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, 2012 - April 6, 2013

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I. SUMMARY

This report is submitted to the Court at the end of the second review period covering October 7, 2012 through April 6, 2013. Some facts were included through May 8, 2013.

There have been two major approaches by the Independent Reviewer to monitoring implementation of the provisions of the Settlement Agreement during the second review period. First, the planning and implementation of the new programs and systems required by the Agreement have been monitored and, second, the outcomes for a selected sample of individuals who received new services have been studied.

There were many provisions of the Agreement scheduled to be accomplished during the second review period. The Reviewer monitored the development of the plans, and the initial implementation of these provisions. An expert consultant was retained to evaluate and report on the status of compliance with two initiatives: the development of crisis services and the planning related to Integrated Day Activities and Supported Employment.

The Reviewer gathered information related to the planning and implementation of provisions with a broad array of methods and sources. These included gathering information from officials and internal reports, holding regular meetings with those leading the efforts, and convening focus groups with stakeholders to hear their perspectives directly. The expert consultant evaluated the planning and implementation efforts using a nationally recognized tool to review the Commonwealth's ability to plan, develop, monitor, and evaluate evidenced-based practices regarding systems development and program implementation. This review included studying related documents and data, interviewing the officials leading the efforts, and interviewing a sample of those involved.

The Reviewer and expert consultants utilized a monitoring questionnaire to gather information to review the status of services to individuals who are receiving new ID waiver services. The individuals selected for review were those with the most complex medical needs. Two-person teams reviewed the services of a statistically significant random sample of individuals; one member of each team was a registered nurse with extensive experience serving individuals with complex medical needs. Each review included studying service planning and case management records, visiting and observing the individuals usually in their homes, and interviewing those providing services.

The results of this monitoring are described in the Findings section of this report. Also, included in the Findings Section are progress reports on targeted recommendations made by the Reviewer in the First Report to the Court. Any new recommendations are included either in the appropriate Findings Section or in the Recommendations Section at the end of the report.

Overall, it is the opinion of the Reviewer that the Commonwealth has made a good faith, concerted, and coordinated effort to comply with the requirements of the Agreement.

Reports of the Commonwealth's efforts and accomplishments are described in the Findings Section of this report. It is important to note that more than 900 individuals are now receiving new ID and DD Waivers under the Agreement. Hundreds more are receiving crisis services and individual supports.

There have been many challenges, and some delays. It is important that the challenges and delays be addressed as soon as possible.

Recommendations and associated concerns in the Findings Sections are related to the Commonwealth's ability to achieve compliance with the respective provisions of the Agreement. The Reviewer's recommendations at the end of the report are for the Commonwealth's consideration. They are steps, if implemented, that the Reviewer believes will help achieve the goals of the Agreement.

The next Report to the Court will be submitted on December 6, 2013. It will report on the third review period, covering April 7, 2013 through October 6, 2013.

Respectfully Submitted;

Donald J. Fletcher
Independent Reviewer
June 6, 2013

II. INTRODUCTION

This is the second report of the Independent Reviewer (Reviewer) to Judge John A. Gibney, District Judge in the United States District Court for the Eastern District Court of Virginia (the Court) in the Settlement Agreement (the Agreement) between the United States (DOJ) and the Commonwealth of Virginia (the Commonwealth), Civil Action No. 3:12cv059. It covers the period from October 7, 2012, to April 6, 2013, with some information gathered through May 13, 2013. The Reviewer's first Report to the Court reported on the period March 6, 2012, through October 6, 2012. That report is posted in the "Settlement" section of the Department of Behavioral Health and Developmental Services (DBHDS) website, as will this and future semi annual reports.

It is the reviewer's opinion that the Commonwealth made a good faith, coordinated, and concerted effort to meet the requirements of the agreement during this second review period. Overall, that effort has resulted in important and considerable progress in many areas. However, there are some areas where progress has not kept pace with the schedule of implementation in the agreement and where improvement is needed. The reviewer recognizes that implementation of the agreement involves many complex initiatives that are being implemented simultaneously. This report includes highlights of accomplishments, areas of concern, and recommendations. It also provides progress reports on targeted recommendations included in the Reviewer's first Report to the Court.

The second reporting period includes more scheduled plans and actions than in any other period. The Agreement was designed to initiate and accomplish significant change – to enhance services and to strengthen safeguards – during the first two years. Much progress has been made since the agreement began. More individuals with intellectual and developmental disabilities (ID/DD) are receiving a wider array of services, and the quality of those services is supported by new and enhanced safeguards. More than 900 individuals have received new community-based waiver services. More than 400 individuals and families on the ID and DD waitlists have received individual and family supports, and at least a total of 700 will by June 30, 2013. The following new safeguards have been implemented or enhanced:

- discharge planning and pre- and post-monitoring for individuals who moved from Training Centers,
- licensing oversight and monitoring,
- crisis services and crisis stabilization programs,
- case management, and
- initial components of a quality and risk management system.

These safeguards, and other provisions of the Agreement, serve as foundation cornerstones of a service system that is able to sustain quality services.

The number and interrelated nature of the new programs and safeguards in the Agreement reflect the magnitude and the complexity of the change process that is now underway. The

Reviewer has found broad support and shared commitment to achieve its long-range goals – a broad array of quality services that promote self-sufficiency, opportunities for integration, and safety. All stakeholders want a community based service system that has the resources, competencies and capacity to support individuals with complex needs. The daily work of this system reform process has been, and will continue to be, challenging. It involves changing established patterns and working relationships among stakeholders with different perspectives, priorities and financial interests.

Many of the new programs and enhanced services created as a result of the Agreement are complex undertakings in their early stages. Many "growing pains" are apparent and expected when changing complex systems. Early problems, closely monitored and carefully evaluated, will help identify the development, organization, communication, and coordination issues that need to be improved. Unplanned and unintended consequences will require the development and refinement of policies, procedures, staff training and monitoring practices. Active involvement of all stakeholders will be vitally important in what will continue to be an evolutionary process.

Only with organized systems that promote continuous improvement will the Commonwealth achieve consistent quality services and the outcomes desired by and for the individuals covered by the Agreement. The development of the Quality and Risk Management System will provide information about where performance does not meet expectations and needs improvement at the individual, program, and state level.

Officials of multiple state agencies and local governments worked together during the second review period. They worked with representatives of stakeholder groups on eighteen project teams and several advisory groups. These workgroups developed and began implementing plans to accomplish many provisions of the Agreement. Some teams have made substantial progress; some steady, but slow progress; others, too little. There have been, and will continue to be, obstacles to developing plans with sufficient detail to support effective implementation.

Although considerable progress has been made, little has changed for families and their family members with ID/DD living in the community who have not received new services or been supported by the new safeguards. They report having difficulty finding and arranging for services. Once arranged, there is an on-going challenge to recruit and retain qualified staff.

For many individuals living in Training Centers and their families much has changed. Enhanced discharge planning and monitoring procedures have supported more than 180 individuals to move to homes in the community. The families and guardians of more than 200 additional individuals have expressed an interest in moving to the community. Many other families and guardians, however, are worried that community programs will not be developed to adequately meet the needs of their loved ones before their Training Center is slated to close.

The Commonwealth has taken steps to increase community-based services for individuals with complex needs. In addition to safeguards described above, these efforts include a study of the Home and Community Based (HCBS) waivers which will be completed during FY 2014, the General Assembly's approval of a higher reimbursement rate for individuals with complex needs, approval of reimbursement for additional individual supported employment activities, and meetings with existing and new service providers to encourage community program development.

These actions by the Commonwealth are intended to address the concerns frequently expressed by the families of both individuals with ID/DD living in the community and those living in the Training Centers. These concerns are:

- the limited community resources for individuals with complex needs,
- the inadequate waiver structure and rates,
- the lack of consistent quality services among private and public providers, and
- that the adequacy and access to certain resources and services depend on where one lives.

For this reporting period, the Reviewer prioritized the following areas for the most in-depth monitoring:

- Serving individuals in the most integrated setting
- Serving individuals with complex medical needs in the community
- Discharge Planning and Transition
- Resolving Barriers
- Safety in the Community
- Waivers
- Youth living in nursing facilities and large ICFs
- Individual and Family Support
- Enhanced Case Management
- Crisis Services
- Integrated Day Activities and Supported Employment
- Access and Availability of Services
- Family to Family and Peer Programs
- Community Living Options/Housing Plan
- Quality and Risk Management

During the third review period, the Reviewer will continue to monitor areas studied during the second review period. The Reviewer will prioritize monitoring:

- Discharge Planning and Transition from Southside and Northern Virginia Training Centers
- Case Management
- Crisis Services
- Quality and Risk Management

The effective implementation of the Agreement will depend on the continued contributions from individuals with ID/DD, their families, advocates, service providers, Community Service Boards, many Commonwealth and local agencies, the General Assembly, and the leadership of the Governor.

The Reviewer has been welcomed and graciously supported statewide by families and stakeholders. He extends a personal thanks to each one of the individuals with ID/DD and their families who shared their stories and perspectives. Some have welcomed the Reviewer, and the Reviewer's expert consultants, into their homes, and into their lives. He is also deeply appreciative to all others who helped. These include service providers, local government and state agencies, as well as volunteers, advocates, experts and consultants. The Reviewer believes strongly that involvement of all these stakeholders is critical to success. It is their on-going and vigorous advocacy, and their willingness to engage and problem solve, that will help achieve the goals of the Agreement. The active involvement of stakeholders will also help sustain success when the Agreement is no longer in effect.

II. ACTIVITIES OF THE COMMONWEALTH

The Commonwealth continued a concerted and coordinated effort to plan, fund, and implement the provisions of the Agreement. The Commonwealth continued to organize and oversee eighteen project teams and several advisory groups to plan and implement the provisions of the Agreement. An overarching Stakeholder Group has also met to receive progress reports and to offer advice.

Having sufficient resources to implement the provisions of the Agreement is essential. The General Assembly met during the second review period and approved funding that is necessary to implement provisions of the Agreement. The new FY 2014 appropriations include:

- $1.25 million toward the development of crisis services for children,
- $3.8 million for a total appropriation of $11.6 million for crisis services,
- $3.7 million for a higher reimbursement rate for serving individuals with complex needs, and
- funding for an additional 350 ID AND 105 DD waiver slots (both are beyond the requirements of the Agreement).

State Agencies have added leadership and other staff to oversee and support effective implementation of the Settlement Agreement. DBHDS reports that thirty staff positions have been established to build needed capacity to effectively implement the Agreement. Six other positions were established prior to the Agreement being signed. Twenty of these positions are devoted to increasing the frequency and intensity of monitoring and oversight by licensing and human rights staff, and to build a statewide system to assure quality services. Leadership positions have been established for major program initiatives.

These include individual and family support, crisis services, integrated day activities - employment support, housing, case management, and discharge planning. DMAS has created a new Deputy Director for Complex Care to coordinate matters related to the Agreement. The Deputy Director has begun attending regularly scheduled meetings with the Reviewer.

The Commonwealth has continued to provide regular monthly and quarterly reports and other information, as requested by the Reviewer and the DOJ. The Commonwealth attended and was well prepared for meetings and informal discussions with the Reviewer. The Commonwealth also organized and facilitated additional "drill down" sessions for the Reviewer and the DOJ. These sessions were to thoroughly discuss the plans and status of Quality and Risk Management and Crisis Services and to ensure full communication and shared understanding.

The DBHDS also worked with the Reviewer to arrange three kick-off meetings with key leadership and project staff and the Reviewer's expert consultants. DBHDS staff, CSBs, and private providers helped arrange for the provision of extensive documentation, interviews and on-site visits to facilitate in-depth monitoring related to three studies – Crisis Services Requirements, Employment Service Requirements, and Reviews of Services for Individuals with Complex Medical Needs.

III. INDEPENDENT REVIEWER

The Reviewer's facts and findings presented in this report come from a broad array of sources and methods. These include:

- observations during site visits,
- reviews of documents (e.g. policies, plans, training materials, records, forms, investigations),
- interviews (e.g. with officials, providers, staff, expert consultants, individuals, families),
- input from stakeholders (e.g. self-advocates, family groups, providers, CSBs, academics, researchers),
- internal reporting (e.g. DBHDS and DMAS summaries on progress, data, external consultant reports, reports on compliance), and
- individual reviews (e.g. expert consultant and clinician interviews with individuals, staff, site visits and review of discharge plans, individual support plans, case management records, monitoring reports, and medical records)

During the second review period (October 7, 2012 – April 6, 2013), the Reviewer utilized internal reports and interviews with officials, comments provided by the DOJ, and his own experience and expertise to monitor some areas. These included the Waiver slots and restructure, youth living in nursing facilities and large ICFs, Individual and Family Support, Access and Availability, Community Living Options/Housing Plan, and Quality and Risk

Management. The Reviewer prioritized monitoring the areas described below for gathering information from other sources and with other methods.

To hear input directly from individuals and families, the Reviewer:

- convened focus groups with guardians and families of individuals, who have newly received waiver services;
- met with parents at Southside, Central, and Southwest Virginia Training Centers; and
- visited the homes and reviewed the new services of individuals with complex medical needs.

To review services to individuals with ID, the Reviewer and expert consultants designed a study of fifty individuals with complex medical needs. A monitoring tool questionnaire was completed by:

- reviewing each individual's service documentation
- visiting individuals, usually at their homes, and
- interviewing family members and staff.

To monitor enhanced case management services, the Reviewer:

- studied the guidelines for enhanced case management,
- completed a review of the new services for twenty-nine individuals with complex medical needs (to establish a base line prior to the implementation of the guidelines),
- convened focus group meetings in three regions with ID and DD case mangers, and
- met with Executive Directors and ID Directors of Community Service Boards in three regions.

To monitor Integrated Day Activities and Supported Employment, the Reviewer:

- interviewed the Project Team Leader,
- reviewed quarterly reports,
- completed an Individual Review study with questions related to offering integrated day activities and supported employment opportunities, and
- retained an expert consultant to review the Employment Services Requirements (Appendix C) and the Commonwealth's compliance.

To monitor Independent Housing Options, the Reviewer:

- interviewed the Project Team Leader,
- interviewed external experts, and
- reviewed documents - quarterly progress reports, "Virginia's Plan to Increase Independent Living Options", DOJ's Comments on the Commonwealth's Plan, and Housing Plan- Next Steps.

To monitor crisis services, the Reviewer:

- met with three of the five Crisis Service Teams,
- visited two of the crisis stabilization homes,
- convened separate focus groups with private providers, case managers and families who have engaged with the crisis services, and
- retained an expert consultant to complete a follow-up review of the Crisis Services Requirements (Appendix B) and the Commonwealth's compliance.

To monitor the safety of the individuals who live in the community, the Reviewer:

- completed a study of services for individuals with complex medical needs;
- reviewed serious injuries and deaths;
- monitored the investigation process related to serious injuries and deaths; and
- monitored the work of the Mortality Review Committee.

The Reviewer's monitoring activities also included studying many plans, project team progress reports, policies, incident reports, investigations, Corrective Action Plans, announcements, regulations, and guidelines. In addition, the Reviewer interviewed family members, individuals served, officials, consultants, staff, and stakeholders. Finally, the Reviewer had regular contact with senior staff at the DBHDS, Secretary's Office for Health and Human Resources (SHHR), Office of the Attorney General (OAG), Department of Medical Assistance Services (DMAS), and U.S. Department of Justice (DOJ).

IV. FINDINGS

Below are the Reviewer's findings regarding the status of the Commonwealth's initiatives.

A. Serving Individuals with DD In the Most Integrated Setting

"The Commonwealth shall develop and provide the community services described in this section…to prevent the unnecessary institutionalization of individuals with ID/DD and to provide them opportunities to live in the most integrated setting appropriate to their needs consistent with their informed choice…(Section III.A."

Note: This Section of the reviewer's report focuses only on individuals with ID. This is because the DD waiver does not provide funds for residential services, and data about the degree of congregation for day services are not available.

The individuals prioritized to move from Training Centers have generally been those who expressed interest in moving to the community and for whom the provider capacity and competencies existed to meet their needs. Many residential service providers have available vacancies and are seeking referrals, but are frequently not able to provide the needed level of services for individuals with more complex medical and behavioral needs.

There is broad agreement that the current funding rates and rate structure are not adequate to support individuals with the most complex needs in the community. The Reviewer previously reported that the ID waiver structure and rates have created incentives to provide community programs in larger congregate facilities.

The profile of living arrangements for individuals who moved from Training Centers is very different from the living arrangements for individuals who were previously on the urgent wait list. Of the 113 individuals who have moved from the Training Centers during FY 2013, as of May 8, 2013, fifty-seven (50.4%) moved to congregate settings* with five or more residents, some with more than one program clustered on a single site. Whereas, DBHDS reports that 347 (75.1%) of 462 individuals with new ID waiver slots are living with their parents or family members and receiving in-home services.

*Note: A more specific breakdown of the sizes of the larger congregate facilities is not available and therefore is not presented.

The Agreement requires that the Commonwealth facilitate individuals receiving services in their family's home when such a placement is their informed choice. That is happening, especially when the individual is a child or young adult. It is a positive quality of the current service system to be able to provide in-home services and to pay family members, usually members of the extended family, to provide care. Family members usually have desirable qualities that other new staff does not typically possess. They have an on-going relationship with the individual, are usually familiar with the individuals' care needs, are committed to provide on-going services, and are trusted by the individual's parents. The challenges to providing and sustaining these services will be described in the next section.

The Agreement does not prohibit individuals from moving into homes of five or more. It does, however, establish provisions to ensure that individuals and their families or Authorized Representatives are provided information about, and are offered, smaller more integrated settings. If recommendations to individuals and families are for residential settings for five or more individuals, barriers to providing services in more integrated settings must first be identified. Then, steps must be taken to resolve these barriers. Some of these provisions, including family-to-family and peer programs, and the Regional Support Teams, were not yet in place during most of the second review period. In the absence of these safeguards to provide information and to identify and resolve barriers for most individuals moving out of Training Centers, the historical pattern of providing residential services in settings for five or more individuals has continued. At least two additional factors appear to contribute to this result – the time and resources required to develop new residential infrastructure and the available vacancies exist in residential programs serving five or more individuals. The development and funding of some new residential programs began before the Agreement was signed.

Living at home with sufficient supports is usually the arrangement of choice for children and young adults. However, four (40%) of the families of the adults who have chosen to live at home have done so, in part, because they have not yet determined if there is a viable and desirable alternative. They report that they need more support to learn about the options

available, to contact potential providers, to visit and evaluate the choices, and to make an informed choice. Many families have reported to the Reviewer that there is a lack of available small group homes and employment support programs, and that the existing larger group homes do not provide the services needed to support their family members with complex needs. It is reported that lack of availability of these services is more acute in rural areas. In northern Virginia, however, families and CSB officials report that there are few available residential vacancies, and rarely can the programs with those vacancies meet the needs of individuals with complex needs.

The DBHDS requirement to offer integrated day services during individual service planning begins on July 1, 2013. The Table below shows baseline data prior to implementation of that requirement. More than 60% of the adults in the Individual Review study were not offered integrated day opportunities, nor did their typical days involve integrated activities.

TABLE 1				
Individual Support Plan – Integrated Day - Items				
Item	**n**	**Y**	**N**	**CND**
Were integrated day opportunities offered?	11	27.3%	63.6%	9.1%
Does typical day include regular integrated activities?	11	27.3%	63.6%	9.1%

Recommendations from the Reviewer's first Report to the Court

The Commonwealth should review how other States' HCBS waivers are structured, and then amend and/or permanently modify the waivers so the payment structure and rates encourage service outcomes desired for individuals (i.e. living in the most integrated setting appropriate to their needs, and developing skills for increased self-sufficiency and independence).

The Commonwealth should take the steps necessary to ensure that those with the most complex needs are provided opportunities to live in the most integrated setting appropriate to their needs and consistent with their informed choice.

Progress Report

1. DBHDS and DMAS are seeking a comprehensive review of the current ID and DD waiver programs. The goal is for this review to help lay out a roadmap to ensure that community-based programs are able to assist those with the greatest needs. A Request For Proposals (RFP) was issued in January 2013 seeking national experts to complete a waiver study. Six proposals are currently under review. A CONTRACT award for a yearlong study during FY 2014 is anticipated in June 2013.

2. A 2014 General Assembly biennial budget appropriation of $3.7 million ($7.4 M total including a 50% match from Medicaid) was requested and approved. This authorizes DMAS to establish a 25% higher reimbursement rate for congregate residential services for individuals with complex medical and behavioral needs. A work plan has been developed to establish the higher rates. The program will begin after required regulations are approved, likely during the first six months of 2014.

3. DBHDS has met with existing and new residential service providers to encourage new residential program development.

4. DBHDS is exploring alternatives for creating and developing residential services for individuals with complex needs. One approach being considered is developing new four-person group homes for individuals who may know one another and choose to live together.

It is the Reviewer's opinion the Commonwealth has taken significant and positive steps to increase opportunities to offer services in most integrated settings. These actions, however, are primarily directed toward longer-range solutions. The ID and DD waiver and rates will be restructured for FY 2015. The higher reimbursement rates for serving individuals with complex needs will likely not be available until the spring of 2014. The most promising options may be new approaches that make it easier for service providers to develop news programs in the short term.

Residential providers who are encouraged to develop new programs in northern Virginia face unique challenges. The high cost of housing or suitable land for new construction without financial assistance is prohibitively expensive.

Based on the Reviewer's experience, developing new programs for individuals with complex needs who know each other, and whose families may know each other, may lead to new program development sooner. It encourages providers to be selected to develop such residential programs and to know the individuals who will be served. If all or most of the future housemates qualify for the higher reimbursement rate, then providers can budget for sufficient resources to provide increased staff competencies and to develop more robust training and monitoring systems that are required twenty-four hours a day.

B. Serving individuals with complex medical needs in the community

The review of services for individuals with complex medical needs involved fifty individuals. All received new community-based services in FY 2013 in either Region 2 (northern) or Region 3 (southwest). Region 2 has the highest population density and the most resources; Region 3 has the lowest population density and the fewest resources. The fifty individuals were selected from the 160 who receive new community-based ID waiver funded residential services in these two regions, as of December 2012. Of these individuals, 140 had previously been on the urgent ID wait list; twenty had moved from

Virginia's Training Centers. None of the individuals had DD, non-ID, because the DD waiver does not provide funds for residential services.

The fifty individuals selected had the most medical needs based on their individual Support Intensity Scale evaluations. From these fifty names, twenty-nine individuals were randomly selected. The sample size provides a 90% confidence level and a 10% confidence interval and, therefore, offers a sufficient degree of confidence that findings can be generalized to the fifty individuals. Three (10.3%) of the twenty-nine individuals had moved from Virginia's Training Centers. The other twenty-six had lived in the community; twenty-four (93%) of whom lived with their families. Thirteen (45%) of them were youth less than twenty-one years of age.

The Individual Review study questionnaire asked the same questions that were asked during the first review period's study (that first study was of the services for individuals who had moved from the Southside and Central Virginia Training Centers). The questions are based primarily on the requirements of the Agreement and DBHDS policies and procedures. For the second review period, a few new questions were added. They were included and provided in this report to establish a baseline of the extent to which the requirements are being met before they are required. A two-person team of experts completed each Individual Review. One member was a registered nurse with extensive experience working with individuals with ID/DD.

Prior to visiting these twenty-nine individuals, the reviewers studied documents relating to each person's needs, circumstances, and services. These included assessments, individual support and behavior support plans, and case manager notes. For the three individuals who had moved from Training Centers, discharge plans and Pre- and Post-Move Monitoring documents were also reviewed.

Adjustments to the planned Individual Review study were made to accommodate the individuals living with their families. To be respectful of the parent-child relationship and their privacy, the individual interview questions were asked primarily of the parents. Because they lacked information in some cases, the answers to more questions could not be determined (CND). Private areas of the families' homes were not reviewed and documentation of medical services was not requested. The parents' word was accepted unless there was other information that conflicted. It was also difficult to arrange visits due to family work schedules. As a result, the reviewers visited the homes of twenty-six (90%) of the twenty-nine individuals. Reviewers met the other three individuals at their day programs. One individual's single parent was not available to be interviewed and did not return phone calls.

The individuals selected had urgent needs and received ID waiver funding for residential services. The reviewers found that twenty-three (95.8%) of the twenty-four individuals continued to live with their families and receive in-home services. Four (40%) of the ten adults and their families initially receiving in-home services want to learn more about and pursue other residential alternatives.

Themes

After completing the reviews, the five reviewers met to discuss the themes identified in the lives and circumstances of these twenty-nine individuals. The random sample offers a sufficient degree of confidence that these findings can be generalized to the fifty individuals.

Although there were exceptions, we met and received excellent support and information from case managers and other staff. The reviewers visited some excellent programs. These included a personalized and comfortable group home for adults who were actively involved in their community and programs that provided daily work and integration opportunities.

- **Strong and patient families**

The Reviewers were impressed by the strength and patience of the families we met. They were thrilled that their loved one was selected to receive a waiver. Then many families discovered that the process of searching for service providers was very difficult. Although the process was difficult, once arranged the new services were a positive for the individuals and their families. A high percentage of new residential services for their family member were arranged in the homes of their families. These families frequently have challenging, yet essential, daily physical care and behavior management responsibilities for their children, in addition to their jobs. Most have devoted their lives, and most hours of every day, to their child with ID/DD since he/she was born.

- **Families need extensive support during transitions**

Families of the adults needed more help than they received to consider the options, to contact possible providers, to arrange visits, to evaluate residential providers, and to make an informed choice. The transition to receiving waiver-funded services is a complicated, time-consuming, and unfamiliar process for families. One mother described being handed a list of providers and being told to "go to it." Four families found that the easiest answer was to accept in-home services. However, families with consumer-directed services then become the Employer of Record with additional responsibilities. Most families had difficulty recruiting and retaining staff, especially with the skills to support their children with complex medical and behavioral challenges. A few families pointed out that their in-home workers had not been paid in a timely manner. The reviewers learned of three situations that resulted in delays of eight weeks for workers to be paid. The reasons were because of forms not being completed properly, communication problems, and complications transitioning from one waiver to another. Several families were very satisfied that an extended family member could be paid to provide support. These arrangements appeared to be best for the individual and the most stable.

- **More coordination of transitions with school systems would help**

Several individuals and families would have benefitted from more robust transition planning between school and adult services. A transition from school that establishes the expectation and provides the opportunity for supported employment would have been especially helpful.

- **Families needed more help thinking through and planning for the future**

These include the future need for environmental adaptations and future choices about what service options will be available and how to prepare to make informed choices

- **Difficulties acquiring needed environmental adaptations or adaptive equipment.**

Many families and case managers gave examples of applications being returned repeatedly for minor word changes. They reported that after applications were repeatedly "pended," there were examples when they were finally approved with too little time to complete the work during the year. In the southwest, there were only a few contractors large enough to have the required worker's compensation insurance; this led to additional delays.

Individual Reviews – Selected Tables

Additional findings for the Individual Review study are found in the tables below. The tables are separated to show highlights of positive outcomes and areas of concern.

Highlight of Positive Outcomes: The reviews found many positive health care outcomes. Note: Because of difficulties interviewing some families there were more cannot determine (CND) answers. These CND answers have not been included in the Table 2, so that the percent of 'yes' and 'no' answers reflect only those families that were able to answer the questions.

TABLE 2			
Health Care Items			
Item	**n**	**Y**	**N**
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?			
b. Physical Therapy	10	90.0%	10.0%
c. Speech/Language	11	100.0%	0.0%
Does the provider monitor fluid intake, if applicable per the physician's orders?	12	100.0%	0.0%
Does the provider monitor food intake, if applicable per the physician's orders?	22	95.5%	4.5%
Does the provider monitor tube feedings, if applicable per the physician's orders?	5	100.0%	0.0%
Does the provider monitor seizures, if applicable per the physician's orders?	17	100.0%	0.0%
Does the provider monitor weight fluctuations, if applicable per the physician's orders?	15	86.7%	13.3%
Does the provider monitor positioning protocols, if applicable per the physician's orders?	4	100.0%	0.0%
Does the provider monitor bowel movements, if applicable per the physician's?	22	100.0%	0.0%
Is there evidence of a nourishing and healthy diet?	26	96.2%	3.8%

Areas of concern: The reviews found that it was more difficult to locate and arrange for certain healthcare related services. These included occupational therapists, behavioral psychologists, and nutritionists. Case managers reported to the reviewer that they had greater challenges in these same areas.

TABLE 3				
Healthcare Items				
Item	**n**	**Y**	**N**	**CND**
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?				
a. OT	12	83.3%	16.7%	0.0%
d. Psychology	8	75.0%	25.0%	0.0%
e. Nutrition	11	81.8%	18.2%	0.0%

Highlights of positive outcomes:

TABLE 4				
Individual Support Plan Items				
Item	**n**	**Y**	**N**	**CND**
Is the individual receiving supports identified in his/her individual support plan?				
Residential	29	100.0%	0.0%	0.0%
Medical	28	100.0%	0.0%	0.0%
Dental	28	89.3%	10.7%	0.0%
Health	28	96.4%	3.6%	0.0%
Recreation	27	89.3%	10.7%	0.0%
Transportation	28	96.4%	3.6%	0.0%

Areas of concern: The reviews found that it was more difficult to locate and arrange some ISP services. These included day/employment, mental health, and communication/assistive technology.

