Commonwealth is in compliance with *Section III.C.6.b.i.A.*

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 continue to train CSB ES staff and report on this quarterly. During this reporting period four regions provided training to CSB ES staff; Region IV as noted earlier did not. The total ES staff trained during this reporting period was 101 which is significantly higher than either of the two previous reporting periods in which twenty-four and sixty-three ES staff was trained. DBHDS requires ES staff to take the online training so it appears this training is supplemental.

Conclusion: The Commonwealth remains in compliance *with Section III.C.6.b.i.B* because the REACH programs continue to train ES staff and a standardized curriculum has been developed that is required of all ES staff.

Recommendation: DBHDS should report as to how it monitors that all ES staff complete the online 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.

The National Center for START Services at UNH continued to provide training to the REACH staff in Regions I and II. REACH leaders in Regions III, IV and V have worked together to develop a training program that will provide similar training for their staffs. DBHDS has reviewed and approved the curriculum for use across the three regions as reported in the last Crisis Services Report. The REACH standards require comprehensive staff training with set expectations for topics to be addressed within 30, 60 and 120 days of hire. Staff must complete and pass an objective comprehension test. Ongoing training is required and each staff must have clinical supervision, shadowing, observation, conduct a case presentation, and receive feedback on the development of Crisis Education and Prevention Plans from a licensed clinician. DBHDS does not provide information on the numbers of REACH staff that take the training. The qualitative clinical reviews that DBHDS is conducting were not provided to the Expert Reviewer. DBHDS also did not provide information as to whether all Regions are meeting the program standards. Absent individual reviews in this review, it is not possible to comment thoroughly on the effectiveness of REACH interventions.

From the data in the Quarterly Reports it appears that REACH services for adults are providing significant preventative support. The majority of individuals who receive mobile crisis services are maintained in their home settings as is evidenced in Table 6. In this reporting period 84% maintained their residential setting and 5% moved to a new appropriate community setting. Another 4% used the CTH, but their final disposition is unknown. However there is no qualitative data to support the type of services and supports the mobile crisis teams offer which would help determine the effectiveness.

Conclusion: The Commonwealth is not in compliance with Section 6.b.ii.A. In the absence of other data it is not possible to determine that compliance has been achieved. This reporting period did not include any qualitative case reviews. DBHDS reported it is doing quality reviews on a quarterly basis that include case studies. None of this information was shared with me. Also, no data on training of REACH staff was included. It is not possible to make any qualitative judgment as a result

Recommendations: DBHDS should report in the future about the number of REACH staff that complete and pass the required training. DBHDS should also report on the findings of its quarterly qualitative reviews and its analysis that the Commonwealth's performance standards for the qualitative aspects of this provision have been achieved.

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 teams continue to provide response, crisis intervention and crisis planning. DBHDS reported providing these services to 223 individuals in QII and 281 individuals in QIII; 504 individuals in the reporting period. This is significantly lower than last reporting period when 659 individuals received services. These numbers are extrapolated from the quarterly reports that list service type by three categories: Mobile Crisis Support; Crisis Stabilization-CTH; and Planned Prevention-CTH. There may be some duplication in the numbers, if some individuals received more than one of these services.

These services included crisis prevention, crisis intervention/prevention planning, crisis stabilization, medication evaluation, therapeutic treatment planning and follow up. Reversing previous review periods, more of these services were provided to 315 individuals through Mobile Crisis Support than the 299 individuals served through the crisis stabilization/CTH programs. These numbers are not an unduplicated count of individuals. Some individuals are likely counted more than once since some individuals receive both mobile support and use the CTH program.

The REACH Standards now require that all individuals receive both crisis education prevention planning and crisis prevention follow up services. The planning results in a Crisis Education Prevention Plan (CEPP) for an individual. The other services may or may not be needed depending on the needs of the individual. The REACH programs in Regions I and II did consistently provide these required elements throughout the review period in both the mobile support program and the crisis stabilization/CTH programs. Regions IV and V were particularly low in the number of CEPPs completed in both settings. Region IV provided prevention follow up to 10% of its participants in all settings. Region V did not provide prevention follow-up services.

The revised standards were in effect July 2015. The performance of the regions improved during this quarter. During this quarter Regions I and III achieved 100% compliance with the requirement to complete a CEPP and to provide crisis prevention follow-up. Region II has not complied with the requirement to provide consultations for prevention follow-up. The overall statewide level of achievement is not in compliance because of the lack of this consistency in Regions II, IV and V. Neither Regions II nor IV reports providing any prevention follow-up services during QIII. Table 6 provides a summary of the plans and follow-up completed and the level of compliance by quarter and for the overall reporting period.

Quarter	Number of Individuals	CEPP done	Percentage of CEPP done	Follow-up done	Percentage of follow-up done
QII	323	231	71%	296	92%
QIII	281	202	72%	101	36%
Overall Compliance			72%		66%

Conclusion: The Commonwealth is not in compliance with *Section 6.b.ii.B*. The REACH programs are not consistently developing CEPPs. They are also not providing strategies and quality follow-up that is adequate to help prevent recurrences of crises experienced by individuals and their families. It is very positive that REACH programs are now required to complete CEPPs. The REACH programs significantly improved follow-up during QII in both areas but this was not sustained for prevention follow-up in QIII.

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 (CTH) program. During the QIIFY16 of this review period 159 officers were trained and 236 were trained during QIIIFY16 for a total of 395 trained police officers compared to 339 in the last reporting period.

This training was provided in all five regions, although Region III trained only four officers and Region II trained only 22.

DBHDS is contracting with Commonwealth Autism to provide training to law enforcement personnel between 2/29/16-6/30/16. The training will provide an overview of intellectual and developmental disabilities. Commonwealth Autism will provide twelve two-hour sessions over the four months. The organization will also provide access to web-based training modules for one year (7/1/16-6/30/17) as follows:

- Module 1- Overview of Developmental Disabilities
- Module 2- Understanding Behaviors Associated with Developmental Disabilities
- Module 3- Response Strategies for Calls Involving Individuals with Developmental Disabilities

There is also a brief description of REACH Services and contacts for law enforcement on the DBHDS website.

DBHDS can also report on individuals who had interaction with law enforcement during their crisis. During QIII sixty-two adults engaged with law enforcement. REACH was involved in all of these calls.

- *23 stayed in the community*
- *5 were admitted to the CTH*
- *2 were admitted to a correctional facility*
- *3 were hospitalized for medical reasons*
- *27 were admitted to psychiatric hospitals*
- *4 had other dispositions*

These are good data for DBHDS to now be able to report. Having more in-depth information on the reasons for the hospitalizations will be helpful in the future.

Conclusion: The Commonwealth is in compliance with *Section 6.b.ii. C* since many officers have been trained in this reporting period. DBHDS has made some information available to law enforcement departments through its website and has retained Commonwealth Autism to provide more comprehensive training directly. This training will also be available in the future to new law enforcement personnel.

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

As reported earlier in Section 4, the REACH Mobile crisis teams are available around the clock and respond at off-hours. There were 553 mobile assessments completed during this reporting period, a significant increase compared to the 260 mobile assessments performed during the previous reporting period. The assessments conducted in individuals' homes, day programs, or another community location where the crisis occurred totaled 43.5% of all the assessments. This is lower than the previous two reporting periods. However, 47% were performed at either a hospital/ER setting (42%) or at an ES/CSB (5%) location. This is higher than either of the previous reporting periods (35% and 38%). This is an indication that the DBHDS requirement that REACH participate in all hospital screenings is being met. Other individuals were assessed at the CTH setting (6%) with the majority being assessed there in Region II (22 of 35 individuals statewide). Nine individuals were assessed at jails, police stations or nursing homes.

The number of individuals who were assessed in their families' homes compared to residential program settings continues to be substantially equal (109 in the family home and 119 in a residential program). This continues the pattern found in the previous periods. This steady engagement by residential providers with the REACH programs may reflect a greater understanding of the benefits of the REACH crisis services and the expertise of the REACH staff.

The trend of referrals being made primarily during normal business hours continues. REACH received a total of 383 referrals during the reporting period which not all require an assessment or onsite response. Seventy-six of these calls came either on weekends (21) or after 5 PM weekdays (55). This compares with forty-four calls in the previous reporting period. Eighty-three percent of all of the calls were made during the normal workday hours. Unlike the previous reporting period all regions received calls on weekends or holidays.

Conclusion: The Commonwealth is in compliance with *Section III.C.6.b.ii.D.*

E. Mobile crisis teams shall provide in-home 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 is devoted to a particular individual. Most regions provided individuals with more than three days on average of in-home support services with the exception of Regions I and V in QII that averaged 1.8 and 2.4 days respectively. Both were above three days on average in QIII with Region V increased to 21.1 days. It may be that some individuals needed fewer days than three for unique reasons including waiting for a bed at the CTH, or for discharge from a CTH. Other regions provide more than an average of three days. It is documented, therefore, that individuals can get an additional three days of support if needed, and possibly more.

Regions vary in the number of individuals served and the total numbers of days of community-based crisis services provided. The range of individuals served was 28 in Region III and 40 in Region V during QII and 13 in Region III and 40 in Region IV during QIII.

Conclusion: The Commonwealth is in compliance with the requirement of *Section III.6.C.b.ii.E.*

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 have added staff to the existing teams. The added staff has resulted in sufficient capacity to provide the needed crisis response within the one and two hours as required. Regions II and IV are urban areas and are expected respond to a crisis referral within one hour.

There were 234 onsite responses in QII and 319 onsite responses in QIII for a total of 553 onsite responses. DBHDS reported on the response time for all but two of these responses. This is a major improvement. Eighteen calls in QII and twenty-four calls in QIII were not responded to in the required time period. The state's records indicate that it responded to 92% of crisis calls within two hours. Reasons for delays usually had to do with traffic.

Conclusion: The Commonwealth achieved compliance with *Section III.C.6.b.ii.G.* and *Section III.C.6.b.ii.H*

Recommendation: DBHDS should address and resolve the lack of an on-call response for children in crisis in Region I

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 now have a crisis stabilization program providing both emergency and planned respite. All Regions have six beds available. Region IV remains in its temporary location. DBHDS reported that the ground breaking was 10/15/15. The Region hoped to transfer the CTH to the new location in March 2016 but it is now delayed until July 2016. The Region III CTH has seven beds, which exceeds the limits allowed by the Agreement.

There were a total of 297 visits to the CTH crisis stabilization programs. This is a slight decrease over the number reported during the last reporting period (327). There were slightly more visits for crisis stabilization (151) than for crisis prevention (146). It is very positive that DBHDS continues to offer planned respite in the REACH Crisis Stabilization Units for individuals at risk of crises. Almost half of the individuals use it for this purpose. This type of planned respite is very beneficial to families who continue to care for their relatives at home.

The average length of stay continues to meet the requirement that stays not exceed 30 days. The average lengths of stay are as follows:

- *Prevention- 4-18 days in QII and 4-20 days in QIII*
- *Crisis Stabilization- 14-29 days in QII and 12-19 days in QIII*

Although, requested to do so in my previous report, DBHDS does not report on each length of stay for individuals whose stays exceeded the Agreement's explicit cap of thirty days or provide the reasons why. There are credible reports, however, that one or more individuals in each Region stayed longer than the cap of 30 days.

There were five individuals on the Waiting List in Regions I (4) and II (1) in QII and fifteen on the Waiting List in QII including Region I (11); Region II (2), Region III (1) and Region IV (1). Region III continues to temporarily operate with seven beds, one more than the maximum allowed by the Settlement Agreement. The Region reports there are rarely seven individuals present. I visited the new site and crisis stabilization home, which is under construction. It has a very suitable design and location. The home is expected to be open before this summer. Region I's larger waiting list is not surprising. The REACH Director reported that individuals are still remaining in the CTH for greater than thirty days because of lack of community residential placement opportunities.

The DBHDS continues to require the REACH programs to admit individuals who do not have a firm discharge plan to ensure that crisis stabilization services are available as a last resort to avoid unnecessary institutionalization. These individuals are in great need for this last resort alternative to institutionalization. The need for a last resort is increased because the Commonwealth allows residential service providers to discharge individuals without a discharge plan to an alternative home setting. The Commonwealth must maintain its commitment to continue to meet the crisis stabilization needs of all of the target population and not allow the needs of one particular group to negatively impact the needs of others. There must be continued review of the plans and resources for individuals who need a new home so that the crisis stabilization homes do not become emergency residences for individuals who are homeless. The outcome of prolonged stays is not always in these individuals best interest as they observe others leaving the CTH after shorter visits. Longer use of the CTH precludes others that need this resource from accessing it in timely manner.

The REACH program continues to provide community-based mobile crisis support and offers it as the first alternative when appropriate. Mobile crisis timely in-home support was provided to a total of 323 individuals. Some of these individuals still required psychiatric hospitalization as has been noted in an earlier section.

There is no indication that any other community placements were used for crisis stabilization during the reporting period for individuals who could not remain in their home setting. Two individuals were supported in the MH Crisis Stabilization program. The Settlement Agreement requires the Commonwealth to attempt to locate another community alternative before using the REACH Crisis Stabilization Unit. REACH teams are attempting to maintain individuals in their own homes with supports as the preferred approach to stabilize someone who is in crisis.

The REACH programs are not currently seeking community residential vacancies before using the Crisis Stabilization Units. In my professional opinion using vacancies in community residential programs is not a best practice. I have expressed my reasoning in previous reports. I will not recommend a determination of compliance regarding this provision until the Parties discuss it and decide if they want to maintain it as a requirement of the Agreement. I continue to recommend that it not be a REACH practice.

The DBHDS is to determine if there is a need for additional crisis therapeutic homes to meet the needs of individuals in the target population. Based on past reviews of the average number of beds that were occupied per day in the existing programs, I previously determined that additional CTHs might not be needed because of unused capacity. The more in-depth qualitative review of individuals in Region I and IV during the last reporting period, however, determined that it is common for there not to be sufficient capacity for individuals in need. During the last review period Case Managers reported not making referrals because of the lack of availability. Individuals at the focus groups in Region III in this reporting period agreed that more crisis stabilization/CTH homes are needed, as are locked community-based settings for crisis stabilization. With the number of psychiatric hospitalizations and the reports of stakeholders about a lack of capacity of community services, especially to support individuals whose needs are considered to severe to be addressed in the CTH, the feedback is compelling that more crisis stabilization beds are required to meet the needs of the target population. Stakeholders that participated in other Focus Groups conducted in other parts of Virginia to gather input about case management services, agreed. There was consensus of the need for more community REACH resources, greater behavioral support capacity in the community, and crisis stabilization settings that could keep people in the community securely. The Commonwealth has not fulfilled the responsibility to assess and determine whether it is necessary to add crisis stabilization programs to meet the needs of the target population. The Commonwealth plans, however, to complete an analysis by June 2016.

Conclusion: The Commonwealth of Virginia is in compliance with Sections III.C.6.b.iii. A or B. It is in substantial compliance with D.

The Commonwealth of Virginia is in non-compliance with Sections III.C.6.b.iii.D. and G. In each Region one or more individuals stayed longer than the explicit thirty-day cap. The Commonwealth has also not yet assessed the need for additional crisis stabilization settings for adults. During the tenth reporting period the rating for this provision will include a determination of whether the Commonwealth has effectively implemented the crisis stabilization services for children and adolescents.