TABLE 5				
Individual Support Plan Items				
Item	**n**	**Y**	**N**	**CND**
Is the individual receiving supports identified in his/her individual support plan?				
Day/Employment	28	81.5%	18.5%	0.0%
Mental Health	15	66.7%	33.3%	0.0%
Communication/assistive technology	13	69.2%	30.8%	0.0%

Highlights of positive outcomes

TABLE 6				
Environmental – Hygiene Items				
Item	**n**	**Y**	**N**	**CND**
Is the individual's residence clean?	26	92.3%	0.0%	7.7%
Does the individual appear well kempt?	28	93.9%	3.6%	3.6%

C. Discharge Planning and Transition from Training Center

"The Commonwealth shall:

By July 2012… have implemented Discharge and Transition Planning processes at all Training Centers…

ensure that discharge plans are developed for all individuals in TC's through a documented person-centered planning and implementation process

develop and implement discharge and planning and transition processe

final discharge plan developed within 30 days prior to discharge

.discharge planning will be done by the individual's Personal Support Team (Section: IV.A-D)."

DBHDS did extensive work in developing a standardized discharge planning process at all five Training Centers by July 2012, as described in the Reviewer's first Report to the Court. DBHDS has since reported several improvements.

Note: The Individual Review study involved three individuals who had moved from a Training Center. This sample size is too small to provide a sufficient degree of confidence that findings can be generalized to a larger group.

Highlights of positive outcomes

TABLE 7				
Discharge Planning Items				
Item	**n**	**Y**	**N**	**CND**
Was it documented that the individual, and, if applicable, his/her Authorized Representative, were provided with information regarding community options?	3	100.0%	0.0%	0.0%
Did the individual and, if applicable, his/her Authorized Representative participate in discharge planning?	3	100.0%	0.0%	0.0%
Was the discharge plan updated within 30 days prior to the individual's transition?	3	100.0%	0.0%	0.0%
Did person-centered planning occur?	3	100.0%	0.0%	0.0%
Were essential supports described in the discharge plan?	3	100.0%	0.0%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	3	100.0%	0.0%	0.0%
Were all essential supports in place before the individual moved?	3	100.0%	0.0%	0.0%
Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists?	3	100.0%	0.0%	0.0%
Did the Post-Move Monitor, Licensing Specialist, and Human Rights Officer conduct post-move monitoring visits as required?	3	100.0%	0.0%	0.0%
Were appointments with medical practitioners for essential services scheduled for and did they occur within 30 days of discharge?	3	100.0%	0.0%	0.0%

The Commonwealth assisted 189 individuals in moving from Training Centers to the community between November 2011 and May 8, 2013. The Agreement required the Commonwealth to create a minimum of 160 waiver slots in FY 2013 to enable individuals in the Training Centers to transition to the community. During FY 2013, the pace of moves increased with 113 individuals (71% of 160) moving as of May 8, 2013 (85% of the fiscal year). This number of individuals who move in a particular month depends on many factors and therefore fluctuates. That said, if the pace of moves during the first ten months of this fiscal year continues, the target of 160 individuals moving will not be achieved. DBHDS reports that some planned moves have been slowed to ensure that plans are in place to meet the essential needs of each individual.

The "Plan to Transform the System of Care for Individuals with Intellectual Disability in the Commonwealth of Virginia" submitted February 13, 2012, projects ending residential operations at the Southside Virginia Training Center (SVTC) by June 30, 2014. Fifty-two individuals have moved from SVTC during the first ten months of FY 2013, while 144 individuals continue to reside there. For all individuals to move by June 30, 2014, will require nearly doubling the pace of moves – from an average of about five per month in FY 2013 to an average of about ten per month in FY 2014.

The Authorized Representatives of many individuals residing at the Training Centers are concerned that they will be forced to choose between a community program, that is inadequate, and a Training Center, that is far away. There are three factors that raise legitimate concerns. There is a limited availability of existing community services for individuals with complex needs. The ID waiver structure and rates need to be restructured to provide sufficient funds for such programs. During FY 2014 the pace of moves from SVTC to the community needs to increase to meet the scheduled closing date. That date is before the ID waiver will be restructured. The Commonwealth reports that it has taken steps to address these concerns and will take more.

The Commonwealth has assured the Reviewer that it has taken several steps to address these concerns. The Commonwealth's plan to cease residential operations at a Training Center will involve a forced choice for individuals and their families/Authorized Representatives (ARs). This occurs in every state that decides to close large residential facilities. Since the Agreement was signed, DBHDS has met with families, providers, and CSBs across the Commonwealth. Emphasis has been on its commitment that an individual will not be moved from a Training Center unless all essential supports are in place. DBHDS has assured ARs that they will have choices of community programs that are equal to, or better than, current services. Safeguards are also built into the process. The Commonwealth's enhanced discharge planning and pre-move monitoring processes are designed to ensure that services are in place to meet an individual's essential needs before a move is approved. These processes include several opportunities for families and authorized representatives to document their concerns or disagreements regarding the transition process and to identify any barriers to moving. The DBHDS reports that they have no documentation of a family or Authorized Representative who has agreed to a move believing that services are or were inadequate or that they were forced to choose a community option. The Reviewer is also not aware of any such documented concerns.

The Commonwealth has reported that it is currently exploring new approaches to create and develop community-based services for individuals with complex needs. One approach under consideration is developing new four-person group homes for individuals who may know one another and choose to live together. It is the reviewer's experience that families of individual's who are considering moving out of congregate state facilities have embraced such an approach.

D. Resolving Barriers – Community Resource Consultants (CRCs), Community Integration Managers (CIMs), and Regional Support Teams (RSTs)

"Upon referral to it (by the CRC), the Regional Support Team (RST) shall work with the Personal Support Teams (PST and the Community Resource Consultants (CRC)...to resolve identified barriers, to ensure placement is the most integrated appropriate to the individual's needs, consistent with the individuals informed choice. (Section III.E.2.)

The CRC shall refer cases to the RST for...assistance in resolving barriers...whenever:

> *the PST recommends...an individual residing in his or her own home, his or her family's home, or a sponsored residence be placed in a congregate setting with five or more individuals...in a nursing home or ICF...there is a pattern of an individual repeatedly being removed from his or her residence...*
>
> *PSTs and CSB case manager shall coordinate with the specific type of community providers...shall facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities (Section IV.B.9.b.).*

CIMs shall be engaged in addressing barriers to discharge, including in the following circumstances:

> *The PST and the CSB case manager shall assist the individual in choosing a provider after providing the opportunities described (Section IV.B.9.c.).*

The State shall ensure that information about barriers to discharge...is collected...aggregated and analyzed...for development of community---based services (Section IV.B.14).

In the event of...a recommendation...to place an individual in nursing home or a congregate setting with five or more individuals...the PST shall identify the barriers to a placement in a more integrated setting...and describe in the discharge plan the steps the team will take to address the barriers (Section IV.B.15)."

The provisions quoted above were included in the Agreement to ensure that individuals, and their Authorized Representatives, have options available and information provided to make informed choices. These options should include residential and day services that are in integrated settings appropriate to the individuals' needs.

The Commonwealth has taken many steps to implement these provisions. These steps include establishing CRC and CIM positions, and establishing the Regional Support Teams (RST). The RSTs were implemented in February and March 2013.

During the first two months of operating the RSTs a few referrals have occurred from the Training Centers and individuals living in the community with waiver services. Several have occurred from the Southside Virginia Training Center. The RSTs have met, reviewed

the referrals, identified barriers to needed services, and made recommendations. The RSTs recommendations focused on confirming that choices were offered and that informed choices were made. The RST recommendations included seeking assistance to locate options, for example, by directing the CIM or CRC to consult with the Family Resource Coordinator or to solicit support from Central Office to help identify viable options. The RST resolutions were to proceed with several placements into congregate settings of five or more individuals, including nursing facilities if choices were offered and an informed choice was made. The barriers that were identified that prevented individuals from moving to more integrated settings included:

- capacity issues at this time,
- community providers need to improve in the area of nursing,
- because other options could not meet medical needs, and
- no other provider with needed equipment in this region.

DBHDS reports that the Regional Support Teams will provide barrier assessments to the Regional Quality Councils, which will forward assessments to the Quality Improvement Committees.

The barriers identified in the referrals to the RSTs are consistent with the information provided to Reviewer by case managers and CSB officials. There is difficult locating placement options that offer integrated settings, especially for individuals with complex needs. This includes the lack of available options to meet the needs of individual residents of Training Centers who are from their area. In many rural areas, including southwest Virginia, there are few available program options in integrated settings. The limited program options are individual or group supported employment, small group homes, and supported apartments.

One mother who was very well informed about the service system and available options chose a congregate residential program with all residents "in their fifties" for her young adult son who had been on the ID urgent wait list. In frustration, she explained that there were no good options, and that she "had to have something". She hopes that there will be more integrated options with age appropriate housemates available it the future.

Under the Agreement, more that 900 additional individuals are receiving new community-based wavier services. The development of programs to meet their needs in the most integrated settings has not kept pace. This has deprived those individuals and families from being provided choice from the full range of options described in the Agreement.

It is the Reviewer's opinion that the Commonwealth has not yet developed a sufficient quantity of community services that offer integrated settings. This includes programs with sufficient resources and supports needed to serve individuals with complex needs. It is recognized that the programs created to resolve barriers are quite new. During the second review period, however, the programs to resolve barriers were not available or did not:

- resolve the significant identified barriers,
- ensure options are available that include integrated residential and day settings, or
- lead to the development of community-based services to fill existing service gaps.

The Commonwealth has reported to the Reviewer that it is developing the capacity and plans to identify existing service gaps for each Health Planning Region. The Commonwealth plans to map the existing service providers by service types.

Recommendation

The Commonwealth should develop the capacity and report to the Reviewer by October 20, 2013 the names of individuals in the target population who have been admitted to a nursing home or ICF since the Agreement began. This report should include plans for involving CRC's and RST's to identify and resolve barriers to providing services to these individuals in more integrated settings.

Refer to the Section VIII on page 62 and 63 for the additional related recommendations.

E. Safety in the Community

The Reviewer monitored reports of serious injuries and deaths (SIRs) during this period. The SIRs for all individuals on the ID waiver are promptly shared with the Reviewer. All such reports for individuals who moved from the Training Centers to the community are read. Those that involve deaths or serious injuries that require ongoing medical care are reviewed. These reviews involve studying the Office of Licensure Services unannounced inspections, investigations, and, if applicable, Corrective Action Plans. A sampling of all other SIRs is reviewed. The Reviewer also monitored the work and products of the Mortality Review Committee.

For all 189 individuals who moved from the Training Centers between October 2011 and May 8, 2013, the reports of serious injuries and deaths were reviewed. During the second review period, the Reviewer monitored deaths or serious injuries that resulted in ongoing medical care for six individuals. Three former Training Center residents died during this period. One person died as a result of choking. Two died of natural causes, one of whom had recently moved to a skilled nursing facility due to his fragile medical condition. During this same period 155 individuals receiving ID waiver services in the community passed away. Twenty-five residents of TCs died during the first ten months of FY 2013. It is the Reviewer's opinion that the number of incidents that have been reviewed is too small a sample to provide confidence that findings can be generalized to a larger group or to other settings. Reviews of serious injuries and deaths, however, can provide insights into actions that may help reduce risks in the future. Two of the SIRs Reports completed to date have included such recommendations.

The Reviewer has completed two SIR reviews during this period; the remaining will be completed when the investigations are closed. The Reviewer's findings, conclusions, and recommendations have been reported to the Court under seal. Copies have been shared with the Parties.

DBHDS shared the Reviewer's SIRs findings, conclusions and recommendations with the Training Centers from which the individual had moved. The facility staff assessed documentation and reviewed quality assurance procedures and documentation prior to individuals' transition to the community. The Reviewer's report of a critical incident was also referred to the DBHDS Quality Improvement Committee. Following its review several actions were taken. A Safety Alert was issued on March 1, 2013 regarding choking and aspirations. This Alert was also posted on the DBHDS website. A workgroup was formed and has begun meeting to examine food consistencies and issues with related training and guidance. Programs in other states were reviewed. The subgroup identified key decisions that are needed and the primary content and methods of training. The major implementation tasks were identified, as were projected timelines for completion. The Report of the subgroup was submitted to the DBHDS Quality Improvement Committee.

F. Waivers

"To enable individuals in the target population in the Training Centers to transition to the community...the Commonwealth shall create…160 waiver slots in FY13, 160 in FY14 (Section III.C.1.a.ii-iii.)

To prevent the unnecessary institutionalization of individuals with ID in the target population...or to transition to the community individuals with ID under 22 years of age from institutions other than the Training Centers (ICF's and nursing facilities)...shall create…a minimum of 275 waiver slots in FY13 (of which 25 prioritized for those under 22 years of age in nursing facilities and the largest ICF's), iii. 225 in FY14 (of which 25 prioritized for those under 22 years of age in nursing facilities and the largest ICF's).(Section III.C.1.b.ii-iii.).

To prevent the unnecessary institutionalization of individuals with DD in the target population...or to transition to the community…under 22 years of age from institutions other than the Training Centers…shall create a minimum of 25 waiver slots in FY13 including 15 for individuals under 22, ii. 25 in FY14 including 15 for individuals under 22. (Section III.C.1.c.ii-iii)."

The Commonwealth has fully complied with the requirements of the Agreement for establishing and distributing waiver slots for FY 2013.

ID waiver slots were established, 60 in FY 2012 and 160 in FY 2013, to enable 220 individuals residing in Training Centers to move to the community. Between October 2011 and May 8, 2013, 189 individuals moved from the Training Centers; 113 have moved since

July 1, 2012. The individuals who moved from Training Centers did not all use waiver slots. Typically, individuals who move to homes with four or fewer residents utilize Money Follows the Person (MFP) funds (MFP funds convert to waiver slots after the first year). Others do not need waiver slots if they move to a community ICF, a Nursing Home, or are already assigned waivers. All waiver slots will be used. Section III.C.4 of the Agreement permits the Commonwealth to re-allocate unused waiver slots from one category to another in any state fiscal year with the approval of the Reviewer and DOJ.

The Commonwealth provided 300 Community ID waiver slots and 160 ID waiver slots for individuals who will move from Training Centers during FY 2013. During FY 13, 50 DD waiver slots were provided and used, 25 more than the minimum required by the Agreement. For FY 2014, 735 ID waiver slots have been approved, 350 more than the minimum required by the Agreement, and 130 DD waiver slots (105 more than required by the Agreement). Of the ID waiver slots established in FY 2013, twenty-five are prioritized for individuals less than twenty-two years of age to move from institutions other than Training Centers (i.e. ICFs and nursing facilities. For FY 2013, DBHDS distributed waiver slots to Community Service Boards (CSBs), which used them for individuals with ID on their urgent waitlists. The Commonwealth also provided fifty DD waiver slots during FY 2013. The waiver slots for individuals with DD were distributed by DMAS to individuals on the DD waiver wait list. Fifteen of the twenty-five were prioritized for individuals residing in nursing facilities and the largest ICFs. They are being held in reserve until the fifteen individuals are identified.

G. Youth Residing in Nursing Homes and the Largest ICFs

DBHDS and DMAS are working with the Centers for Independent Living and the Virginia Board for People with Disabilities to determine how to identify the children residing in nursing facilities or the largest community ICFs who would fill the FY 2013 waiver slots.

Recommendation from the Reviewer's first Report to the Court

> The Commonwealth should identify individuals with a developmental disability residing in nursing facilities or community ICFs to transition to integrated settings during FY 2013.

Progress Report

> The Commonwealth's assigned project team met and developed an initial plan. Representatives from three large institutions and two nursing facilities attended the most recent project team meeting. Plans were developed for DBHDS staff to attend family meetings at each institution to present information about the waiver services and how loved ones can be supported in the community. DBHDS also has drafted a letter to families who have children in large ICFs or nursing facilities. The letter informs them about the availability of slots and how to get more information. DBHDS expects to distribute the initial forty waiver slots by June 30, 2013.

H. Individual and Family Support Program

"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"…In FY13, a minimum of 700 individuals supported (Section III.C.2.a.).

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 (Section II.D.)."

The Commonwealth has made substantial progress implementing the Individual and Family Supports Program. With an annual fund of three million dollars, the program was launched on March 11, 2013. Every individual on the ID and DD waitlists was mailed notification of the program. DBHDS reports that as of April 12, 2013, more than 1200 applications for support were received and were being reviewed; 235 applications were approved and $460,515 had been awarded. It has been a challenge to review applications that were received all at the same time. For FY 2014, the program will begin on July 1, 2013.

The DBHDS determined that those on the wait lists are "most at risk of institutionalization" Due to the delay in implementing crisis services, there is inadequate data to determine whether individuals with ID/DD who are <u>not</u> on the wait lists are experiencing crises and are at risk of institutionalization.

This program is in its first months of operation. As the program is rolled out during FY 2014, the DBHDS should review whether it meets the definition of individual and family supports as a "comprehensive and coordinated set of strategies".

It is the experience of the Reviewer that referrals to crisis services and/or admissions of individuals with ID/DD to behavioral health, nursing, and correctional facilities are key indicators of who is most at risk of institutionalization.

Recommendation:

The Commonwealth should evaluate if being on the wait lists is the most appropriate and sole criterion for determining those "most at risk of institutionalization." Report to the Reviewer by October 20, 2013.

I. Case Management

"The Commonwealth shall ensure that individuals receiving HCBS waiver services…receive case management services (Section III.C.5.)."

The Individual Review study established that all individuals whose services were reviewed were receiving case management services. These individuals all met the criteria for having urgent needs and in recent months have been prioritized to receive an ID waiver. As a result, their ID waiver funded services were relatively new. Some were still being established. Although the Individuals Review study involved a period of significant change, it was also positive that 89.9% had Individual Support Plans that were current. Individuals with DD, non-ID, who receive services through the DD Waiver were not included in the Individual Review study.

"The Commonwealth shall include a provision in the Community Services Board Performance Contract that requires CSB case managers to give individuals a choice of service providers…and to present practicable options of service providers based on the preferences of the individual (Section III.C.5.c.)."

A provision has been established in the FY 2013 and FY 2014 Performance Contract (e. 1.-21.) related to case management. The new Performance Contract provisions address the items required by the Agreement.

"The Commonwealth shall develop a core competency-based training curriculum…based on the principles of self-determination (Section V.F.6.)."

The Commonwealth developed and implemented a statewide core competency-based training curriculum for case managers built on self-determination and person centered principles prior to the Agreement being signed. As of April 2013, a total of 3,642 DBHDS and CSB staff, case managers and private providers had completed all six of the modules. During the second review period, a sixth training, the "Accountability" module, has been developed. A total of 1,856 staff has completed that module. The available data, merged from different DBHDS and DMAS sources, indicate that very few DD case managers have completed the core competency training modules. DBHDS, however, reports that these data may be unreliable. DBHDS is working with the DMAS Deputy Director for Complex Care to improve outreach to DD case managers regarding the requirements of the Agreement

Recommendation: DBHDS and DMAS should create the capability to reliably report the number of DD case managers who complete the core competency training modules and report this quarterly.

The findings from the Individual Review study related to case management are in separate tables that illustrate positive outcomes and areas of concern.

Positive outcomes

TABLE 8				
Individual Support Plan Items				
Item	**n**	**Y**	**N**	**CND**
If this individual is not competent to make medical decisions, is there a guardian or Authorized Representative?	26	96.2%	3.8%	0.0%
Is there evidence of person-centered (i.e individualized) planning?	29	93.1%	6.9%	0.0%
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her individual support plan?	29	89.7%	10.3%	0.0%
Are essential supports listed?	29	86.2%	13.8%	0.0%
Is the individual's support plan current?	26	88.3%	10.7%	0.0%

Positive outcomes

TABLE 9				
Individual Support Plan Items - staffing				
Item	**n**	**Y**	**N**	**CND**
Does the individual's support plan reflect specific staffing levels for support of this individual?	29	51.7%	48.3%	0.0%
If yes, were those staffing levels in place during the review?	15	93.3%	0.0%	6.7%
Is the staff working with the individual as detailed (consider the individual's Behavior Support Plan or ISP regarding the level of support needed)?	26	96.2%	3.8%	0.0%
Is there evidence the staff has been trained on the desired outcome and support activities of the individual's support plan?	29	93.1%	3.4%	3.4%
Is residential staff able to describe the individual's likes and dislikes?	28	96.4%	0.0%	3.6%
Is residential staff able to describe the individual's talents/contributions, preferences and weaknesses?	28	96.4%	0.0%	3.6%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	28	96.4%	0.0%	3.6%

Areas of concern:

TABLE 10				
Individual Support Plan – Adaptive Environment/Equipment - Items				
Item	**n**	**Y**	**N**	**CND**
Does the individual require an adapted environment or adaptive equipment?	29	86.2%	13.8%	0.0%
If yes, has all the adaptation been provided?	14	50.0%	50.0%	0.0%
If yes, is the equipment available?	25	48.0%	52.0%	0.0%

Baseline data: the first three items in the below table were not required by the Agreement or DBHDS to have occurred during the individual support planning process for the second review period. They will be as of July 1, 2013. Note that these same questions were not applicable for school age children.

TABLE 11				
Individual Support Plan Items				
Item	**n**	**Y**	**N**	**CND**
Has the individual been provided with opportunities for an informed choice regarding supported employment, including goals and services that will lead to supported employment?	14	14.3%	85.7%	0.0%
Have any barriers to employment been identified?	13	7.7%	92.3%	0.0%
Was placement, with supports, in affordable housing, including rental or housing assistance, offered?	12	0.0%	100.0%	0.0%
Has the individual's support plan been modified as necessary in response to a major event for the person, if one has occurred?	13	46.2%	53.8%	0.0%

Recommendations from the first Report to the Court

- monitor implementation of the ISP to ensure timely additional referrals for medical professionals (e.g. dental examination, nutritional assessment), day services, and communication; to ensure that all individuals are receiving the supports identified in the ISP and that staff are aware of and monitor the major side effects of psychotropic medications, including tardive dyskinesia;
- ensure that all ISPs include objectives that are measurable and focused on the development of skills for increased independence; and

- ensure that all providers and staff provide sufficient habilitation in order to teach skills and competencies that increase an individual's self-sufficiency and independence.

Progress Report

- A case management training module on Accountability was issued on February 15, 2013.
- The DBHDS Case Management Coordinator will work with Licensure to assess the level of execution statewide and work with Project Team #9 and the Regional Quality Councils to make improvements based on recommendations in this report.
- For the Training Center discharges, the Post-Monitoring Move tool has been updated to include more specifics related to these recommendations. The Training Centers are developing training for providers regarding psychotropic medications and their major side effects.
- The DBHDS Quality Improvement Committee will address this recommendation.
- The Office of Licensing will monitor the administration of psychotropic medications as part of the new licensing standards as of March 2013.

"For the purposes of this agreement, case management shall mean: assisting the individual to gain access to needed medical, social, educational, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP (Section III.C.5.ii.)."

During the Individual Review process, the reviewers observed a contrast between how different case managers provide assistance. Some were clearly in tune with and very supportive of the family. Some who visited the individual's home when the review occurred knew the family well and took careful notes when the expert consultants described needed assessments or ways services might be improved. The contrast was with other case managers who seemed on the periphery. These case managers gave families lists of potential providers, or manuals on how to apply for a benefit, and told them to call back after they had made a decision.

It continues to be the Reviewer's opinion that significant improvements are necessary to accomplish both the Agreement's required performance standards for case management and the long-term goals of the Agreement. Needed improvements include, but are not limited to, developing and discussing employment goals and supports and offering supported employment, offering integrated day opportunities, providing assistance to access services, convening the individual service planning team to address changes in status, and monitoring the ISP to make referrals, service changes, and amendments as needed. Note: see pages 56 and 57 for more information about case management.

Progress in complying with these requirements and the case management provisions in Section V of the Agreement will be prioritized for monitoring during the third review period.

J. Crisis Services and Prevention

"The Commonwealth shall:

develop a statewide crisis system for individuals with intellectual and developmental disabilities (Section III.C.6.a.).

provide timely and accessible supports to individuals with intellectual and developmental disabilities who are experiencing crisis

provide services focused on crisis prevention and proactive planning to avoid potential crisis

provide in-home and community-based crisis services that are directed at resolving crises and at preventing the removal of the individual from his or her current setting whenever practicable (Sections III.C.6.a.i-iii.)."

The Independent Reviewer retained an expert consultant to review compliance with the crisis service requirements of the Agreement. The Reviewer and consultant agreed upon the measures and evaluation methods to determine the Commonwealth's compliance in this area. This evaluation did not include a review of the quality of services provided, given that program components are either in their early stages of operations or not yet operational. The consultant's report "Crisis Service Requirements" (Appendix B) is paraphrased and quoted in this section of the Reviewer's report.

The expert consultant's report describes the status of compliance efforts as of April 6, 2013. It also describes accomplishments and areas of potential non-compliance with the Agreement. It also includes the status of planning for the requirements that are to be met by June 30, 2013. The Reviewer's findings were also informed by:

- on-site visits and interviews with staff at three regional crisis services programs,
- focus groups with service providers, case managers, and family members who have been engaged with crisis services,
- quarterly reports by the external consultant guiding program implementation, and
- quarterly reports by the DBHDS-assigned project team.

The Reviewer previously commended the Commonwealth for the decision to implement crisis services and stabilization programs statewide using a "reliable, well-tested and comprehensive service delivery model, Systemic Therapeutic Assessment Respite and Treatment (START)." The success of the model is that it is based upon:

- linkages and agreements with existing providers,
- cross-system crisis intervention planning (CSCP),

- support and technical assistance to all its community partners including individuals and their families, and
- comprehensive systemic and clinical training with follow-up consultation."

Currently, Virginia is in the first full year of implementation of its statewide crisis response system for individuals with ID and DD. When undertaking such a broad, complex initiative, there are typical causes of delays. These include the hiring of staff and the purchase and renovation of buildings. New programs that are based on a cooperative model of service delivery also experience challenges establishing structure and operating norms within an existing system.

The Sufficiency and Sustainability of Funding for START services

Recommendations from the Reviewer's first Report

Provide adequate funds for crisis service operations in FY 2014, including for mobile crisis teams in each region to respond to on-site crises within two hours by June 30, 2013.

Progress Report:

An additional $3.8 million has been approved to expand funding for mobile crisis teams from $7.8 to $11.6 million, as of July 1, 2013. This will help mobile crisis teams to respond to a crisis calls. The regions' ability to have full funding to address their costs and function as planned is dependent upon Medicaid billing, since the total projected budget is $12.5 million for FY 2014. DBHDS will need utilization and waiting list information to make targeted budget requests to properly fund the regional START programs.

Serving Adults with Developmental Disabilities

The data collected by the START teams reflect an increase in the number of individuals with DD being seen. The number remains small, though it is expected to increase. DBHDS has started doing outreach and education about START Services with case managers who coordinate services for individuals with DD.

Access to START is the same for both populations and is available to all individuals with ID/DD not only those eligible for HCBS waiver services. The DBHDS Commissioner clarified in June 2012 that individuals with DD are eligible for START services.

Recommendation from the Reviewer's first Report to the Court

Ensure that adults with DD have case management to facilitate full access to crisis services and stabilization programs, and that they have access to community supports necessary to prevent future crises.

Progress Report

DMAS announced in January 2013 that targeted case management services are available for individuals with DD who are not on the DD waiver, if they are on the wait list, in crisis, and served by START during the return to the community. Without waiver-funded services, however, these individuals will not have access to services that are integral to the way in which the START programs provide on-going support. Without access to in-home and other supports, individuals with DD will not have access to the on-going support to prevent future crises. Similarly, individuals with DD who are in crisis and served by START, but not on the DD wait list, are also excluded from the support needed to avoid unnecessary institutionalization.

Recommendations

DBHDS and DMAS should determine if individuals who have DD and have used START should be considered a priority for case management whether or not they are on the wait list.

Refer to the Section VIII on page 62 and 63 for the additional related recommendations.

Serving Children with Intellectual and Developmental Disabilities

Recommendation from the Reviewer's first Report to the Court

Develop a plan and approve sufficient resources to provide crisis services for children with either ID or DD.

Progress Report

At the time the Reviewer completed his first Report to the Court, there was no plan or funding for providing crisis services for children with ID and DD. Recently, $1.25 million was approved as part of the FY 2014 budget to develop crisis prevention and intervention for children. This funding level was not based on a plan and is only eleven percent of the funding provided for adult crisis services. Crisis Services for children were required by the Agreement as of July 1, 2012. The General Assembly's approval of funding for crisis services for children is a positive step forward. DBHDS has informed the reviewer that it will develop a plan that provides crisis services to all children, regardless of age, in the target population. DBHDS plans to bring stakeholders together to consider the program model, costs, funding sources, and the other factors included in the Reviewer's recommendation below.

DBHDS has convened initial discussions to plan crisis services for children with ID and DD. DBHDS faces challenges in developing these services. Currently, children's crisis services in three of its five regions serve a broader population than ID and DD. These programs may not be prepared to address the needs of this group without changes to the program structure and additional training. There is also no utilization data about children with ID and DD needing or accessing crisis services.

Crisis Services staff has advised the Reviewer that an evidence-based model, like START, should be selected and that a careful roll out should be planned. The plan that is developed should include an operating program model and philosophies for the children's crisis services that fits seamlessly with the START crisis services that have been developed for adults.

The Commonwealth is not in compliance with the Agreement's requirements to provide crisis services for children.

Recommendation
A written implementation plan with timelines for addressing the needs of all children with ID or DD should be provided to the Reviewer by October 20, 2013. This plan should include:

- the program model,
- projected costs and funding sources,
- education of families,
- marketing with school systems,
- case management,
- coordination with the state agency responsible for children with DD, and
- the availability of ongoing supports and services for children who have experienced crises and are stabilized, including access to waiver services.

START Services and Staffing

The START regional programs have had difficulty filling and maintaining staff in crisis services positions. Gaps have existed in several program and clinical leadership positions. The Clinical Director position has been vacant in three regions due to difficulty finding the right person or the terminations of individuals who were hired. As a result, Cross System Crisis Plans were not developed or were significantly delayed. Family members have reported these delays to the Reviewer, often with anecdotes involving unfulfilled promises of when the CSCP would be completed.

Having consistent program and clinical leadership is critical to the ability of START teams to respond in the time frames expected by the Agreement. The external consultant guiding the implementation of the START model reports similar staffing difficulties in other states during the initial phase of development. There are additional challenges when implementing a unique service that requires staff to function in a new and different role. It takes time and is critical to the program's success to find and retain leaders with the program and clinical expertise, philosophies, and values that fit the program model.

Recommendation:
DBHDS should report quarterly to the Independent Reviewer on the staffing of the START programs. If recruitment and retention remain a problem, then DBHDS should report to the Reviewer its analysis of the problem and plans to address the problem by October 20, 2013.

Training

Full compliance with Sections 6.a.i, 6.a.ii, and 6.a.iii "will be determined by how well staff in both the ID and Emergency Services divisions of the CSBs, providers and the START programs are prepared to address the needs of individuals with ID/DD who are at risk of or are experiencing a crisis."

The "Crisis Services Requirements" report describes the training in crisis response and de-escalation required of staff who work directly with individuals who exhibit behavioral challenges. Because of the difficulty of filling positions, training must continue to assure that all staff complete the necessary requirements to achieve certification. It is essential to the ongoing quality of the program.

Crisis Point of Entry:

"The Commonwealth shall utilize existing CSB Emergency Services, 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 (Section III.C.6.b.i.)"

The Reviewer has recently learned that DBHDS previously determined that the mobile crisis team member who responds to address the crisis will be a member of the START program's mobile crisis team. This was not the Reviewer's understanding when his first Report to the Court stated "The variance in CSB response on-site in people's homes has the potential to impact the capacity of the START Mobile Crisis Teams to respond". The expert consultant's evaluation during the first review period raised concerns about the variance in CSB Emergency Service mobile crisis teams' responses to crises on-site. The Reviewer again retained the expert consultant to complete follow-up study during the second review period. This study focused on areas of concern identified in the first study, including whether CSB ERs were responding on-site. The questions to be asked of those interviewed were shared with DBHDS prior to beginning the study. One question asked whether "CSBs are now willing to respond to a crisis in a person's home". The expert consultant's follow-up study was completed with that focus.

The Reviewer has learned that the Community Services Performance Contract with DBHDS for FY 2013 and FY 2014 assigned the responsibility to respond on-site as follows: "These requirements shall be met through the regional START program that is staffed 24 hours per day and seven days per week by qualified individuals able to assess and assist individuals and their families during crisis situations and has a mobile crisis team to address crisis situations and offer services and supports on-site to individuals and their families within 3 hours". The Reviewer has, therefore, not gathered sufficient data to determine if this provision of the Agreement is being met. In the Reviewer's focus group meeting with families who have engaged crisis services, one family with an adult family member in crisis

provided a log of interactions with the START mobile crisis staff. One response to a crisis call was "we just meet you at the hospital." This one example is not sufficient to determine statewide compliance with this requirement.

The Reviewer will prioritize monitoring whether mobile crisis teams are responding on-site to crises during the third review period.

Recommendation
The DBHDS should report to the Reviewer by October 20, 2013 the status of its compliance with the requirement of the Agreement to "respond to individuals at their homes…to de-escalate their crisis."

"By June 30, 2012, the Commonwealth shall train CSB Emergency Services personnel in each Health Planning Region ("Region") on the new crisis response system it is establishing, how to make referrals, and the resources that are available. (Section III.c.6.b.i.B)."

Training continues to be offered to CSB ES staff. A recent training was provided to CSB staff in Region 5. The Commonwealth plans to replicate this model in other regions. As of March 31, 2013, seventeen CSBs (41%) have trained 100% of their ES staff in the START model, and twenty-one CSBs (51%) have fewer than 75% of their ES staff trained.

The DBHDS Crisis Services Coordinator for the START programs and its Crisis Intervention Support Specialist who works with the CSB ES teams are working collaboratively to expand training to the CSB ES staff. They are currently reaching out to and offering training for the staff of the ten existing crisis stabilization units that support individuals primarily with mental health and substance abuse needs. This is a positive development that will likely build a more effective working relationship between the ES and START teams and their respective crisis stabilization units.

Refer to the Section VIII on page 62 and 63 for the additional related recommendations.

Work with Law Enforcement

The Agreement expects that the Commonwealth will have a planned approach to reaching out to and working with law enforcement personnel. The goal is to improve interactions with individuals with ID/DD who experience crises and come into contact with law enforcement.

DBHDS offers a training curriculum, the Crisis Intervention Training (CIT), throughout the state. The curriculum includes information on individuals with ID. The regions vary in their contacts with police and the trainings that have been offered.

Refer to the Section VIII on page 62 and 63 for the additional related recommendations.

"Mobile Crisis Teams:
F. By June 30, 2012…shall have at least one mobile crisis team in each Region that shall respond to on-site crises within three hours (Section 6.b.ii.)."

None of the regions had their full teams in place by June 2012 due to delays in hiring and being funded less than planned for by DBHDS. Regions 3, 4 and 5 were reported to be fully operating their mobile crisis teams by October 2012, the end of the previous reporting period. Regions 1 and 2 did not have their teams in place until December 2012 because of delays in becoming licensed. There was a seven-month range of start dates (September 2012-April 2013), in the Regions' provision of in-home respite component of START services.

The most recent START quarterly report provides a wealth of information about the demographics, needs, and supports that have been provided. Highlights include:

- 350 individuals have been referred to START statewide with 117 of those individuals being served in the most recent quarter,
- 35% of the individuals referred lived at home at the time of referral,
- 52% of the referrals of people in crisis were at risk of losing their placements, but through the provision of START services, placements were maintained.
- Case Managers are the primary source of referrals, followed by families and residential service providers. Only 11% (13) of the referrals this quarter were made by the ES mobile crisis teams

The Agreement requires a response time to crisis referrals of no more than three hours during the first year of implementation; this is reduced to two hours by June 30, 2013. The START report for the quarter that ended March 31, 2013 indicated that only 31 (39.2%) of responses occurred in less than the required two hours. Data was not available, however, for twenty-six (32.9%) of the seventy-nine responses because START teams have not consistently reported this information. It is critical that data on all responses be tracked and reported. Missing data in future reports will undermine the Commonwealth's ability to provide information that demonstrates compliance. The mobile crisis teams are not yet meeting the two-hour response time that is required as of June 30, 2013. The goal of responding within two hours for all crisis referrals will depend on having a sufficient number of Transition Coordinators hired and available, especially in rural areas.

Meeting the two-hour response time standard by June 30, 2013, does not ensure either that future response times will continue to meet this standard or the quality of services or planning once on-site. One contributing factor will be that referrals to START programs will likely increase as further outreach occurs and as all respite programs become fully operational.

The DBHDS is to have a second mobile crisis team in each region by June 30, 2013 that shall respond to on-site crises within two hours. The DBHDS reports that each region is deciding what it needs in terms of resources. The regions are planning to deploy the existing and additional Transition Coordinators differently. These plans are not yet final. The next START Quarterly Report will be used to determine if the staffing is adequate to meet the requirements of the Agreement as of June 30, 2013.

Recommendation: The DBHDS should report to the Reviewer by October 20, 2013, the steps it took to expand the mobile crisis teams' capacity to respond to on-site crises and the actual response times during the first quarter of FY 2014.

"By June 30, 2012…shall develop one crisis stabilization program in each Region (Section III.6.b.iii.)."

The Commonwealth is not in compliance with this provision. As of the end of the second review period, April 6, 2013, two regions still do not have crisis stabilization programs.

There were typical delays caused by home location, acquisition, renovation, licensing, and staff recruitment and training. Two units opened in December 2012 and a third opened in March 2013. Both Regions 4 and 5 remain without a facility in which to operate the stabilization programs. Region 5 has a facility that is projected to be available by October 2013. The Reviewer agreed to an exception for Region 5, until October 2013, to the requirement that crisis stabilization programs not be located on the grounds of Training Centers. Use of the site on the grounds of the Training Center is not in compliance with the Agreement. It will, however, provide a temporary location where planned and emergency services can be provided until October 2013. Region 4 had a site in Richmond that was not approved by zoning. They are looking for an alternative site, but have no projected start date.

The Commonwealth is to decide by July 2013 how many crisis stabilization units will be needed. In light of the significant delays in opening these units and given that two are not yet available, it is unrealistic for the DBHDS to make assessments in all Regions by July. It does appear that there is sufficient data to make a preliminary assessment in Region 3. It will be important, however, to make a determination of the level of need by the time the Department submits its FY 2015 budget requests to the Governor. If additional units are not included in the FY 2015 appropriation, the level of crisis stabilization will remain at fewer than thirty beds statewide for at least two more years. The Reviewer expects that the DBHDS will develop a projection of need based on utilization of the three existing units through the next review period (October 6, 2013). This projection should factor in the needs of adults with DD, which will likely increase, and for children with ID or DD.

The Reviewer has received reports of gaps in whom the crisis stabilization programs will support. The individuals who could not be supported include people who run away/elope and those who are assaultive. DBHDS has confirmed to the Reviewer that everyone with an ID or DD diagnosis should be referred to START; and that there are no automatic

exclusionary criteria, other than an individual who is a danger to self or others and needs hospitalization. They also report that individuals who historically elope from settings can be served, if they are willing and can be maintained by the physical environment (a fenced yard) and the supervision and direction of staff.

In addition to the issues already raised in this section, other systemic issues have been identified. Refer to the Section VIII on page 62 and 63 for the additional related recommendations.

K. Integrated Day Activities and Supported Employment

The Reviewer retained an expert consultant to review compliance with the Integrated Day Activities and Supported Employment requirements of the Agreement. The Reviewer and consultant agreed upon the measures and evaluation methods to determine the Commonwealth's compliance in this area. That report "Employment Service Requirements" (See Appendix C) is quoted in this section of the Reviewer's report.

The Reviewer agrees with the conclusion in the expert consultant's report, as follows:

> "The Commonwealth is commended for its progress to date establishing its Employment First Policy and initiative and its efforts to comply with the requirements of the Settlement Agreement as it directs change to employment services. The support of the Governor and General Assembly provide a strong message of leadership as to the importance of this undertaking. There is significant involvement of various state agencies and an identification of the barriers they must address to fully support the desire for people with disabilities to have a meaningful employment and participation in community life."

"The Commonwealth shall…to the greatest extent practicable…provide individuals in the target population receiving services under this agreement with integrated day opportunities, including supported employment (Section III.C.7.a.)."

Sections of the status report are paraphrased and quoted from "Employment Service Requirement" (Appendix C).

DBHDS reports the following information related to the number of people who have been provided with supported employment.

Table 12 Individuals Enrolled in Employment Services		
	First period 10/12-12/12	Second period 1/13-3/13
Newly enrolled in ISE	43	71
Newly enrolled in GSE	36	79
Total enrolled in SE	79	150
Newly enrolled in Pre-Vocation	59	124

The first reporting period (10/12-12/12) includes individuals on both the ID and DD waivers. The total receiving supported employment was 79. During the second reporting period, this increased to a total of 150 people. Table 12 also includes pre-vocational enrollment. This enrollment may decline, as it becomes a standard practice to offer supported employment as the first option for new enrollees.

There is a difference in the data sources for the two reporting periods. The first period includes enrollments in the ID and DD Waivers. The second period includes data from ***only*** the ID waivers. There is a positive increase in the number enrolled in supported employment during the second quarter even though the information is only from the ID waivers. The DD waiver data is only available on an annual basis at the end of a year. Also, DBHDS reports that because the Department of Aging and Rehabilitative Services (DARS) funding was closed during the second period, people could access the ID waiver for employment directly since the primary funder was unable to provide employment supports. This may have increased the numbers enrolled in the ID waivers. This may be positive for these individuals. It may increase the continuity of services and cause less confusion to families than dealing with the two different Departments.

Unfortunately, the Commonwealth is unable to report the number of people who receive other integrated day services. The data collection system does not distinguish between community-based and facility-based day services.

The data indicate that there may have been an increase in the number of people receiving supported employment. However, there has been no change to the waiver rates and structure that currently encourages day support services in congregate setting. Effective July 1, 2013, job development and job placement activities will be reimbursable through the ID, DD and Day Support Waivers, when the individual is not present. This is a positive change and should help make the provision of individual and group supported employment more financially viable for providers. During the second review period CSB officials informed the Reviewer that staff assigned to implement supported employment had been

redeployed to other functions because, "The current funding for the program is not adequate. We have to make decisions based on the bottom line."

It is the Reviewer's opinion that the Commonwealth has achieved several accomplishments that will provide more integrated day opportunities in the future. These accomplishments, described elsewhere in this report, include a comprehensive plan for employment, a strong employment first policy, related training, and progress with respect to comparable pay for supported employment services provided through the waivers or DARS. These accomplishments and the restructure of the waiver and rates will be essential because there is a long way to go before individuals in the target population are provided…"to the greatest extent practicable…with integrated day opportunities, including supported employment".

Recommendation: DBHDS and DMAS should create the capacity to report the number of individuals with ID and DD who are receiving integrated day activities and supported employment and report this to the Reviewer on a quarterly basis.

"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…be based on the following principles:

> *individual supported employment in integrated setting is the first and priority service option for individuals with ID or DD receiving day program or employment services from of funded by the commonwealth;*
>
> *the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and*
>
> *employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in ISPs.*

Employ at least one employment services coordinator to monitor the implementation of Employment First practice.

Maintain its membership in the State Employment Leadership Network (SELN) established by NASDDDS (Section III.C.7.b.)."

The Commonwealth established and issued a state policy on Employment First in December 2012. It is a strong policy statement that stresses the benefits of employment for persons with disabilities. Integrated community-based employment is appropriately defined to mean regular or customized employment, with minimum or competitive wages and benefits, for a person who is on the employer's payroll and has interaction and integration with the business workforce. The Employment First Policy also directs DBHDS:

- to provide training and consultation to providers,
- to create teams to use evidence-based supported employment models,
- to build these options into the waivers for both ID and DD,
- to maintain the SELN Advisory Group as a resource for systems development, and
- to develop an implementation plan to increase integrated day opportunities.

The CSBs Performance Contract with DBHDS requires demonstration of compliance with the Employment First Policy starting in July 2013. A planning form has been restructured so that employment will be the first topic discussed with the individual. The case managers will submit a report indicating that employment was explained, discussed, and offered to the individual. CSB representatives on the SELN Advisory Group have reported that there has been no further guidance provided, and the expectation has not yet been set for case managers.

The Agreement's integrated day and supported employment provisions apply to individuals with either ID or DD. DBHDS, however, does not have a direct relationship with case managers who support individuals with DD who are accessing the DD waiver. DBHDS has shared the Employment First Policy with DMAS, and asked DMAS to share it with the DD case managers and to strongly encourage them to discuss employment as the first option. However, there appears to be no requirement being set forth to insure this occurs.

The Commonwealth has met the requirements of this section of the agreement by:

- maintaining its membership in the SELN and creating a statewide SELN committee,
- developing and issuing the Employment First Policy,
- issuing the performance contract requirement of the CSBs, and
- hiring an Employment Services Specialist who oversees and coordinates the employment first initiative.

Recommendation: DMAS should make the Employment First policy a requirement for individual support planning for people with DD who are receiving waiver services and to have a mechanism to make sure it is being implemented.

"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…The plan shall:

> *Provide regional training on the Employment First policy and strategies throughout the Commonwealth; and*
>
> *Establish, for individuals receiving services through the HCBS waivers: Annual baseline information… and; Targets to meaningfully increase (Section III.C.7.b.i)."*

The Strategic Plan for Employment First was submitted on November 7, 2012. It was subsequently updated with additional information. The targets to increase supported employment were added in March 2013. The expert consultant utilized the State Health Authority Yardstick (SHAY) rating scale to evaluate and determine the adequacy of the plan. It is a nationally recognized tool developed at Dartmouth University to review state's ability to plan, develop, monitor, and evaluate evidence-based practices regarding systems development and program implementation.

The Commonwealth has substantially complied with the requirement of developing a plan that to accomplish the systems change that is necessary to fully realize the Employment First Policy. There are recommendations below, however, to strengthen the plan.

During the second review period, the primary focus of DBHDS' activity has been centered on developing the Employment First initiative. The goal of the Employment First plan, however, is to serve only 20% of individuals with waiver services in supported employment. More than 80% of individuals on the ID waiver are receiving day supports that are typically in large congregate segregated facilities. DBHDS reports having sought advice on developing community-based non-work integrated day activities from the SELN national team. This is a new, and much needed, area of program development for many states including Virginia. To date, the Commonwealth has not been engaged with any formal planning to develop an implementation plan to create a robust service delivery system that meets the Agreement's requirements for integrated day activities including community volunteer opportunities and integrated recreation activities.

Recommendation:
DBHDS and DMAS work together to develop and submit a plan that identifies strategies, goals, action plans, resources, responsibilities and timelines to address Integrated Day Activities for individuals with ID and DD. The Plan should be shared with the Independent Reviewer by October 20, 2013.

Training
There is an understanding that an initiative such as this can only be accomplished through significant education to increase stakeholders' awareness of Virginia's Employment First initiative, national trends and federal expectations. The Employment plan includes the following training initiatives:

- an annual state employment summit with key leadership,
- quarterly regional summits,
- the development of a dedicated website,
- the development of a comprehensive training plan in employment practices,
- training for case managers and service providers,
- training on innovative employment support models for direct service staff,
- outreach to families and individuals, and
- outreach to the business communities.

Two of the initiatives have been implemented. The first two employment summits have occurred and the outreach packet for families and individuals has been developed. The remaining components are projected to be available in September 2013.

The DBHDS Employment Coordinator has arranged and directly provided a significant amount of outreach, education and training to a wide range of stakeholder groups.
It is the Reviewer's opinion that the Commonwealth is meeting its obligation under the Settlement Agreement to provide training on the Employment First policy and strategies throughout the Commonwealth. The plan to develop more specific training for employment providers and other stakeholders will be important to the success of this initiative.

Engaging stakeholders
The Commonwealth's Supported Employment Leadership Network (SELN) has an important role in the planning and implementation of provisions of the Agreement. That role includes:

- serving on the DBHDS DOJ Employment First Project Team,
- setting the targets,
- providing ongoing guidance and assistance to implement the plan and the Policy, and
- monitoring the baseline data and the targets" (DBHDS transmittal letter).

The Commonwealth's SELN members represent stakeholders including self-advocates, families, advocacy organizations, CSBs, state agencies, universities, and employment providers. The Commonwealth's SELN, established in 2008, completed a self- assessment with assistance from the national SELN. That assessment helped the Commonwealth's SELN develop a work plan. That work plan was used in the creation of the "Strategic Plan for Employment First: Expanding Employment Opportunities" that was published November 8, 2012.

The expert consultant interviewed nine members of the Commonwealth's SELN as part of the research to determine the compliance with the employment services requirements of the Agreement. Those interviewed included CSB, state agency, provider, family, and advocacy representatives. All were very committed to advancing the employment first policy. Questions addressed the involvement of Commonwealth's SELN in creating the strategic plan; the adequacy of the plan; the effectiveness of the interagency coordination; outreach that has been done; the barriers facing the Commonwealth as it seeks to implement its employment strategies; and the adequacy of the employment targets that have been set.

The Commonwealth's SELN members shared the concern that they did not have the opportunity to have meaningful input into the design of the strategic plan or to provide feedback before it was submitted to the Independent Reviewer. A subgroup of the Commonwealth SELN members were involved in setting the targets for the plan.

The Commonwealth's SELN members agreed that the plan includes the essential elements needed to be successful, but question whether it goes far enough. The DBHDS Strategic Plan for Employment First comprehensively identifies current barriers to increasing supported employment. The barriers include that the Commonwealth's rate setting and supported employment policies and procedures are not in line with federal guidance on supporting integrated employment, and do not incentivize delivery of employment services over other services. The Commonwealth's SELN members also expressed concerns that these barriers have long been recognized and that the plan lacks specificity about the strategies to implement the plan and to monitor progress. Since the plan was completed, there have been no meetings of the Commonwealth's SELN that focused on implementing the plan to accomplish the many objectives due in September 2013. The Commonwealth's SELN Advisory Group wants to build on the momentum of a recent legislative committee study and to identify the collaborations more specifically to accomplish the plan. One important step is to collect and analyze data to make sure the baseline in the plan is correct and that progress can be accurately assessed.

DBHDS and DMAS have made recent progress. Effective July 1, 2013, job development and job placement activities will be reimbursable through the ID, DD and Day Support Waivers, when the individual being served is not present. This is a positive change and should help make providing individual and group supported employment more financially viable. DBHDS has also issued an RFP to study and restructure the waivers that will specifically include employment.

Targets for increasing employment

The Commonwealth's SELN members initially discussed the targets, and a subgroup assisted DBHDS to develop them. Most of the Commonwealth's SELN members interviewed for this report believe that the targets are too modest; though they acknowledge that systemic barriers that interfere with progress have not yet been addressed. There are also concerns that individuals served in both individual and group supported employment may have been double counted, and that some people in congregate settings primarily with people with disabilities were included in the count, if some people without disabilities are also employed there.

Nationally twenty percent of individuals served in day services are receiving supported employment. The target set for the Commonwealth is to increase the number of new enrollees by twenty-seven individuals, a twenty percent increase over the 135 people who were enrolled in the previous year. The other goal of having 138 individuals maintain employment in an integrated work setting is an increase of five individuals from the previous year.

In setting these targets DBHDS did not seem to adequately consider important factors. The Commonwealth is currently serving very few of its waiver participants in supported employment. Of the 9027 individuals enrolled in the ID, DD, and Day Support Waivers in FY 2011, only two percent were in individual supported employment and six percent were in

group supported employment. Waiver enrollment will increase by at least 4170 individuals over the term of the Agreement. By the end of FY 15 the number of individuals on waivers will increase to more than 10,700. To reach an overall enrollment in supported employment of twenty percent, DBHDS would need a multi-year plan to increase to 2,140 people receiving supported employment. Whether such an increase is realistic and over what period of time should be the focus of SELN discussions and planning. Such discussions will assist the Commonwealth in implementing the Employment First Policy and set more ambitious targets to support the implementation of its Employment First Policy.

In DBHDS's transmittal letter to the Reviewer of March 29, 2013, the target to increase supported employment is set at 162 in each year. The Commonwealth's SELN has discussed increasing the target by an additional twenty percent the second year and by fifty percent the third year. Accomplishing these more ambitious targets would result in the Commonwealth providing supported employment to twelve percent of the individuals in day services, compared with a national average of twenty percent During the recent two quarters 114 individuals have enrolled in supported employment. It is likely that the goal of 162 individuals in supported employment will easily be achieved because only 38 more individuals will need to be enrolled during the next two quarters. DBHDS is planning for the Regional Quality Council's, in consultation with the Commonwealth's SELN and providers, to periodically review the targets. This review will include the extent to which the targets are being met, the need to take additional measures to further enhance these services, and determining whether the targets should be adjusted upward.

It is the Reviewer's opinion that the targets that have been set are too modest. It is also the Reviewer's experience that improved performance results from setting realistic and achievable goals that involves stretching to achieve them. Generally, targets should increase as barriers to improvement are removed and success is demonstrated. A standardized assessment tool, such as the Support Intensity Scale, should be used to determine people's interests and abilities to work. Creative approaches should be considered. These might include determining strategies to increase the capacity of Employment Services Organizations or targeting a set number of school graduates who are on the wait lists and interested in individual supported employment.

L. Access and Availability of Services

The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population (Section III.C.8.a.)."

Information was gathered related to this provision as part of the Individual Review studies completed during the first and second review period. There was a distinct pattern to answers about transportation. Of the individuals who received transportation from their family, or service provider, very few problems were reported with transportation. Alternatively, nearly all those who received transportation from a Commonwealth contractor or subcontractor, reported problems. These problems ranged from excessive

delays in arranging transportation, poor communication, not being picked up as scheduled, transportation only covering medical needs, being dropped off at medical appointments but not picked up, and inadequate support to individuals provided by drivers and aides in the vehicle.

DMAS has reported making several significant changes in the past six months to strengthen and improve the delivery of transportation services through DMAS' contracted vendor. DMAS:

- restructured and strengthened oversight,
- expanded and strengthened field monitoring,
- created a task force to ensure issues are addressed and resolved in a timely manner,
- improved monthly executive level communication, problem solving, and reporting, and
- assigned liquidated damages for contractual non-compliance.

Transportation vendor:

- filled key vacant positions,
- centralized operations for improved consistency in policy and procedures statewide,
- formed an internal quality assurance committee,
- created regional Quality Council Meetings for regionally specific problem solving with community stakeholders,
- improved monthly reporting to, and subsequent communication with, DMAS, and
- implemented requirements that all new providers who furnish hand-to-hand service complete PASS training.

DMAS has also reported planned actions for the next year. These include:

- to continue to expand and enhance monitoring efforts,
- to revise further staff roles and responsibilities,
- to identify network deficiencies by region,
- to implement new complaint protocol review and modify the contract for improved quality and performance, and
- to develop a quarterly review and update process.

Recommendation: DMAS should create the capacity to report on the quality and performance of the Commonwealth's vendor to provide transportation to individuals with ID/DD and to report this to the Reviewer quarterly.

"The Commonwealth shall…publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services (Section III.C.8.b.)."

Progress Report

The Commonwealth reported creating an interagency workgroup comprised of staff from Health and Human resources (HHR), the Department of Medical Assistance Services (DMAS), the Department of Aging and Rehabilitative Services (DARS), and the Department of Behavioral Health and Developmental Services (DBHDS). The workgroup agreed to use Easy Access as the main portal for access to apply for and find services. DBHDS reported that the final revisions, additions, and simplified information for ID and DD services were made to Easy Access. A new user-friendly website was outlined. DBHDS plans to incorporate guidelines into the new website.

Families have consistently reported complaints that underline the need for this requirement of the Agreement. Families describe the lack of a clear and understandable path to receiving services and supports. Examples include making inquiries and repeatedly being referred elsewhere for answers. In one case, for instance, a family made a complete circle after several referrals backs to the original person who could not help and had started the process.

One theme identified during the reviews of services for individuals with complex medical needs was the difficulty in acquiring needed environmental adaptations and/or adaptive equipment. The table below depicts the result. Half of those reviewed had not been provided the environmental adaptation needed. More than half had not been provided all the adaptive equipment needed.

Areas of concern:

TABLE 13				
Individual Support Plan – Adaptive Equipment/Environmental Modifications - Items				
Item	**n**	**Y**	**N**	**CND**
Does the individual require an adapted environment or adaptive equipment?	29	86.2%	13.8%	0.0%
If yes, has all the environmental adaptation been provided?	14	50.0%	50.0%	0.0%
If yes, is the equipment available?	25	48%	52%	0.0%

These numbers do not adequately reflect the frustration of families. In some cases the adaptations or equipment had not been ordered. In another, a family, already overwhelmed with challenges associated with providing needed support to their loved one, was directed by the case manager to research the options and decide the equipment to purchase. Families in southwest Virginia reported that they could not find contractors with the required worker's compensation insurance. Once adaptations or equipment were requested, delays were common. Requests were frequently "pended" for additional information or changes in wording. Examples include:

- rejection of a canopy to keep away inclement weather over an exposed wheel chair ramp because the contractor described it as a roof, rather than a covering;
- rejection of a building supply list that included items named "deck 2X4s," to be used in the construction of a wheelchair ramp, because "decks" are not allowed; and
- repeated delays followed by approval of outdoor construction in mid-December with too little time to complete construction, as required, within the calendar year.

A common thread to concerns was the lack of DMAS guidelines describing the path, the criteria, or the expected time for each step in the approval process. Some families reported that the same request was approved when resubmitted because a different staff processed it. Case managers described a lack of consistency and uniformity in DMAS decision-making related to adaptive equipment and environmental modifications.