I will not make a determination about Section III.C.6.b.iii.C until the Parties make a decision about the practice of using community residential resources for crisis stabilization.

Recommendations-The Commonwealth should use the data from its analysis to determine if additional CTHs and it needs community locked settings as an alternative to psychiatric hospitals for some individuals with ID/DD. I reiterate that it should report on the number of individuals that exceed the 30-day stay in the CTH and should evaluate the impact of using the CTH as emergency housing has on individuals on the waiting list for the out of home crisis stabilization services.

SECTION 6: SUMMARY

The Commonwealth of Virginia continues to make progress to implement a statewide crisis response system for individuals with I/DD. During this reporting period, DBHDS made significant effort to address previous recommendations and enhance community capacity. It is promising that DBHDS implemented the Children's REACH program successfully, although these services have not yet achieved full compliance. It will be interesting to determine how effective the various organizational models are for children's crisis services, which differ between regions more significantly than do the Adult REACH programs.

More individuals are utilizing REACH and there is an increase in training in the adult program and training being conducted by the children's programs.

There have been significant efforts during this reporting period to set training expectations for Case Managers and ES staff; create a comprehensive training series for law enforcement personnel, and to ramp up training by the Children's REACH programs.

DBHDS has made information about REACH more available to DD consumers and their families and is starting to serve more adults with DD. The number of children with DD that were supported by REACH during this reporting period is noteworthy.

There is better data regarding individuals that are psychiatrically hospitalized and the required involvement of REACH should be beneficial. However, there continues to be a need to report more specifically on multiple hospitalizations and the reasons for admission. The data provided does not allow any conclusions to be drawn about the necessity of these hospitalizations or how many were driven by a lack of community resources. It is positive that DBHDS is reviewing and analyzing admission data for both children and adults to make determinations about the additional need for community crisis stabilization settings. DBHDS should also determine if there is a need for more secure community stabilization settings than the REACH CTHs and if the development of these alternatives may reduce hospitalizations.

Individuals need highly specialized providers with well-trained staff in sufficient numbers to provide the structure and programming individuals' need. DBHDS is planning and implementing many initiatives to build community capacity to address the needs of individuals with co-occurring conditions or behavioral challenges including its RFP in Region III as the first area to fund the expansion of providers with expertise to better serve this population. Its other efforts to increase rates for BCBA's, expand training of BSPs, and articulate behavioral competencies will also strengthen the community service capacity.

Table 8- Summary of Compliance Ratings

SA Section	Rating	Comment	Status
III.C.6.a.i	Non Compliance		
III.C.6.a.ii	Non Compliance		
III.C.6.a.iii	Non Compliance		
III.C.6.b.i.A	Compliance		Sustained
III.C.6.b.i.B	Compliance		Sustained
III.C.6.b.ii.A	Non-Compliance		
III.C.6.b.ii.B	Non-Compliance		
III.C.6.b.ii.C	Compliance		Sustained
III.C.6.b.ii.D	Compliance		Sustained
III.C.6.b.ii.E	Compliance		Sustained
III.C.6.b.ii.G	Compliance		Achieved
III.C.6.b.ii.H	Compliance		Achieved
III.C.6.b.iii.A	Compliance		Sustained
III.C.6.b.iii.B	Compliance		Sustained
III.C.6.b.iii.D	Non-Compliance	RIII still has 7 beds. One or more individuals has stayed for more than 30 days in each Region.	Not Sustained
III.C.6.b.iii.E	Compliance		Sustained
III.C.6.b.iii.F	Compliance		Sustained
III.C.6.b.iii.G	Non-Compliance	The Commonwealth has not completed an analysis and determination of the need for additional crisis stabilization programs	

ATTACHMENT 1- SUMMARIES of FOCUS GROUP DISCUSSIONS

A. VA REGION 3 ROANOKE FOCUS GROUP 3/31/2016

Attendees: BRBH (2), Piedmont CSB (1), REACH (1)

Positives about Region III's behavioral supports:

- Outpatient Services
- REACH has office space in all CSB's
- Blue Ridge- REACH Hotline, 24 hour crisis line, in-patient stabilization unit (16), and can be accessed by ID/DD, Support Coordinator is Gatekeeper for WRAP
- Piedmont- MH Skill building (carve out service) with families and for independent living are all supplied by private providers who are certified and paid by DMAS. Training is similar to CSB's
- Piedmont ID CM's have met with DD CM's
- In-home Supports
- Residential, Day, Host Homes/Sponsored Homes & GH's
- ICF
- Psychiatry
- BCBA Quality
- PBS Quality
- Psychiatric Quality
- REACH will serve an individual who is without a place to go when other regions would not.
- One REACH staff member becoming PBS certified as Facilitator
- Blue Ridge- always responds immediately and thus has kept individuals out of hospitals. Will meet at the home or hospital in crisis which will divert the hospitalization

Positives for Children that need behavioral and crisis supports:

- Therapeutic day in home by CSB or private provider
- Piedmont & Blue Ridge- CM's assigned to schools
- Private Providers also have links to schools
- After school program by private providers
- Intensive in home support by providers, case management and crisis services
- Blue Ridge- has their own child psychiatrist but not FT
- REACH serving in the community
- CTH serves individuals with seizures, diabetes (does not serve with G-tube; does not have 24 hour nursing)

Negatives about the region's behavioral support capacity:

- Only 4 providers for individuals with significant behavioral challenges
- Fewer than four providers for individuals with medical needs
- Very few specialized GH's/providers
- Piedmont- average caseload for CM's is 32
- More availability of community services for ID than DD
- BCBA shortage- demand far outpacing resources

Negatives about the region's behavioral supports for children:

- Capacity issues- Psychiatry and PBS
- Difficulty placing children with medical needs
- GH providers just pop up with no experience -where is oversight?

REACH Coordination:

- Piedmont- ES counselors' part of protocol. Work with REACH to find least restrictive option. REACH provides education to ES staff and attends all crisis meetings and CSB meetings
- REACH has trained new GH provider staff and has collaborated where needed for training, plan and transition
- REACH- staff are extremely knowledgeable and involved
- CEPP very detailed and comprehensive and easy to follow, distributed widely, training provided to all and is reviewed and modified in timely fashion
- Piedmont- when asking for CTH, d/c planning starts immediately
- When individual has a need for behavior plan a facilitator is put in place before leaving the TC

Enhancements/Recommendations:

- Expand REACH-region is 11,000 square miles and includes 11 CSB'S
- Add at least one more CTH
- ID/DD as more TC's close further expansion will be required to accommodate the demand for crisis services
- PBS -more needed
- BCBA's- more needed
- Day Support-more for individuals with behavioral challenges/co-occurring conditions
- Training
- Specialized providers for medically fragile and significant behaviorally challenging individuals
- Franklin/Martinsville Hospital CIT training
- New training academy
- Have REACH training built into CIT consistently
- CTH build rapport with Roanoke Chief of Police, do so with other police departments
- Roanoke- meet in home to make recommendation for diversion from ES screening, others should do this

- Need more homes for children with challenging behavioral needs
- Roanoke-only one BCBA in area but is very good- need to clone her!

B. VA REGION 3 FOCUS GROUP MARION (3/30/2016)

Attendees: Highlands CSB (3), DTGC Guardianship (2), Highlands Community Services (1), SWV MHI (1), REACH (2)

Positives about the region's behavioral support capacity:

- Residential, Day and Host Home
- Consultative Services (PBS, OT, ST, PT)
- Nursing, Respite
- Supported Employment
- Agency Directed PA
- Personal PA
- Good Psychiatrist for ID/DD
- Using Tele-Psychiatry (10)
- PCP considering role of medication prescribing and management
- REACH crisis response in Mt. Rogers area
- REACH arrives quickly to Court Commitment Hearings
- Mt. Rogers uses Life Coach and Mentor in some places
- Highlands staff joins all call which ES notifies them about screenings
- REACH providing behavior driven Safety Training (MANDT) for families in home. Applying also to individuals with Autism
- A report of CM's having Adult caseloads of 20 Community and 15 SWTC (adults) and the Children CM's having caseload of 26

Positives about the region's support for children that need behavioral and crisis support:

- Safety Care Training
- In Home Crisis
- WRAP around services, REACH, school program, life skills training with Saturday 9-2 and summer program
- Safety Zone
- Clinic (Neuro, Seizure and Medication)
- Good Psychiatrist (2) great response (Highlands)
- REACH response to crisis (within 2 hours)
- REACH very engaged throughout crisis and coordination
- Staff with child at medical appointments for advocacy purpose

Negatives about the region's behavioral support capacity:

- CBS Giles County- only 1 of the 119 BCBA's serves this area
- Highlands: referrals to DD CM's but CM's do not return calls
- DD CM's do not join regular support groups
- 1-2 year waiting list for behavioral consult
- ES sending individuals to hospitals not CTH because CTH cannot offer a secure setting
- State hospitals keeping individuals and not diverting to CTH
- Individuals experiencing longer stays in hospitals due to no availability of REACH beds
- Waiting List for REACH CTH
- Individuals experiencing significant behavior not receiving services (reluctance to serve could be a factor; supply/demand and experience of consultant provider)
- Far SW section of region lacking PBS certified consultants
- Many on MH side not receiving services
- MH support comes from CSB MH side: only 2 CM's on DD side
- DD waiver waiting list
- ES teams with per diem staff are not always aware of the requirement to notify REACH of screenings
- Too few residential providers for individuals with co-occurring dx
- Very few on DD Waiver
- Crisis service system within CSB's needs professionals trained to serve the ID/DD population
- No step down available to individuals experiencing court commitment
- Approximately 3 month wait for face to face with a psychiatrist (however tele-psychiatry is appropriately filling this gap-see research on why development of methodology for rural areas)
- High staff turnover in Mt. Rogers area (1/shift/month)
- No separation of child and adult staffing and assessments in Mt. Rogers area
- Mt. Rogers - one individual with DD hospitalized 3 times to 3 different hospitals since January. Difficult to coordinate REACH involvement
- Region has poor work force to draw from (only 15% of population are college graduates)
- Individual still hospitalized due to serious behavioral challenges
- Sometimes can only find providers in the Richmond area
- VA still has large number of Board and Care homes. Hundreds still exist even with reduction over past five years. Region 3 has 116 B&D Homes. This funding could support ID/MH supported living
- Example-18 year old individual with ID aged out and needed behavior supports ended up having to go to an ALF, sometimes only option to receive food, Medicaid and medication. Typically for individuals with behavior challenges state hospital is either only choice or first option chosen by ES

Negatives about the behavioral and crisis support for children

- Very few residential providers for children experiencing significant behavioral issues. Most providers are out of the area/region.
- Highlands-children in and out of crisis mostly due to above bullet
- No respite
- If hospitalization is required it is 5.5 hours away from parts of SW VA (CCCA is only state psychiatric facility for children in state)
- TDO to Stanton Hospital/CCCA (2.5 hours away)
- Schools have track record of sending children to residential treatment schools

REACH Coordination:

- Involved
- Always at meetings
- Provides very good information
- Provides in home supports
- In home training provided
- Parent extremely positive about the Children's REACH program

Enhancements/Recommendations:

- Children- more GH's, some behavior specific, another REACH CTH
- A home with a continuation of care component that can be secure/locked as an alternative to hospitalization
- Additional funding for community services
- Highlands has a large autism program but nothing comparable on DD side
- Additional education (Judicial, Law Enforcement and Community)
- Additional training for crisis staff
- Additional crisis workers
- PBS training is challenging and takes a long time to complete, staff need support and time to complete all requirements

APPENDIX E

INTEGRATED DAY ACTIVITIES AND SUPPORTED EMPLOYMENT

By: Kathryn du Pree MPS

**2015 REVIEW OF THE EMPLOYMENT SERVICES REQUIREMENTS
OF THE US v COMMONWEALTH OF VIRGINIA'S SETTLEMENT
AGREEMENT**

REVIEW PERIOD: OCTOBER 7, 2015- APRIL 6, 2016

**SUBMITTED TO DONALD FLETCHER
INDEPENDENT REVIEWER**

**BY: KATHRYN DU PREE, MPS
EXPERT REVIEWER
May 6, 2016**

TABLE OF CONTENTS

Section I: Overview of Requirements	3
Section II: Purpose of the Review	4
Section III: The Review Process	5
Section IV: The Employment Implementation Plan	5
Section V: Setting the Employment Targets	18
Section VI: The Plan for Increasing Opportunities for Integrated Day Activities	21
Section VII: Review of the SELN and the Inclusion of Employment in the Person-Centered ISP Planning Process	27
Section VIII: Regional Quality Councils	32
Section IX: Summary	33

Graph 1: Type of Work Setting by Funding Source June 2015	11
Graph 2: Type of Work Setting by Funding Source December 2015	12
Graph 3: Type of Work Setting by Disability December 2015	13
Graph 4: Average Hourly Wages by Employment Type December 2105	15
Graph 5: Number of Individuals Earning Above and Below Minimum Wage	16
Table 1: Statewide Distribution of Wages December 2015	16
Table 2: Employment Targets for FY 15-19	18
Graph 6: Type of Work by HPR December 2015	19
Table 3: Summary of Compliance	33

I. OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Consultant to perform the review of the employment services requirements of the Settlement Agreement for the time period 10/7/15 – 4/6/16. The review will determine the Commonwealth of Virginia’s compliance with the following requirements:

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.

7.b. The Commonwealth shall maintain its membership in the State Employment Leadership Network (SELN) established by NASDDDS; establish state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy; [use] the principles of employment first include offering employment as the first and priority service option; providing integrated work settings that pay individuals minimum wage; discussing and developing employment options with individuals through the person- centered planning process at least annually; and employ at least one employment services coordinator to monitor the implementation of employment first practices.

7.b.i. Within 180 days the Commonwealth shall develop an employment implementation plan to increase integrated day opportunities for individuals in the target population including supported employment, community volunteer activities, and other integrated day activities. The plan shall:

A. Provide regional training on the Employment First policy and strategies throughout the Commonwealth; and

B. Establish, for individuals receiving services through the HCBS waivers:

1. Annual baseline information regarding:

- a. The number of individuals receiving supported employment;*
- b. The length of time people maintain employment in integrated work settings;*
- c. The amount of earnings from supported employment;*
- d. The number of individuals in pre-vocational services as defined in 12 VAC 30-120-211 in effect on the effective date of this Agreement; and*
- e. The lengths of time individuals remain in pre-vocational services*
 - 2. Targets to meaningfully increase:*

- a. The number of individuals who enroll in supported employment in each year; and*
- b. The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment*

III.C.7.c Regional Quality Councils, described in Section V.D.5 below, 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 to the Regional Quality Councils and the Quality Management system by the providers. Regional Quality Councils shall consult with those providers and the SELN regarding the need to take additional measures to further enhance these services.

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

II. PURPOSE OF THE REVIEW

This review will build off the review completed last fall by the Independent Reviewer for the review period 4/7/15 through 10/6/15 and the recommendations the Independent Reviewer made in his last Report as a result of the conclusions and findings of that review of Employment Services. At that time the Independent Reviewer was concerned about the under-reporting of ESO's and the lack of comprehensive data about the reporting areas; the lack of implementation of the plan to offer integrated day activities other than employment; and the lack of meaningful involvement of the Regional Quality Councils (RQCs) in the review of the employment targets.

This review will cover all areas of compliance to make sure the Commonwealth has sustained compliance in areas achieved during the previous reporting period. It will focus on those areas that were not in compliance and the Independent Reviewer's related recommendations. This focus will be on:

- The Commonwealth's ability to meet the targets it set and the progress toward achieving the FY 2016 targets for the number of people in supported employment, those who remain for at least twelve months, and the average earnings for those in supported employment,
 - The refinement of the implementation plan to increase integrated day activities for members of the target population including the strategies, goals, action plans, interim milestones, resources, responsibilities, and a timeline for statewide implementation,
 - The continued involvement of the SELN in developing the plan and in reviewing the status of its implementation, and
- The expectation that individuals in the target population are offered employment as the first option by Case Managers and their teams during the individual planning process in which they discuss and develop employment goals.

III. REVIEW PROCESS

I reviewed relevant documents and interviewed key administrative staff of DBHDS and members of the SELN to provide the data and information necessary to complete this review and determine compliance with the requirements of the Settlement Agreement. Initially a kickoff meeting was held in January 2016 with the Independent Reviewer, the Expert Reviewer, Heather Norton, Peggy Balak, and Jae Benz to review the process and to clarify any components before initiating the review.

Document Review: Documents reviewed include:

1. VA DBHDS Employment First Plan: FY2016-2016: Goals, Strategies, and Action Items: December 2015, updated April 2016
2. DBHDS Semiannual Report on Employment: October 21, 2015
3. DBHDS Semiannual report on Employment: April 8, 2016
4. Employment and Integrated Service Definitions Draft (not dated)
5. RFP to Implement the IDA/Community Engagement Plan
6. SELN Work Group meeting minutes relevant to the areas of focus for this review. The SELN now includes two advisory groups: the Employment First Advisory Group (EFAG) and the Community Engagement Advisory Group (CEAG)- meetings from October 2015-April 2016
7. Regional Quality Council meeting minutes and recommendations for implementing Employment First- The two quarterly meetings occurred during July and December 2015
8. Community Engagement Report-December 29, 2015

Interviews: The Expert Reviewer interviewed members of the SELN; Connie Cochran, Assistant Commissioner for Developmental Services, and Heather Norton, Director of Community Support Services, DBHDS; employment staff at New River Valley CSB; the Medicaid Quality Coordinator at Goodwill of Roanoke, and two ARC Directors involved in community engagement initiatives from the Arc of Southside and the Harrisburg/Rockingham Arc.

IV. THE EMPLOYMENT IMPLEMENTATION PLAN

7.b.i.A. Within 180 days the Commonwealth shall develop an employment implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer and recreational activities, and other integrated day activities. The plan shall:

A. Provide regional training on the Employment First policy and strategies throughout the Commonwealth:

Review of Virginia's Plan to Increase Employment First Plan: FY 2016-FY2018- Goals, Strategies, and Action Items.

DBHDS with the input of the Employment First Advisory Group (formerly the SELN Advisory Committee) has revised the FY13-FY15 plan to increase employment opportunities. I was provided with the Status Report as of 12/31/15. The Plan includes five goal areas each of which has sub-goals.

Goal 1: Align licensing, certification, accreditation, data collection, and other activities between state agencies that facilitate employment for individuals with disabilities.

Status: The DBHDS, DARS and DOE efforts continue to be in the planning stages. There is still now a Memorandum of Understanding between DBHDS, DMHAS, DARS, and VDOE. The goals for the Interagency Workgroup and the identification of interagency projects will not be accomplished until June 2017. No specific projects are identified. The training curriculum regarding allowable employment activities under the HCBS waiver programs was completed and training was provided to DMAS and DBHDS staff including Community Resource Consultants. There is no further mention of the interagency project that was proposed in the spring of 2015. This proposal was to use a DOE funded position as an Employment Specialist in the northern Virginia area to assist schools and ESOs to plan for transition or whether DBHDS is appropriating four positions to DARS to expand this initiative to other parts of the state. Also stalled, are the discussions among the three state agencies to undertake an initiative in a rural part of Virginia. The purpose of the initiative was to improve employment opportunities for individuals upon high school graduation appears. DBHDS did transfer four positions to DARS to expand the availability of employment specialists, but these are not funded positions. DARS will need to allocate funding to use the positions. A current alternative being considered is whether DBHDS is appropriating four positions to DARS to expand this initiative to other parts of the state. Accreditation of ESOs is still in the discussion phase.

DBHDS has made progress on its data collection by using data from the ESOs and DARS. ESOs will be provided this information for its participants in the data survey and will only need to add the data for individuals who receive waiver or other funding. DBHDS continues to provide education to other state agencies. This quarter the department's staff provided technical assistance to DMAS staff and formal training to DARS and DBHDS staff about currently allowable employment services under the HCBS waivers.

Goal 2: Education and training of stakeholders, providers and state agency staff.

Status: The Employment Action Plan lists a number of activities to occur between 3/31/16 and 6/30/16. These include:

- ◆ developing information and tools for families and self-advocates;
- ◆ creating a process map for families of school children;
- ◆ writing training fact sheet about benefits; and
- ◆ identifying local advocacy groups and family resource networks.

The Commonwealth has not made progress on the sub-goal in the Employment Action Plan (Spring 2014) to reach out to businesses. The outreach goal was to educate and increase awareness of employing individuals with disabilities. Contacts with local advocacy groups and family resource networks to schedule presentations are projected for 6/30/17. There is an ongoing goal of posting information on the Employment First website. There are also initiatives to support and train employers that, at the time of this review were scheduled to occur between 3/1/16 and 5/20/16. As of 4/19/16 the EFAG training sub-group had drafted training materials for Case Managers and had developed a fact sheet on workplace

assistance. Regional training that was provided between January and March included training five new potential providers and training in Martinsville on Employment First. Technical assistance was also provided to four service providers

Goal 3: Service delivery system that supports and incentivizes integrated community-based employment.

Status: The Action Plan lists:

- ◆ developing regional strategies;
- ◆ creating process maps to avoid employment disruptions;
- ◆ using data to drive future employment decisions;
- ◆ identifying service delivery gaps; creating practice standards; and
- ◆ developing mechanisms to use existing quality indicators.

The timelines for completing these actions range from 6/30/16-6/30/17. As of 4/19/16 the EFAG has drafted quality outcome measures.

Goal 4: Financing and contracting methods within and across agencies to support community-based employment service delivery.

Status: This goal is no longer referenced and appears to have been discontinued with no explanation.

Goal 4 (previously Goal 5): Virginia will have a system wide data collection and performance measurement system and procedures for employment data for people in supported employment.

Status: This Goal previously included an indicator to have the SELN AG and Regional Quality Councils (RQC) review the employment data and targets quarterly. This recommended action has been removed from the Goal and Strategies in terms of the RQC role because it is an overall expectation of the SA. This goal still includes efforts to develop data gathering tools, to undertake data analysis, to analyze provider capacity and to develop a plan to increase capacity. The dates for completion are between 6/30/16 and 9/1/16.)

Goal 5 (formerly Goal 6): Virginia's Employment First Advisory Group will have a formalized structure with clearly defined roles and responsibilities for members.

Status: The Employment First Advisory Group has added the responsibility to develop a self-evaluation tool to determine the group's efficiency, effectiveness, and diversity in stakeholder input.

Conclusion and Recommendations: DBHDS is in compliance with provision 7.b.i.A. It provides regional training on the Employment First policy and strategies. DBHDS submitted a report for the Quarter 2 of 2016 (10/15-12/15). Approximately 165 family members, CSB staff, advocates, provider staff and transition teachers and supervisors were trained. Training continued with providers through March 2016 as noted above. I continue

to recommend, however, that the Commonwealth determine how best this information can be shared with families and to report in the future on its outreach to this group specifically. DBHDS does plan to engage youth and families through youth and family summits throughout the next year. The purpose of these engagements is to continue to hear from these stakeholders even though their representation on the SELN will be reduced, as will all other groups. The DBHDS should include summaries of these summits and the number of individuals who attend during future reporting periods. DBHDS continues to make progress implementing its employment implementation action plan. Outreach should include specific strategies to reach the DD community.

The Employment First Plan for FY2016-2018 was revised December 29, 2015. The Plan is disappointing in both its lack of specificity and the lack of progress reported toward reaching the plan's goals. The format of the plan should be modified to provide actual updated information and specifics regarding implementation. The current report does not include any specificity as to how actions will be implemented or what has been accomplished to date to achieve them. The plan does not include the involvement of the RQCs and does not describe the accomplishments during the prior 6-12 months. Doing so would be a good step toward providing greater specificity and accountability.

7.b.i.B.1.a-e: The Commonwealth is to develop an employment implementation plan to increase integrated day opportunities for individuals in the target population including supported employment, community volunteer activities, and other integrated day activities. The plan shall establish, for individuals receiving services through the HCBS waivers: Annual baseline information regarding:

- a. The number of individuals receiving supported employment;*
- b. The length of time people maintain employment in integrated work settings;*
- c. The amount of earning from supported employment;*
- d. The number of individuals in pre-vocational services; and*
- e. The lengths of time individuals remain in pre-vocational services.*

DBHDS has changed the data source and the data that it is collecting about individuals who are employed and those who are in sheltered work. DBHDS has vastly improved its data collection since October 2014. It has continued to obtain more comprehensive data. DBHDS shared its second and third Semiannual Reports on Employment dated October 21, 2015 and April 8, 2016 respectively. These reports include statewide data and analysis; goal setting for Individual Employment; and summaries and recommendations. They cover points in time in June 2015 and in December 2015 respectively. While representing points in time, these reports can be compared on a semiannual basis. These comparisons over multiple years allow stakeholders and reviewers to note trends in progress or areas of regression or stagnation.

DBHDS has worked in partnership with the Department for Aging and Rehabilitative Services (DARS) to refine its data collection methodology and analysis. DBHDS continued to collect data from employment providers that were identified using Medicaid Home and Community Based Services waiver billing data.

The Commonwealth acknowledged that the data that I have reviewed during earlier review periods, prior to the spring of 2015 have been faulty. It did not address all of the requirements of the Settlement Agreement. It could not account for individuals entering and temporarily leaving employment so may have over or underreported both data elements. Most notably it did not include wage data or the number of hours individuals work. The DBHDS worked with the SELN, now the Employment First Advisory Group (EFAG), to determine an approach to regularly collect more accurate data. DBHDS does not have its own database for individuals who participate in employment services through the HCBS waivers. DARS does have employment data for individuals it funds. The EFAG advised the department to collect this data directly from the Employment Service Organizations (ESO).

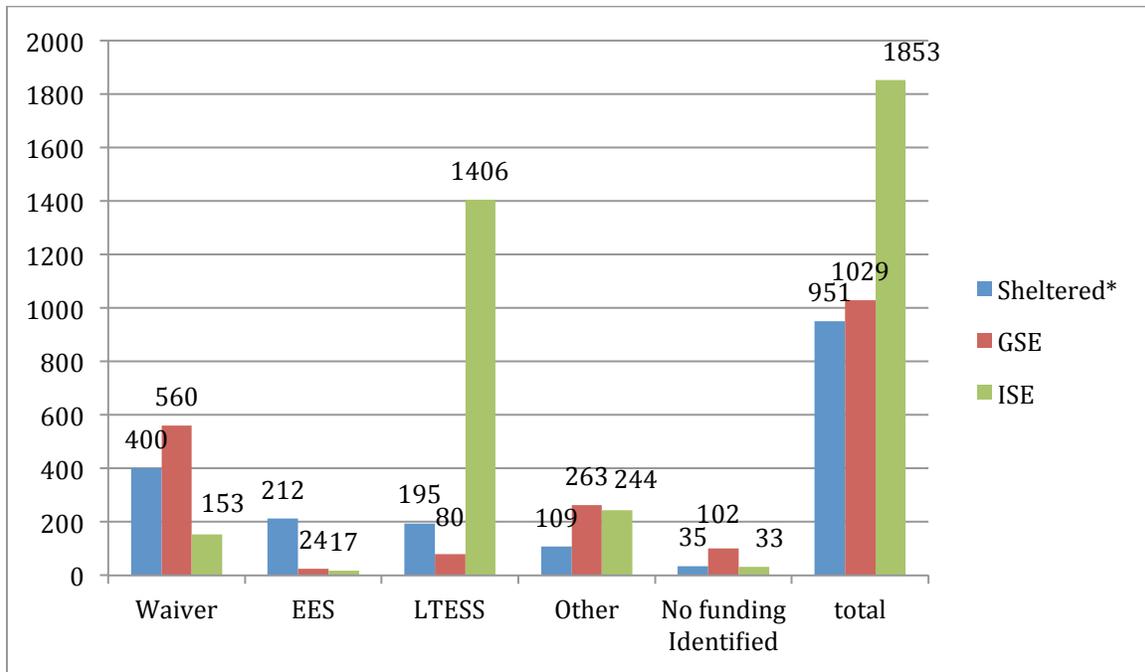
The first full survey was sent out in October 2014. DBHDS had a response rate of 44%. The second survey covering the reporting period through the end of fiscal year 2015 (FY 2015), received a much higher return rate. DBHDS report that 95%, fifty-seven of the sixty ESO providers responded to the survey. Thirty-three of the thirty-six ESOs that are waiver service providers responded for a 92% response rate. There was no missing data for Individual Supported Employment (ISE). Data was not received for 105 individuals in Group Supported Employment (GSE) in the second reporting period and was missing for 111 in the third reporting period. The data for the third semiannual report (through December 2015) were returned by 56 (93%) of sixty providers. Of this number 32(89%) of the thirty-six waiver providers responded. One fewer provider responded in the third semiannual reporting period than did in the second. This compares very positively, however, with the 44% response rate from the February 2015 Semiannual Report. DBHDS credits this success to the extensive efforts of the ESOs, DARS and the data subcommittee of the EFAG. The analysis and data in this report are based on the data DBHDS received through the end of FY15 and the first two quarters of FY16. However, since my analysis DBHDS reports recently receiving data from one additional provider. This reduces the number to ninety-five individuals with missing data.

DBHDS also gathered data from a second source for both Employment Reports. DBHDS used its data sharing agreement with DARS to gather data regarding individuals with developmental disabilities who receive Extended Employment Services (EES) and Long Term Employment Support Services (LTESS). These employment services are funded by DARS.