Refer to the Section VIII on page 62 and 63 for the additional related recommendations.

M. Community Living Options

"The Commonwealth shall:

facilitate individuals receiving waiver services under this agreement to live in their own home, leased apartment, or family's home

provide information and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding

Within 365 days develop a plan to increase access to independent living options

Within 365 days…establish and begin distributing, from a one-time fund of $800,000 to provide and administer rental assistance

The plan will be developed under the direct supervision of a dedicated housing service coordinator for DBHDS and in cooperation with…" other Virginia agencies including the Virginia Board for People with Disabilities (Section III.D.)."

The Commonwealth completed and submitted "Virginia's Plan to Increase Independent Living Options" (Housing Plan) on March 6, 2013, to comply with the Agreement's provision requiring a Housing Plan within 365 days. The purpose of the Housing Plan is to "facilitate individuals receiving HCBS waivers…to live in their own home or leased apartment…".

DBHDS reported that its Housing Specialist, working with the Interagency Housing Committee, developed the Housing Plan. The Plan sets forth five major goals with nine strategies and actions to achieve the objectives established in the Agreement. The Housing Plan also provides a demographic profile of the intended population of individuals with ID/DD, and other baseline information regarding the number of individuals who are

projected to choose these options. The Plan estimates that 2,530 individuals with ID/DD might choose independent living in FY 2014 and FY 2015.

DBHDS reported, "the Housing Plan seeks to make available more independent living options" as a result of:

- increased development of affordable and accessible rental units,
- improvements in federal and state funding and eligibility policies,
- the design and assessment of a new approach to rental assistance, and
- increased understanding and promotion of independent living..."

The implementation of the Housing Plan goals and strategies will be administered by DBHDS, and coordinated and advised by the Interagency Housing Committee. The Housing Plan states, "to ensure success, these agency representatives are committed to coordinating their resources, engaging local and state partners to advance the implementation of the plan, and tracking and analyzing results for increased efficiency and impact."

It is the Reviewer's opinion that the Commonwealth has substantially complied with the requirement of the Agreement to complete a plan to increase access to independent living options. Although the Reviewer has recommendations to strengthen implementation of the Plan, it provides a foundation to increase independent living options. Part of that foundation is the recognition, "individuals with developmental disabilities can live fuller lives in integrated community settings" and "affordable housing and community-based support services are keys to independence."

The Reviewer has evaluated the Housing Plan using elements of the State Health Authority Yardstick (SHAY). It is a rating tool developed by researchers at Dartmouth University to review states' or public authorities' ability to plan, develop, monitor, and evaluate evidence-based practices regarding systems development and program implementation. The Housing Plan, and its development, includes several characteristics that will increase the likelihood of successful implementation. The plan was developed with interagency collaboration that involved the agencies' leadership. It identifies the partners and specific strategies to include local, state, and federal agencies. Communication, training and a coordinated outreach effort are included. It identifies training resources among the agencies that developed the Plan. The Housing Plan was developed with stakeholder involvement and recognizes the important role of Medicaid, as well as the Commonwealth's housing agencies.

The Commonwealth's interagency objective to apply for HUD's 811 program funding is a positive sign. The Commonwealth will receive extra points (due to the Agreement) in the competition with other states for these funds. The 811 program requires an ongoing collaborative effort and offers a helpful potential resource to increase rental assistance options for individuals with DD.

The Housing Plan does not yet include two elements that are required by the Agreement.

1. These are the "recommendations to provide access to these settings during each year of the Agreement." DBHDS reports that it will estimate the number of individuals who have access "to these settings" by September 2013.
2. Distributions from the $800,000 rental assistance fund did not begin within 365 days of the Agreement. A recommended action item in the Housing Plan is to explore using the established $800,000 rental assistance fund as part of "a pilot rental assistance project to identify and assess the most effective way to provide affordable, accessible, and high quality rentals for individuals with developmental disabilities."

It is the Reviewer's opinion that the Housing Plan lacks elements that will be important to effective implementation: These missing elements include:

- an agreed upon implementation action plan. The actions items in the Plan are referred to as "recommended actions".

- identified resources to complete individual action items. Each item currently lists "existing resources." It would be helpful for the resources to be defined and quantified.

- interim and measurable milestones and dates for most action items. This is indicated by the lack of end dates for approximately half of all action items.

- targets and measurable outcomes that represent a meaningful increase. As explained below, two of the indicators of success can be achieved without a significant increase in access to independent housing.

The Housing Plan was developed pursuant to a "cost neutral" charge, "using existing resources or savings generated through implementation of the Plan." It is not clear to the Reviewer whether the "housing" savings related to downsizing and ending residential operations of Training Centers will be included in the calculation for a cost neutral approach.

The two "indicators of success" benchmarks listed below may be achievable without achieving a significant increase in the number of people who access independent living.

1. "A five percent increase each year in the number of individuals who are new to the waiver requesting in-home rather than congregate services."

2. "A ten percent increase each year in the use of Medicaid for independent living, as measured by the increase in the number of individuals receiving Medicaid ID or DD Waiver services."

The challenge to understanding the potential impact of these two "indicators of success" is that there are no baseline numbers available. Most stakeholders believe that a very small number of individuals with ID or DD Waiver services live in independent housing because there are so few options available. The Plan explains well why there are so few. The problem with both of these goals is that a five or ten percent increase in a small number remains a small number. For example, if twenty (5.0%) of the 400 individuals who received new FY 2013 ID Waiver services in independent housing in FY 2013, then a 5% increase would result in an increase of one person (20 X 1.05=21) in FY 2014. There are eight years remaining in the term of the Agreement, with a successful 5% increase annually by FY 2021 only twenty-nine out 400 individuals would receive this option. The ten percent increase over the same eight-year period will result in *less* of an increase to the percentage of individuals living independently. That result occurs because the number of individuals with waivers will increase.

There are two other problems with the goal to increase the number of individuals *requesting in-home* services. The first problem is that an increase in "requests" that are not fulfilled does not indicate that a desired outcome has been achieved. The second is that DBHDS reports that seventy-five percent of individuals with ID Waivers in FY 2013 chose to receive "in-home" services. The second problem is that an increase in the number of individuals who receive in-home services actually indicates other factors. It primarily indicates that a large percentage of children received ID Waivers. Living at home is the option of choice for children and there are few alternatives. Based on feedback to the Reviewer from older families living with an adult child who has received an ID waiver, the 'choice' to receive in-home services frequently indicates either a lack of desirable and available alternative or their inability to figure out what to do. An increase in requests for in-home service will likely be a misleading indicator.

Recommendation
Complete the plan to use and begin to distribute the $800,000 rental assistance, and report to the Reviewer on its distribution by October 20, 2013.

Refer to the Section VIII on page 62 and 63 for the additional related recommendations.

N. Family-to-Family and Peer Programs

"The Commonwealth shall …coordinate with the specific type of community providers identified in the discharge plan…to provide individuals, their families…with opportunities to speak with…and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice.

…develop family-to-family and peer programs to facilitate these opportunities (Section IV.9.b.)."

The Commonwealth has created a Family Resource Consultant (FRC) who has developed a Family Mentor Network. This program is intended to facilitate family members of Training Center residents to receive coaching on and support with the process of making the transition to the community. The coaching and support will be provided by volunteer family members who have successfully made the transition or from people familiar with the ID/DD service system. The program is not currently available for families of individuals on the waitlists.

DBHDS reports that a manual for training and providing resources to mentors, based on an existing model, has been completed. A template of information has also been developed and, once it is approved, will be distributed to families for use at the initial Pre-Move Meeting. A referral to the Family Resource Coordinator will be made as recommended by the individual's Personal Support Team (PST) or the family may self refer.

As of March 31, 2013, the Family Mentor Network has been developed and trained a total of twelve mentors at three of the Training Centers. Five families have accepted family mentor services. Two families who have been referred to the Family Mentor Network have refused and one family has terminated mentor services. At the Southside Virginia Training Center (SVTC), the Training Center slated to close first, two mentors have been trained and no families have chosen to receive coaching on and support with the process of making the transition to the community. DBHDS reports that families of individuals in the process of transitioning from the training centers are now being offered services by the Family Mentor Network.

The Commonwealth, in collaboration with a statewide advocacy organization, has prepared and submitted a grant application to receive funding to establish a peer-to-peer program.

The Reviewer's opinion continues to be that families and peers who have successfully made the transition from a training center to the community can provide helpful information and insights to those who have not. The Family Mentor Network program is in its first few months of operations. It is important for individuals who reside at the training centers and their families to have this resource available to them, especially at the SVTC where the most Authorized Representatives have expressed interest in considering a move to the community for their loved one. This program will also be helpful to families of individuals who are currently on the wait lists, especially when individuals receive new waiver slots. This program is one of several that the Parties envisioned to help resolve barriers to moving to integrated settings in the community. More progress is needed to develop a robust program that is able to reach more families and individuals during the next review period.

O. Quality and Risk Management System

"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 harm, stable community living, and increased integration, independence, and self-determination in all life domains…and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system (Section V)."

Several provisions of the Agreement were due to be implemented during the second review period. The Reviewer monitored the workflow of the project teams that are planning and implementing new programs and systems to meet the Agreement's Quality and Risk Management requirements. He held in-depth meetings with the DBHDS Directors of Quality Improvement and Licensure. DBHDS organized a drill-down session with the project team leaders to present the status of their work and to allow the Reviewer and DOJ to ask probing and follow-up questions.

Below is a brief update on each Quality and Risk Management provision that was due as of March 6, 2013. The DBHDS project teams are also developing and implementing plans related to provisions of the Agreement that do not have specific due dates during this period. The Reviewer has monitored that work as well. During the third review period the Reviewer plans to retain an expert consultant to evaluate the Commonwealth's work and progress implementing the Quality and Risk Management System.

"The Commonwealth shall…within 12 months of this Agreement…have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps (Section V.C.3.)."

DBHDS has established a reporting and investigation process. Information about serious injuries and critical incidents are reported and promptly shared with the Reviewer, as are the completed investigations and, if applicable, Corrective Action Plans.

"The Commonwealth shall develop measures that the CSBs and other community provider are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program…The Measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from the Regional Quality Councils (Section V.E.2.)."

Providers began using the Computerized Human Rights Information System (CHRIS) in March 2013. The first of three phases began on March 27, 2013. Phase 2 and 3 are in development. CHRIS provides critical incident data. DBHDS is also collecting data from case managers on the number, type and frequency of visits to individuals. DBHDS Quality

Improvement Committee was established in March 2013. DBHDS is currently recruiting and hiring staff for the Regional Quality Councils.

"…the individual's case manager shall meet with the individual face-to-face at least every thirty days…for individuals who" (meet the criteria listed in the 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 (Sections V.F.1-6.)."

Case Management guidelines were issued to CSB ID case managers and to DD case managers in December 2012. The guidelines included standards for implementing enhanced case management consistent with the criteria specified in the Agreement for individuals receiving waiver services in the target population who meet specific criteria.

Although there are new requirements for gathering and recording information, the biggest challenge has been complying with the requirement for a face-to-face visit every thirty days. Some of the CSBs decided that it was easier to provide enhanced case management for all individuals on the ID waiver. Others decided to meet the standard for individuals who meet one or more of the criteria in the Agreement. DBHDS hired a Case Manager Coordinator in February 2013 to assist with implementation of the criteria and for quality assurance.

The Assistant Commissioner for Quality Improvement and the Case Management Coordinator are evaluating implementation statewide to determine problems that need to be addressed. In March and April 2013 they visited twenty-one CSBs to obtain feedback about the impact of the new guidelines. Visits to the other regions are planned for May 2013. DBHDS reported to the Reviewer what they have learned during these visits. CSBs are taking different approaches to meet the requirements. These approaches include hiring new staff, reassigning staff to case management, and reducing caseloads. Some case managers requested that a guide be developed to help them when conducting visits. Some case managers have had their case loads rearranged so they cover a smaller geographic area to reduce travel time.

The CSBs have made changes in their electronic systems to collect information and to accommodate the new requirements. The data were due to DBHDS by the end of April. Reports will be evaluated by DBHDS in late May to determine progress in meeting new service and reporting requirements.

The Reviewer convened three focus groups to hear directly from case managers and their supervisors about this effort. Implementing the enhanced case management standards has been challenging and stressful for case managers. Several changes are occurring simultaneously. These include:

- additional face-to-face visits,
- more visits happening in the home of the individual,
- a change in role from a supporter of families to one with increased monitoring,
- implementing new electronic systems, and
- increased record-keeping and new standards for case management notes.

Case managers report that it has been very difficult to meet the new standards within a reasonable workweek. There is increased work required for each person on their case loads. They report that the changes have caused a very high level of stress and some unintended and undesirable consequences. Some families object to the increased number of visits and monitoring as overly intrusive. Case managers report that it is difficult to spend quality time with the individuals on their case loads who need extra support because they must visit each individual each month including those whose circumstances are stable and who have lived for many years with families or service providers with histories of providing quality services. Others described the dilemma of having to complete paper work for visits to individuals who are in good situations, rather than on providing needed supports to those who are not.

CSBs officials informed the Reviewer that the number of case manager positions has been increased to reduce caseloads to between twenty-five and thirty. This reduction will allow more time to fulfill the increased requirements. During a March focus group with ID and DD, case managers reported to the Reviewer having caseloads of between thirty and forty individuals. The case loads were reported to remain high, in part, due to vacancies that needed to be filled.

Based on input from case managers in three focus group meetings with the Reviewer, case managers hope that:

- there will be flexibility with the five-day grace period for face-to-face visits,
- a clear and reasonable time limit will be set for how long a family can choose to keep the same case manager when their family moves to another part of the state, and
- caseload standards will be established so there is sufficient time to fulfill new responsibilities and to comply with the enhanced case management guidelines.

In the experience of the Reviewer the case manager's role is different from all other services. It is the core service, the hub of the system, for individuals and their families. Case managers help them to understand how the system works and to navigate the system. Case managers assist them to access the services needed to achieve successful outcomes. Then case managers monitor the performance of the services provided, ensure periodic reassessments, and reconvene the individual's support team to modify the support plan, as needed.

DBHDS plans to continue the evaluation it began in April to learn how successful CSBs and case managers have been meeting new service and reporting requirements. Additional visits to three regions are planned. Reports from data collected will be available in May.

The information gathered will be compiled and analyzed to determine where problems exist.

It is the Reviewer's opinion that the DBHDS evaluation is important in making future improvements. Hearing from the CSBs and the ID and DD case managers directly and reviewing related data will help identify the core challenges of complying with the new requirements. As problems are identified, strategies and an action plan may be needed to improve the ability of case managers to provide reliable services consistent with the terms of the Agreement.

"The Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals under this Agreement, including (six criteria are listed in Section V.G.2.a.-f.)."

The Office of Licensure implemented protocols for conducting more frequent licensure visits as of March 6, 2013. Draft guidelines have been developed and shared with the Reviewer. The guidelines are under review and will be published.

VI. ADDITIONAL INFORMATION AND CONSIDERATIONS

The DBHDS Office of Licensure fills a vital role in the Commonwealth's service system. Its job is to monitor and oversee the adequacy and quality of service providers. Service systems that provide quality services have effective mechanisms to monitor performance. They also have effective tools to recognize providers who consistently exceed regulatory standards and tools to hold underperforming providers accountable.

It is important to note that the Reviewer and his expert consultants have met and observed many excellent service providers and dedicated qualified staff. These organizations and individuals have often devoted their lives to the well-being and growth of individuals with ID/DD. They have found creative ways to enhance skills and to ensure meaningful participation in the community.

During the past year, representatives of all stakeholder groups have expressed concerns, however, about "marginal" service providers. These concerns have been heard from individuals served, family members, case managers, and service providers ("when their mistakes are reported in newspapers, they make us all look bad"). Marginal service providers are those who lack the core competencies and internal systems to consistently deliver services that meet standards. Stakeholders and officials have shared that, historically, the requirements to become a licensed provider have been relatively easy to meet. Consultants have also been available to fill out the required paperwork for applicants who lack knowledge and experience.

When the Reviewer has shared this perception in various stakeholder group meetings, most nod in agreement. Rarely is the point argued. The only argument has been, "many years without rate increases to offset the impact of inflation have eroded the capacity of service providers." That concern is valid. One major impact of long-term flat funding is on human service workers. When wage levels remain flat for many years, qualified and experienced employees look for alternative employment that allows them to more effectively support their families. Although there are many factors, stagnant wage levels contribute to high staff turnover and reduced ability to recruit qualified staff. This is especially true in areas where there is a high cost of living, where there is low unemployment, and in rural areas where workers must drive long distances with high transportation costs to earn low wages.

Based on the Reviewer's experiences, flat funding does erode the capacity of programs and the service system to provide quality supports over time. There are other significant factors, however, that that have been reported to the Reviewer by stakeholders and officials that contribute to the presence of marginal providers. Two factors are:

1. it has been too easy to become a service provider; and
2. the DBHDS Office of Licensure does not have effective tools to hold accountable the providers who are not able to consistently meet program standards.

For providers who do not meet regulatory standards, the Office of Licensure has authority to deliver three types of consequences. They are:

1. to require Corrective Action Plans,
2. to reduce the provider's licensure status, or
3. to revoke a provider's license.

In addition, under circumstances identified and pursuant to the Virginia code, the Commissioner of DBHDS is authorized to revoke, suspend, or deny a license for any violation of the Licensing Regulations. The Commissioner may also issue an order of summary suspension of a residential facility or issue a special order for a violation of any provision of the Licensing Regulations or the Human Rights Regulations. The special order may impose sanctions.

It has also been very rare for the Office of Licensure to either reduce the status of a provider's license to provisional status or to revoke a license. The Office of Licensure has the authority to fine providers, for example, for not fulfilling responsibilities agreed to in a Corrective Action Plan. The Office of Licensure reports that such authority has been used, but not within the ID service system. The Commonwealth reported that there has not been either a summary suspension or a special order issued during the second review period.

The Office of Licensure reports that it uses communication to hold providers accountable. The Office of Licensure posts its completed investigations on the DBHDS website which are then available to the public. Most importantly, they are available to families of loved ones who are currently served by the provider or who are considering using the provider. When

investigations raise serious concerns, the Office of Licensure reports that it notifies case managers of the issues raised and encourages them to share this information with the families and guardians of the individuals served. DBHDS reports that such communication with families leads to many transferring their loved ones to another service provider. As a result, the provider frequently loses revenue when guardians decide to move their loved ones to other programs. Making information about provider investigations public is positive, as is sharing such information with families. However, such communication should not be used because other accountability mechanisms are not workable. Licensure tools that are used effectively can prevent substandard performance and keep individuals and families from being placed in difficult positions.

The Office of Licensure has tools to recognize providers that consistently exceed performance standards. Among these tools is the authority to increase the status of a provider's license, and as a result to reduce program monitoring visits.

Providers are recognized for demonstrating ongoing compliance with Licensing Regulations when they are granted a two-year, or the highest level, a three-year (triennial) license. A full multiple-year license is determined and granted at the sole discretion of the Commissioner. Providers welcome such recognition because it enhances their reputation for providing reliable and dependable services. It may also provide increased confidence for families when they are choosing a provider to support their loved ones. As a result of demonstrating a record of providing ongoing quality services and being awarded a full multiple-year license, the level of oversight and monitoring can be and is reduced.

DBHDS reports that there are 586 providers of services for individuals with ID in Virginia, and that since the Agreement was signed:

- four providers of services to individuals with ID have had their group home licenses reduced to provisional status (one out of every 146 providers).
- no licenses have been revoked, and
- no fines have been issued.

It is the Reviewer's opinion that the continued presence of marginal providers is not because of the number of Licensing Specialists, the number of unannounced visits, the promptness of responses to concerns, or the quality of investigations. The number of licensing specialists has more than doubled in the past four years, and has increased by 50% since the Agreement began. The number of supervisors and back room staff supporters has also increased. As a result, the number of on-site and unannounced visits to programs has increased significantly. More frequent and intense monitoring has occurred. DBHDS reports that Corrective Action Plans are also being issued more frequently and implementation is being monitored more closely. The Reviewer has found that when there has been a critical incident, an unannounced visit typically happens within twenty-four to forty-eight hours. The subsequent investigations have generally been completed in a thorough, thoughtful, and timely manner.

Based on information reported, it is the opinion of the Reviewer that the continued presence of marginal providers is because regulations historically set a low standard to qualify, and because the Office of Licensure rarely uses three accountability consequences for substandard performance.

If the Office of Licensure recommends a consequence for substandard performance that interferes with a provider's ability to do business, then the Virginia Administrative Process Act must be followed. Doing so involves an arduous, lengthy and time-consuming process. During that process, the Office of Licensure must base its evidence of substandard performance on the failure of the provider to comply with regulations or to effectively implement Corrective Action Plans. However, 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.

DBHDS reports that there are approximately one hundred current applicants to become licensed providers in the Commonwealth. To better understand the existing process, the Reviewer interviewed a national service provider who has recently completed the process to become a licensed provider in Virginia. The process involved many steps and took nearly a year to complete. The applicant, an experienced national provider, found that the process helped them refine some written policies. This is evidence that DBHDS has made the application review and screening process more stringent and demanding. This will help ensure that new providers in Virginia are fully qualified. However, the foundation of this more stringent process continues to be the existing regulations. They are not as helpful as they should be in setting well-defined and clear standards.

VII. CONCLUSION:

During the second review period many action plans were developed and programs implemented. Many new programs and systems are being designed, planned, and implemented simultaneously. The Agreement was designed to accomplish a great deal during the first two years.

The Reviewer prioritized monitoring progress toward overarching goals of the Agreement, progress of initiatives that were planned or implemented during the first review period, and the provisions that had due dates during this period.

The Commonwealth has made significant progress. This has been challenging, however, and there have been significant delays and "growing pains" in some areas.

The Reviewer looks forward to the next phase of the Agreement during which implementation of several new programs and systems will occur and the status of others will be evaluated and refined. These efforts will take another important step toward compliance with and achieving the goals of the Agreement.

VIII. RECOMMENDATIONS

Based on the findings in this report, the Reviewer recommends that the Commonwealth consider the following:

Resolving Barriers

1. In each region, the Commonwealth should determine the service gaps between the services that are currently available and the estimate of the current and future needs of the target population. The gaps identified should include congregate residential and supported apartment programs for fewer than five individuals, integrated day options including individual and group supported apartments, clinical services including behavioral support and skilled nursing, and agency directed in-home services. For each region where gaps are identified, the Commonwealth should develop a strategy and a action plan to expand the array of needed programs.

Crisis Services and Prevention

2. The training of CSB Emergency Services staff to familiarize them with the START program and to train them on clinical assessment of individuals with ID should be scheduled as soon as possible in each region. Attendance should be required of all CSB ES staff within a year.

3. All regions' CIT training should have standardized information about START and working with individuals with ID/DD in crisis. That information should include content about working with individuals with Autism Spectrum Disorders.

4. DBHDS's outreach to law enforcement should include discussion of how best to link people with ID/DD with START before incarceration occurs. Arrangements should be made for START to provide consultation for individuals, who have a mental health diagnosis, to better assure appropriate medical and clinical care while in jail and to assist with discharge planning.

5. All DD case managers should receive basic training to ensure awareness of START services and how to make referrals.

6. DBHD should consider forming a workgroup to determine when training should be required of residential and day providers. Training may be needed to assure that providers can be effective partners in the coordination of the follow-up services the individual will need to maintain their home and other services.

7. DBHDS and DMAS should review and determine if bridge funding can be provided to make sure that a person's residence is available to them when they have been stabilized out of the home and are ready for discharge.

8. DBHDS should review and determine whether written policies and procedures are needed to establish clear protocols to guide the implementation of START services given the decentralized nature of the services system. The policies should include:

    - the expectations of START teams to collaborate and consult in planning for eligible people in the State Hospitals and those moving from the Training Centers,
    - guidelines for medical screenings prior to admission to the START crisis stabilization units,
    - the need to quickly assign case mangers to individuals eligible for ID or DD waiver services when they experience a crisis and are referred to START, and
    - the relationship between the ES Teams and START Services regarding the training expectations for ES personnel.

<u>Access and Availability of Services</u>

9. New guidelines for ID and DD waiver and other services should be broadly disseminated to agencies. These should include schools, pediatric and family medical practices, and other agencies that support children and youth.

10. DBHDS and DMAS should solicit input on needed modifications to the guidelines from users (eg. individuals, families and ID and DD case managers), especially those who used the guidelines during the prior year.

<u>Community Living Options</u>

11. To effectively implement the Housing Plan, the Commonwealth should develop the capacity and determine:

    - the baseline data of the number of individuals with the ID waiver who lived in Independent housing during FY 2013.

    - the total number of individuals, and the number of new individuals, on the ID and DD Waivers, who access rental subsidies annually

    - the number of individuals who live in their families' or relatives' homes and receive "in-home" residential services should be tracked <u>separately</u> from those who live in their own home or leased apartment.

<u>Quality and Risk Management</u>

12. The Commonwealth should consider developing more efficient, timely, and effective mechanisms to recognize providers for exceeding performance standards, as well as, to hold providers accountable for failure to meet standards or for not effectively implementing Corrective Action Plans.

Respectfully Submitted;

Donald J. Fletcher
Independent Reviewer
June 6, 2013

IX. APPENDICES

A. INDIVIDUAL REVIEWS - SELECTED TABLES

B. CRISIS SERVICES REQUIREMENTS

C. EMPLOYMENT SERVICES REQUIREMENTS

APPENDIX A.

INDIVIDUAL REVIEWS - SELECTED TABLES

Fiscal Year 2013

APPENDIX A.