Statewide Data Analysis-The data in Graph 1 below for June 2015 indicates that 1,853 individuals are in Individual Supported Employment services and 1,029 are in Group Supported Employment services. Additionally, 951 people are receiving services in sheltered workshops. Individuals in sheltered workshops are not counted toward the DBHDS employment targets. These numbers change in the report through December 2015 (depicted in Graph 2) as follows:

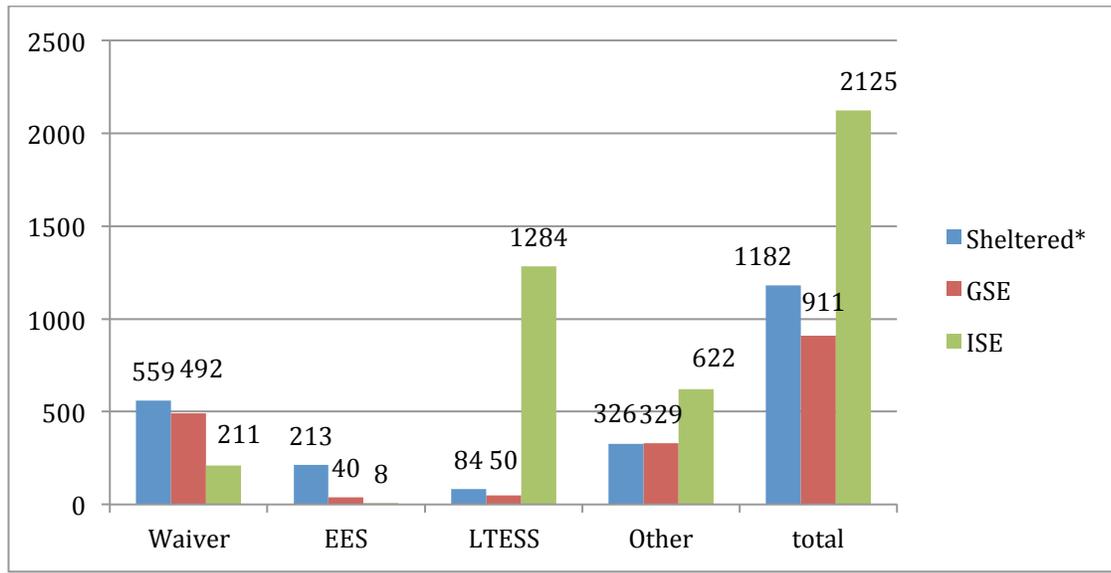
- 272 more individuals are employed in ISE
- 118 fewer individuals are employed in GSE
- 231 more individuals are in sheltered work
-

Graph 1: Type of Work Setting by Funding Source- June 2015



DBHDS reports: *“This data indicates that 2,882 people are employed with supports from individual supported employment and group supported employment. DBHDS data indicates that 19.69% percent of people with ID/DD are employed. This is an increase from the 10% that was reported in the February 2015 Semiannual Report. DBHDS does not think that this is a true 9.69% increase of people being employed but instead a function of the refinement of the data collection, and a more accurate projection of the involvement of individuals in employment. ”*

Graph 2: Type of Work Setting by Funding Source-December 2015



DBHDS reports: *“This data indicates that 3036 people are employed with supports from individual supported employment and group supported employment. Our data indicates that 20.02% percent of people with ID/DD are employed.”*

It is helpful that DBHDS has been able to increase the accuracy and comprehensiveness of the employment data in terms of the overall number of individuals with disabilities that are employed. DBHDS continues, as it should, to report on both the number of individuals employed in ISE or GSE. The long-term goal of the Settlement Agreement, however, is to have individuals employed through ISE and eventually competitive employment. Overall 70% of the individuals employed in December 2015 in either ISE or GSE are employed in ISE. Sixty (60%) of these individuals are in ISE through LTESS funded by DARS. This compares to 75% in the previous reporting period. Only 30% of the individuals in HCBS waiver funded employment services are in ISE. There was an increase, however, of 58 (27%) individuals in ISE from June 2015 to December 2015. The DBHDS reported that there is a need to increase the employment capacity of the HCBS waivers overall and that the Employment First Advisory Group’s Policy Subgroup is analyzing this issue.

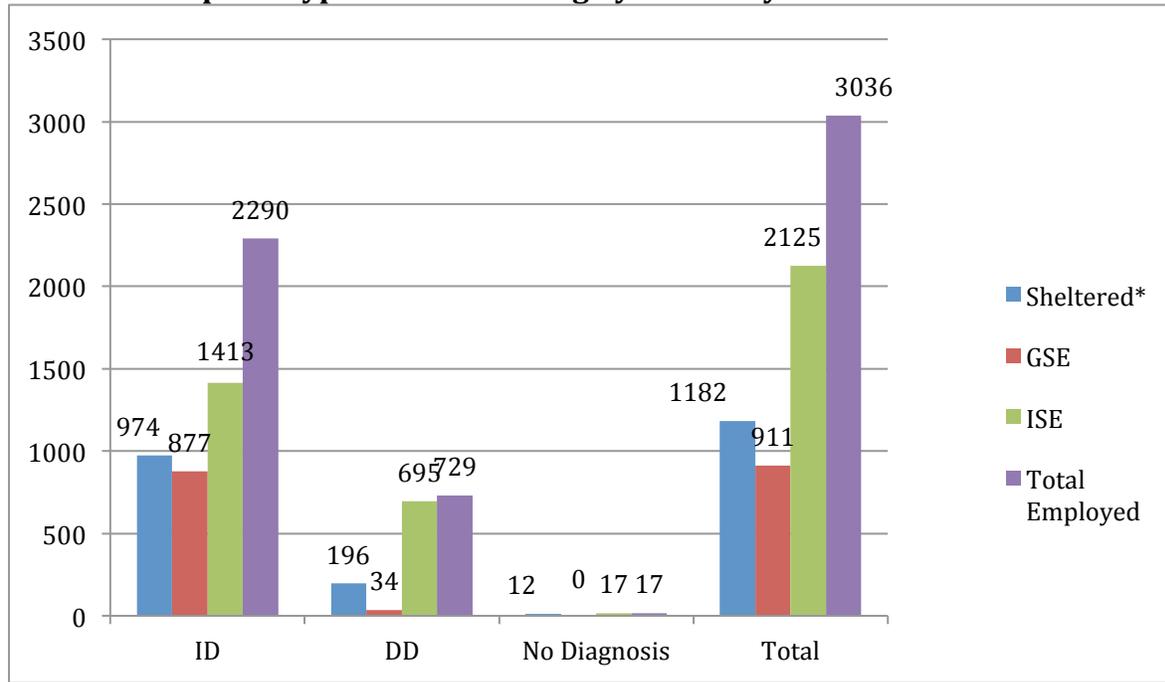
The most significant increase in the number of individuals employed between the two reporting periods was in the “Other” category. The increase of 378 more individuals was 155% more than the 244 reported in June. There are substantially more individuals in ISE who are funded by “other” than there are funded through the HCBS waivers.

It is of some concern that the number of individuals in sheltered work increased both for those who are funded by the waivers and overall. The number increase in those with waiver-funded services was 151, a 27% increase from June to December 2015. This is concerning at a time when DBHDS is working to prepare providers to no longer offer pre-vocational services as part of the waiver redesign that will become effective July 2016.

Sheltered work settings are most prevalent in Health Planning Regions (HPRs) I, III and IV. In Region III 64% of individuals in SW, GSE or ISE are in SW. DBHDS, the Employment First Advisory Group, and the RQC's should analyze this and determine whether additional effort is needed to ensure appropriate and timely transitions to employment and community engagement for these individuals.

Graph 3 shows the employment involvement of individuals by disability group.

Graph 3: Type of Work Setting by Disability- December 2015



DBHDS reports: *“The data in the graph above compares employment settings by disability. When this data is compared against the target population (people on the waiting list and people on the waiver), an interesting backdrop emerges. Of the 13,545 individuals with ID in the target population, 2,290 (17%) are employed an increase from the last report of 1%. Of the 1,463 individuals with DD in the target population, 729 (49%) are employed this is a 2 percent reduction but it should be noted the target population increased by 134, while the number employed only increased by 38. “*

A further analysis of the data of individuals that have ISE, which is the goal of the Settlement Agreement, provides less evidences of progress. Of the 2290 individuals with ID who are employed, 1413 are in ISE. This is only 10% of the ID target population, which is 13,545 individuals. Of the 729 individuals with DD 95% are involved in ISE, which is noteworthy. The DBHDS needs to focus on increasing individualized employment especially for individual who are in the HCBS waiver funded programs and particularly for the individuals with ID.

Average hours worked- Individuals who have an ID worked an average of 21 hours per week in both the second and third reporting periods. This is a 2 -hour increase from the 19-hour average that was reported in Spring 2015. Individuals who have a DD worked an average of 20 hours per week in the second reporting period. This increased to an average of 22 hours per week in the third reporting period.

The range of “average hours worked” for individuals with DD is 21 hours per week in Regions I, III and V, to 25 hours per week in Region II. All regions have reported an increase in the average number of hours worked. The average hours worked per week for individuals with ID ranged from 18 in Regions I and IV up to 25 hours per week in Region II in the second reporting period. There was a decrease from the second reporting period for some regions, but an increase in Region II. This information is aggregated for ISE, GSE and SW. Individuals across all the regions work between 2-40 hours per week. DBHDS does not report on whether individuals are working the number of hours they want to be employed. Many of the individuals may be underemployed.

Average length of time at current job- the average length of time for individuals with ID at their current jobs through ISE is six years. Individuals with DD in ISE worked an average of three years. Individuals in ISE have had their jobs for periods ranging from 0 to 32 years. This range included 262 individuals who started their jobs within the last year and 468 who have held their jobs for more than one year. The December 2015 report is the first report in which this detailed information is reported distinctly for ISE, GSE and SW. The average length of time individuals have had their current GSE job is seven years for individuals with ID and five years for individuals with DD. In GSE, 123 individuals have held their jobs for one year and 703 have held them for more than two years. The expectation is that 85% of individuals will hold their jobs for at least twelve months. The Commonwealth has exceeded this expectation. Eight-eight (88%) have worked at their job for one year or more in ISE and 91% have held their jobs for one year or more in GSE.

This information was also reported in June 2015 specifically for individuals who are in ISE but not reported by disability group. Individuals in the waivers on average have a longer period of time holding one job. This report breaks these data down by program/funding source:

- *HCBS Waiver- 5 year average*
- *EES- 4 year average*
- *LTESS- 4 year average*
- *Other- 3 year average*

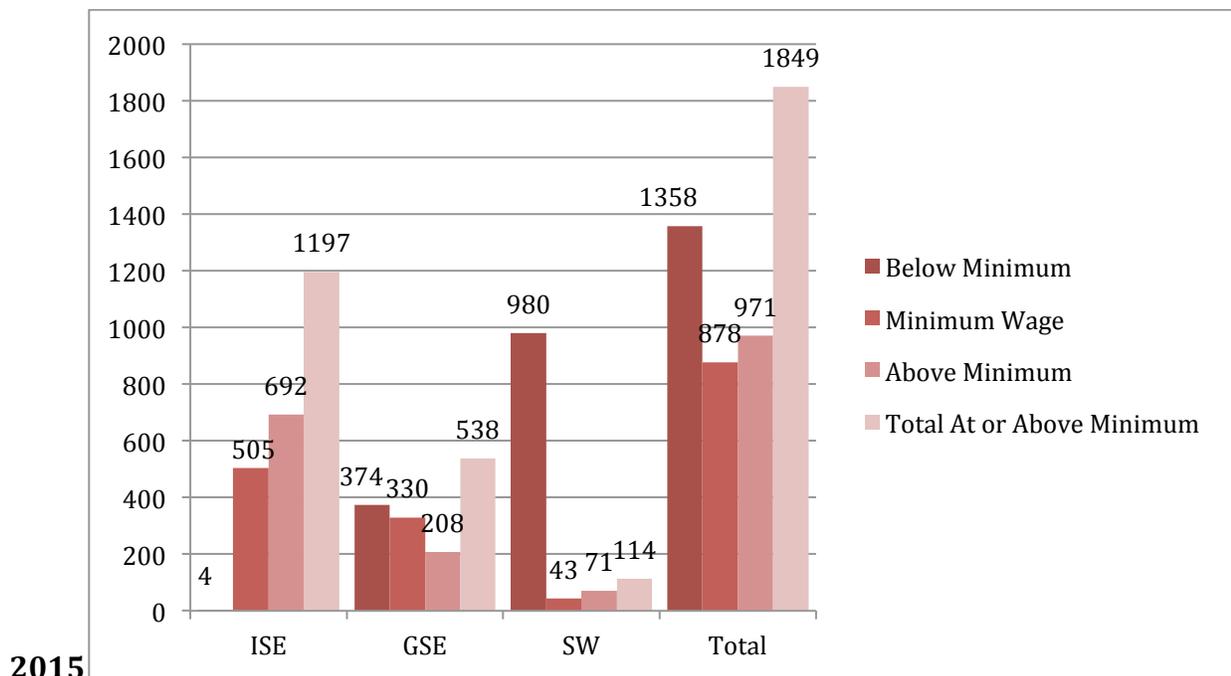
Earnings from supported employment- DBHDS collected information regarding wages and earnings. The two tables below depict the data in terms of the average hourly wages and the number of individuals that earn above or below minimum wage. All but four individuals in ISE earn at least minimum wage. However 41% of individuals in GSE earn below minimum wage. The difference in the average wage between individuals with ID and DD varies the least for individuals in ISE (\$.31 per hour). The following graphs and table illustrate the wage information.

Graph 4: Average Hourly Wage by Employment Type/Disability-December 2015



DBHDS reports: *The chart above depicts average hourly wage based on type of employment. Persons in individual supported employment average above minimum wage. Individuals with intellectual disability average below minimum wage in group supported employment while individuals with developmental disabilities average above minimum wage. Both individuals with intellectual and developmental disabilities average below minimum wage in sheltered employment.*

Graph 5: Number of Individuals Earning Above and Below Minimum Wage-December



2015

Table 1:Statewide Distribution of Wages December 2015

ID/DD	Lowest hourly wage	Highest hourly wage
Sheltered*	\$0.13	\$13.05
GSE	\$0.20	\$20.70
ISE	\$2.31	\$21.47

Individual Employment- In June 2015, 1847 individuals were in ISE, of whom 1229 (66.5%) have an ID and 618 (33.5%) have a DD. In December 2015, 2125 individuals were in ISE, of whom 1413 (66.5%) have an ID and 695(32.7%) have a DD. The 17 (0.8%) remaining individuals in ISE have no diagnosis. This is a far more significant number of individuals than have been previously reported. The data sources have become more robust and the rate of response has increased dramatically from the ESOs. These data includes only people who are actually working and being paid.

Group Supported Employment- In June 2015 1029 individuals were in GSE, of whom 959 (93.2%) have an ID and 63 (6.1%) have a DD. In December 2015, these numbers decreased to 877 (96.3%) and 34 (3.7%), respectively.

Pre-Vocational Services- In June 2015, 951 individuals were receiving Pre-vocational services. Six months later, in December 2015, the number of individuals in pre-voc services had increased by 231 to1182 individuals. This includes 974 (82.4%) individuals with ID and 196 (16.6%) individuals with DD. An additional 12 (0.1%) individuals are in pre-vocational who do not have a diagnosis. This represents a significant (24.3%) increase between June and December of 2015. Previously, and only in its June 2015 report, DBHDS reported on the average length of time individuals remained in pre-vocational services. In the HCBS waiver funded services, there are 758 of whom 691 (91%) have been in pre-vocational for 12 months. Half of these individuals have been in pre-vocational programs for over 42 months demonstrating little transition to employment. DBHDS should continue to report these data semiannually. DBHDS reports that the change in number is more likely related to better reporting than to an actual increase in participants in pre-vocation.

Conclusion and Recommendations: The DBHDS is in compliance with 7.b.i.B.1.a, b, c, d, and e. Its data reflects information from 93% of all providers and 89% of the providers who offer HCBS waiver funded services. It also includes 100% data from DARS. This is significantly improved from previous data collection. DBHDS can now report on earnings and the length of time individuals have been employed. It is positive that more individuals were employed in December 2015 than were in June 2015. There were 272 additional individuals were engaged in ISE. Fewer individuals received GSE; so the overall increase in the number of individuals in supported employment overall was.

It is extremely positive to have data that includes all individuals with ID and DD who are employed rather data limited to only those individuals who are employed using HCBS waiver funded services. DBHDS now has more accurate information about both the ID and DD populations related to employment. It is encouraging that more individuals are employed and earning wages. It is a concern that more individuals are receiving pre-

vocational services, which are typically provided in large congregate settings that do not include activities in integrated community settings.

I applaud the efforts that DBHDS has made to collect and report more accurate data. The inclusion of the DARS data has made the data much more robust and accurate. It remains a concern, however, that the department is relying on the ESOs to report and that this reporting continues to be voluntary. These data are not complete unless DBHDS requires reporting and achieves 100% compliance. DBHDS needs to require all ESOs to provide employment data.

The Parties should decide what if any outcomes are expected and required in the following areas: the amount of earnings; the number of individuals in pre-vocational services; and the length of time individuals are in pre-vocational services. Currently the Agreement only requires that DBHDS report accurately on these data elements.

V. SETTING EMPLOYMENT TARGETS

Sections 7.i.B.2.a and b. require the Commonwealth to set targets to meaningfully increase the number of individuals who enroll in supported employment in each year and the number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.

The targets depicted in **Table 2** are for the total number of individuals in ISE for each of the next five fiscal years.

Table 2: EMPLOYMENT TARGETS FOR FY15 – FY19

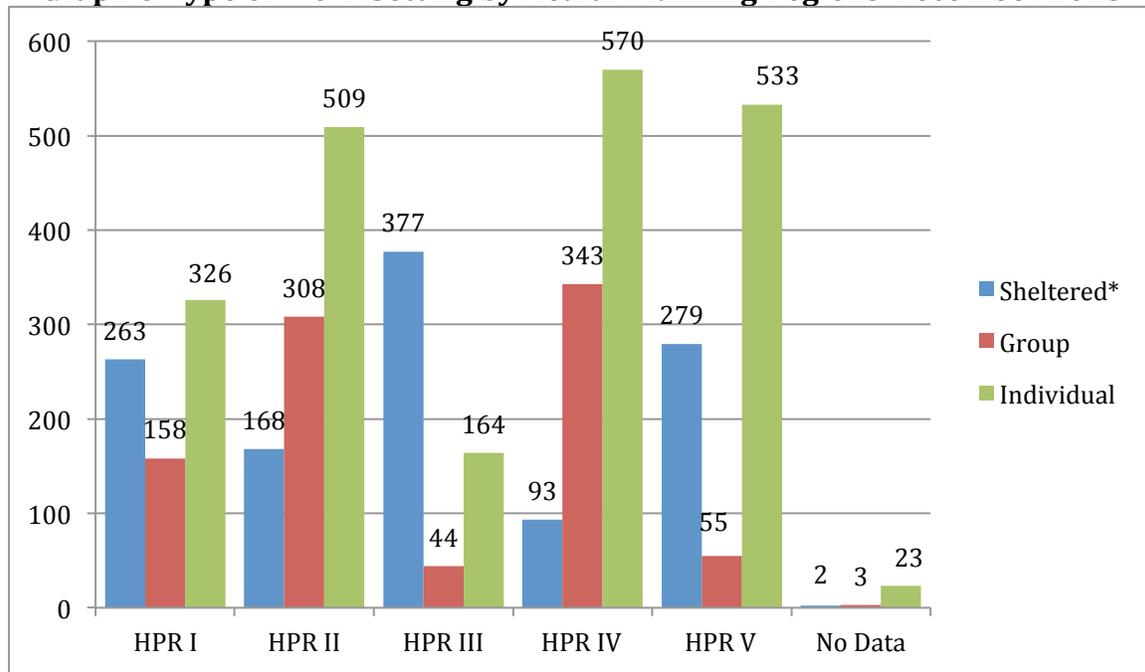
FY	ISE Total Start of FY	Total in Day/Employment Services	% in ISE at start of FY	% in ISE by end of FY	ISE Total End of FY	Increase in Base %
15	204	7292	2.79%	7.79%	568	5%
16	568	7292	7.79%	12.79%	932	5%
17	932	7292	12.79%	17.79%	1297	5%
18	1297	7292	17.79%	22.79%	1661	5%
19	1661	7292	22.79%	27.79%	2026	5%

Increasing the number of individuals in IE: The targets in **Table 2** reflect the targets set by the DBHDS in March 2014. The Commonwealth is continuing to use these goals for the number of individuals who are receiving ISE HCBS waiver funded services. These targets were based in the information available from the HCBS waiver data. The Semiannual Employment Report for 2015 includes data that only 153 individuals with HCBS waivers are employed in ISE, but that 232 participate in ISE. DBHDS reports that the target goals are based on the number of individuals who participate in ISE versus the number that are actually employed. The December 2015 report indicates that 211 individuals are participating in ISE who have HCBS waiver slots who are employed. A section within the semi-annual report that uses DMAS data indicates that 231 individuals who receive ID and DD waiver funded services are in ISE. This number counts individuals, however, who previously discontinued service and joined back in during the quarter. The number of 232 individuals in June 2015 and 231 in December of 2015 are both from the DMAS ISE report. The Commonwealth's FY 2015 goal for the number of employed individuals with ID and DD was 568 individuals. The goal for FY 2016 increased to 932. The target for FY15 was not met. DBHDS does not appear to be on track to meet the target of 932 individuals with ID/DD in ISE by the end of FY16. DMAS reported that the number of individuals in ISE did not vary between June and December 2015. It is encouraging that the number of individuals actually employed increased from 153 to 211 during that same time period.

The DBHDS has revised its overall target for employment to include all of the eligible individuals with ID or DD and all of the employment options available through DBHDS or DARS. To establish its target, DBHDS used the national average that 25% of individuals with ID and DD who participate in employment services. DBHDS includes the number of adults now on the HCBS waivers (11,000) and those on the waiting list (3,640), many of whom may be receiving DARS services, to determine the universe seeking employment. DBHDS worked with the EFAG to revise the employment targets of individuals with ID and DD who will be employed. The target is increased significantly from the previous target of 1661 to 3660 individuals by FY19. Individuals in both ISE and GSE, who are working and earning at least minimum wage, will also be counted toward achieving this target.

The Commonwealth is on track to reach this target. As of December 2015, 3036 individuals are in either ISE or GSE. Graph 6 below depicts the distribution of individuals by work setting by HPR.

Graph 6: Type of Work Setting by Health Planning Regions-December 2015



The graph above indicates clear variations in work settings throughout the Commonwealth's five Health Planning Regions. Three of the five regions, Regions I, III and IV, have a significant percentage of individuals who are receiving Sheltered Work services, which are typically provided in large congregate facilities. In Region III, 64% of individuals with ID or DD are in such "sheltered work" settings. The DBHDS, EFAG and the RQC's should analyze these data and determine the necessary actions to change this balance so that more individuals have the opportunity to work in integrated settings.

Individuals in Supported Employment The Commonwealth's current goal is to reach 85% of the total number of individuals who are in ISE to remain employed for 12 or more months. As noted earlier, the Commonwealth has surpassed this expectation. Because the Commonwealth could not previously report accurately, it is difficult to know whether this reflects recent progress.

Conclusions and Recommendations: the Commonwealth is not in compliance with Section 7.b.i.B.2.a and is in compliance with 7.b.i.B.2.b.

In terms of meeting its targets, the Commonwealth is falling woefully short for its targets for individuals in the waiver programs, but it is making significant progress towards its overall targets for employment including all DARS and other funding sources.

The Commonwealth is reporting that many more individuals are employed. It can now report on individuals with ID and DD separately. I suggest it develop separate targets for each of these groups and continue its new practice of reporting on each group separately. The DBHDS should also determine its targets separately for individuals in ISE and for those

in GSE to insure its decision to pursue an Employment First Policy is implemented as intended. Currently, of the individuals with ID who are employed, 57% are in ISE and 43% are in GSE. Of the individuals with DD, however, 74% percent are in ISE and only 26% are in GSE. DBHDS should not reduce the percentages of individuals that it expects should be independently employed when it sets its new targets for GSE and ISE.

In order for the Commonwealth to reach these targets for individuals in the HCBS waivers the DBHDS will need to concentrate its efforts on completing its waiver redesign plan to address employment service definitions and revise its rate structure, focus on building provider capacity. Provider capacity is going to be critical to the success of meeting these targets. Provider capacity seems critical to Region I, III and IV that still have a preponderance of sheltered work settings, especially Region III.

I continue to recommend that the Commonwealth further refine these targets by indicating the number of individuals it hopes to provide ISE to from the following groups: individuals currently participating in GSE or pre-vocational programs; individuals in the target population who are leaving the Training Centers; and individuals in the target population who become waiver participants during the implementation of the Settlement Agreement. I am pleased that the EFAG has also made this recommendation. Creating these sub-groups with specific goals for increased employment for each will assist DBHDS to set measurable and achievable goals within the overall target and make the undertaking more manageable and strategic. Realistic and successful marketing and training approaches to target these specific groups can be developed through discussions between the DBHDS and the EFAG to reach out to families, Case Managers, CSBs, Training Center staff, and ESOs to assist the DBHDS to achieve its overall targets in each of the next five fiscal years.

VI. The Plan for Increasing Opportunities for Integrated Day Activities

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.

Waiver Redesign: The Commonwealth is continuing its planning efforts to redesign its waivers serving individuals with ID and DD is undertaking a significant redesign of its HCBS waivers. The redesigned HCBS waivers include a definition for integrated day activities, which DBHDS now refers to as Community Engagement. The Commonwealth submitted its HCBS waiver amendments to CMS in March 2016. At the time of this review, the Commonwealth is awaiting approval to begin implementation in July 2016. The General Assembly has delayed the implementation of the Community Guide/Peer Mentoring service has been delayed until 2017. The Commonwealth's General Assembly also delayed implementation of two employment related services until 2017: benefits planning and non-medical transportation.

Integrated Day Activity Plan: The DBHDS is required to provide integrated day activities, including supported employment for the target population. The Settlement Agreement states: *To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under the Agreement with integrated day opportunities, including supported employment.*

Since the Commonwealth of Virginia entered into the Settlement Agreement with the US DOJ, DBHDS has focused its work and activities on increasing employment opportunities for individuals with ID and DD. With rare exception providers in Virginia still do not offer individuals who are not employed other types of integrated day activities. DBHDS was directed by the Independent Reviewer to develop a plan by March 31, 2014 to describe its approach to create integrated day activity capacity throughout its provider community and ensure that individuals in the target population can participate in these integrated activities as the foundation of their day programs. During this review period, DBHDS submitted the revised Community Engagement Plan FY2016-FY2018 on December 29, 2015.

DBHDS has added new service definitions to its waiver-funded services. These include: community coaching, community engagement, community guide services, peer mentor support services, and group day services. Each includes a service definition, a list of allowable activities, and pay rates. Community coaching provides for individual one to one support to assist individuals engage in community activities and to access public transportation. Community engagement helps individuals develop or enhance skills to be more independent and to engage in community activities including education and training, retirement or volunteer activities. The focus of these newly defined services is on relationship building and using natural supports. Community Guide Services provide assistance to persons brokering community resources and assess interests. Peer support services allow an individual with a disability who are trained mentors to assist empowering the individual to access community living. Group day services include skill building or supports in the areas of self-help, community integration, employability and adaptive skills. All of the new services include a detailed list of allowable activities. The definitions are clear and the allowable activities are extensive. This effort should, over time, further the availability and success of integrated day activities.

Definitions have also been included for supported employment, including individual and group supported employment with allowable activities and rates for GSE. ISE is negotiated. Workplace assistance service has been added to the list of employment services. It provides supports to individuals who need more than the typical funded amount of job coach services to stabilize their employment.

DBHDS, with the input of the CEAG, drafted a comprehensive Community Inclusion Policy. It set this direction and clarifies the values of Community Inclusion for all individuals with intellectual and developmental disabilities, regardless of the severity. The policy supports the use of natural supports and promotes opportunities occurring at naturally occurring times to not limit individuals to offerings available only weekdays and daytime. It requires that the individuals be involved in the planning and selection process. The policy also identifies the types of activities that are included: community education or training,

retirement activities, and volunteer activities. The Community Inclusion policy, if implemented effectively, should build positive behavior, interpersonal competence, independence, employability and personal choice. The policy requires the involvement of both the DBHDS and the CSBs:

- ◆ to establish outcomes with specific percentage goals;
- ◆ to identify strategies to address barriers;
- ◆ to expand capacity of providers;
- ◆ to collaborate with the State Department of Education (and schools to promote transition planning; and
- ◆ to conduct a statewide education campaign about Community Engagement.

Implementation requires DBHDS to provide training and consultation; to work with DMAS to incorporate these services in the waivers; to continue the role of the CEAG; to develop an implementation plan; and to maintain membership in the SELN.

The DBHDS has also drafted answers to frequently asked questions about community engagement, community coaching and the availability of transportation for community engagement. The redesigned waiver application includes these services.

I was provided the DBHDS Community Engagement Plan Draft: December 10, 2015 as revised December 29, 2105 and the Quarterly Updates (2/23/15, 4/15/16). The Plan has six goals, one of which is new and three of which have been modified since the Quarterly Update of February 2015.

There is an overall goal to develop a common understanding and philosophy among stakeholders, providers, and state agencies of Community Engagement (CE) based on accepted national standards and in compliance with federal regulations.

STATUS- DBHDS has created the CE Advisory Group with broad stakeholder membership. It has also completed its service definitions within CE. The CEAG education and training sub-committee has been charged to assist DBHDS to develop and deliver training by 7/1/16. No specifics or update on these activities were provided.

1. Establish Policies to promote and encourage CE Activities.

STATUS- Policy statements, regulation language, outcome measures and a tool for data collection methodology is to be developed by 3/30/16. The CE AG is also to assure consistency in compliance documents by that date. A monitoring process is to be in place by 7/1/16. No specifics or update on these activities were provided.

2. Develop funding sources that promote and encourage implementation of CE.
(Previously-System transformation for the implementation of Community Engagement Activities.)

STATUS- The Burns and Associates data review for waiver redesign was completed. Rates have been developed for community engagement, community coaching, and

community guide as of 7/1/15. Rates have been approved to be effective 7/1/16. The monitoring and evaluation of the implementation of the rates will be completed 6/30/18. The Commonwealth is on track to achieve this goal.

3. Ensure that structures, at both the state and provider level, will support delivery of CE in the least restrictive and most integrated settings that are appropriate to the specific needs of the individual as identified through the person centered planning process. *(Previously-Implementation of best practices in the provision of Community Engagement Activities.)*

STATUS- DBHDS issued a RFP for Community Engagement 7/9/15 to assist two providers serving at least 100 individuals to convert from center-based programs to CE. The grants were to be awarded, but this has been delayed. The DBHDS will meet monthly with the grantee organizations for the purposes of gathering information to develop a guidebook by 7/1/16. Fact sheets for providers, families and individuals, and the general importance of CE have been developed. The CEAG is scheduled to develop a training curriculum detailing how to engage individuals in CE by 6/1/16. The CEAG is to collect information on best practices and to identify those practices to make available to providers. DBHDS is to provide training and technical assistance by 3/30/16 and to develop a fact sheet for DOE by 1/30/16. This goal is partially on track. There are no updates on progress related to best practices, training, or the DOE fact sheet. These timelines will be impacted by the delay in awarding the contracts.