INDIVIDUAL REVIEWS - SELECTED TABLES

Fiscal Year 2013

Demographic information

Sex
Male 22 (75.9%)
Female 7 (24.1%)

Regions
2 – 15 (51.7%)
3– 14 (48.3%

Age ranges	n	%
less than 21 years old	13	44.8%
21 to 30	10	34.5%
31 to 40	1	3.4%
41 to 50	2	6.9%
51 to 60	2	6.9%
61 to 70	1	3.4%

Levels of Mobility	n	%
Ambulatory without support	13	44.8%
Ambulatory with support	6	20.7%
Uses wheelchair	8	27.6%
Total assistance	1	3.4%
Confined to bed	1	3.4%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	9	31.0%
Limited spoken language, needs some staff support	3	10.3%
Communication device	2	6.9%
Gestures	5	17.2%
Vocalizations	3	10.3%
Facial Expressions	7	24.1%
Other	0	0.0%

TABLE A				
Discharge Planning Items				
Item	**n**	**Y**	**N**	**CND**
Did discharge occur within six weeks after completion of trial visits?	3	100.0%	0.0%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	3	100.0%	0.0%	0.0%
Did the individual and, if applicable, his/her Authorized Representative participate in discharge planning?	3	100.0%	0.0%	0.0%
Was the discharge plan updated within 30 days prior to the individual's transition?	3	100.0%	0.0%	0.0%
Was it documented that the individual, and, if applicable, his/her Authorized Representative, were provided with information regarding community options?	3	100.0%	0.0%	0.0%
Did person-centered planning occur?	3	100.0%	0.0%	0.0%
Were essential supports described in the discharge plan?	3	100.0%	0.0%	0.0%
Did discharge occur within six weeks after completion of trial visits?	3	100.0%	0.0%	0.0%
Did the Post-Move Monitor, Licensing Specialist, and Human Rights Officer conduct post-move monitoring visits as required?	3	100.0%	0.0%	0.0%
Were all essential supports in place before the individual moved?	3	100.0%	0.0%	0.0%
Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists?	3	100.0%	0.0%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	3	100.0%	0.0%	0.0%
Have any identified concerns been resolved?	3	66.7%	33.3%	0.0%

TABLE B				
Individual Support Plan Items – adults				
Item	**n**	**Y**	**N**	**CND**
Has the individual been provided with opportunities for an informed choice regarding supported employment, including goals and services that will lead to supported employment?	14	14.3%	85.7%	0.0%
Have any barriers to employment been identified?	13	7.7%	92.3%	0.0%
Was placement, with supports, in affordable housing, including rental or housing assistance, offered?	12	0.0%	100.0%	0.0%

TABLE C				
Individual Support Plan Items				
Item	**n**	**Y**	**N**	**CND**
If this individual is not competent to make medical decisions, is there a guardian or Authorized Representative?	26	96.2%	3.8%	0.0%
Is there evidence of person-centered (i.e individualized) planning?	29	93.1%	6.9%	0.0%
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her individual support plan?	29	89.7%	10.3%	0.0%
Are essential supports listed?	29	86.2%	13.8%	0.0%
Is the individual's support plan current?	29	89.7%	10.3%	0.0%
Does the individual's support plan address barriers that may limit the achievement of the individual's desired outcomes?	29	72.4%	27.6%	0.0%
Has the individual's support plan been modified as necessary in response to a major event for the person, if one has occurred?	12	50.0%	50.0%	0.0%

TABLE D				
Individual Support Plan Items – Employment/Integrated Day - adults				
Item	**n**	**Y**	**N**	**CND**
If applicable, were employment goals and supports developed and discussed?	15	13.3%	86.7%	0.0%
If yes, were they included?	2	50.0%	50.0%	0.0%
If not discussed or not included, were integrated day opportunities offered?	14	28.6%	64.3%	7.1%
Does typical day include regular integrated activities?	13	23.0%	69.2%	7.7%

TABLE E				
Individual Support Plan – Adaptive Environment/Equipment - Items				
Item	**n**	**Y**	**N**	**CND**
Does the individual require an adapted environment or adaptive equipment?	29	86.2%	13.8%	0.0%
If yes, has all the adaptation been provided?	14	50.0%	50.0%	0.0%
If yes, is the equipment available?	25	48.0%	52.0%	0.0%
Is the equipment in good repair and functioning appropriately?	22	95.5%	4.5%	0.0%
Has the equipment been in need of repair more than 30 days?	1	100%	0.0%	0.0%
Has anyone acted upon the need for repair?	1	0.0%	100.0%	0.0%
Is staff knowledgeable and able to assist the individual to use the equipment?	21	100.0%	0.0%	0.0%
Is staff assisting the individual to use the equipment as prescribed?	21	100.0%	0.0%	0.0%

TABLE F				
Individual Support Plan Items				
Item	**n**	**Y**	**N**	**CND**
Is the individual receiving supports identified in his/her individual support plan?				
Residential	29	100.0%	0.0%	0.0%
Medical	28	100.0%	0.0%	0.0%
Dental	28	89.3%	10.7%	0.0%
Health	28	96.4%	3.6%	0.0%
Day/Employment	28	81.5%	18.5%	0.0%
Recreation	27	89.3%	10.7%	0.0%
Mental Health	15	66.7%	33.3%	0.0%
Transportation	28	96.4%	3.6%	0.0%
Communication/assistive technology	13	69.2%	30.8%	0.0%

TABLE G				
Individual Support Plan Items				
Item	**n**	**Y**	**N**	**CND**
Does the individual's support plan reflect specific staffing levels for support of this individual?	29	51.7%	48.3%	0.0%
If yes, were those staffing levels in place during the review?	15	93.3%	0.0%	6.7%
Is the staff working with the individual as detailed (consider the individual's Behavior Support Plan or ISP regarding the level of support needed)?	26	96.2%	3.8%	0.0%
Is there evidence the staff has been trained on the desired outcome and support activities of the individual's support plan?	29	93.1%	3.4%	3.4%
Is residential staff able to describe the individual's likes and dislikes?	28	96.4%	0.0%	3.6%
Is residential staff able to describe the individual's talents/contributions, preferences and weaknesses?	28	96.4%	0.0%	3.6%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	28	96.4%	0.0%	3.6%

TABLE H				
Environmental - Hygiene Items				
Item	**n**	**Y**	**N**	**CND**
Is the individual's residence clean?	26	92.3%	0.0%	7.7%
Does the individual appear well kept?	28	93.9%	3.6%	3.6%

TABLE I				
Healthcare Items				
Item	**n**	**Y**	**N**	**CND**
If ordered by a physician, was there a current physical therapy assessment?	13	76.9%	23.1%	0.0%
If ordered by a physician, was there a current occupational therapy assessment?	14	85.7%	14.3%	0.0%
If ordered by a physician, was there a current psychological assessment?	11	81.8%	18.2%	0.0%
If ordered by a physician, was there a current speech and language assessment?	11	90.9%	9.1%	0.0%
If ordered by a physician, was there a current nutritional assessment?	9	66.7%	33.3%	0.0%
Were any other relevant medical/clinical evaluations or assessments recommended?	29	44.8%	48.3%	6.9%
Are there needed assessments that were not recommended?	29	34.5%	58.6%	6.9%

TABLE J				
Healthcare Items				
Item	**n**	**Y**	**N**	**CND**
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?				
a. OT	12	83.3%	16.7%	0.0%
b. PT	10	90.0%	10.0%	0.0%
c. Speech/Language	11	100.0%	0.0%	0.0%
d. Psychology	8	75.0%	25.0%	0.0%
e. Nutrition	11	81.8%	18.2%	0.0%
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?	17	82.4%	17.6%	0.0%

TABLE K				
Healthcare Items				
Item	**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?	29	100.0%	0.0%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	29	82.8%	17.2%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	24	95.8%	0.0%	4.2%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	29	93.1%	0.0%	6.9%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	23	91.3%	4.3%	4.3%

TABLE L				
Healthcare Items				
Item	**n**	**Y**	**N**	**CND**
Does the provider monitor fluid intake, if applicable per the physician's orders?	12	100.0%	0.0%	0.0%
Does the provider monitor food intake, if applicable per the physician's orders?	22	95.5%	4.5%	0.0%
Does the provider monitor tube feedings, if applicable per the physician's orders?	5	100.0%	0.0%	0.0%
Does the provider monitor seizures, if applicable per the physician's orders?	17	100.0%	0.0%	0.0%
Does the provider monitor weight fluctuations, if applicable per the physician's orders?	15	86.7%	13.3%	0.0%
Does the provider monitor positioning protocols, if applicable per the physician's orders?	4	100.0%	0.0%	0.0%
Does the provider monitor bowel movements, if applicable per the physician's?	22	100.0%	0.0%	0.0%
Is there evidence of a nourishing and healthy diet?	26	96.2%	3.8%	0.0%

APPENDIX B

CRISIS SERVICES REQUIREMENTS

The LEWIN GROUP®
Center for Aging and Disability Policy

Report to the Independent Reviewer

UNITED STATES vs. COMMONWEALTH OF VIRGINIA

CRISIS SERVICE REQUIREMENTS

REVIEW PERIOD: Through April 6, 2013

Prepared by Kathryn du Pree, MPS

Vice President
Center for Aging and Disability Policy
The Lewin Group

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I. Introduction and Methodology

Donald Fletcher, Independent Reviewer for the US v Commonwealth of Virginia's Settlement Agreement, requested a review of the crisis system requirements of the Settlement Agreement. This is the second review that will be completed of the Crisis Services requirements of the Settlement Agreement. The first review was conducted in June 2012 and was primarily a review of the planning DBHDS had engaged in to develop comprehensive crisis prevention and intervention services. To accomplish this second review I proposed measures and evaluation methods to determine the state's compliance in this area and to what extent the system has been developed through this reporting period. DBHDS has undertaken the responsibility of creating a comprehensive system that requires policy and procedural development, resource allocation, program design and implementation, effective community linkages and training. It should be noted that the system will continue to evolve and be further refined during the course of the Settlement Agreement. There will be a need to continue to monitor progress and evaluate the crisis system's effectiveness on a semi-annual basis.

Currently Virginia is in the first year of implementation of its crisis response system for individuals with intellectual disabilities (ID) and developmental disabilities (DD). This report focuses on those aspects of crisis system development that were to be in place by April 6, 2013 and the status of planning for the requirements that are to be met by June 30, 2013. It is a review of:

- Statewide Crisis System: Sections 6.a.i. ii. & iii;
- Crisis Point of Entry: Section 6.b.i.A;
- Mobile Crisis Teams: Section 6.b.ii. and
- Crisis Stabilization Programs: Section 6.b.iii.

A review process was developed that described the measurements and methods that would be used to determine the state's compliance with each requirement. The review process consisted of document review and interviews with key DBHDS and START personnel. The documents reviewed include: budget updates, training documentation, staffing updates, the Virginia START Quarterly updates (10/12-12/12 and 1/13-3/13), and the DOJ Project Crisis Intervention and Prevention Plan Report 1/25/13. The measures and methodology are contained in the "The Lewin Group's Proposal to Evaluate the Implementation of the Virginia Settlement Agreement Requirements for Employment Services and Crisis Services through 4/6/13": Attachment A. This approach was discussed with the Administration of DBHDS before the review was initiated.

Interviews were conducted with:

Heidi Dix, Assistant Commissioner for Developmental Services, DBHDS

Bob Villa, State START Liaison, Office of Developmental Services, DBHDS

Mary Bagor, Crisis Intervention Community Support Specialist, DBHDS

Joan Beasley, Director, Center for START Services

This review was conducted within a 3 week timeframe and could not have been accomplished without the assistance of Bob Villa. All necessary updates and documents were provided in a timely fashion and he was very flexible in scheduling time to discuss the

progress of the START Services. Mr. Villa was always available to answer questions or to make pertinent documents available. He is very knowledgeable of the START program and the state's approach to implementing a well- coordinated crisis response system that will bring a consistent and proven approach to crisis prevention, intervention and stabilization to the service delivery system in Virginia for persons with intellectual and developmental disabilities. I also want to thank Dr. Beasley. Her vast experience developing START in other states provides a realistic perspective as to the time it takes to develop a truly comprehensive crisis support system and what are the critical elements for it to be successful and sustainable.

II. Virginia's Compliance with the Components of the Settlement Agreement

1. Section 6. a. The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities

i. Provide timely and accessible supports to individuals with intellectual and developmental disabilities

ii. Provide services focused on crisis prevention and proactive planning to avoid potential crisis

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 setting whenever practicable

The Development of the Crisis Services System

The Virginia DBHDS began planning for the development of a Crisis Intervention and Prevention statewide system in the summer of 2011 before the Settlement Agreement was completed or signed. To review the Commonwealth's compliance with this section at this point in time I focused on the adequacy of the budgetary allocation, the ability of people with development disabilities to utilize the crisis service offered though START and whether funding and access for children with intellectual and developmental disabilities (ID and DD) has been addressed since the first review completed June 30, 2013. The status of the mobile crisis teams' responses to persons in crisis will be addressed in subsequent sections.

START promotes serving people with co-occurring conditions in the least restrictive setting, providing 24/7 response to people experiencing a crisis with immediate telephonic access and in-person assessment within 2 hours of the call to the mobile crisis team, and clinical treatment, assessment and stabilization services both planned and emergency through short-term respite. It is a model that does not try to supplant what exists within a service delivery system but rather builds upon the existing crisis response system and strengthens it. The success of the model is based upon linkages and agreements with existing providers cross system crisis prevention and intervention planning (CSCP), support and technical assistance to all of its community partners including individuals and

their families and comprehensive systemic and clinical training with follow-up consultation.

The Sufficiency and Sustainability of Funding for START Services

A measure that is important to the Commonwealth's ability to meet the crisis system expectations of the Settlement Agreement is the sufficiency and sustainability of funding for this new crisis service system. The majority of the funding is being provided by the Commonwealth through an appropriation to the DBHDS. Each regional START Program is expected to seek Medicaid reimbursement as appropriate for services delivered that are covered by this funding source. The original appropriation of approximately $10 million for FY13 was reduced to $7.8 million which was confirmed in Commissioner Stewart's 6/21/12 memo to Executive Directors and ID Directors of the CSBs, and to the START Regional Directors. However regions were also allowed to carryover unspent FY12 funding for the START project. Total funding includes carryover funds unspent in FY12 ($2.16m), the FY13 appropriation ($7.8m) and anticipated revenue from Medicaid ($2.56m). **Table 1** summarizes the original request for START funding from each region and the final allocations.

Table 1: START Services Funding Summary

Region	Proposed Budget	Actual Budget FY 13
I	$1.85 M	$2.31 M
II	$2.79 M	$2.79 M
III	$2.90 M	$2.60 M
IV	$2.28 M	$2.24 M
V	$2.20 M	$2.53 M

Assistant Commissioner Dix had reported last June that the department was committed to requesting the full annualized amount of funding needed for full operation of the START Programs for FY14. All regions were projecting adding an additional respite home and many propose to add to the mobile crisis teams and in-home support services depending on the level of need in the region. These proposed expansions may be necessary to meet the Settlement Agreement requirements for timely response to individuals with ID/DD and challenging behaviors experiencing a crisis. Utilization data will need to be regularly analyzed to determine the volume of crisis referrals to START and the regional programs' capacity to respond in a timely fashion to provide assessment and appropriate community supports. This will assist in determining the level of expansion that will be required in subsequent years.

Bob Villa reports that the DBHDS received an annualized allocation of $11.6M in its FY14 appropriation for START Services. I was unable to determine how much was actually requested by DBHDS. The department has not determined how the funds will be allocated among the regions as of the date of this report. However, each region will receive at least $2 million for FY14. The remaining $1.6 million will be distributed based upon need,

current utilization patterns and the level of operation of the crisis stabilization units in each region. The regions' ability to have full funding to address their costs is dependent upon Medicaid billing since the total budgetary need is $12.5 million. Regions will be able to bill under the HCBS waivers for crisis stabilization and supervision and under the Mental Health State Plan Option (SPO) for crisis stabilization and intervention for persons served who are not on one of the waivers. Billing has just started for the crisis intervention services and Region III is the first region to seek Medicaid reimbursement.
DBHDS will need to monitor the billing and reimbursement levels to insure that adequate funding is in place. It is also projected that referrals and utilization of START will increase as there is greater knowledge about the service, staffing is consistently available and all crisis stabilization units are operational. Each year DBHDS will need to use utilization and waiting list information to make targeted budget requests to properly fund the regional START programs.

Serving Adults with Developmental Disabilities

The latest quarterly report of Joan Beasley, Ph.D. indicates that 21 people have been served who have normal or borderline intelligence. This is an increase from the previous quarter during which 7 individuals that did not have ID were referred. While this remains a small percentage of the overall number of individuals referred the increase is promising. Also of note is that during the quarter ending 3/31/13, 45 people with autism accessed START Services.
DBHDS has started to do outreach and education about START Services with case managers who coordinate supports for individuals with DD. These case managers work for private entities or are independent. They are not linked to the CSBs as are the case managers for individuals with ID. Bob Villa attended a DMAS conference and spoke to DD case managers. A WebEx is now available for these staff to access. He also presented to an ***arc*** conference regarding START services availability to individuals with DD. Bob Villa and the START Regional Directors have also met locally with DD Case Managers. The availability of this training for DD case managers is positive. I recommend that all DD case managers be required to attend or view the WebEx in order to insure they are aware of START services and how to make referrals.
Access to START is the same for both populations either through the CSB Emergency Services (ES) or by directly calling START. DBHDS has informed all CSBs that individuals with DD are eligible to use START Services when they experience a crisis. The person should be referred to START whether they are currently on the DD Waiver or not. START will work with them and try to connect them to services and resources in the community. However, while this was initially communicated to the CSBs by the DBHDS Commissioner in June, 2012, the CSB's responsibility to respond to crisis requests from individuals with DD is not part of the affiliation agreement or stipulated in the FY2013 and FY2014 Performance Contracts with CSBs. There has been no other written communication regarding this as reported by Bob Villa. I recommend that this be added to the affiliation agreements between START regional programs and each CSB or that a protocol be issued by DBHDS to the CSBs.

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Recently a decision has been made to provide active case management to a person with DD who is in crisis and served by START and not yet on the DD Waiver. While this is a positive step there are 800 individuals on the DD waiver waiting list. A case manager will have limited ability to refer the person for supports or resources if s/he does not have waiver funding and access to waiver services. The premise of START is that it is an interim intervention and prevention support service that will coordinate with case managers to create linkages to the appropriate ongoing supports once the person is stabilized. The DMAS should determine if individuals who have DD and have used START should be considered as a priority for waiver services especially in light of the current number of people on the waiting list for the DD waiver.

Serving Children with Intellectual and Developmental Disabilities

At the time of the first review of crisis services there was no decision made as to how crisis services would be made available to children with either ID or DD. Recently $1.25 million was approved as part of the FY14 budget to develop crisis prevention and intervention for children. It should be noted that this is only 11% of the current allocation for crisis services for adults. This funding has been made available to DBHDS to plan prevention and crisis intervention for children but will be operated by a different division within DBHDS that already operates a children's crisis program in Regions 1, 3 and 4. Only in Region 4 is the program operated under the same authority as START. The existing children's programs serve a broader population than ID and DD and may not be prepared to address the need of this target group without changes to the program structure and additional training. Currently Regions 2 and 5 do not offer any support services to children in crisis but DBHDS expects programs will be developed in these areas. DBHDS is considering whether the new allocation should only go to the 2 regions without existing supports for children.

Dr. Beasley has indicated that she is willing to assist regions to develop the START services for children and can provide assistance based on existing models available in other parts of the country. Since START appears to be an effective model for adults, there is developed training, assessment, in-home and out of home stabilization components as well as existing linkages and partnerships developing with CSBs and other community stakeholders I recommend that this be the first approach considered for children. It is an evidenced based practice and has been effectively used to support children in other states, albeit on a more limited basis than adults.

The DBHDS is considering at what age this intervention would start and are considering serving children 14-18 or 16-18. It will be important that the crisis stabilization units be distinct and separate from the one for adults in each region. If DBHDS uses this new allocation for this adolescent age group it will need to determine how crisis intervention will be provided to younger children to support them in their homes and communities.

There is no utilization data about children needing or accessing crisis services. Not all CSBs provide case management for children. DBHDS should decide how each region will serve children and adolescents either through expansion of existing programs or the creation of new ones. A written plan with timelines for addressing the needs of all children with ID or DD should be required of DBHDS within the next 3 months. The plan should include:

- The program model
- Projected costs and funding sources

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- Education of families
- Marketing with school systems
- Case management
- Coordination with the state agency responsible for children with DD
- The availability of ongoing supports and services for children who have experienced a crisis and are stabilized including access to waiver services

START Services and Staffing

Both Bob Villa and Joan Beasley have reported on the difficulty filling all positions and maintaining staff in these positions. A few core staff were terminated during the reporting period and regions have struggled to have all Transition Coordinators positions filled especially in the more rural parts of the state. Region I experienced gaps in its leadership positions and the Clinical Director position remains unfilled which impacts the team's ability to provide robust clinical consultation. Cross System Crisis Plans (CSCP) were not all developed in a timely fashion because all of the Transition Coordinator positions were not consistently filled resulting in higher caseloads for those on the team. Region IV had similar staffing shortages and the same delay in completing CSCPs. Region III has experienced significant staff turnover and has recently replaced the Clinical Director. Region V terminated its Clinical Director and refilled the key position in March, 2013.

Having this capacity consistently available is critical to assuring that START teams can respond in the time periods expected by the Settlement Agreement. Dr. Beasley has helped numerous states to implement the START model and is not surprised to have these staffing challenges during the initial phase of development. It is a unique service and requires staff to assume a different role than they may have done before. Leadership is important and making sure there is a fit of philosophy and values as well as having the clinical and program expertise is critical to the program's success. It may take time to create the most effective team. I do recommend that the Independent Reviewer continue to monitor the staffing of the START programs. If recruitment and retention remain a problem in the second year of operation the DBHDS may need to determine if remuneration is an issue and if there need to be specific workforce development strategies used particularly in the rural areas of Virginia to assure adequate numbers of Transition Coordinators to respond in a timely fashion to crisis and develop the Crisis Intervention Plans.

Table 2 summarizes each region's status hiring START staff through 4/13.

Table 2: Regional START Staff Hiring Summary

Region	Core Staff	In-Home Staff	Respite Home Staff
I	START Director Medical Director Clinical Director: vacant, interviewing, hire by 6/13 Respite Director Clinical Team Leader START Coordinators: 6 hired,	In-home Respite Counselors: 2 FTE hired and 3.15 FTE in process to be filled by 7/13	Respite Counselors: 13 FTE hired 3 FTE in process to be filled by 7/13

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Region	Core Staff	In-Home Staff	Respite Home Staff
	interviewing 1, hire by 5/13		
II	START Director Medical Director Clinical Director Respite Director Clinical Team Leader START Coordinators: 5 hired, interviewing 1, hire by 5/7/13	In-home Respite Counselors: 16 hired	Respite Counselors: 14.5 FTE hired 1 FTE to be filled 5/13
III	Director Medical Director Asst. Medical Director Clinical Director Respite Director Asst. Respite Director Clinical Team Leader START Coordinators 6 hired, interviewing 1 Coordinators (2): interviewing	In-home Respite Counselors: 5 filled 1 in process	Respite staff (13FTE) Continue to interview and are creating a relief pool
IV	Director Medical Director Clinical Director Respite Director Team Leader START Coordinators (5)	In –home Respite Counselors (3)	Respite staff: (1.5 FTE) Recruiting for 11 FT and 9PT Recruiting for a nurse
V	Director Medical Director: PT Consulting Psychiatrist hired in 3/13 to fill this function: 25 hours/month Clinical Director: original director left 1/13. The PT Psychologist was hired FT in 3/13 Respite Director Team Leader START Coordinators: 7 filled, 1 in process	16 FT and 10 PT to be shared between in –home and therapeutic respite unit when it opens Currently only 1 position is filled	

Training

The ability of the Commonwealth and DBHDS to fully comply with the requirements of Sections 6.a.i, ii, and iii will be determined by how well staff in both the ID and Emergency

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Services divisions of the CSBs, providers and the START programs are prepared to address the needs of individuals with ID/DD who are at risk of or experiencing a crisis.
START training from the National Center is ongoing and is offered throughout the state and through online learning opportunities. Dr. Beasley's Third Quarter Progress Report lists these trainings and indicates that the number of sites offering the training has expanded. Clinical consultation is also offered on a monthly basis to different teams and offers an important learning opportunity for team members. There is an extensive certification process for START Coordinators and Respite Directors.
The certification process for START Coordinators includes 56 hours of training through courses and lectures, 50 hours of clinical supervision from the regional START Clinical Director and consultation from Dr. Beasley. Trainers affiliated with the Center for START Services are national experts in services and supports for people with co-occurring conditions. Training is provided on-site and online. Unfortunately because of the difficulty of filling positions not all Coordinators will be certified by the end of the first year of operation as was anticipated. Efforts should continue to have these staff complete the necessary requirements to achieve certification which is essential to the ongoing quality of the program.
The training issues related to CSB ES staff are in the next section.

Crisis Point of Entry (Section b.i.)

A. The Commonwealth shall utilize existing Community Services Boards (CSB), including existing CSB hotlines, for individuals to access information 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 telephone and assist the caller in identifying and connecting with local services. Where necessary, the crisis hotline will dispatch at least 1 mobile crisis team member who is adequately trained to address the crisis.

Each region has between 5-10 Community Services Boards (CSB) that are currently responsible to provide 24/7 emergency response to crises for individuals within their catchment area including people who have intellectual and developmental disabilities. Each CSB has a hotline which accepts emergency calls and emergency services staff who respond. The type of response varies across the CSBs and regions as does the expertise to respond to the needs of individuals with ID or DD and behavioral challenges. They provide consultation for people living at home, comprehensive assessments, crisis behavioral plans and consultation to other providers.
Regions reported that while all CSBs have a mobile crisis team that conducts face to face assessments, the majority of CSBs will only do so at the hospital emergency department. Less than 50% will respond on-site to a crisis in another community location including group homes or an individual's personal residence. In fact the number that will respond in someone's home has decreased in 2 of the regions since the first report (Region I and Region V),and remains the same in the other 3 regions with no CSBs in Region III responding in a person's home. This information is summarized in **Table 3.**

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Table 3: CSB Mobile Crisis Team Response by Location

Region	Onsite response to a hospital	Onsite response to person's home or community location 6/12	Onsite response in person's home or community location 4/13
I	8	4	1
II	5	3	3
III	10	0	0
IV	8	4	4
V	9	6	2

The premise of the START Program is that it will have a 24/7 response capacity and will accept referrals from the CSB Emergency Services (ES) Mobile Crisis Teams. START is modeled on a cooperative response that involves the CSB Emergency Services staff. The determination of whether someone in crisis needs hospitalization is the responsibility of the ES Mobile Crisis Team, not the START team. For those people experiencing a crisis who are not in need of hospitalization of for whom that may depend on the availability of other supports, the CSB ES Mobile Crisis Team is expected to contact the regional START program and coordinate the response to the crisis.

The expectation of the Settlement Agreement is that the CSB ES staff will accompany START staff to do the crisis assessment. Since the first review the number of CSB ES' that will actually do this has reduced in Regions I and V and has not increased in the other regions. This lack of willingness to respond to an individual's home is actually supported by the FY 2013 and FY 2014 Community Services Performance Contract stipulated below which is the contract between the DBHDS and the CSBs.

e.) Department of Justice Settlement Agreement Requirements

8.) CSB emergency services shall be available 24 hours per day and seven days per week, staffed with clinical professionals who shall be able to assess crises by phone and assist callers in identifying and connecting with local services, and, where necessary, the services shall dispatch at least one mobile crisis team member adequately trained to address the crisis [section III. C. 6.b.i.A]. ***These requirements shall be met through the regional START program that is staffed 24 hours per day and seven days per week by qualified individuals able to assess and assist individuals and their families during crisis situations and has a mobile crisis team to address crisis situations and offer services and supports on site to individuals and their families within 3 hours.*** (Italics added).

Heidi Dix indicated that this was always the intention of DBHDS.

When I asked Dr. Beasley about this provision in the Community Services Performance Contract between DBHDS and the CSBs she said she was unaware that the CSB ES staff was no longer expected to accompany START Services staff as needed to individual's homes for assessment. She indicates this will be problematic when individuals need to be assessed for safety considerations and to determine if they need hospitalization, neither of which are the responsibility of START. Many people with ID and DD, especially individuals with autism do not do well with the unstructured and somewhat traumatic nature of emergency rooms. It is less distressing for these individuals to be assessed at home when they are in a crisis.

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Additionally START teams are having difficulty keeping all of the Coordinator positions filled especially in rural areas. Until the teams are consistently operating at full staff and able to meet the requirement for response time, the CSB ES staff may be needed to respond in community settings including group homes and people's own homes This provision of the CSB Performance Contract needs to be discussed between the Parties and the Independent Reviewer to determine if it meets the requirements of the Settlement Agreement and if it proves to be effective. If it remains as the standard practice it will be useful to develop a protocol detailing when it is appropriate for START to request the presence of an ES staff in the home setting to assist with assessment.

Since each CSB responds differently to crisis referrals the region is expected to also develop an affiliation agreement with each CSB in its area. A template for this agreement was developed by DBHDS at the time of last year's report. This outlines the responsibilities of both emergency response teams to work collaboratively to provide quality crisis intervention and divert people with ID from hospitalization when clinically appropriate to do so. Nine responsibilities of the START Program are specified in the template. The ES/CSB agrees to provide 24/7 response, contact the regional START Program, work to develop the Crisis System Crisis Plan, participate in team meetings and relevant training, and arrange for an inpatient psychiatric setting when clinically and systemically appropriate. It should be noted that this agreement only speaks to serving adults with ID. The VA START third quarter progress report notes that affiliation agreements have been signed as follows:

- Region I has agreements with 4 of its 8 CSBs
- Region II has agreements with all 5 of its CSB ES
- Region III has agreements with all 10 of its CSBs
- Region IV has agreements with 5 of its 8 and has 3 other requested submitted
- Region V has none officially signed but all are in process to be formalized by June 30, 2013

I reviewed 4 of these affiliation agreements as examples. These were all with Region II. The CSB ES Teams differ in where they will conduct a face to face assessment. The Alexandria and Arlington CSB ES' will go to a person's home if accompanied by the police. The Loudon CSB ES will only respond in the emergency room and the Prince Williams CSB ES will go to any setting where there is other professional staff but not to a private residence. It appears from this small sample that CSBs do differ in their response and assistance to assessing emergencies with START staff. It should also be noted that none of the affiliation agreements specify assessing individuals with DD.

2. 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.

Training continues to be offered to CSB ES staff. Bob Villa and the START Regional Managers continue to reach out to new ES staff to familiarize them with the START program. Dr. Beasley recently provided training on clinical assessment of individuals with ID to CSB staff in Region 5 which was very successful. The state plans to have this replicated in Region 3 by the end of April. This training should be scheduled as soon as possible in all regions and it should be required of all CSB ES staff within a year. UNH has the capability to track the training attendance of the ES staff.

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Table 4 summarizes the percentage of ES staff that has been trained since January 2012 about serving people with ID/DD and accessing START services:

Table 4: Staff Trained by CSB

	1-25% of staff trained at CSB	26-50% of staff trained at CSB	51-75% of staff trained at CSB	76-100% of staff trained at CSB
Region I	3	0	2	3 (all at 100%)
Region II	0	0	2	3 (all at 100%)
Region III	0	0	0	10 (9 at 100%)
Region IV	0	4	2	2 (1 at 100%)
Region V	2	4	2	1 (100%)

Just over 50% of the CSBs have less than 75% of their staff trained in the START model. Throughout the implementation of this agreement START training should be continuously offered and required of ES personnel to enhance their understanding and expertise in addressing the needs of individuals in crisis who have co-occurring conditions to build an effective systemic response and successful collaboration between the CSB and START mobile crisis teams as they respond to referrals for crisis intervention and stabilization. Mary Bagor is the Crisis Intervention Support Specialist in DBHDS. Her role is to provide Technical Assistance for emergency services to the 40 CSBs in Virginia. She also consults with the 10 existing crisis stabilization units operated by CSBs. The target population for these units is primarily individuals with mental health or substance abuse needs but she estimates that out of 2,000 people served approximately 100 individuals with ID/DD have been served. The units are not currently equipped to support individuals with severe cognitive disabilities but can serve those who can participate in the activities and benefit from the structure of the units.

Mary Bagor and Bob Villa work cooperatively to reach out to these programs and teams to educate them to the availability of START Services and to determine if there are opportunities to cooperatively serve individuals with ID. They are discussing whether individuals could be served in these settings with support from START staff. She hopes the crisis stabilization units can supplement the START therapeutic respite homes over time as staff are trained and linkages to START are formalized.

Ms. Bagor meets twice a year with the directors of the stabilization units. She asked Jarret Stone, Regional START Director in Region I to present to this group in March, 2013 to increase their awareness of the needs of individuals ID/DD in crisis. The group responded favorably and requested more training. She spoke very positively about the recent training Dr. Beasley offered in Region V to CSB ES staff that will be replicated in Region III in late April. Forty (40) ES staff are registered for this training event. During this training Joan discusses the role of ES staff in advocating for people with ID/DD in ERs and explained the underpinning of medical issues that must be explored in determining the root causes of the person's behavior. Ms. Bagor suggests training be directed at the CSB staff and focus on assessment and program management and they be trained separately from START staff since they have the need for more introductory material on serving individuals with ID/DD.

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ES staff are used to completing assessments quickly and making determinations about hospitalization. The training helps them to understand the more comprehensive assessment protocol that START uses to successfully address the crisis for the person with ID/DD.
Bob and Mary will together continue to reach out to the Association of CSBs (ACSB) through the Emergency Services Council that meets 3 times a year to continue the dialogue about crisis services for this population and determine ongoing opportunities for education, training and partnerships. CSB ES staff are also encouraged to attend the monthly clinical consultation meetings offered by the regional START programs. Ms. Bagor's credibility with the ES teams and her willingness to collaborate with Bob Villa and the Regional START Directors is very positive and should help to build more effective working relationships between START Services and the CSB Emergency Services.

Work with Law Enforcement

The Settlement expects that the Commonwealth will have a planned approach to reaching out to law enforcement to help them better interact with individuals with ID/DD who experience a crisis that brings then into contact with police and related public services. As described in some detail in the first report, DBHDS does offer a training curriculum for law enforcement which is Crisis Intervention Team (CIT) training which is offered throughout the state and includes information on the needs of individuals with ID. The Regions vary in the contacts they have been able to make with law enforcement and the training that has been offered. Region I has not offered anything specific as yet and not all of its CSBs have established CIT training for law enforcement personnel. Region II has added information about START Services to its CIT curriculum including information about interacting with individuals who have autism as well as those with ID and piloted it in Louden County. Region III plans to include a module about START Services as part of its CIT officer training. Region IV presented a segment about START Services to the Richmond Police and has added a component on ID/DD and assessing individuals when in a crisis. In this Region there was an example of a coordinated response involving law enforcement to respond to a particular crisis. This relationship is providing further inroads to this police department. Region 5's CIT training includes a module on ID and the region plans to include a section on START Services. All regions should be expected to have information about START and working with individuals with ID/DD in crisis in the CIT training that is standardized and in all regions includes information about DD including autism.

Mobile Crisis Teams (Section 6.b.ii.):

3. F. By June 30, 2012 the Commonwealth shall have at least 1 mobile crisis team in each Region that shall respond to on-site crises within 3 hours:

None of the regions had their full teams in place by June, 2012 due to delays in hiring and budget reductions. Regions III, IV and V had started to provide some level of consultation and mobile crisis response mostly for individuals at risk of behavioral crises but not currently experiencing a crisis by last June and had fully functional teams by the Fall of 2013. Regions I and II did not have their teams in place until December, 2012 because of

delays in becoming licensed. Regions abilities to offer in-home respite as part of START Services ranged started between 9/12- 4/13. Region V is just starting to offer in-home respite and has to use its Transition Coordinators part time to do so because of its staff vacancies.

To date 350 individuals have been referred for START Services with 117 of those individuals being served in the most recent quarter. However, data is missing on 1/3 of the clients. This data is important to project resource needs in the future and a focus should be put on timely and accurate data entry in all regions. Currently Region III is consistently reporting its data. Dr. Beasley projects that 700-1,000 individuals will be supported annually once the program is fully operational.

Dr. Beasley's report has a wealth of information about the demographics, needs and supports provided. This report has been shared with DBHDS and with the Independent Reviewer. Some important highlights to note in light of the requirements of the Settlement Agreement are:

- 35% of the individuals lived at home at the time of referral
- Case managers are the primary source of referrals followed by families and residential service providers
- Only 11% (13) of the referrals were made by the ES Mobile crisis teams
- 52 % (41) of the referrals of people in a crisis were at risk of losing their placements. Through the provision of START Services placements were maintained
- Only 6 people were admitted to psychiatric facilities
- Over 60% of the crisis assessment was conducted in the individuals' homes and 16% (19) were assessed in emergency rooms. With the exception of 7 assessments all were conducted in-person rather than over the telephone

There was concern expressed by the Independent Reviewer from information he was receiving from stakeholders that not all individuals with ID/DD who were in crisis could be served by START. Both Joan Beasley and Bob Villa confirm that everyone should be referred and the START definition of who is eligible is very broad. The therapeutic respite units can serve a range of individuals and there are no automatic exclusionary criteria unless a person is a danger to himself or others and requires hospitalization. Individuals who historically elope from settings can be served if they are willing and can be maintained by the physical environment (a fenced yard) and the supervision and direction of staff.

The Settlement Agreement required that the response time to crisis referrals be no more than 3 hours during the first year of implementation and reduced to 2 hours by June 30, 2013. For the 79 people referred who were in crisis, the response time was less than 2 hours in 31 cases, and 2 hours or more in 22 cases with an average response time of 1 hour and 45 minutes. Unfortunately there is no data from the regions for 26 of the events so a determination cannot be made if in all cases the response was within 3 hours. The goal of 2 hours to be met by this summer will be dependent on having a sufficient number of Transition Coordinators hired and available especially in more rural locations.

The DBHDS was to have a second mobile crisis team in each region by June 30, 2013. Bob Villa reports that each region is deciding what it needs in terms of resources since the DBHDS believes the teams are already generally meeting the response time requirement. Some regions will look to split existing coordinators into 2 teams under the leadership of 1Team Leader and others may add a Team Leader. All regions will have at least 2 START

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Coordinators available at all times to respond to crisis referrals. Plans are not finalized as yet. An accurate assessment of response time cannot be made since there is outstanding data missing. The next VA START Quarterly Report should be used to determine if the staffing is adequate to meet the requirements of the Settlement Agreement. The DBHDS should report to the Independent Reviewer by 6/15/13 as to its plans to expand the availability of mobile crisis teams.

Crisis Stabilization Programs (Section 6.b.iii.):

4. F. By June 30, 2012 the Commonwealth shall develop one crisis stabilization program in each region.

None of the regions opened the Therapeutic Respite Units (crisis stabilization programs) by June 30, 2012. There were the normal delays caused by home location, acquisition, renovation and licensing and staff recruitment and training. The first units to open were in Regions I and III which both opened in December, 2012. Region 2 opened its Respite home in March, 2013. Both Regions IV and V remain without a facility in which to operate the stabilization programs. Region V just received approval by the Independent Reviewer to use a cottage at the Training Center temporarily until the house the region has located is ready for occupancy which is anticipated for October 2014. Region IV had a site in Richmond which was not approved by zoning and continues to look for a site that may be outside of the city of Richmond. They do not have a projected date to open the crisis stabilization unit and are using the other region's sites when necessary if a bed is available, although to date this has been infrequent. They are also using their staff to provide in-home respite.
Table 5 below provides a summary of when each region had its mobile crisis team operational, in-home respite available and the existence or plan for the therapeutic respite site (*crisis stabilization unit*).

Table 5: Status of START Services Program Components

Region	Mobile Crisis Response	In-home Support	Respite Home
I	Licensed 12/12	Available 1/13	Opened 12/12
II	Licensed 12/12	Available 1/13	Opened 3/13
III	Available fall of 2012	Available 9/12	Opened 12/12
IV	Available fall of 2012	Available 3/13	Not opened and no site identified
V	Available fall of 2012	Available 4/13	Will open a temporary site 7/13 Will open permanent site 10/13

The Commonwealth is to decide by July, 2013 how many additional crisis stabilization units will be needed. In light of the significant delays in opening these units and the fact that 2 remain undeveloped it is unrealistic for the DBHDS to make this assessment by July.

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However, it will be important to have a sense of the level of need by the time the department is expected to make its budget requests to the Governor for the FY 15 budget. If some additional units are not included in the FY15 appropriation the level of crisis stabilization will remain at a total of 30 beds statewide for at least 2 more years. The department should be expected to develop a projection of need based on utilization of the 3 existing units through 10/13 factoring in the needs of adults with DD and for children with either ID or DD. This information should be used to make its budget request for FY15. Although some referrals for crisis intervention services have been made for people with DD it is a very small number to date. In all likelihood these referrals will increase as the availability of START Services is better known and there is greater coordination between DBHDS and DMAS for the use of these services for people with DD using the DD waiver and those on the waiting list.

Systems Issues to Address

In addition to the issues of full coordination of services for adults with developmental disabilities, funding and service development for children with ID and DD, financial sustainability, and consistent involvement of the CSB ES teams that I have raised in this report, a number of systemic concerns were raised in both the VA START second and third quarterly progress reports that should be addressed.

Supports for individuals with co-occurring conditions while in jail: 8 individuals were in jail during the preceding 12 months prior to their referrals to START. In at least 2 cases individuals did not continue to receive their prescribed medications and these were abruptly discontinued resulting in one person suffering seizures. DBHDS' outreach to law enforcement personnel should include discussion of how best to link people with START before incarceration occurs and how consultation might be provided by START for individuals who have a mental health diagnosis once jailed to better assure appropriate medical and clinical care while in jail and assist with discharge planning .

Support for the residential and day service providers: Two issues have been identified in Dr. Beasley's report regarding the provider community. The first is that training and follow up are critical components to assure that providers can be effective partners who coordinate support for the individual who is in crisis and uses the START services. DBHDS has made training available to providers but decisions need to be made as to when training should be required and for which providers and how START and the providers will effectively partner to coordinate the follow up services the individual will need to maintain their home and employment or other day services. DR. Beasley's recommendation of forming a task force should be considered by the department and a decision made.

A second concern focuses on continuity of funding for an individual who may leave their residence for emergency respite or a short term hospitalization. DBHDS does not currently have the ability either directly or through the CSBs to provide funding to the residential provider to make sure the person's residence is available to them when they are ready for discharge. The BDHDS should be asked to review this suggestion, determine if and how bridge funding can be made available and report back to the Independent Reviewer.

Policies and procedures: There appears to be a need for clearly articulated written protocols to guide the implementation of START Services especially given the decentralized nature of the service delivery system and the number of partners who are needed to make this a successful endeavor. Dr. Beasley has recommended policies and procedures to address:

- The expectations of the START teams to collaborate and consult in planning for eligible people in the state hospitals and those leaving the Training Centers who have co-occurring conditions
- Guidelines for medical screenings to be performed prior to admission to the START therapeutic respite sites
- The need to more quickly assign case managers to individuals eligible for ID or DD waiver services when they experience a crisis and are referred to START
- The relationship between the ES Teams and START Services regarding the training expectations for ES personnel

I support these recommendations and suggest the DBHDS be required to review them and provide a written response as to which will be acted upon and in what timeframe.

III. Conclusion

The Commonwealth of Virginia's DBHDS has initiated a planning process and is providing leadership to enhance the state's ability to respond to the crisis needs of individuals who have ID and DD and a co-occurring mental health diagnosis or a behavioral challenge that places them at risk of institutionalization. The commitment to build a comprehensive service delivery model, START Services, is encouraging and holds promise for individuals with ID and DD and their families. This offers the potential to build communities' capacity, expertise and ability to respond in a timely and positive manner to individuals in crisis and support them to remain in their home communities. The leadership of DBHDS, Office of Developmental Services including the START Directors is very committed to creating a successful service delivery model based upon the tenets of the START Model.

Delays in program implementation have created a situation of non-compliance in the timely development of the crisis stabilization units and staffing shortages have resulted in slower starts in some regions for the crisis intervention and prevention aspects of START. However, the DBHDS continues to make progress in its implementation of START Services and in creating the necessary community linkages to develop a comprehensive approach to serving these individuals with co-occurring conditions. Success has been seen for the over 300 people who have used START Services with few people requiring hospitalization and individuals being able to maintain their residence.

Summary of recommendations: I have made a number of recommendations to assist Virginia to be in compliance with the Settlement Agreement requirements for Crisis Services, build a sustainable crisis intervention and prevention system and build the community infrastructure that START is modeled on. These recommendations include:

- Funding: use utilization, waiting list and response time data to make the budget request for the crisis stabilization units for FY15 and to determine the needed capacity of the mobile crisis teams. Monitor the Medicaid reimbursement to make sure it is adequate.
- Serving individuals with developmental disabilities: DBHDS should issue a directive to the CSBs and include this in the affiliation agreements between START and the CSBs; all DD case managers should be required to be trained about START Services and the Settlement

Agreement; DMAS should determine if individuals with DD on the waiver waiting list who are served by START should receive priority for waiver services

- Serving children with ID and DD: DBHDS should develop a work plan within 3 months
- Staffing START Services: DBHDS should develop a workforce development plan if retention and recruitment problems remain in 6 months
- Involvement of CSB emergency Services: the performance contract provision should be reviewed by the Court to determine if it meets the provisions of the Settlement Agreement and a written protocol should be issued to describe under what circumstances ES staff will directly support START staff during crisis assessments. All Emergency Services staff should attend Joan Beasley's training within 6 months
- Law Enforcement: the CIT training should be standardized to include a module on serving people with ID/DD and autism and accessing the START services
- Mobile Crisis Teams: BDHDS should report to the Independent Reviewer by 6/15/13 as to each regions plan to have 2 mobile crisis teams operating by 6/30/13

Future reviews of this requirement of the Settlement Agreement will need to include an analysis of the existing community service delivery partners' ability to enhance and expand their ability to coordinate and provide ongoing community support to individuals at risk of crisis and those who experience crisis and need emergency support. This will include continued review of the engagement with the CSBs, the coordination with day and residential providers for both ID and DD, and the interface with the DD system of case management. The START program will need these formal partnerships in order for the system to be able to maintain people with co-occurring conditions at home and within their communities so that they do not experience unnecessary institutionalization.

The next review should include a review of consumer and family satisfaction with START Services.

IV. Attachment A

Proposal to Evaluate the Implementation of the VA Settlement Agreement Requirements for Crisis Services through 4/6/13

Prepared by Kathryn du Pree, Vice President, Center for Aging and Disability Policy, The Lewin Group: March 26, 2013

Crisis Services

The Settlement Agreement contains a number of requirements regarding the implementation of comprehensive crisis services by the Commonwealth of Virginia. Following is a description of these requirements and the approach the expert consultant will use to confirm the implementation of these systems elements through April 6, 2013. The review will build upon the previous review conducted for the Independent Reviewer in 2012.

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

i. Provide timely and accessible to individuals who are experiencing crises, including crises due to 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 services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable.

- The specific data on the mobile crisis team responses will be addressed in subsequent sections. As a follow up to the crisis services evaluation completed in June, 2012, the expert consultant will focus on the Commonwealth's ability to develop a statewide crisis response system for all individuals with intellectual or developmental disabilities by determining if the budgetary requests for the regional programs have been funded through legislative appropriation; if individuals with developmental disabilities have also been able to utilize the crisis service system; and whether funding and access had been provided for children with ID or DD to make use of these prevention and intervention services.

Data Sources

The expert consultant will address these systemic issues through interviews with Bob Villa and Lee Price. Any data sources that they are able to identify will be reviewed regarding the budget and utilization by adults with DD and children with ID or DD.

6.b. The crisis system shall include the following components:

i. Crisis Point of Entry

A. The commonwealth shall utilize existing CSB Emergency Services including the existing CSB hotlines, for individuals to access information about and referrals to local resources. Such hotlines shall be operated 24 hours a 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 1 mobile crisis team member who is adequately trained to address the crisis.

- The expert consultant will report on the involvement of the CSB's in responding to emergency calls, making referrals to the regional mobile crisis team, and assisting them with the crisis response as needed.

Data sources:

The Virginia START Quarterly Consult Summary provides referral source information. The DBHDS will need to provide additional data regarding the CSB Emergency Service involvement accompanying the mobile crisis team staff when responding to a referral for crisis intervention. The expert consultant will address this in her interviews with Bob Villa, Lee Price and Joan Beasley.

ii. Mobile crisis teams

A. Mobile crisis team members adequately trained to address the crisis shall respond to individuals in 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.

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

C. 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.

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

E. Mobile crisis teams shall provide local and timely in-home crisis support of an additional period of up to 3 days, with the possibility of an additional period of up to 3 days upon review of the Regional Mobile Crisis Team Coordinator.

F. By June 30, 2012 the Commonwealth shall have at least one mobile crisis team in each Region that shall respond to on-site crises within 3 hours.

G. By June 30, 2013 the Commonwealth shall have at least two mobile crisis teams in each Region to respond to on-site crises within two hours.

- The Expert consultant will report on the number of mobile crisis team members trained and in what topic areas; the type of START services requested and provided to determine the START programs' engagement with crisis planning and diverting future crises by providing assessment, plan development, consultation, and respite; the availability of crisis team response and the response time; how many individuals received in-home crisis support and for how long; the outcome of the provision of crisis intervention in terms of the ability to maintain the person in his home or the community; and the status of the Commonwealth's development of an additional mobile crisis team in each region by 6/30/13.

Data Sources

The DOJ Project 4 Crisis Intervention and Prevention Plan Report 1/25/13; Virginia START Quarterly Consult Summary: 10/12-12/12; updates of both of these status reports through 3/31/12;written updates from the regional directors on the hiring of mobile crisis team members; interview with Bob Villa and Lee Price; interview with Joan Beasley, Ph.D.. Topics to be addressed with Dr. Beasley include team training, response time, and follow up to data elements in the quarterly report. The interview with Bob Villa and Lee Price will focus on the development of the 2nd mobile crisis team in each region, engagement by the mobile crisis teams with law enforcement, and follow up on the Crisis Intervention and Prevention Plan data elements.

ii. 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 lengths of stay shall not exceed 30 days.

E. With the exception of the Pathways Program operated by the Southwestern Training Center crisis stabilization programs shall not be located on the grounds of Training Centers or hospitals with inpatient psychiatric beds.

F. By June 30, 2012 the Commonwealth shall develop one crisis stabilization program in each Region.

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.

- The expert consultant will report on the development, availability and utilization of the crisis stabilization programs in the 5 regions to make sure they comply with the requirements of the Settlement Agreement; and the options used before consideration was given to use of the stabilization program and the status of the Commonwealth's planning for additional crisis stabilization programs based upon need.

Data Sources

The DOJ Project 4 Crisis Intervention and Prevention Plan Report 1/25/13, and the updated report through 3/31/13. Dr. Beasley's Quarterly Report for 1/13-3/13 will be used if it has these data elements as the programs were not operational for her to report on utilization during the first quarter reporting period. The expert consultant will interview Bob Villa and Lee Price focusing on the data being used by the Commonwealth to determine the need for additional crisis stabilization programs and to follow up on data elements in the Crisis Intervention Plan Report.

The expert consultant will produce a report for the Independent Reviewer that summarizes her findings and recommendations. In order to prepare this report she will need access to the documents listed and will interview The DBHDS administrative representatives and Joan Beasley, Ph.D. START consultant, using the interview guide that follows.

Interview Questions for Crisis Services

The following questions will be asked of Bob Villa.

1. What is the level of funding requested and allocated for the crisis mobile teams and the crisis stabilization units in FY14? Were there any changes in the funding allocations for these components in FY13?
2. What is the utilization of the START program by adults with developmental disabilities? How were people in this target group informed of the availability of the program? How do they access crisis services?
3. What is the funding for children with ID or DD for crisis services? How have their families been notified of the availability of crisis services? How do they access the services? What is their utilization of the services? If the START program is not available to children what crisis services are in place for them?
4. What is the DBHDS definition of a crisis making an individual eligible to access the mobile crisis team?
5. Which CSBs are now willing to respond to a crisis in a person's own home?
6. What training has been provided to CSB emergency staff? What topics? How many have been trained?
7. What is the status of the development of the 2nd mobile crisis team in each region and what data has been used to determine the capacity each region needs?
8. What is the Commonwealth's plan to develop additional crisis stabilization units?

The following questions will be asked of Joan Beasley.

1. What training has been provided by START to CSB emergency staff? What topics? How many staff have been trained in each subject?
2. What is the definition of a crisis that is used by the START Program to determine if someone is an appropriate referral?
3. What is the average response time to a crisis call by each regional START team? How many responses have exceeded the expected response of 3 hours?
4. What has been the involvement of the CSBs in partnering with START staff to directly respond to a crisis referral? How many times have a CSB sent emergency personnel to accompany START? Which CSBs do so?
5. What has the involvement of the START program been with individuals who have committed a crime or whose emergency situation has involved law enforcement?
6. Has START provided crisis services to any adults with DD or to any children with either ID or DD?

APPENDIX C

EMPLOYMENT SERVICES REQUIREMENTS

The LEWIN GROUP®
Center for Aging and Disability Policy

Report to the Independent Reviewer

UNITED STATES vs. COMMONWEALTH OF VIRGINIA

EMPLOYMENT SERVICE REQUIREMENTS

REVIEW PERIOD: Through April 6, 2013

Prepared by Kathryn du Pree, MPS

Vice President
Center for Aging and Disability Policy
The Lewin Group

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V. Introduction and Methodology

Donald Fletcher, Independent Reviewer for the US v Commonwealth of Virginia's Settlement Agreement, requested a review of the employment services requirements of the Settlement Agreement. This is the first review that will be completed for these requirements. To accomplish this review I proposed measures and evaluation methods to determine the state's compliance in this area. This includes a review of documents and interviews with DBHDS staff and SELN Advisory Group members. DBHDS has undertaken the responsibility of developing an employment first policy and a strategic plan to assist the Commonwealth to achieve employment for individuals with intellectual and developmental disabilities. This requires policy, regulatory and procedural development, waiver amendments, resource allocation, program design and implementation, effective interagency collaboration, engagement of stakeholders and training. It should be noted that the system will continue to evolve and be further refined during the course of the Settlement Agreement. There will be a need to continue to monitor progress and evaluate the system's effectiveness on a semi-annual basis at achieving greater employment outcomes for the target population. Before reporting on my findings I want to extend my thanks to the many SELN AG members who agreed to participate in an interview. Nine people spoke with me and the information and perspectives they shared has added to the depth of this report. I also want to thank Adam Sass for making himself available throughout this process to answer questions, share the initiatives of the DBHDS and provide needed documents. He is extremely committed to Employment First and I appreciated his insight and extensive knowledge of the system of employment service delivery.
The Settlement Agreement requires the Commonwealth to accomplish the following:

VI. Integrated Day Activities and Supported Employment

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.

Adam Sass reports the following information related to the number of people who have been provided with supported employment:

Table 6: Individuals Enrolled in Employment Services

	10/12-12/12	1/13-3/13
Newly enrolled in ISE	43	71
Newly enrolled in GSE	36	79
Newly enrolled in Pre-Vocation	59	124

The first reporting period includes individuals on both the ID and DD waivers. The total receiving supported employment was 79 and 54% of these individuals received individual supported employment (ISE) as compared to group supported employment (GSE) for 46%of those newly enrolled. During the second reporting period this increased to a total of 150 people of which 47% received ISE and 53% received GSE. Although this is not to be expected to be a measure of pre-vocational enrollment I have included this data as well. Forty two (42) % of new waiver participants enrolled in pre-vocational employment the first quarter and 45% during the second quarter. It will be of interest to note in subsequent reviews if this enrollment declines as it because a standard practice to offer supported employment as the first option for new enrollees.

There is a difference in the data sources for the 2 reporting periods. The period 10/12-12/12 includes enrollments in the ID and DD waivers. The period 1/13-3/13 includes data from **only** the ID waivers. There is a positive increase in the number enrolled in supported employment during the second quarter even though the Commonwealth can only include information from the ID waivers.
Adam Sass reports that this is because data from DMAS for the DD waiver was only available on an annual basis at the end of a year. The departments have signed an agreement that data will be available on a quarterly basis going forward and are coordinating the data sharing process. In all likelihood the number of people reported in the first quarter of 2013 under-represents the number of people offered employment since it excludes the DD waiver participants. DBHDS reports that because DARS funding was closed during 1/13-3/13 people could access the waiver for employment directly since the primary funder was unable to provide employment supports which may have increased the numbers enrolled in the ID waivers. This may actually be positive for these individuals in terms of the continuity of services it offers them to start their employment supports with DBHDS and may cause less confusion to families than dealing with the processes and requirements of 2 distinct departments.
The DBHDS is unable to report the number of people who receive other integrated day services because the data collection system does not currently distinguish between community based and facility based day services. It is recommended that the departments be asked to create the capability to report this on a quarterly basis to be in compliance with the Settlement Agreement.
b. The Commonwealth shall;

- Maintain its membership in the State Employment Leadership Network (SELN) established by NASDDDS.
- 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 principles of the EF 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 employment first practices

VII. The Employment First Policy and DBHDS Support

The Commonwealth has established a state policy on Employment First that was approved and issued in December, 2012 by the State Board of Behavioral Health and Developmental Services [Policy 1044 (SYS) 12-1 Employment First]. It is a strong policy statement that stresses the benefits of employment for persons with disabilities. Integrated community-based employment is appropriately defined to mean regular or customized employment, with minimum or competitive wages and benefits, for a person who is on the employer's payroll and has interaction and integration with the businesses workforce. It also honors self-employment for people with disabilities. It is supported by Senate Joint Resolution 127 which addresses individuals with intellectual, developmental and other disabilities. The policy is guided by the principles of working and earning wages, developing a plan for employment using a person-centered planning process, contributing to one's own support and supporting individuals with severe disabilities to choose integrated employment, and recognizes the value of both full and part time employment.

It goes further to direct the DBHDS to provide training and consultation to providers; create teams including DARS, CSBs and ESOs to use evidence-based supported employment models; build these options into the waivers for both ID and DD in partnership with DMAS, maintain the SELN AG as a resource for systems development; and develop an implementation plan to increase integrated day opportunities including supported employment, community volunteer activities, community recreation opportunities and other integrated day activities.

The DBHDS is expected to work with the CSBs to establish outcomes for increasing employment, address barriers, set performance contract goals to include employment and expand evidence-based practices and monitor progress and results. It is also expected to work with the provider community to establish and sustain real work for people with disabilities and collaborate with the State Department of Education and local schools on transition planning and supporting employment.

The DBHDS has included a provision in its FY13 and FY14 Community services Performance Contract that states:

e. Department of Justice Settlement Agreement Requirements

9.) Comply with State Board Policy 1044 (SYS) 12-1 Employment First [section III.C.7.b]. This policy supports identifying community-based individual supports employment in integrated work settings as the first priority service option offered by case managers and support coordinators to individuals receiving day support or employment services.

The CSBs are to demonstrate their compliance starting in July, 2013. Workgroup 8: the compliance and data committee has been charged to verify that case managers have offered this to all individuals who are seeking day or employment services by discussing it as part of the individual planning process. The DBHDS planning form has been reformatted so that employment is now the first topic discussed with the consumer. The case managers will submit a report that includes information that employment was explained, discussed and offered to the individual. In my interviews with CSB representatives on the SELN AG it was reported that there has been no further guidance and the CSBs have not yet set the expectation for the case managers specifically. One CSB has formed a workgroup to develop its own protocol. Further guidance regarding this requirement should be issued from DBHDS to the CSBs that also clarifies how this will be monitored.

The DBHDS does not contract or have a relationship with case managers who support individuals with DD who are accessing the DD waiver. DBHDS has shared the Employment First Policy with DMAS and asked them to communicate this to the DD case managers and strongly encourage them to discuss employment as the first option. However there appears to be no requirement being set forth to insure that this is being discussed with individuals with DD. Although the Settlement Agreement does not specifically address contractual requirements for the DD wavier and the population it serves, the intention of this agreement is to benefit both individuals with ID and with DD. I recommend that DMAS be directed to make this a requirement for individual planning for people with DD who are receiving waiver services and to have a mechanism to make sure it is being implemented. The DBHDS has met the requirements of this section of the agreement by maintain its membership in the SELN and creating a statewide SELN committee; developing and issuing the Employment First Policy; issuing the performance contract requirement of the CSBs; and hiring Adam Sassler as the Employment Services Specialist who is devoted full time to oversee and coordinate the employment first initiative. The involvement of the state SELN AG as the broad based stakeholder group to assist the state in implementing the policy and strategic plan will be addressed in the next section.

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 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; 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. 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 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.

VIII.The DBHDS Strategic Plan for Employment First

Heidi Dix, Assistant Commissioner, Developmental Services, DBHDS submitted its strategic plan for Employment First on November 7, 2012 to Donald Fletcher, Independent Reviewer for the Settlement Agreement. Additional details and updates were added to the plan in

January and April of 2013.As agreed I used the State Health Authority Yardstick (SHAY) rating scale to determine the adequacy of the plan since it is a nationally recognized tool to review state's or public authorities' ability to plan, develop, monitor and evaluate evidence based practices regarding systems development and program implementation. There are 15 sections to the SHAY that cover: plan development, financing, training, leadership, policy and regulations, quality improvement, and stakeholder involvement.