4. Ensure CE services are being offered and provided to individuals across the state in the most integrated community settings based on the needs of the individual as determined through the person-centered planning process. *(Previously-Monitoring to ensure implementation.)*

STATUS- The CEAG is to work with regions to identify additional providers of CE by 3/31/16 and to work with stakeholders to determine how to create incentives by 7/1/17. The CEAG is also to review information from grantees by 12/31/16. There are no updates provided on the progress on these activities.

5. Ensure that there is an increase in meaningful CE for each individual. Virginia's vision is to have an array of integrated service opportunities available for individuals with disabilities and wants individuals to be able to choose to have services delivered to them in the least restrictive and most integrated setting.

STATUS – DBHDS and the CEAG are reviewing provider's practices on collecting data and plan to use NCI and QSR data on CE activities by 7/1/17. QMR staff will be trained by 10/30/16.

The DBHDS and the CEAG have developed a robust definition of Integrated Day Activities, which it now calls Community Engagement. These definitions will be used to describe this service type in the redesigned waiver. The definition the plan offers of integrated day activities assures that they are meaningful, offered at times to benefit the person to have an active community-based daily routine, Activities will include community education or training and retirement, recreation and volunteer activities.

The definition is outcome focused. Integrated day activities must be offered in the community, facilitate the development of meaningful relationships with typical individuals, and facilitate community inclusion. Transportation, which is included, will be a key element to successfully offering these services. The DBHDS is to be commended on developing this comprehensive definition of integrated day activities.

I visited programs in Region III on March 31 and April 1, 2016. I was able to meet with the Program and Assistant Program Director at the New River Valley CSB and interview two Support Coordinators about employment and community engagement. New River Valley operates a center-based day program that they are in the process of converting to community engagement. The individuals who are appropriate will be referred to employment services. They were very proud of one of the women they served who was supported by DARS to become gainfully employed. She is currently working in a Goodwill retail store in Blacksburg and no longer needs employment assistance. The staff reports that competition with 30,000 Virginia Tech students will make finding a sufficient number of jobs a challenge.

The New River Valley CSB staff report having already started to increase community-integrated activities for individuals who are currently in the center-based programs. They are taking advantage of the many community offerings at nearby Virginia Tech and through volunteer opportunities. They are working with the Support Coordinators and families to explain the changes in opportunity for community engagement and to develop plans that reflect the unique needs and interests of their program participants. They are meeting some resistance or concern from families, especially those who have used the program for several years. Families are unsure of the impact the lack of a full day center-based setting will have on them. Their family member will have options for various community-based activities. These may vary in duration and whether they occur on, weekdays or on the weekend, Transportation may be added to the daily schedule. Fortunately transportation will be a funded service for CE under the HCBS waiver. I was impressed with the creativity and commitment of the lead staff. They believe they have adequate staffing and transportation resources to make the conversion from center-based to integrated activities. They report there will be a core of approximately twenty individuals who will still use the center as a drop off and pick up location. These individuals will travel from the center throughout the day to engage in community activities of their choice.

The two NRV CSB Support Coordinators I spoke with are starting to see some momentum to increase employment opportunities. They report an improved relationship with DARS, with assistance from DBHDS, to set the direction and expectation for prompt action on referrals. There has also been some success in securing employment. They caution that the number of referrals is small to date. They report the most significant challenge is family resistance. Families are not always educated about the impact of employment on benefits and, therefore, remain more comfortable with the certainty of sheltered work. They are not always invested in employment for their family members. Transportation to work is a concern for families as well. Families are comfortable with volunteer work. The Support Coordinators find that pairing employment with community engagement or with in-home supports positive are options that will allow families to accept the changes. There is a need

to increase the capacity of ESOs in the greater Blacksburg area, which currently has only two employment providers.

The second program I visited was the Goodwill in Roanoke where I toured the adult daily living skills, pre-vocational, and organized employment support programs. The living skills program is divided into two groups. One is for 17-20 individuals who are medically involved. The other supports 20-24 individuals who present behavioral challenges. All of these individuals are funded through the waiver. The pre-vocational program is also waiver funded. It serves twenty-five individuals who have participated for several years. Many are close to or of retirement age. The employment support program offers in-house contract work to approximately 20 individuals who are funded by DARS.

Currently only 10% of the individuals who are served in either the pre-vocation or employment support are estimated to make minimum wage. I met with the Medicaid Quality Coordinator who said that Goodwill would no longer pay sub-minimum wage in the pre-vocational program, as of July 2016. They will be phasing it out of the employment support program as well, but are awaiting direction from DARS. Individuals can remain with Goodwill. They will either pursue employment opportunities or community engagement. Goodwill is using the individual planning process to assist families and individuals to determine the correct direction. There has been reluctance on the part of families and particular concern about transportation for work since this is not funded during the first year of the waiver redesign. Goodwill does assist individuals to use public transportation wherever possible.

Other concerns are about the impact of work on the individuals' benefits and the inability to pay an individual who cannot produce at a level or work commensurate with minimum wage. Goodwill has reached out to DARS for benefit information and has conducted informational sessions for families. The agency is also transitioning its HCBS waiver adult daily living skills programs by the summer of 2016. The Medicaid Quality Coordinator reports that some of the individuals with behavioral challenges may be supported to find employment. The other group will most likely transition to community engagement. She was very complimentary of the assistance the agency is receiving from Heather Norton at DBHDS. Ms. Norton has met with them to provide technical assistance about both CE and employment conversions and has engaged DARS to join the planning process.

I also interviewed the Executive Directors of the Arc of Southside and of the Harrisonburg/Rockingham Arc. Both of these agencies have conversion activities underway. Individuals who have received services in a congregate day settings will be provided opportunities for community engagement. The Arc of Southside has already reduced its workshop from serving 125 to 90 individuals. This has resulted from the development of supported employment options. Other individuals will be considered for community engagement. The Harrisonburg/Rockingham Arc, which has thirty-six individuals who receive sheltered work, is developing community engagement opportunities. They are engaging staff to help individuals to find volunteer activities. They have needed to increase staffing, address the inaccessibility of the community; change transportation vehicles, and help individuals build their stamina to engage in a full day in

their communities. They both appreciate the leadership of DBHDS and note that DARS is more helpful on the supported employment side.

Conclusion and Recommendations:

The Commonwealth is not in compliance with *III.C.7.a* and is also not in compliance with *III.C.7.b.i* because it does not have a comprehensive implementation plan and it still is unable to offer its consumers integrated day activities.

It is encouraging to discover the extent of the work that has occurred over the past year. The Commonwealth has defined services that will be offered under community engagement. These include creating a robust set of services in the redesigned waiver, actively engaging the CEAG, developing a policy statement, and issuing a RFP to begin to address the existing limited capacity. The DBHDS is also commended for its resolve to keep this effort active without its employment coordinator who had worked on this initiative. Providers are very positive about the consultation, technical assistance and responsiveness of Ms. Norton representing DBHDS. The department has done a nice job of engaging in more specific planning of its implementation of Community Engagement.

It will be helpful for the Commonwealth to establish baseline data, to develop targets (as stated in the draft Community Inclusion Policy), and to implement a statewide training plan with the assistance of the CEAG.

VII. Review of the SELN and The Inclusion of Employment in the Person-Centered ISP Planning Process

III.C.7.b. The Commonwealth shall:

- ✓ *Maintain its membership in the SELN established by NASDDDS.*
- ✓ *Establish a state policy on Employment First (EF) for this target population and include a term in the CSB Performance Contract requiring application of this policy.*
- ✓ *The principles of the Employment First Policy include offering employment as the first and priority service option; providing integrated work settings that pay individuals minimum wage; discussing employment options with individuals through the person-centered planning process at least annually.*
- ✓ *Employ at least one Employment Services Coordinator to monitor the implementation of the employment first practices.*

Virginia has maintained its membership in the SELN and issued a policy on Employment First. DBHDS employed the Employment Services Coordinator until his resignation in January 2016. The agency is currently recruiting applicants to hire a replacement. DBHDS anticipates hiring two individuals who will share responsibilities for employment and autism services. This is intended to allow staff to be more regionally based and to be available to more stakeholders. This will allow more efficient provision of assistance to providers who are transitioning and the provision of regional based training. I applaud the department's effort to increase its leadership capacity for employment. Hopefully, DBHDS will be able to find and attract candidates who possess the requisite backgrounds in both

autism and employment. The Commonwealth has maintained its membership in the SELN, which the Community Inclusion Policy will require, once it is finalized.

The Settlement Agreement requires the Commonwealth to ensure that individuals in the target population are offered employment as the first day service option. DBHDS includes this requirement expectation in its Performance Contracts with the CSBs for FY2015 and FY2016.

The CSB Performance Contract for FY2015 and 2016 requires the CSBs to monitor and collect data and report on these performance measures:

I.C. The number of employment aged adults receiving case management services from the CSB whose case manager discussed integrated, community-based employment with them during their annual ISP meeting, and

I.D. The percentage of employment-aged adults in the DOJ Settlement Agreement population whose ISP included employment-related or employment-readiness goals. From the small sample of ISPs I reviewed there is no indication that CSBs are in compliance with the Performance Contract regarding employment planning for members of the target population or with the requirement to include employment related or readiness goals in the ISP.

The Commonwealth expects that 100% of individuals with I/DD with a case manager will have “employment services and goals developed and discussed at least annually” by 12/30/15, and that 35% of these individuals will have an employment or employment-related goal in the Individual Service Plan (ISP). The October 2015 Employment Report includes the following information from June 2015 data regarding these goals:

- ISP meetings were conducted for 4,983 adults during the six-month reporting period. DBHDS reports that 4,442 (89%) of these individuals had a discussion with their team about integrated employment
- A total of 1,825 (37%) of the individuals that had ISP meetings had an employment or employment-related goal in their ISP.

The April 18, 2016 Employment Report did not include these data. However, DBHDS was able to send me the raw data for my analysis. What is striking is that annual ISP meetings were only conducted for 2,579 individuals out of the 14,327 individuals on CSB caseloads. This is only 18% of individuals that CSBs serve. One would project that approximately 50% of these individuals would have had an annual meeting in the six-month period of July – December 2015. Of the individuals who had an annual meeting, employment was reported discussed with 2,011 of them, which is 78%. The CSBs reported that employment goals were set for 894 of these individuals. It is impossible to support that the CSBs met the targets with so few individuals reported as having an annual meeting. Even of those who did have an annual meeting the goal of 100% engaging in a discussion about employment was not met. Eight CSBs did not report that their Case Managers conducted any annual meetings.

Since the spring 2015 review instructions have been issued to the CSBs, the requirement is in the performance contract. The ISP format was changed to place greater emphasis on employment discussion and goal setting. The CSB's did determine and self-report whether the goals they were involved in setting had been met in both June and December 2015. Heather Norton reported that the DBHDS Case Management Coordinator did review thirty randomly selected records. DBHDS also reviews the records that the Independent Reviewer and his Individual Services Review teams review. Review of these records is also part of the Quality Service Review that are performed by Delmarva. DBHDS acknowledges that the quality of the employment discussions can be improved. It plans to identify best practices across the CSBs and to share this information with a goal to strengthen the employment discussion between Case Managers, individuals and other team members. The DBHDS should provide the results of these quality reviews for future employment service reviews. The Commonwealth is not in compliance with *III.C.7.b*. The Commonwealth is not meeting the requirement to have employment addressed in the individual planning process through meaningful discussion and goal setting.

The Engagement of the SELN: The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, to set the targets for the number of individuals in the target population who will be employed, and to provide ongoing assistance to implement the plan and the Employment First Policy. DBHDS changed the structure and membership of its Advisory Group during the summer of 2015. The SELN Advisory Group was also renamed the Employment First Advisory Group. Its members were appointed for two-year terms: August 2015- July 2017. The EFAG has twenty-six members. It includes self-advocates, family members, advocacy organization representatives, CSB staff, state agency administrators, educators, and employment providers. DBHDS, DMAS, DARS, and VDOE are the state agencies that are represented. The Advisory Group has several sub-committees: membership, training and education, policy, data and interagency collaboration. I reviewed the EFAG meeting minutes. These meetings were well attended. There were reports from each sub-committee, except the interagency sub-committee. This subcommittee was still in the process of forming as of October 2015. DBHDS has formalized the work of the Community Engagement Advisory Group (CEAG). It has a membership of twenty-three individuals, which includes representatives of all of the stakeholder groups. VDOE does not, however, have a representative unlike with the former Employment First AG. Members have also been appointed for two-year terms. Two sub-committees, policy and training, have been established. DBHDS provided minutes from the meetings held in October 2015 and in December 2105, and from AG and sub-committee reports from meetings in February 2016. The AG has reviewed the DBHDS plans, assisted with the creation of service definitions and are active planning training. They have reviewed and contributed input in creating the timelines to increase the number of individuals that participate in community engagement

The two AGs remain active in their advisory capacities to DBHDS regarding its employment initiative. I have reviewed the minutes of the meetings of the SELN and its sub-committees and interviewed five members who represent a variety of stakeholders.

1. *The operation of the SELN and the opportunity afforded its members to have input into the planning process.* All members who I interviewed report that the EFAG, the new name for the SELN, has made significant progress since restructuring its membership in the summer of 2015. Members appreciate the organization and structure that Heather Norton and Adam Sass have brought to the committee during the past several months. Ms. Norton has continued to support the group since Mr. Sass' departure in January. EFAG members report that the meetings and agendas are well structured. They also appreciate more regularly receive reports and data with time to review them prior to meeting discussions. Members report that the opportunity for meaningful input has improved.

2. *Improving employment data-*The EFAG continues to contribute significant input to the department's initiative to improve the data that it has about employment. The Data Committee's input to improve data collection with ESOs was used. This resulted in a dramatically improved provider response rate has dramatically from 44% last spring to 95% in June 2015. The higher response rate was sustained with 93% reporting in December 2015. Members report much greater faith in the accuracy of these data. These data can be used to determine next steps in their efforts to promote greater employment for individuals with ID ad DD.

3. *Training-* Both the EFAG and the CEAG have active training committees, which assist DBHDS to plan training for various stakeholder groups. Numerous trainings are set up for the waiver redesign. These trainings will occur, which have been provided in the past, will occur throughout the spring of 2016. All of the committee members who I interviewed give credit to the training Heather Norton, DBHDS, and Donna Bonessi, DARS, have provided throughout the state to employment service organizations and to other providers that are undertaking the transition process to supported employment and/or to community engagement.

4. *Reviewing the employment targets and waiver redesign plans-* EFAG members report that DBHDS is engaging them in the review of the targets. The DBHDS reviewed this information with the EFAG as recently as April. EFAG members have provided input to the WDAC regarding the employment related service definitions. They also report that DBHDS has kept them more abreast of the development of the new and redesigned waivers and issues with implementation.

5. *Review of the Community Engagement Plan-* DBHDS has created a second Advisory Committee to provide recommendations regarding the implementation of the plan for Integrated Day/Community Engagement Activities. All members who were interviewed think this is a positive step. The CEAG now has input into policy development and into education and training. This allows the EFAG to devote its time and energies to the implementation of the Employment Plan. The CEAG is very active and meets regularly. It has policy and training sub-committees, which are engaged with DBHDS in setting policy and developing materials for training events. Members want to produce a video that will include testimonials from individuals involved in community activities that are inclusive as a way to more clearly demonstrate what community engagement is about.