I did not rate the system on the 4 areas related to training or the 2 areas related to quality. The training rating scale is based on determinations of the merits of the didactic training materials used, supervision of trainers, the use of evidence based training practices, and the use of active training strategies. This is not the type of training that is being offered as part of this initiative nor is it a requirement of the settlement agreement. I will review the training that has been offered later in this section without using the SHAY rating scale. I did not use the 2 sections related to quality improvement: fidelity assessment or client outcomes because it is too early in the planning and implementation process to evaluate the system regarding these components.

Using the SHAY rating scale in the other areas, the plan and planning process have an overall rating of 3.3 out of 5. Each section is rated and an explanation of the rating is provided in Attachment A. It also includes recommendations for improvement. While there are recommendations for areas that may be strengthened in terms of implementing the plan, the Commonwealth had met the requirement of developing a comprehensive plan that can serve as the foundation to accomplish the systemic change that is necessary to fully realize the Employment First Policy now in effect in Virginia.

However, there has not been any formal planning to develop a robust service delivery system that includes integrated day activities including community volunteer opportunities and integrated recreation activities. It is notable that the Commonwealth is focused on advancing employment and has a desire to establish itself as a leader in employment for people with disabilities. Nationally states are striving to achieve employment for all individuals with disabilities as recognized through the Alliance for Full Participation, the active engagement of a majority of states in the SELN and the issuance of many Employment First Policies. Employment is the age appropriate endeavor for adults and working brings individuals a wealth of tangible and intangible benefits. These include: moving people out of poverty, helping them to be respected members of their communities recognized for their skills and abilities, and providing opportunities for them to make contributions to these communities.

However, the DOJ and Commonwealth have agreed though this settlement that integrated day services will be part of the response to improve the system of supports for persons with ID and DD. It is recommended that DBHDS and DMAS work together to submit a plan that includes strategies and resources to address this requirement and share it with the Independent Reviewer within 6 months.

IX. Training

Section II of the Strategic Plan addresses training and technical assistance. There is an understanding that an initiative such as this can only be accomplished through significant education to increase stakeholder's awareness of Virginia's Employment First initiative, national trends and federal expectations. The plan includes many initiatives including: an

annual state employment summit with key leadership; quarterly regional summits; the development of a dedicated website; development of a comprehensive training plan in employment practices; training for case managers and service providers in work incentives and benefits counseling; training on innovative employment support models for direct service staff; outreach to families and individuals, and outreach to the business communities. With the exception of the summits which have occurred and the outreach packet for families and individuals that has been developed, the remaining components are to be available in September 2013.

DBHDS and particularly Adam Sass are to be complimented on the amount of outreach, education and training he has arranged and directly provided. His focus is on education and outreach and he conducts 4-5 sessions each month with stakeholder groups and often coordinated with local CSBs. He has presented to the Employment Service Organizations (ESO) which are the providers of pre-vocational and employment services. Many of these offer sheltered workshops and Adam talks to them about changing their business model. He attends Career Supports meetings that CSBs hold with ESOs to continue the dialogue about how to change the course of their services to supported employment. He has also presented to case managers their supervisors and the managers of CSBs. He has presented to parent and advocacy groups and schools about employment and its benefits. He is creating linkages with the VA Interagency Community Transition Councils in each county which is coordinated by DARS and DOE to provide information to local schools about resources for transition planning for college and employment.

The DBHDS reports that over 54 presentations were offered between 5/2011 and 12/2012 and Mr. Sass has continued to educate groups in the first quarter of 2013. Over 1800 people attended these trainings which include the First and Second Annual Employment First Summits which had attendance of almost 300 stakeholders in 2011 and 175 attendees in 2012. Other training opportunities have been provided across Virginia and have included state agency staff, CSB case managers and employment staff, ESOs, residential providers, training center staff, advocates, self-advocates, and community colleges. These presentations are summarized in Attachment C.

The Commonwealth is meeting its obligation under the Settlement Agreement to provide training and its plan to develop more specific training for ESO providers is critical to the success of this initiative. Providers who have historically operated sheltered workshops or other segregated settings for day services will need both training and technical assistance to shift the business model to one of providing supported employment. The plan also includes training for families and individuals about benefits. People are often very confused about the impact of earing wages on the benefits they receive by virtue of their disabilities. Much has changed over the past decade in recognition of the loss of benefits as a barrier for individuals and families to pursue competitive employment with commensurate wages. Adam Sass does include the topic of benefit retention in his presentations. VA-access has a grant to provide free training on this topic. DARS offers benefit training and has one work incentive specialist to help people plan for benefit retention. DBHDS and DARS are working to create a new work incentive manual to provide another resource to individuals and their families. Information is also on the DBHDS website entitled Work World and Virginia Commonwealth University (VCU) is developing work incentive training. The availability of this information and an understanding by individuals, their families and case managers as

to how to access it will be very important in helping people to make informed decision about employment.

X. The Engagement of Stakeholders

The VA SELN AG was established to assist the DBHDS in creating the strategic plan, setting the targets and providing ongoing guidance and assistance to implement the plan and the Employment First Policy. The SELN AG represents stakeholders including self-advocates, families, advocacy organizations, CSBs, state agencies, universities and employment providers. The SELN AG has been in existence since 2008 and undertook a self- assessment with the consultants from the national SELN from which the group developed a work plan. That work plan was used in the creation of *the Strategic Plan for Employment First: Expanding Employment Opportunities* written in October 2012.
As part of the research for this review of the Commonwealth's compliance with the employment services requirements of the Settlement Agreement, I interviewed 9 members of the SELN AG. This included CSB, state agency, provider, family and advocacy representatives. I asked the members questions about the involvement of the SELN in creating the strategic plan; the adequacy of the plan; the effectiveness of the interagency coordination; outreach that has been done; the barriers facing Virginia as it seeks to implement its employment strategies; and the adequacy of the employment targets that have been set. Members are very committed to the work of the SELN and in advancing employment first as the policy of Virginia.

7. **SELN AG members input into the plan and its adequacy to advance employment for people with ID and DD:** There is general concern that the SELN AG did not have the opportunity to have meaningful input into the design of the strategic plan or to provide feedback before it was submitted to the Independent Reviewer. SELN AG members want the opportunity to review any documents prepared and have enough advance time to insure a thorough review and meaningful input. Members would like to return to regularly scheduled meetings. The DBHDS may want to consider conducting these as webinars to get more consistent participation from members who now travel far distances to attend. Members think that the meetings can be better organized to help the group achieve its goals and use the time most productively to focus on strategic planning and implementation. Changes in membership make it difficult to build and maintain momentum. It is recommended by a member that by-laws be developed that include a term limit and appointment process.

SELN AG members who were interviewed agreed the plan included the essential elements that needed to be addressed but question if the plan goes far enough. The barriers that the plan seeks to address are comprehensively identified. One member believes there should be more focus on the transition of students to adult services. This perspective is supported by another comment that the plan is currently too focused on the waiver participants rather than the broader group of people with ID and DD. Concern is expressed that these barriers have been known to the Commonwealth for

years and the plan lacks specificity about the strategies that will be taken to implement the activities and monitor progress. Since the strategic plan has been completed there have been no subsequent discussions with the SELN AG about the implementation of the various recommendations many of which are expected to be completed by September 2013 according to the document's timetable.

8. **Interagency Cooperation:** The state agencies that participate are committed to the philosophy and direction of the employment initiative and are active members of the SELN AG. A recent study on autism by the Joint Legislative Audit and Review Committee which addressed employment issues and the inclusion of employment in the Settlement Agreement have helped to create a common vision and bring stakeholders together. The general consensus is that DBHDS needs to empower the SELN AG to build on this momentum and identify the collaborations more specifically that must occur to accomplish the plan. One example is that the agencies all agreed to the questions to be used to review policies and regulations and make sure they are aligned with the Employment First Policy but there has been no use of them or follow up. A commitment to data collection and using it to make sure the baseline is correct and that the progress towards meeting the targets can be assessed accurately is critical.
9. **Outreach:** As has been noted earlier the DBHDS has made a significant commitment to outreach. All SELN AG members interviewed stressed the importance of this endeavor and suggested the SELN AG be involved in this to support the department as it seeks to inform families and individuals of this initiative and it works with schools, CSBs and ESO providers.
10. **Barriers to achieving Employment First:** There is a variety of opinion of the most significant barrier but those interviewed identified and focused on the following:

    - The need to address the rate structure for employment services in the waivers, the service definitions, and incentives existing ESOs will need to transform their business model
    - The mindset of case managers and providers
    - The availability of funding for individuals with ID and DD for supported employment

    DBHDS and DMAS have made progress on the rates and have started to address the need to pay for comparable services under the HCBS waivers as the Commonwealth does through DARS for supported employment. The DBHDS has also issued an RFP for consulting support to assist DMAS and DBHDS to rewrite the waivers to include employment modifications.
    This years' budget added funding to DARS to start to address the VR Order of Selection (waiting list) by providing funding for 1/3 of the 2,280 people with disabilities who are waiting for DARS vocational support. It also restored some funding for the long-term employment support services (LTESS) which assists people with more significant disabilities to stay employed. As has been noted before the Commonwealth is significantly increasing the funding for the HCBS waivers in its response to the DOJ and the numbers of waiver participants will increase over the course of the agreement. This will help many people to transition to the

community and come off the waiting lists. During the course of the implementation of this agreement it will be important to determine how many of the new slots benefit people seeking employment.

11. **Targets for Increasing Employment:** The review of the DBHDS targets follows this section. This is a summary of the SELN AG members' feedback on the adequacy of these targets. The SELN AG members discussed the targets initially and a sub-committee of the SELN assisted DBHDS to develop them. The majority of members who I interviewed did not think that the targets were set high enough. However, members do acknowledge that the numbers set for the first year needed to factor in the systemic barriers that are in the process of being addressed but are not yet resolved. There is also some concern about the accuracy of the baseline data and whether it is duplicative especially related to individuals who may move between GSE and ISE. There is agreement among the members that the Commonwealth will be able to meet these targets.

XI. Baseline Information and New Targets For Supported Employment

The DBHDS set its employment targets for the time period March 6, 2013 – February 28, 2014. This was shared along with the baseline information required by the Settlement Agreement with the Independent Reviewer in correspondence from Olivia Garland, Deputy Commissioner on March 29, 2013. The baseline information is summarized in **Table 2**.

Table 7: Baseline Employment Information

Baseline Categories	Number Served
The number of individuals receiving ISE in the past year	176 (**135 new enrollees**)
The number of individuals receiving GSE in the past year	634
The total number receiving supported employment in the past year (ISE and GSE)	810
The number who remained in ISE for 12 or more months	133
The number in pre-vocational services as of the date of this agreement	819
The number who remained in pre-vocational services for 12 or more months	675

Of the total number of people in Supported Employment, the majority are in GSE (78%) and 22% receive individual support through ISE.GSE does include individuals who may be in congregate facilities if people without disabilities are employed there as well. The parties may want to review the Commonwealth's definition of GSE and determine if these individuals should continue to be included and counted under GSE for the purposes of

determining compliance with the Settlement Agreement. Of those in ISE, 76% maintained employment in integrated work settings for at least 1 year.
During the baseline period the average earning for individuals in supported employment was $1,171.08 per quarter.
DBHDS worked with the SELN AG to develop the targets for the coming year ending 2/28/14. The full advisory committee reviewed the baseline data and discussed the parameters for consideration in setting the targets. The specific methodology used resulted from more in-depth conversations with the SELN AG data sub-committee. Table 3 provides a summary of the targets set in response to the requirements of the Settlement Agreement.

Table 8: Targets to Meaningfully Increase Employment

Target Category	Numerical Target
The number of individuals who enroll in supported employment each year	162 new enrollees
The number of individuals who remain in integrated work settings for 12 or more months	138 individuals (85% of new enrollees)

These targets set a modest increase from the accomplishments of the previous year. The DBHDS hopes to increase the number of new enrollees by 27 individuals which represents a 20% increase over the number enrolled in the previous year. The goal of having 138 individuals maintain their employment in an integrated work setting increases that by 5 individuals from the previous year. This increases the retention to 85% of those employed versus 76% previously.

The SELN AG Data Subgroup was charged to assist DBHDS to develop the targets. Adam Sass reports that the committee discussed the following factors in determining the target goals. They reviewed the baseline information; considered national data that indicates that 20% of people served in day services are receiving employment support; accounted for the number of providers who currently offer supported employment; and reflected the systemic barriers that needed to be addressed and the status of progress to correct or eliminate them.
While there is no intention to exclude individuals who are coming into the system new to any type of day or employment support, the subgroup and DBHDS decided to focus the goals on people already receiving either pre-vocational services or participating in GSE. This decision was influenced by the department's and SELN's analysis that these are important groups to prioritize because the success in moving these individuals would benefit the system in two ways. First and foremost more individuals will have real employment which is the overall goal. Second, if ESOs that currently are primarily invested in the operation of sheltered workshops are part of successful transitions for individuals they serve, they will hopefully embrace the state's employment first direction. It is to the department's credit that they want to use the target setting in a strategic way that will

contribute to the infrastructure changes that are necessary to achieve meaningful employment for individuals with intellectual and developmental disabilities. It is also a strong statement in support of the Employment First Policy that the state seeks to increase ISE rather than GSE.

However the department did not seem to take into account the following:

- Virginia has very few participants of its waivers who receive supported employment out of the total number of people served through the HCBS waivers. The DBHDS reports a total of 9027 individuals are enrolled in the 3 HCBS waivers serving people with ID or DD in FY11. As of that fiscal year only 2% were in ISE and were 6% in GSE. Another 8% were in pre-vocational programs.
- Waiver enrollment is expected to increase by an additional 4170 individuals over the course of the Settlement Agreement. Between FY12- FY 15 this increase will be as follows:
  - 470 people from the Training Centers
  - 975 people from the waiting list for ID waivers of whom 75 are children under the age of 22
  - 225 people form the waiting list for the DD waiver of whom 45 are children under the age of 22

  This adds 1,670 individuals to the waivers for a total of almost 10,700 waiver participants by the end of FY15. To reach an overall number enrolled in supported employment percentage to 20% the DBHDS would need to have a multi- year plan to increase to 2,140 people receiving supported employment. Whether or not this is achievable and in what timeframe it is realistic to accomplish such a goal should be an ongoing discussion between the DBHDS, DMAS and the SELN AG. This will assist the Commonwealth to implement the Employment First Policy and set more ambitious targets to support those waiver participants interested in employment. The letter from Deputy Commissioner Garland states the target is 162 individuals in each year. Adam Sass reported that the SELN AG is interested in increasing that target by 20% more in the following reporting period and then 50% in the 3rd year. This would indicate future targets of 194 for Year 2 and 233 for Year 3 adding a total of 589 individuals to ISE. This will demonstrate progress if the DBHDS accepts the recommendations of the SELN AG but will only result in a total of 12% in ISE and GSE, if GSE holds constant at 634 people and ISE expands to 765 of which 85% retain their employment for 12 or more months. The total percentage of ISE and GSE is 8%.

  The parties should discuss after reviewing the achievements of this first year of targeting setting whether future year targets should be increased. The fact that 114 individuals have been enrolled in ISE in the last 2 quarters indicates the DBHDS should exceed its target of 162 even if the number for 1/13-3/13 is somewhat higher because of the Order of Selection being implemented at DARS. That higher number does not include anyone who may have enrolled in the DD waiver because of the previously mentioned data reporting problem.
- DBHDS did not consider new people from the waiting lists enrolling in the waivers when it set the targets for this first year. As a strategy it is appropriate to plan to move people from pre-vocational and GSE to ISE as they are already participating in some type of work or job training and the goal for them should be individual supported employment and eventually competitive employment if appropriate as they have the interest and skill base to work.

However, the Commonwealth has issued its Employment First Policy which stresses that employment should be the first option offered to people newly entering the service delivery system as well as those who are on waivers but not employed. In recognition of the number of people who will receive waiver services for the first time as a result of the Settlement Agreement the DBHDS and DMAS should project that a percentage will want to pursue employment and need support to do so.

- The targets do not reflect the number of people leaving the Training Centers who will transition to waiver services. These individuals are also to be offered employment as the first option and a percentage of them will also be interested and will need to have supports offered to them.

These are recommendations that DBHDS might want to consider in projecting future targets:

- Set separate targets for DBHDS and for DMAS and track individually
- Assess individuals on the waiting list and those who reside at the Training Centers using a standardized assessment tool such as the SIS to determine people's interest and abilities to work. This data should be reviewed by the DBHDS, DMAS and the SELN AG and used to project future targets
- Determine the existing capacity of the ESOs to respond to growing demand for ISE and determine if it is necessary to implement actions to increase this capacity
- Determine if it is possible to target any waiver funding to a set number of school graduates each year who are on the waiting list and who want employment support as another approach to increasing the number of people with ISE.

I also recommend that DBHDS utilize the expertise of the national SELN to assist them to set employment targets for future years.

XII. Conclusions

The Commonwealth is to be commended for its progress to date establishing its Employment First Policy and initiative and its efforts to comply with the requirements of the Settlement Agreement as it directs changes to employment services. The support of the Governor and Legislature provide a strong message of leadership as to the importance of this undertaking. There is significant involvement of the various state agencies and an identification of the barriers they must address to fully support the desire for people with disabilities to have meaningful employment and participation in community life.
This effort is in its initial stage and as with all comprehensive initiatives to achieve systemic change is fraught with challenges. To insure the success of this endeavor it will be important to maintain and strengthen the involvement of stakeholders especially through the established SELN AG utilizing the expertise and commitment of this group to implement the strategic plan; pursue the necessary changes to the HCBS waivers; continue to provide adequate funding for employment supports; fund the needed training of CSB case managers and employment specialists, ESO staff, families and consumers; provide support to providers who want to change their business model; and focus on providing employment support to the number of people with ID and DD who wish to work.
Throughout this report and the attached SHAY rating scale recommendations are made in an effort to assist the Commonwealth to further it employment services and integrated day services goals.

XIII.Attachment 1— Proposal to Evaluate the Implementation

Proposal to Evaluate the Implementation of the VA Settlement Agreement Requirements for Employment Services and Crisis Services through 4/6/13

Prepared by Kathryn du Pree, Vice President, The Lewin Group: March 12, 2013

Employment Services

The Settlement Agreement requires the Commonwealth to accomplish the following:
7. Integrated Day Activities and Supported Employment

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.

- The expert consultant will report on the day service opportunities offered to individuals placed on the waiver during FY12 and FY13 (to date) who are part of the target population.

Data source:
DBHDS will provide a written summary of the day service options provided to these individuals and evidence of the discussions about these options during the person-centered planning process.

b. The Commonwealth shall;

- Maintain its membership in the State Employment Leadership Network (SELN) established by NASDDDS.
- 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 principles of the EF 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 employment first practices
- The expert consultant review the activities of this group related to furthering the Commonwealth's ability to meet the employment service requirements of the Settlement Agreement including their involvement in creating the strategic plan and participating in planning and implementation activities.

Data sources:
The DBHDS Strategic Plan for Employment First; minutes of the SELN Advisory Group's quarterly meetings and interviews with SELN members

- The expert consultant will review the Employment First Policy to determine if it is inclusive of the principles set forth in the Settlement Agreement and affirm that it includes a contractual requirement of the CSBs and that this contract revision has been executed

Data Sources:
The DBHDS Employment First Policy; the contract template for the CSBs; documentation of contract execution

- The Reviewer will determine if the DBHDS has issued its expectations to case managers and providers that employment is to be discussed at the person-centered planning meetings for the target population.

Data Sources:
The DBHDS will be asked to provide any policies, protocols, and guidance that have been issued to case managers, providers, families and individuals.

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 and recreational activities, and other integrated day activities. The plan shall:

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

I. 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. 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 length of time individuals remain in pre-vocational services.
2. Targets to meaningfully increase:
   a. The number of individuals who enroll in supported employment 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.

The expert consultant will review the strategic plan to determine if it is comprehensive and supports fully the implementation of the Settlement Agreement requirements for the Commonwealth to create a system that fully supports individuals with intellectual or developmental disabilities to be fully employed or participate in integrated day activities

through its infrastructure, policies, regulations, and funding mechanisms. The Commonwealth's progress toward serving people in supported employment, helping them maintain their jobs and be paid competitive wages will be reviewed against the targets set by DBHDS.

The expert consultant will use the State Health Authority Yardstick (SHAY) plan review criteria; leadership criteria; policy and regulations, and program standards criteria to determine the adequacy of the plan considering the requirements of the Settlement Agreement. The criteria include the following elements:

Plan Review Criteria: The plan has a defined scope for initial and future implementation efforts; there is a strategy for outreach and consensus building among providers and other stakeholders; the plan identifies partners and community champions; identifies funding sources; includes training resources; identifies policy and regulatory levers to support the plan; defines the role of other state agencies in supporting and implementing the plan; defines how the initiative interfaces with other priorities and supports the mission; has an evaluation approach for implementation and outcome achievement; has evidence that the plan is written and endorsed by the lead state agency.

Leadership Criteria: The leadership of the department is perceived as effective to lead the employment initiative and sets it as a top priority; the employment plan is incorporated in the state plan or other agency documents; at least one staff is allocated to the initiative and has the necessary authority to lead it; there is allocation of non-personnel resources; the leadership uses internal and external meetings including meetings with stakeholders to move the employment initiative forward; can cite successful examples of removing policy barriers or establishing new policy supports for the employment initiative; the employment leader has adequate time for implementation; there is evidence that the employment leader has the necessary authority to implement the initiative; the leader is viewed as effective.

Policy and Regulations: DBHDS has developed effective interagency relationships (state, CSBs, legislature) to support and promote the employment initiative; identifies and removes or mitigates barriers to employment implementation; has introduced new regulations or policies as necessary to support employment; DBHDS has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to employment.

Program Standards: DBHDS has developed and implemented program standards consistent with the employment model that explicitly sets expectations consonant with employment principles and fidelity components for service delivery; has incorporated the standards into contracts and criteria for grant awards, licensing and certification; monitors whether the standards are met; defines the consequences if the standards are not met.

Data Sources:

The Strategic Plan for Employment First; updates from DBHDS on activities and accomplishments of any short term objectives to be accomplished by 4/6/13 or that will have an interim status report by this time. This includes Activity I.1., II.1, 2 3,4,5,6,7; V.1,2,3,4;training documentation; DOJ Project Employment First 1/27/13 and 4/13 updates; interview with the Employment Services Coordinator.

A. Regional Quality Councils shall review the data on a quarterly basis and shall consult with providers and the SELN regarding the need to take additional measures to further enhance these services.
B. The regional Councils will annually review the targets set pursuant to Section III C. &. B.i.B.2 and will work with providers and the SELN to determine if the targets should be adjusted upward.

The activities of the Regional Quality Councils will be reviewed during a subsequent review.
The expert consultant will produce a report for the Independent Reviewer that summarizes her findings and recommendations.

Interview Questions for Employment Services

The following questions will be asked of the Employment Services Coordinator. SELN members will be asked about their involvement in creating the employment first policy, the employment strategic plan and the targets for increasing employment options, and their sense of the progress to date of the initiative.

1. Who are the identified partners in VA working with DBHDS to advance the employment strategic plan and do their missions, goals and policies align with DBHDS in the area of employment?
2. How has the new Employment First Policy been communicated and with which stakeholders?
3. Is the state's commitment to Employment First translated into regulation or policy?
4. How did DBHDS arrive at its targets? What data and input was used to create them? How are the targets communicated and how is success being tracked and documented?
5. How is employment as a service priority communicated to families and individuals? How is it captured in the individual planning process and the plan?
6. Who is involved in this initiative at the leadership level within DBHDS? Other state agencies? Family and advocacy groups including self-advocates? Providers?
7. How are these leaders in the strategic planning process?
8. Are the rates for employment services set and competitive? Are there incentives built in for providers who offer supported employment? Is there reimbursement for providers for non-direct service, employment related activities? Do individuals have their own budgets and portability of funding to shift among providers to find the right fit?
9. Do the waiver definitions include employment services?
10. What is the status of sheltered work in VA?
11. What are the contractual expectations regarding employment outcomes for CSBs and providers and how are they monitored?

12. What training has been provided to CSB case managers and employment staff regarding the employment first policy and benefit retention for individuals who are employed?

XIV. Attachment 2—Shay Rating Scale

State Health Authority Yardstick

The SHAY Rating Scale Version of 3-12-07

1) EBP PLAN

The DBHDS has an EBP plan to address the following: (Use boxes to identify which components are included in the plan)

> *Note: The plan does not have to be a written document, or if written, does not have to be distinct document, but could be part of the state's overall strategic plan. However if not written the plan must be common knowledge among state employees, e.g. if several different staff are asked, they are able to communicate the plan clearly and consistently.*

13. A defined scope for initial and future implementation efforts,
14. Strategy for outreach, education, and consensus building among providers and other stakeholders,
15. Identification of partners and community champions,
16. Sources of funding,
17. Training resources,
18. Identification of policy and regulatory levers to support EBP,
19. Role of other state agencies in supporting and/or implementing the EBP,
20. Defines how EBP interfaces with other DBHDS priorities and supports DBHDS mission
21. Evaluation for implementation and outcomes of the EBP
22. The plan is a written document, endorsed by the DBHDS

Score: 4- fully meets components 1, 2, 3, 6, 7, 8, 9,and 10

Score

1. No planning activities
2. 1 – 3 components of planning
3. 4 – 6 components of planning
4. 7 – 9 components
5. 10 components

Evidence Used to Justify Rating:

DBHDS has created a very comprehensive Strategic Pan for Employment First. It is a broad plan that targets not only people with intellectual and developmental disabilities but also those with serious mental illness and substance abuse. It builds upon the SELN Strategic Plan Assessment (2009) developed by the SELN Advisory Group. This advisory group has

broad representation of self –advocates, family members, the educational community, CSB directors, state agencies, and providers. The plan includes:

- Interagency collaboration and an expectation that other state agencies will commit to Employment First and change regulations and policies to assure full alignment including the DBHDS plan to revise the waiver day support regulations to emphasize integrated employment and address reimbursement barriers that currently limit providers' interest in providing individualized employment support over pre-vocational activities (sheltered work);standardize allowable services funded by both DARS and DBHDS to encourage providers of HCBS waiver services for ID to offer individualized supported employment
- Interagency collaboration that involves the agencies' leadership
- An expectation that roles and responsibilities of state agencies will be defined to support streamlined coordination of resources
- Comprehensive identification of partners and specific strategies to include them in the SELN, Summits and other stakeholder engagements
- Training and technical assistance through Statewide and Regional Employment First Summits; plan to develop training for employment staff, work incentives and benefits trainings in place and widely available; training for families; and outreach to business communities
- Clear understanding of the important role the state Medicaid agency (DMAS), the state vocational agency (DARS) and the state educational agency (DOE) have in achieving the goals of this project.
- While the employment strategic plan supports the mission of DBHDS and the requirements and intent of the Settlement Agreement, the relationship to other DBHDS initiatives appears to require further exploration. There are person-centered planning resources within the department that could assist with training for the case managers to strengthen their understanding of effectively using this individualized process to encourage employment. There also needs to be a focus on how the department will use its resources to also further integrated day service options that provide opportunities for community inclusion for individuals who do not make an informed choice to seek employment opportunities.
- Identification of funding sources and plans to: braid funding sources of DARS and DBHDS to make supported employment more seamless and coordinated for individuals and develop funding policies and rates that encourage employment providers to expand or newly establish individualized supported employment
- More fully utilize the Ticket to Work program through outreach and education to increase access and use of this among individuals with ID/DD
- The plan includes an understanding of the importance of setting goals and using data to determine if the outcomes are being achieved. And sets an objective to establish MOAs with other state agencies to commit the agencies to data sharing for employment and develop the data gathering methodology.
- Targets have been established specifying the increase in supported employment the DBHDS plans to achieve and there is an expectation that the SELN and the Regional Advisory Councils will have a role in monitoring and evaluating the outcomes.

The plan recognizes the importance of training and there has been significant outreach by the DBHDS Employment Specialist to a variety of groups which will be discussed in the training section of the full report. However, there is no indication of a funding source for ongoing and comprehensive training that will be needed for case managers and

employment providers. Funding is not clearly identified in the HCBS waivers to make sure all individuals who are capable of employment and choose work will have the opportunity to do so.

2) FINANCING: ADEQUACY

Is the funding model for the EBP adequate to cover costs, including direct service, supervision, and reasonable overhead? Are all EBP sites funded at the same level? Do sites have adequate funding so that practice pays for itself?

Note: Consider all sources of funding for the EBP that apply (Medicaid fee-for-service, Medicaid waiver, insurance, special grant funds, vocational rehabilitation funds, department of education funds, etc.) Adequate funding (score of 4 or 5) would mean that the practice pays for itself; all components of the practice financed adequately, or funding of covered components is sufficient to compensate for non-covered components (e.g. Medicaid reimbursement for covered supported employment services compensates for non-covered on inadequately covered services, e.g. job development in absence of consumer). Sources: state operations and budget, site program managers. If financing is variable among sites, estimate average.