6. Interagency Initiatives- the initiative shared in the last report has not been planned. This initiative was to create collaboration among DARS, DOE and DBHDS to work with a rural school district to improve the employment readiness of its students. However, there are positive interagency initiatives between DARS and DBHDS that will enhance the employment initiative. First among them is the data sharing that has been occurring for the past two reporting periods. DARS data are both comprehensive and accurate. These data illustrate the larger universe of individuals with ID and DD in Virginia who are employed. The members of the EFAG have a positive view of the co-training that is being provided by Ms. Norton of DBHDS and Ms. Bonessi of DARS. DBHDS and DARS are also collaborating on using DARS ID/DD Resource Specialists and two positions that DBHDS plans to devote to employment to insure that the entire state has employment expert resources. These resources would be more readily available regionally to work with community partners, DARS staff, and providers to improve employment outcomes for this population. The Employment First Advisory Group has made other related recommendations to monitor more specific information about individuals with ID/DD who are receiving. These recommendations are to gather and segment data to track employment services by:

- Individuals granted new waiver slots
- Individuals discharged from training centers who start receiving community services
- Individuals who shift employment services within a waiver and who shift from center-based, non-integrated day services to integrated employment services

The Employment First Advisory Group will develop targets for these subgroups after DBHDS is able to collect and share baseline data.

Conclusion and Recommendation: The DBHDS continues to meet the Settlement Agreement requirements to maintain the SELN, but is not in overall compliance with *III.C.7.b*. It cannot produce the data from the CSBs to determine compliance with implementing the Employment First initiative since June 2016. Only 18% of the ISP annual meetings were reported.

VIII. Regional Quality Councils

III.C.7.c. Regional Quality Councils, [described in Section V.D.5 below,] 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 to the Regional Quality Councils and the Quality Management system by the providers. Regional Quality Councils shall consult with those providers and the SELN regarding the need to take additional measures to further enhance these services.

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.

DBHDS shared minutes of the Regional Quality Councils' meetings that occurred in Quarter 1 FY16 and Quarter 2 FY16. The DBHDS representatives, who also are SELN members, attended

the Q1 meetings. The RQC’s reviewed the number of individuals employed and the length of time in employment targets set for 2015, the state’s achievement in reaching these targets, and the future targets for FY16-19. The RQC’s were also informed of the supplemental targets set for individuals’ teams to discuss employment options and to set employment goals. All five regions discussed the number of individuals employed target and barriers and voted in favor of the multi-year target plan.

The target for increasing the number of individuals in the waiver in ISE was not progressing as projected. This was not discussed by the RQCs. Six months after the employment review with the RQC’s the Commonwealth exceeded the target for individuals sustaining employment for twelve months or more.

Conclusions and Recommendations: DBHDS is in compliance with III.C.7.c. and d.

The RQC’s should discuss additional measures to be taken by DBHDS or by the SELN/Employment First Advisory Group to improve progress toward achieving future targets for the number of individuals who are employed in integrated settings.

DBHDS has made significant gains during this reporting period in its data collection and in its efforts to prepare the system to implement community engagement. It has seen increases in the number of individuals who are employed. DBHDS is working with many providers to assist them to transition individuals from workshops and center-based day habilitation to employment or community engagement. It is still a concern, however, that there is still no availability of integrated day activities/Community Engagement, for individuals on the HCBS waivers. DBHDS also needs to ensure that the data reported by the CSBs is accurate and that Case Managers are developing and having meaningful discussions about employment goals at least annually. This expectation should be set for DD Case Managers as well in July 2016 when case management for these individuals becomes the responsibility of the CSBs.

IX. SUMMARY

Table 3 Summary of Compliance

SA Element	Compliance	Status
III.C.7.a	Not Met	Continued
III.C.7.b	Not Met	Continued
III.C.7.b.i.	Not Met	Continued
III.C.7.b.i.A	Met	Continued
III.C.7.b.i.B.1.a	Met	Achieved
III.C.7.b.i.B.1.b	Met	Achieved
III.C.7.b.i.B.1.c	Met	Achieved
III.C.7.b.i.B.1.d	Met	Continued
III.C.7.b.i.1.e	Met	Continued
III.C.7.b.i.B.2.a	Not Met	Continued
III.C.7.b.i.B.2.b	Met	Achieved
III.C.7.c	Met	Achieved
III.C.7.d	Met	Achieved

APPENDIX F

INDEPENDENT HOUSING

**By: Patrick Rafter, CEO
Creative Housing Inc.**

Date: May 12, 2016

To: Donald Fletcher, Independent Reviewer

From: Patrick Rafter, CEO, Creative Housing, Inc.

Re: Housing Plan Review

At your request, I reviewed the current status of Virginia's *Plan to Increase Independent Living Options*. This memo summarizes observations made this week as a follow up to my visits in November of 2014 and November of 2013.

I reviewed associated progress reports and staff meeting minutes. I also discussed the plan progress directly with team members involved in the plan development and implementation in my latest visit. In addition, I met with housing advocates and solicited their "ground level" assessment of the Plan implementation.

Progress Noted:

In my two previous reviews, I noted "I had significant concerns about the Plan's actual capacity to develop community based housing for the target population". My concerns at the time were born out in my last review of 2014 when at the time only two new individuals had been provided independent housing in the target population.

My review this week shows a different and positive housing development picture. Information on the DBHDS Independent Housing Outcomes Table (3/29/16) indicates that since July of 2015, 91 additional individuals in the target population are now living in their own homes bringing the total number of people in the target population living in their own home to 434. This puts DBHDS ahead of its Outcome Timelines projections (Updated *September 2015*). In that report DBHDS projected 393 adults living independently by June of 2016.

An additional 200 "rental assistance resources" are now also set-aside for the target population.

Much of the progress shown proceeds from Virginia Housing Developmental Authority and Public Housing Authorities ability and willingness to set aside rent subsidies for the target population. This is a welcome collaboration in that it readily provides housing options within an up and running state program. Also, the Housing Authority's adjustments made to the Low Income Housing Tax Credit Program provides incentives for developers to serve the target class which, I was informed, has the long term capability of yielding 40 – 75 units of what could be accessible units.

Recommendations:

Provider Capacity: It has been my experience that a strong provider system is the key element in the development of a scattered site and community integrated residential system. As DBHDS “goes to scale” and moves to rapidly expand its independent housing program, I urge that it also focus on assisting the provider industry in adapting new business models that can best serve individuals in the independent living program. Turnover, staff training, staff supervision, emergency back up, and quality assurance each take on more critical dimensions when clients are scattered through a community. In almost every discussion during my visit, the existing provider capacity to provide scattered site supports emerged as a concern. As things now stand, I would not be surprised that some individuals eligible for the existing rent subsidies are not able to obtain the necessary supports for them to live independently.

The Independent Living Options Action Plan lists several provider training objectives which may have some positive impact on the issue. I am suggesting that DBHDS take a more in-depth look at provider development, engage forward leaning providers in a system review, and recognize that an almost new industry needs to be developed to support scattered site housing for people with intellectual and developmental disabilities.

Service Coordinator/Case Manager Orientation: Central to the development of an independent living program for the target population are well-rounded case managers. These case managers should not only be able to wrap services around an individual, but also have an understanding of both the local housing market and the landlords willing to partner with the program. If this combined skill set is lacking in local case management, individuals who could be well served in independent living will be directed to congregate living since that has been the historic case management “default response.” While I did not examine this issue thoroughly during my visit, there was anecdotal evidence of individuals in the target population not being presented with an independent housing option. I would recommend that DBHDS staff evaluate the training and case management re-orientation process. Case Managers have the most critical role in the blending of housing and supports and the eventual growth of this important program.

I appreciate the willingness of all parties during my visit to be generous with their time and candid in their discussions with me. I am also happy to make myself available to DBHDS staff if additional discussion would be useful to them.

APPENDIX G

LICENSING AND INVESTIGATION REQUIRMENTS

by: Ric Zaharia, Ph.D.



Consortium on Innovative Practices

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

Licensing and Investigation
Requirements

By

Ric Zaharia, Ph.D.
Consortium on Innovative Practices

April 30, 2016

Introduction

At the request of the Independent Reviewer, we evaluated progress at the Office of Licensing Services (OLS) and the Office of Human Rights (OHR) towards expectations set in the Settlement Agreement (SA). This review is also based on our previous reviews, findings, and conclusions.

The Commonwealth's primary system for regulating the conduct of provider agencies is the Office of Licensing Services (OLS) and the Office of Human Rights (OHR). Therefore, the effective functioning of OLS and OHR in accordance with the requirements of the Settlement Agreement is critical to the goal of improving the lives of people with intellectual and developmental disabilities in Virginia.

The OLS system is also the primary compliance mechanism for Community Service Board (CSB) performance under their contracts with the Commonwealth for the Case Management function. The Department of Behavioral Health and Developmental Services (DBHDS), however, has implemented various other strategies to accomplish the case management monitoring responsibilities outlined in the Settlement Agreement (SA), such as the *Supports Efficiency Checklist*, the Internal Auditors Operational Reviews, and DBHDS Quality Management staff focused on case management. The status of these strategies will be evaluated.

Finally, since OLS and OHR operate in tandem in identifying and addressing abuse and neglect, this review will again assess the quality of OHR investigations, provider investigations of allegations of abuse and neglect, and the effectiveness of the relationship between the two Offices. It will also assess the coordination between DBHDS and DSS/APS/CPS (Department of Social Services/Adult Protective Services/Child Protective Services) when APS/CPS investigates allegations of abuse and neglect of individuals who live in settings funded by DBHDS.

DBHDS has taken a huge step forward in its development of a Data Warehouse, a central repository of data and data analytics from one or more disparate sources. Evidence of the capabilities of the Data Warehouse is present in data reports received for the OLS/OHR review project.

The Compliance Table on the following page recaps our conclusions as to DBHDS success at meeting the terms of these selected elements of the Settlement Agreement.

Compliance Table

Settlement Agreement Section	Settlement Agreement Language	Compliance Rating	Page
III.C.5.d Case Management	<i>The Commonwealth shall establish a mechanism to monitor compliance with performance standards.</i>	Non- Compliance	6
V.C.2 Abuse and Neglect Investigations	<i>The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.</i>	Compliance	11
V.C.3 Abuse and Neglect Investigations	<i>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. The Commonwealth shall be required to implement the process for investigation and remediationin effect on the effective date of this Agreement, and shall verify the implementation of corrective action plans required under these Rules and Regulations.</i>	Non-Compliance	11
V.C.6 Abuse and Neglect Investigations	<i>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 pursuant to the DBHDS Human Rights Regulations....</i>	Non-Compliance	11
V.G.1 Licensing	<i>The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.</i>	Compliance	8
V.G.2 Licensing	<i>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 under this Agreement.</i>	Compliance	8
V.G.3 Licensing	<i>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.</i>	Non-Compliance	9
IX.C Implementation	<i>The Commonwealth shall maintain sufficient records to document that the requirements of the Agreement are being properly implemented....”</i>	Non-Compliance	6

I. Case Management

Settlement Requirement:

III.C. 5. Case Management

d. The Commonwealth shall establish a mechanism to monitor compliance with performance standards.

Methodology:

- Reviewed current OLS *Office Protocol*; reviewed OLS *Guidance for Selected Licensing Requirements (2/15)*;
- Reviewed minutes and other communication and work products of groups;
- Reviewed CSB and other surveys for CY 2015 where compliance problems with ID and DD case management requirements were identified;
- Reviewed available Data Warehouse reports for CSB licensing results around case management requirements;
- Reviewed Internal Auditor reports completed in CY 2015;
- Reviewed actions taken in CY 2015 by DBHDS Quality Management Section;
- Reviewed the Quality Services Review *Support Coordinator Interview* and the *Support Coordinator Record Review* tools.

Findings:

OLS revised its *Office Protocol*, which guides Licensing Specialists in their conduct of the work of Licensing, in February 2016. The latest version continues the improvements to the 2015 version, vis-à-vis areas to be assessed (V.D.3) and monthly follow-up on Corrective Action Plans (CAPs) until conditions are corrected.

Licensing regulations (12VAC35-105-10 to 105-1410) align generally with the case management expectations in the Agreement. The regulations do not align specifically as to the case management expectations detailed in the Agreement (i.e. regularized face to face meetings with the individual being served, enhanced visit frequency, identifying risks to the individual, offering choice among providers, assembling professionals and non-professionals who provide supports, etc.). DBHDS takes the position that other mechanisms of quality improvement address these issues. In addition, the OLS *Guidance for Selected Licensing Requirements (2/15)* details the evidence expected by Licensing for case management and aligns with the SA but appears solely reliant on case manager interviews and documentation review. This approach overlooks an examination of individual needs, supports, and outcomes. For example, 12VAC35-105-675 requires that: “The provider shall review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment ...The provider shall update the goals, objectives and strategies contained in the ISP, if indicated, and implement any updates made.” This regulation generally includes the case manager but when OLS reviews only the case management record, and not the experience and status of the individual, there is no way to specifically test the case manager’s fulfillment of the requirement “... *to make timely additional referrals, service changes, and amendments to the plans as needed (SA III.C.5.b)*”.

During 2015 there were more than 100 investigations/inquiries into complaints about sixteen (16) CSBs. However, by report, only one of these resulted in a CAP. The implication is that

in a review of 100 case management records no documentation deficiencies were identified. Based on our review of a selected sample of twenty-one (21) ID Waiver cases (See Case Management Requirements report, April 2016) across four CSBs, at least two of four (50%) CSBs performed significantly below DBHDS performance targets (20 - 23% discrepancies) and on case management performance items. These performance concerns should have resulted in one or more citations for case management.

OLS piloted the *Supports Efficiency Checklist* approach to CSB case review during late 2014 and early 2015. At that time it was terminated when DBHDS initiated the Quality Service Reviews (QSRs). It appears that the DBHDS also discontinued the use of the *Supports Efficiency Checklist* because most providers during the pilot period typically had “no verifiable data” to support activities towards outcomes. By dropping the use of the *Supports Efficiency Checklist* the OLS returned the focus of its licensing review process of CSB case management services to documentation. This more narrow approach in the review of CSB case management services results in problems being overlooked, substandard performance not being discovered, and opportunities for improvement being missed. Again, our review of twenty-one (21) cases in a separate study during this review period found that there are isolated problems that do not appear to be identified through current OLS reviews of CSB case management because of this focus primarily on documentation.

The Internal Auditors Operational Reviews specific to case management align with the SA. The reported sampling size of fifteen (15) individuals with ID served at each CSB appears adequate, although two of the Reviews reported results on as few as eight. Management Responses from CSBs are required for deficiencies that are noted. However, only a few Operational Reviews are conducted in a year (five were issued in 2015), which suggests that for all CSBs to be reviewed, it could be eight to nine years before each of the forty CSBs is reviewed. Given the rate at which the quality of case management services can improve or decline and the frequency of change in case management practice (e.g. a new ISP was rolled out before two of these reviews and after three of these reviews), the Operational Review every eight or nine years can only be viewed as a supplement to the needed and required case management monitoring function.