Score: 3

1. *No components of services are reimbursable*
2. *Some costs are covered*
3. *Most costs are covered*
4. *Services pays for itself (e.g. all costs covered adequately, or finding of covered components compensates for non-covered components)*
5. *Service pays for itself and reimbursement rates attractive relative to competing non-EBP services.*

Evidence Used to Justify Rating:

Individuals with ID/DD receive funding through DARS for employment services if they qualify for this agency's employment support or may receive employment support through the HCBS waivers for both ID and DD. Through its commitments under the Settlement Agreement the Commonwealth has committed to increase funding through its expansion of waiver slots for people leaving the training centers and people on the waiting lists. However, the DBHDS and CSBs use the urgency criteria to determine who from the waiting list is served. Many people interviewed reported that during this first phase many children and adolescents have been placed on the waivers. Others in the urgent category of need include individuals with significant behavioral issues or those with medical complexity who may not engage in employment immediately. There has been no targeting of any waiver funding for individuals who are on the waiting lists who want to work. The DD

waiver has a different methodology for its waiting list. Those on for the longest time period are the first to be placed on the waiver as funding/slots become available. This may provide more opportunity for people with DD seeking employment to receive waiver funding. School graduates are not a priority group to receive waiver funding as they are in some other states. This is often a group ready and interested in working for competitive wages. CSBs provide county funding for this group but the amount of funding varies by county.

There are issues that must be addressed in order for all components of supported employment to be funded at a level that attracts providers to offering individual supported employment to all who request it. Funding within the DMAS waivers was not fully aligned with the rates of reimbursement paid for similar services by DARS. The Commonwealth has begun to address this through legislative changes that matched the hourly rate for ISE between the 2 agencies and addressed the issue of funding transportation while staff accompanies the consumer. The time involved in transportation to pick up the consumer and the return time after he is returned to his residence is not a reimbursable cost. Providers report that this is a major deterrent to providing ISE in rural areas. It is still necessary to address indirect activities that are part of job development and to determine how to reimburse providers for the documentation that is required for ISE. The departments need to continue to determine how to address these outstanding issues of reimbursement and will hopefully use its redesign of the HCBS waivers to do so. DARS has had 2 years of no new funding during which time it enacted its order of selection process which constitutes a waiting list for new applicants. This year limited funding has been made available which is directed to individuals with the severest level of need. There is also no current process for people who receive DARS support to automatically transition to one of the HCBS waivers when DARS' short term employment support ends. This is another aspect of the systems coordination and funding of employment support that should be addressed through the waiver amendment process.

3) FINANCING: START-UP & CONVERSION COSTS

Are costs of start- up and or conversion covered, including: 1) Lost productivity for staff training, 2) hiring staff before clients enrolled (*e.g. ACT*), 3) any costs associated with agency planning and meetings, 4) changing medical records if necessary, 5) computer hardware and/or software if necessary, etc.

Note: If overall fiscal model is adequate to cover start-up costs then can rate 5. If financing is variable among sites, estimate average. Important to verify with community EBP program leaders/ site program managers.

Score: 2

Score:
1. No costs of start-up are covered
2. Few costs are covered
3. Some costs are covered
4.Majority of costs are covered
5. Programs are fully compensated for costs of conversion

Evidence Used to Justify Rating:

This aspect of planning for the conversion of a system does not appear to have been addressed in the strategic plan. State agencies are participating in the SELN, Summits and other planning initiative and agreements to share data are being pursued. As the DBHDS moves further along with data collection it will be important to determine if there is the need to develop a common platform for interagency data sharing and to determine what resources are needed to support this. The majority of providers in the DBHDS system provide segregated day services including sheltered workshops. Members of the SELN who were interviewed believe that these providers will need technical assistance, training and funding to convert their existing model to a new business approach that builds supported employment. As new funding has not been available from DARS, and DBHDS is developing its supported employment initiative some providers have not been able to retain their job coaches without these new referrals. The job coaching capacity in Virginia will be important to be able to respond to individuals wanting supported employment once it becomes a priority to discuss at individual planning meetings starting in July, 2013.

4) TRAINING: ONGOING CONSULTATION AND TECHNICAL SUPPORT

Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills:
(Use boxes to indicate criteria met.)

> *Note: If there is variability among sites, then calculate/estimate the average visits per site.*

23. Initial didactic training in the EBP provided to clinicians (*e.g. 1-5 days intensive training*)
24. Initial agency consultation re. implementation strategies, policies and procedures, etc. (*e.g. 1 – 3 meetings with leadership prior to implementation or during initial training*)
25. Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (*minimum of 3 months, e.g. monthly x 12 months*)
26. On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (*minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months*).
27. Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (*minimum of 3 months, e.g. monthly X 12 months*)

Not Rated

Score:
1. 2 components
2. 3 components
3. 4 components
4. 5 components

Evidence Used to Justify Rating:

5) TRAINING: QUALITY

Is a high quality training delivered to each site? High quality training should include the following:
(Use boxes to indicate which components are in place.

Note: If there is variation among sites calculate/estimate the average number of components of training across sites.)

28. credible and expert trainer,
29. active learning strategies (e.g. role play, group work, feedback,
30. good quality manual, e.g. SAMHSA Toolkit,
31. comprehensively addresses all elements of the EBP,
32. modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,
33. high quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc, e.g. SAMHSA Toolkit/ West Institute.

Not Rated

Score:
1. 0 components
2. 1 -2 components
3. 3 -4 components
4. 5 components
5. all 6 components of a high quality training

Evidence Used to Justify Rating:

6) TRAINING: INFRASTRUCTURE / SUSTAINABILITY

Has the state established a mechanism to allow for continuation and expansion of training activities related to this EBP, for example relationship with a university training and research center, establishing a center for excellence, establishing a learning network or learning collaborative. This mechanism should include the following components:
(Use boxes to indicate which components are in place)

34. offers skills training in the EBP,
35. offers ongoing supervision and consultation to clinicians to support implementation in new sites,
36. offer ongoing consultation and training for program EBP leaders to support their role as clinical supervisors and leaders of the EBP,
37. build site capacity to train and supervise their own staff in the EBP,
38. offers technical assistance and booster trainings in existing EBP sites as needed,
39. expansion plan beyond currently identified EBP sites,
40. one or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs,
41. SMHA commitment to sustain mechanism (*e.g. center of excellence, university contracts*) for
foreseeable future, and a method for funding has been identified.

Not Rated

Score:
1. No mechanism
2. 1 -2 components
3. 3 -4 components
4. 5 -6 components
5. 7 -8 components

Evidence Used to Justify Rating:

7) TRAINING: PENETRATION

What percent of sites have been provided high quality training (score of 3 or better on question #5, see note below), and ongoing training (*score of 3 or better on question #4, see note below*).

> *Note: If both criteria are not met, does not count for penetration.*
>
> *Refers to designated EBP sites only. High quality training should include 3 or more of the following components:*

42. credible and expert trainer,
43. active learning strategies (*e.g. role play, group work, feedback*),
44. good quality manual (*e.g. SAMHSA toolkit*),
45. comprehensively addresses all elements of the EBP,
46. modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,
47. high quality teaching aids/ materials including workbooks/ work sheets, slides, videos, handouts, etc. e.g. SAMHSA toolkit/ West Institute.

Ongoing training should include 3 or more of the following components:

48. Initial didactic training in the EBP provided to clinicians (*e.g. 1-5 days intensive training*)
49. Initial agency consultation re. implementation strategies, policies and procedures, etc. (*e.g. 1 -3 meetings with leadership prior to implementation or during initial training*)
50. Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (*minimum of 3 months, e.g. monthly x 12 months*)
51. On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (*minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months*).
52. Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (*minimum of 3 months, e.g. monthly X 12 months*)

Not Rated

Score:
1. 0-20%
2. 20-40%
3. 40-60%
4. 60-80%
5. 80-100%

Evidence Used to Justify Rating:

8) DBHDS LEADERSHIP: COMMISSIONER LEVEL

Commissioner is perceived as an effective leader (*influence, authority, persistence, knows how to get things done*) concerning EBP Implementation who has established EBPs among the top priorities of the DBHDS as manifested by:
(Use boxes to indicate components in place.)

Note: Rate existing Commissioner, even if new to post.

53. EBP initiative is incorporated in the state plan, and or other state documents that establish DBHDS priorities,
54. Allocating one or more staff to EBP, including identifying and delegating necessary authority to an EBP leader for the DBHDS,
55. Allocation of non-personnel resources to EBP (*e.g. money, IT resources, etc.*),
56. Uses internal and external meetings, including meetings with stakeholders, to express support for, focus attention on, and move EBP agenda,
57. Can cite successful examples of removing policy barriers or establishing new policy supports for EBP.

Score: 3- fully meets components 1, 2, and 5

Score:
1. 0 -1 component
2. 2 components
3. 3 components
4. 4 components
5. all 5 components

Evidence Used to Justify Rating:

The DBHDS has put an emphasis on employment for its consumers in the past 2 years. It has been able to get the support of both the Governor and the Legislature resulting in Executive Order 55 and the General Assembly Joint Resolution No. 127 2012 supporting the Employment First Policy by creating an expectation for both the Secretary of Health and Human Resources and the Superintendent of Public Instruction to encourage adoption and disseminate this resolution. Employment First Summits have been held in the past 2 years involving the Commissioner and other state leaders to share a consistent message of the importance of Employment First. The Employment First Policy has been issued and the strategic plan has been developed to guide its implementation. The department has designated a full time Employment Specialist to lead this initiative who brings great commitment and knowledge to the role. This new policy is an incredibly strong statement of support for Virginia's efforts to support more people with disabilities to work and be paid fairly in integrated employment settings. While all barriers have not yet been addressed, the DBHDS has started by working with DMAS to address waiver rate and

definitional issues. It has identified other barriers in the strategic plan that need to be addressed.

The next step in beginning to roll out the activities of the strategic plan will be to determine what other resources are needed to assure its successful implementation including training , IT and staffing support if the initiative proves to be more labor intensive than can be handled by the statewide employment specialist (*Component 3*).

The DBHDS is to be commended on establishing the SELN and providing staff support to coordinate its efforts. However the department must do more to demonstrate its administrative support for the work of the SELN and to make sure that the appropriate decision makers are part of the SELN or the Employment Specialist is empowered to assume a decision making role as the representative of the DBHDS. SELN members express concern that the strategic plan is not moving forward and that there needs to be more focus on providing leadership to make sure the policies, program standards and service definitions are consistent across the state agencies that are responsible to support people with ID and DD as the work relates to vocational preparation, transition and employment.

9) DBHDS LEADERSHIP: CENTRAL OFFICE EBP LEADER

There is an identified EBP leader (*or coordinating team*) that is characterized by the following:
(Use boxes to indicate which components in place.)

Note: Rate current EBP leader, even if new to post.

58. EBP leader has adequate dedicated time for EBP implementation (*min 10%*), and time is protected from distractions, conflicting priorities, and crises,
59. There is evidence that the EBP leader has necessary authority to run the implementation,
60. There is evidence that EBP leader has good relationships with community programs,
61. Is viewed as an effective leader (*influence, authority, persistence, knows how to get things done*) for the EBP, and can site examples of overcoming implementation barriers or establishing new EBP supports.

Score: 3- fully meets components 1 and 3

Score:
1. No EBP leader
2. 1 component
3. 2 components
4. 3 components
5. All 4 components

Evidence Used to Justify Rating:

Adam Sassler is the State Employment Specialist for DBHDS and is devoted full time to the employment initiative. He has excellent relationships with community programs, and is positively engaged with stakeholders including other state agencies, CSBs, advocates, parents, and providers. He demonstrates an understanding of supported employment and grasps the various elements of systems change that need to occur for this initiative to be successful. He is passionate about employment for people with ID and provides needed leadership. He has single handedly accomplished a great deal in terms of the communication and initial training needed to launch this initiative.
What is less clear is to what extent the DBHDS is empowering him to play a decision making role as he works with the SELN to develop the strategic approach and begin to implement the strategic plan. SELN members do not consistently report that he is able to make decisions on behalf of the DBHDS and they are frustrated that this delays the work of the SELN and may slow the implementation of the plan elements. Some are concerned that other members of the DBHDS leadership team either do not attend the SELN meetings regularly and when they do may not take an active role. Mr. Sassler does have influence and

is seen as a persistent advocate and good spokesperson for this initiative. The DBHDS should determine how it will best support his efforts and as the plan is implemented ensure that necessary policy, funding and strategic decisions are made in a timely way for this initiative to be successful.

10) POLICY AND REGULATIONS: NON DBHDS STATE AGENCIES

The BDHDS has developed effective interagency relations (other state agencies, counties, governor's office, state legislature) to support and promote the EBP as necessary/appropriate, identifying and removing or mitigating any barriers to EBP implementation, and has introduced new key facilitating regulations as necessary to support the EBP.

Ask BDHDS staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way? Note: give most weight to policies that impact funding.

Examples of supporting policies:

- Medicaid agency provides reimbursement for the EBP
- The state's vocational rehabilitation agency pays for supported employment programs

Examples of policies that create barriers:

62. Medicaid agency excludes EBP, or critical component, e.g. disallows any services delivered in the community
63. State vocational rehabilitation agency does not allow all clients looking for work access to services, or prohibits delivery of other aspects of the supported employment model

Score: 4

Score:

1. *Virtually all policies and regulations impacting the EBP act as barriers*
2. *On balance, policies that create barriers outweigh policies that support/promote the EBP*
3. *Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers*
4. *On balance, policies that support/promote the EBP outweigh policies that create barriers*
5. *Virtually all policies and regulations impacting the EBP support/promote the EBP*

Evidence Used to Justify Rating:

The policies of DOE and DARS are generally supportive of Supported Employment for people with ID and DD. DOE maintains data as a result of its federal regulations that is probably the most comprehensive in terms of tracking the numbers of youth by disability category and having outcome data related to their IEP outcomes and graduation. They have a number of initiatives to support transition, engage youth in post- secondary education and educate students and families to become leaders. DARS policies do not restrict access

to individuals with disabilities although pre-vocational programs including sheltered work remains as service options. The primary barrier in policy and regulation outside of DBHDS is evidenced within the state Medicaid agency (DMAS) which administers the HCBS waivers. Not all service definitions match those of DARS for supported employment and the rates were unequal historically. However, DMAS adjusted the rates a few years ago and recent legislation is addressing some of the differences in allowable services i.e. job development. What remains to be addressed is the reimbursement for the indirect costs associated with providing supported employment. The recent creation of the Employment First Policy should provide the foundation for agencies to address any inconsistencies in policies and regulations. DBHDS has led an interagency effort through the SELN AG to develop a list of questions for each agency to use to determine the policies and regulations are aligned and to then take steps to address any that cause barriers to full implementation of Employment First. This needs to be used to start the alignment process.

11) POLICIES AND REGULATIONS: DBHDS

The DBHDS has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to EBP implementation, and has introduced new key regulations as necessary to support and promote the EBP.

> *Ask BDHDS staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way? Examples of supporting policies:*

- DBHDS ties EBP delivery to contracts
- DBHDS ties EBP to licensing/ certification/ regulation
- DBHDS develops EBP standards consistent with the EBP model

Examples of policies that create barriers:

64. DBHDS develops a fiscal model or clinical guidelines that directly conflict with EBP model, e.g. ACT staffing model with 1:20 ratio
65. DBHDS licensing/ certification/ regulations directly interfere with programs ability to implement EBP

> *Score:*
> *1. Virtually all policies and regulations impacting the EBP act as barriers*
> *2. On balance, policies that create barriers outweigh policies that support/promote the EBP*
> *3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers*
> *4. On balance, policies that support/promote the EBP outweigh policies that create barriers*
> *5. Virtually all policies and regulations impacting the EBP support/promote the EBP*

Score: 3

Evidence Used to Justify Rating:

Generally the policies and regulations impacting DBHDS are those of DMAS for the HCBS waivers. DBHDS does have contractual relationships with the CSBs that receive waiver funding and provide resources for people on the waiting list to receive waiver support. DBHDS has added a contractual requirement that each CSB is responsible to address employment as the first option for individuals with ID who are receiving waiver services including day and employment support. The policy of DBHDS that creates a barrier to employment is the criteria to determine who is a priority for waiver services who is on the waiting list. DBHDS has determined that people's emergency status and urgency for need of waiver services is the determining factor which is understandable when allocating limited resources that do not meet the level of demand as expressed by the magnitude of the waiting list. However, with no funding set aside for individuals to receive employment

support who may not be in urgent situations it may leave many people with ID without access to gainful employment. The department's lack of policy to address the needs of youth graduating from school who seek employment is also a barrier to the employment first policy being fully realized.

12) POLICIES AND REGULATIONS: DBHDS EBP PROGRAM STANDARDS

The DBHDS has developed and implemented EBP standards consistent with the EBP model with the following components:
(Use boxes to identify which criteria have been met)

66. Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services. *(Note: fidelity scale may be considered EBP program standards, e.g. contract requires fidelity assessment with performance expectation)*
67. DBHDS has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms
68. Monitors whether EBP standards have been met,
69. Defines explicit consequences if EBP standards not met (*e.g. contracts require delivery of model supported employment services, and contract penalties or non-renewal if standards not met; or licensing/accreditation standards if not met result in consequences for program license*).

Score: 4- components 1, 2 and 3 are fully met

Score:
1. No components (e.g. no standards and not using available mechanisms at this time)
2. 1 component
3. 2 components
4. 3 components
5. 4 components

Evidence Used to Justify Rating:

DBHDS has defined supported employment for both individual and group employment. Providers are required to be CARF accredited and DARS certified. The employment first policy is clear that employment is in integrated settings, provides minimum wages or better and benefits, and that the individual works for the business employer. DBHDS required in the FY14 performance contract with the CSBs that employment be discussed as the first option with individuals requesting day or employment supports through the HCBS waivers. The department plans to monitor compliance with this requirement but needs to develop its monitoring protocol. To date the explicit consequences are not defined.

13) QUALITY IMPROVEMENT: FIDELITY ASSESSMENT

There is a system in place for conducting ongoing fidelity reviews by trained reviewers characterized by the following components:
(Use boxes to indicate criteria met.)

> *Note: If fidelity is measured in some but not all sites, answer for the typical site.*

70. EBP fidelity (or functional equivalent designed to assess adherence to all critical components of the EBP model) is measured at defined intervals
71. GOI fidelity (or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals.
72. Fidelity assessment is measured independent (e.g., not assessed by program itself, but by SMHA or contracted agency)
73. Fidelity is measured a minimum of annually
74. Fidelity performance data is given to programs and used for purposes of quality improvement
75. Fidelity performance data is reviewed by the BDHDS
76. The BDHDS routinely uses fidelity performance data for purposes of quality improvement, to identify and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.).
77. The fidelity performance data is made public (e.g. website, published in newspaper, etc.)

Not Rated

Score:
1. 0 – 1 components
2. 2 –3 components
3. 4 – 5 components
4. 6 – 7 components
5. All 8 components

Evidence Used to Justify Rating:

14) QUALITY IMPROVEMENT: CLIENT OUTCOMES

A mechanism is in place for collecting and using client outcome data characterized by the following:
(Use boxes to indicate criteria met.)

> *Note: Client outcomes must be appropriate for the EBP, e.g. Supported employment outcome is persons in competitive employment, and excludes prevoc work, transitional employment, and shelter workshops. If outcome measurement is variable among sites, consider typical site.*

78. Outcome measures, or indicators are standardized statewide, AND the outcome measures have documented reliability/validity, or indicators are nationally developed/recognized
79. Client outcomes are measured every 6 months at a minimum
80. Client outcome data is used routinely to develop reports on agency performance
81. Client specific outcome data are given to programs and practitioners to support clinical decision making and treatment planning
82. Agency performance data are given to programs and used for purposes of quality improvement
83. Agency performance data are reviewed by the SMHA +/- local MHA
84. The SMHA routinely uses agency performance data for purposes of quality improvement; performance data trigger state action. Client outcome data is used as a mechanism for identification and response to high and low performers (*e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.*).
85. The agency performance data is made public (e.g. website, published in newspaper, etc.)

Not rated

Scores:
1. 0 components
2. 1 – 2 components
3. 3 – 5 components
4. 6 – 7 components
5. All 8 components

Evidence Used to Justify Rating:

15) STAKEHOLDERS

The degree to which consumers, families, and providers are opposed or supportive of EBP implementation.

> *Note: Ask -Did stakeholders initially have concerns about or oppose EBPs? Why? What steps were taken to reassure/engage/partner with stakeholders. Were these efforts successful? To what extent are stakeholders currently supportive this EBP? Opposed? In what ways are stakeholders currently supporting/ advocating against this EBP? Rate only current opposition/support.*

Scores:

86. Active, ongoing opposition to the EBP
87. Opposition outweighs support, or opinion is evenly split, but no active campaigning against EBP
88. Stakeholder is generally indifferent
89. Generally supportive, but no partnerships, or active proponents.
90. Stakeholder advocacy organization leadership/opinion leaders currently offer active, ongoing support for the EBP. Evidence of partnering on initiative.

15. Summary Stakeholder Score: (Average of 3 scores below): 4

15.a Consumers Stakeholders Score: 5

15.b Family Stakeholders Score: 5

15.c Providers Stakeholders Score : 2

Evidence to Justify Ratings:

I have arrived at this rating based upon my interviews with Adam Sassler and 9 members of the SELN AG. DBHDS has done a wonderful job of reaching out to stakeholders through its statewide Employment Summits, regional summits, interagency work with DOE, the many and varied trainings provided and the creation of the SELN. The SELN AG has active participation from all groups of stakeholders. Families and consumers generally are very supportive of the initiative but can use more education and information about the transition from school to work, how to access employment, what impact employment will have on benefits, and the different options between DARS and DBHDS/HCBS waivers. The providers I spoke to individually who are on the SELN AG are supportive of employment first. Most of the individuals interviewed indicated the barrier of the attitudes of some of the larger, well established providers of sheltered workshops and segregated day services who continue to resist this change and new direction.

16) SUMMARY OF SCORES

91. EBP Plan -4
92. Financing: Adequacy-3
93. Financing: Start-up and Conversion Costs-2
94. Training: Ongoing Consultation & Technical Support -NR
95. Training: Quality -NR
96. Training: Infrastructure / Sustainability-NR
97. Training: Penetration-NR
98. SMHA Leadership: Commissioner Level-3
99. SMHA Leadership: EBP Leader -3
100. Policy and Regulations: Non-SMHA-4
101. Policy and Regulations: SMHA -3
102. Policy and Regulations: SMHA EBP Program Standards-4
103. Quality Improvement: Fidelity Assessment-NR
104. Quality Improvement: Client Outcome-NR
105. Stakeholders: Aver. Score (Consumer, Family, Provider)- 4

OVERALL SHAY SCORE = (30) SUM TOTAL ÷ 9 = 3.3

XV. Attachment 3—Summary of Employment Presentations

List of Employment First Presentations to date

DATE	SITE	Location	# attending	Affiliation
5/2/2011	Hermitage Enterprises	Glen Allen	5	CSB
5/13/2011	WorkSource	Charlottesville	5	ESO, DRS, vaACCSES
6/17/2011	TACIDD	Richmond		
7/29/2011	Region 10	Charlottesville	20	ESO, CSB, advocates
8/12/2011	Arc Convention	Virginia Beach	35	ESO, CSB, Advocates, residential
8/31/2011	ARC of the Southside	Danville	8	ESO
9/7/2011	FutureWorks	Charlottesville	1	ESO
10/2/2011	Collaborations Conference	Virginia Beach	30	DRS, CSB, ESO, advocates
10/4/2011	Employment First Summit	Virginia Beach	285	CSB,DRS,ESO,advocates,DOE,DARS,VACSB,DMAS, DDHH
10/14/2011	Greater Roanoke Valley Autism Conference	Vinton		
11/18/2011	Alliance for Full Participation	Arlington	40	advocates, ESO, DRS,
12/7/2012	Employment First Alliance	Richmond	15	APSE, AFP,DRS,ESO
12/9/2011	TACIDD	Richmond	45	advocates, DBHDS, DMAS, CSB
1/18/2012	VACSB	Richmond	40	CSB
2/14/2012	SVTC	Petersburg	17	TC staff
2/24/2012	Southside CSB	South Boston	20	CSB
3/7/2012	Hampton NN CSB	Hampton	25	CSB
3/8/2012	Person Centered Training	Fishersville	20	CSB, providers
3/13/2012	Virginia Transition Forum	Roanoke	20	CSB, DOE, DRS,advocates
3/16/2012	DBHDS	Fishersville	15	CRCs

DATE	SITE	Location	# attending	Affiliation
3/15/2012	Crossroads CSB	Farmville	20	CSB
3/21/2012	VBPD	Richmond	8	advocates, DDHH, VACSB
3/29/2012	District 19	Petersburg	8	ESO, CSB, DRS
4/16/2012	Colonial CSB	Williamsburg	15	CSB
4/17/2012	SEVTC	Chesapeake	5	TC, ESO,DRS
5/3/2012	VACSB	Williamsburg	25	CSB, DRS, ESO, advocates
5/3/2012	PRS	Arlington	5	ESO
5/17/2012	Rapahannock CSB Regional Summit	Fredricksburg	70	CSB, ESO, DRS,advocates
6/25/2012	SEVTC Regional Summit	Chesapeake	17	TC, CSB, ,ESO
7/22/2012	NAMI Housing Summit	Richmond	20	CSB, advocates, providers
8/1/2012	Career Development Initiative	Richmond	30	DOE, providers
8/6/2012	Reinventing Quality	Baltimore	50	different states
8/10/2012	Arc Convention	Virginia Beach	22	advocates,DRS,ESO
8/15/2012	Piedmont CSB Regional Summit	Martinsville	65	CSB, ESO,DRS,advocates, providers
8/17/2012	DARS New Vendors Meeting	Richmond	20	DARS, potential ESOs
8/21/2012	MPNN CSB	Kilmonarch	15	ESO
8/23/2012	Danville - Pittsylvania CSB	Danville	35	CSB, ESO
8/24/2012	Fredricksburg BH Collaboration	Fredricksburg	80	MH providers, advocates, CSB, ESO,DRS
8/28/2012	Region 10 CSB	Charlottesville	20	CSB, ESO, advocates
8/30/2012	kenmore Club	Fredricksburg	17	CSB, DRS, ESO, advocates
9/6/2012	EDI/DEN Executive Cmty	Richmond	15	DARS, ESO, DOE, VEC
9/11/2012	Fredricksburg BH Clients Conference	Fredricksburg	45	CSB, ESO, DRS, advocates

DATE	SITE	Location	# attending	Affiliation
10/1/2012	Collaborations Conference	Virginia Beach	25	CSB, ESO, DRS, advocates
10/2/2012	2nd Annual Employment Simmit	Virginia Beach	185	CSB, ESO, DRS, advocates
10/10/2012	Fredricksburg Council on Transition	Fredricksburg		
10/12/2012	Hanover CSB	Ashland	23	CSB
10/2/2012	Collaborations Conference	Virginia Beach	30	DARS, CSBs, ESOs
10/2-3/12	2nd Annual Employment First Summit	Virginia Beach	175	Self Advocates, advocacy organizations, CSBs, DARS, ESOs, DOE
10/12/2012	Hanover CSB	Hanover	33	case managers, employment staff, day program staff
10/22/2012	DOJ Settemment Committee	Richmond	40	committee members, public
10/31/2012	Arc of Agusta	Waynesboro	3	leadership of Arc
11/10/2012	Fredericksburg Area Council on Transition "Pathways to the Future"	Fredericksburg	25	students, parents, teachers
11/29/2012	Disability Employment Initiative/program Navigator	Richmond	20	DARS staff, Virginia community college (WIA) staff, VEC staff
12/12/2012	Piedmont CSB	Martinsville	17	ED, directors, employment staff, case managers
1/31/2013	Beyond Barriers	Martinsville	52	Employment staff, DARS, Case Managers, Employers, Advocates, Day program agencies, city government
2/8/2013	Arc of the Piedmont	Danville	6	DBHDS staff, employment, special education and residential staff

DATE	SITE	Location	# attending	Affiliation
2/12/2013	Mount Rogers CSB	Wythville	12	Program Director, Integration staff, BH staff ID staff, employment staff, day programming staf
2/15/2013	Piedmont Workshop Group	Roanoke	8	Goodwill staff, MARC director, PARC director, Danville-Pitts CSB staff
2/21/2013	STAND UP	Lynchburg	10	Private ESO staff
2/25/2013	VALIDD	Richmond	20	providers and CSBs
3/12/2013	South West Regional Summit Alleghany Highlands CSB	Clifton Forge	50	CSB staff, ESO staff, Case managers, employers, DARS stadd DSS staff, residential staff, day program staff, advocates/family
3/14/2013	12 Annual Autism conference	Richmond	35	Advocates, Autism staff, educators, case managers, families, DARS staff