When the Quality Service Reviews (QSRs) were initiated, DBHDS appears to have also discontinued the Quality Management Section’s use of technical assistance teams to support CSB case management functioning as part of the 360 review. The templates for the QSR *Support Coordinator Interview* and the *Support Coordinator Record Review* align generally with SA domains (V.D.3) and should help surface case management issues at the CSB level. The challenge will be to reliably assess case manager performance and then to translate shortcomings identified in QSRs into formal follow-up and corrective actions by OLS or some other entity. The SA envisions the product of these Reviews being used to “improve practice and the quality of services” but our studies have found (and OLS’s experience is) that many problematic providers will ignore or give short shrift to this type of feedback unless they are held to a plan of action and follow-up.

OLS does not regularly compile the results of licensing reviews into a report on trends related to compliance patterns across CSBs. The Data Warehouse capability that now exists within DBHDS gives OLS a tremendous ability to assess the health of the system vis-à-vis CSB performance.

Conclusions:

The Commonwealth is not currently in compliance with III.C.5.d, the requirement to have a mechanism to monitor CSB compliance with performance standards. The Commonwealth is also not currently in compliance with Section IX.C, which requires that there be "...sufficient records to document that the requirements of the Agreement are being properly implemented..."

Recommendations to achieve compliance:

OLS should create a supplement to the case management checklist that operationalizes the expectations of the Agreement. This supplement should be outcome focused (versus documentation focused) and specifically include probes of: identifying risks to the individual, offering choice among providers, assembling professionals and non-professionals who provide supports, modifying the ISP when needed, etc.

OLS should require Licensing Specialists to assess case management services while they are examining services at the individual and provider level. The root cause of service delivery problems is often the poor coordination of services, the absence of monitoring by an outside party, or the absence of leadership/advocacy on behalf of the individual.

OLS should compile an annual narrative trend report on licensing results for case management, using information now available in the Data Warehouse. Detecting and reporting patterns and frequencies in the results of licensing reviews across CSBs ensures system improvements are discovered and identified.

II. Provider Licensing

Settlement Requirement:

V.G.1-3

V. Providers Quality

G. Licensing

1. *The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.*
2. *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 under this Agreement, including:*
 - a. *Providers who have a conditional or provisional license;*
 - b. *Providers who serve individuals with intensive medical and behavioral needs as defined by the SIS category representing the highest level of risk to individuals;*
 - c. *Providers who serve individuals who have an interruption of service greater than 30 days;*
 - d. *Providers who serve individuals who encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;*
 - e. *Providers who serve individuals who have transitioned from a Training Center within the previous 12 months; and*
 - f. *Providers who serve individuals in congregate settings of 5 or more individuals.*
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.*

Methodology:

- Reviewed minutes and other work products of groups;
- Reviewed deliverables in *Licensing Business Process Modeling Project* (Hyzer, 2015);
- Reviewed current OHR protocols, procedures and operating guidelines;
- Reviewed OLS *Supports Efficiency Checklist* data from CY 2015;
- Reviewed provider surveys for CY 2015 in which DBHDS identified compliance problems;
- Reviewed any available summaries or trend reports for provider licensing results;
- Reviewed OLS use of provisional licensing and other available tools to sanction providers;
- Reviewed proposed draft of revised *Rules and Regulations for Licensing Providers* (6/15);
- Interviewed OLS and OHR leadership and staff, in order to clarify DBHDS organization structure, changes, and training.

Findings:

Licensing regulations (12VAC35-105-10 to 105-1410) align generally with the expectations in the Agreement. Licensing protocols (checklists) align generally with the Licensing regulations. The Licensing strategy of interviewing staff and clients, in order to assess whether actual services have been provided and whether the expectations of the Licensing regulations and the Agreement have been achieved, is still unstructured. The lack of structure to these interview leads to wide variation in what Licensing Specialists examine.

There is renewed energy and activity under new leadership at OLS, which has completed a business mapping process, implemented enhanced training opportunities, and generated analytics from the Data Warehouse. The Licensing reviews that were examined for this study include clear statements of provider problems, when problems were identified. These OLS reviews also included corrective action plans that were related to the problems that were identified.

OLS also provided a listing of twenty-one ID provider agencies that had officially closed one or more sites in 2015; a provider decision to self-exit is a bona fide but insufficient quality management strategy, since these “closings” will often be a site the provider agency is not using or a service site where conditions, staffing, etc., have seriously deteriorated.

Reports supplied by OLS, and verified on their provider search web page, suggest that only one provider was placed on provisional status during 2015, which is less than the seven placed on provisional status in 2014. Further, one provider, who had been placed on provisional status for six months in 2014, received critical reviews in December of 2015 and in January 2016 for a number of repeat citations and for citations of ‘systemic non-compliance’; as of March 2016 this provider was not placed on provisional status and further sanctions had not been applied. OLS cited another provider, while on provisional status, for numerous financial irregularities (e.g. issuing checks for staff payroll knowingly having insufficient funds, etc.) with no consequences beyond another CAP. This provider was removed from provisional status soon after these citations but was subsequently cited for

repeat violations. Following these citations this provider was not placed on provisional status, was not otherwise sanctioned, and is not listed on the roster of “closed” agencies.

The review of a sample of ad hoc OLS investigations suggests appropriate attention to detail and fact gathering. Investigations that reveal regulatory compliance problems (in our view too few based on our own studies) may evolve into corrective action plan requirements of the provider. Licensing Specialists verify and follow-up within forty-five (45) days on Corrective Action Plans.

Although OLS does not regularly compile the results of licensing reviews, report trends and analyze patterns across providers, OLS now has access to the Data Warehouse and its information, where there is a rich data mine for system improvements.

DBHDS has proposed revisions to its *Rules and Regulations for Licensing Providers* during the past year. The June 11, 2015, draft that we reviewed, if approved as written, would, clean up language, clarified licensing statutes, clarified/updated DD and ID definitions, and added requirements for providers: data sharing, risk management programs, monitoring serious injuries, conducting death reviews, quality improvement programs including root cause analysis, and ISP reviews. It also makes available the appeals processes in the Administrative Process Act to providers placed on provisional status.

OLS appears to have the necessary regulatory tools to require improvements among substandard providers and to eliminate substandard providers who have demonstrated an inability or refusal to improve their services. These tools include mandatory training, fines up to \$500 per violation, provisional licensing, revocation of licenses, summary suspension in emergencies, probation, reduced licensed capacity, admission freeze, and funds withholding (Va. Code. §37.2-418 & 419). The use of provisional status with only one provider and the continued lack of use of the other half dozen tools suggests that an increased emphasis on enforcement is necessary.

OLS revised and streamlined its complaint process with the addition of a fillable form suitable for emailing in to DBHDS. This is positive. However, the form is difficult to find. Placement of the *File a Complaint* tab under the main OLS web page makes it very unlikely that consumers of services or their families will be able to locate the form and use it.

Finally, due process and regulatory protections for providers appear sufficient and appropriate to ensure that actions OLS might take are based on substantive issues and to ensure that OLS will only take such actions after it makes multiple attempts to clarify, assist and support a provider. The *Rules and Regulations for Licensing Providers*, 6/15 draft revision, if approved as written, would clarify appeal rights for providers placed on provisional status. Given OLS’s reluctance to use the existing sanction tools, DBHDS will need to be vigilant to avoid the increased reluctance to use even provisional status as a corrective strategy after it implements an enhanced and more cumbersome due process.

Conclusions:

DBHDS continues to be in compliance with Section V.G.1. and 2.

DBHDS is not currently in compliance with the requirements of Section V.G.3. Based on this review of OLS, DBHDS does not have evidence at the policy level that OLS is identifying systemic patterns of compliance problems with the Agreement, including its “data and assessments” across the eight (8) domains at Section V.D.3.

Recommendations to achieve compliance:

OLS should fulfill the role of systemic analysis of the “adequacy of individualized supports and services” by compiling regularly, at least annually, a narrative trend report on and analysis of licensing results for ID provider services. The information to complete this report is now accessible through the Data Warehouse. Detecting and reporting patterns and frequencies in the results of licensing reviews across regions, agencies and services will help ensure that system improvements are discovered. It will also become a continuing source of information for the identification of needed guidance instructions, alerts, trainings, etc.

OLS should develop an outcomes focused checklist for interviews with staff and clients.

Suggestions for Departmental consideration:

OLS might consider a formal, annual inter-rater reliability check for each Licensing Specialist’s annual performance appraisal. This would help identify areas of the regulations that need interpretive guidelines. It may also inspire increased confidence among providers who are skeptical about the “fair” application of the regulations.

DBHDS should assess the legal counsel resources available to OLS in the pursuit of increased enforcement activity. The need for this resource will become more pressing if a new grievance/appeal process becomes available to providers placed on provisional status.

OLS should evaluate other non-statutory interventions to deal with providers who are not performing well. One example would be requiring a provider to contract with a non-agency consultant, above and beyond Community Resource Consultants, to support the agency’s successful implementation of corrective action plans. Another example might be requiring a provider on provisional status to align/partner with an experienced provider who has a good track record of services and licensing reviews.

III. Abuse and Neglect Investigations

Settlement Requirement:

V.C.3 & 6

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. The Commonwealth shall be required to implement the process for investigation and remediation detailed in the Virginia DBHDS Licensing Regulations (12 VAC 35-105-160 and 12 VAC 35-105-170 in effect on the effective date of this Agreement) and the Virginia Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (“DBHDS Human Rights Regulations” (12 VAC 35-115-50(D)(3)) in effect on the effective date of this Agreement, and shall verify the implementation of corrective action plans required under these Rules and Regulations.

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 pursuant to the DBHDS Human Rights Regulations (12 VAC 35-115- 240), the DBHDS Licensing Regulations (12 VAC 35-105-170), Virginia Code Section 37.2-419 in effect on the effective date of this Agreement, and other requirements in this Agreement.

Methodology:

- Reviewed OHR investigations and provider investigations where abuse or neglect was confirmed in CY 2015;
- Reviewed OHR *Protocols, Procedures, and Practices Manual* (2/16);
- Reviewed completed OLS incident investigations where corrective actions, provisional status or other regulatory actions was taken in CY 2015;
- Reviewed operating protocols or procedures governing the working processes between DBHDS/OLS-OHR and DSS (Department of Social Services);
- Reviewed listing of providers cited one or more times for late reporting in CY 2015;
- Reviewed a DBHDS listing of cases referred to DSS/APS/CPS during CY 2015;
- Interviewed selected field based OHR Advocates.

Findings:

OHR receives all initial reports of abuse or neglect through the CHRIS (Computerized Human Rights Information System) electronic reporting system. It then triages what type of investigation of abuse and neglect is warranted. Some may be forwarded to OLS for their investigation or for a joint investigation, particularly when conflicts of interest exist at the provider level (e.g. agency director is alleged to have exploited an individual). All substantive allegations are investigated, but providers complete the largest share of these investigations; the investigations completed by providers are submitted to OHR for review and closure. OHR staff will clarify investigation reports for details and missing components before closing the report. Summaries of the provider investigation are then entered into the Abuse Allegation Report (AAR) database. The electronic database for OHR reports is not always complete (e.g. missing advocate name, closure date, etc.). Quality improvement resources and strategies have been established that include a quality improvement staffer who will audit the electronic AAR database and samples of provider reports. These changes hold promise to positively impact OHR records, because OHR is currently dependent on the quality of the AAR database for making systemic improvements and on provider integrity for the content and extent of provider investigations.

Documents reviewed for this study included reports on twenty-seven investigations that were jointly completed by OLS and OHR in 2015. Allegations of abuse and neglect may be forwarded by OHR to OLS for investigation because Virginia's enforcement statute authorizes OLS to determine violations of regulations and to require that providers to implement corrective action plans. There appears to be an effective collaboration between OLS and OHR at the field and policy level.

A recent revision to the OHR *Protocols, Procedures and Practices Manual* has added a quarterly sampling process. Through this process OHR and OHR field staff will 'look behind' a 10% sample of closed provider investigations and compare their timeliness and content to OHR expectations. OHR expects that this 'look behind' review process will identify areas where training or follow-up assistance is warranted in order to improve the investigative results reported to OHR. This is a positive quality improvement step for OHR.

We look forward to future reviews of the 'look behind' reports as well as the actions taken and the improved outcomes that result.

During 2015 OLS/OHR cited 120 agencies for human rights issues. This indicates active oversight of violations of human rights.

OLS cited twenty (20) ID providers during CY 2015 for 'late reporting' (i.e. longer than 24 hours); six (6) had been cited for 'late reporting' in the previous 3 years. Beyond corrective action plans there appear to have been no enforcement actions on these repeat citations. However, the Independent Reviewer notes through his review of CHRIS reports an improvement in timeliness. In addition, during FY 2014 fifty-eight (58) provider agencies were cited for late reporting, suggesting a systemic improvement in timely reporting.

DBHDS linkages with DSS appear healthy and continuous. DSS Adult/Child Protective Services accepted forty-seven (47) investigations from OLS/OHR. Providers are consistently reminded to fulfill their obligations to report all incidents of potential abuse or neglect to DSS Adult or Child Protective Services. Communication occurred between these entities about both the status and the outcome of investigations. A lack of communication, although it may occur in some individual cases, does not appear to be a systemic issue affecting the functioning of DBHDS.

The reviews of the deaths of individuals who have moved from Training Centers have not been completed in a timely manner and have not always included a review of ISPs and case manager notes. This indicates incomplete death reviews, which may overlook significant events surrounding an individual's death.

Conclusions:

DBHDS is in compliance with V.C.2. DBHDS has significantly improved timely reporting through its CHRIS electronic web-based reporting system. DBHDS reports that the service provider, as required, submits 90% of CHRIS reports within 24 hours. The Independent Reviewer's tracking system confirms that noticeable improvement has occurred.

DBHDS is moving toward compliance with the investigational requirements at V.C.3. Progress is evident in improved timely reporting and in OLS monitoring implementation of CAPs. OLS investigations (except investigations into the deaths of individuals who have moved from Training Centers) have also shown improved attention to detail, fact gathering and development of related CAPs. However, OLS is still not taking appropriate follow-up actions where a provider fails to implement corrective action plans.

DBHDS has achieved compliance as it relates to 'timely reporting', but DBHDS is not in compliance with the requirements of V.C.6. to "take appropriate action" when action is needed beyond Corrective Action Plans.

Recommendations to achieve compliance:

DBHDS should complete and publish needed revisions to its Licensing Regulations to ensure that they align with the all related requirements of the Settlement Agreement and to ensure that it can and does take appropriate actions as needed.

DBHDS should ensure and support the implementation of the recently initiated quality improvements and 'look behind' activities of OHR.

APPENDIX H.

LIST OF ACRONYMS

APS	Adult Protective Services
AR	Authorized Representative
AT	Assistive Technology
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
CM	Case Manager
CMS	Center for Medicaid Services
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTH	Crisis Therapeutic Home
CVTC	Central Virginia Training Center
DARS	Department of Rehabilitation and Aging Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disabilities
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
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
ICF	Intermediate Care Facility
ID	Intellectual 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
LIHTC	Low Income Housing Tax Credit
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
ODS	Office of Developmental Services
OHR	Office of Human Rights
OLS	Office of Licensure Services
PASSR	Preadmission Screening and Resident Review
PCP	Primary Care Physician
POC	Plan of Care
PMM	Post-Move Monitoring
PST	Personal Support Team
QI	Quality Improvement
QIC	Quality Improvement Committee
QSR	Quality Service Review
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
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
WDAC	Waiver Design Advisory Group