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

April 1, 2019 – September 30, 2019

Respectfully Submitted By

Donald J. Fletcher
Independent Reviewer
December 15, 2019

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

This is the Independent Reviewer's fifteenth Report on the status of compliance with the provisions of the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress and compliance during the fifteenth review period from April 1, 2019, through September 30, 2019.

During the past four years, to reform and restructure its community-based service system for individuals with intellectual and developmental disabilities (IDD), the Commonwealth developed and executed three strategic initiatives. In part, these initiatives allow the Commonwealth to fulfill certain provisions of the Agreement. These initiatives are:

- Redesigning Home- and Community-based (HCBS) waiver programs;
- Revising the Department of Behavioral Health and Developmental Services (DBHDS) Licensing Regulations; and
- Transforming Community Service Board's (CSB) case management services.

The design of these strategic initiatives set the stage for the Commonwealth to advance implementation of a broad array of improvements to the structure, performance expectations and services provided by its community-based services system. By redesigning its HCBS waiver program, and by developing and approving new regulations that align with the requirements of the Agreement, the Commonwealth acknowledged its responsibility and strengthened its ability to ensure improvements in areas that are critical and that have been resistant to change. The Commonwealth's execution of these initiatives has resulted in it making considerable progress toward achieving compliance across a number of areas.

During its early years of implementing the Agreement, the Commonwealth achieved compliance with most of the provisions related to the creation of additional waiver slots, discharge planning and transition from Training Centers, reporting of serious incidents, and increasing the frequency of case manager face-to face visits and licensing inspections. The Commonwealth's subsequent efforts, which were guided by its planning, resource investment, and implementation, including the three strategic initiatives mentioned above, have resulted in achieving the Agreement's requirements related to offering choice among options of service providers, developing 24/7 mobile crisis teams and crisis stabilization programs, creating State and CSB Employment First policies, setting meaningful targets for supported employment, developing independent housing, licensing and human rights investigations, creating Regional Support Teams and Regional Quality Councils, and increased participation in community engagement.

However, the pace of change in other arenas remains sluggish. There is continued evidence of systemic obstacles to making needed progress required by the Agreement. The Commonwealth must clearly and assertively identify, address and resolve these obstacles in order to make substantive improvements and to achieve compliance. Six primary causes have slowed the Commonwealth's implementation progress:

- The community-based service system has insufficient staff and provider capacity;
- The Commonwealth has not been able to enforce adherence to its standards for some CSBs and providers who consistently do not fulfill requirements;
- The Commonwealth has not implemented the two external monitoring mechanisms required by the Agreement (i.e. Licensing assessments of service adequacy and Case Manager assessments of appropriate implementation of services);
- The Commonwealth has no standards to determine the adequacy or appropriate implementation of behavioral support services;
- Quality Improvement Programs are not functioning for all community services; and
- The Quality and Risk Management system is hampered by the lack of valid and reliable data.

Overall, for the provisions studied during the fifteenth period, the Independent Reviewer is determining that the Commonwealth has successfully sustained previous ratings of compliance.

In addition, the Commonwealth has also made sufficient progress to achieve one new rating of compliance, offering Root Cause Analysis and related training and guidance to providers. Commonwealth also took actions to achieve substantial progress in provider training, transportation, and mortality reviews, but has not yet made sufficient progress to achieve compliance. The Commonwealth's lack of meaningful progress and continued ratings of non-compliance with remaining provisions are frequently due to the six systemic obstacles described above.

The Commonwealth's development of the Section V - Quality and Risk Management (QRM) system - has been particularly slow, with multiple self-assessments and new beginnings, yet without substantial overall progress. With approximately one year remaining, until January 1, 2021, for the Commonwealth to demonstrate sustained compliance, some elements of the quality system, i.e. Quality Services Reviews, will likely take 18 to 24 months of effective implementation before compliance can be achieved for the first time, and an additional six months to demonstrate sustain compliance. The provisions of this section were deliberately designed by the Parties to integrate with one another so that services provided are of "good quality, meet individuals' needs, help individuals achieve positive outcomes, and ensure that appropriate services are available and accessible for individuals in the target population".

To be successful, each part of a quality system must carry its load. These include defining the data elements; gathering, submitting, and processing reliable and valid data; and analyzing and reporting. Only when each part is working effectively can systemic weaknesses be identified and prioritized for design and implementation of needed improvement initiatives. The development of a complex community-based service system would have benefitted from a functioning QRM.

However, the Commonwealth, now in its eighth year of implementing the requirements of the Agreement does not yet have a fully working QRM system. It's fledgling system to ensure quality continues to be hampered by a long standing and fundamental problem: the lack of reliable and valid data. This block to sufficient progress is also related to the Commonwealth's inability to effectively enforce adherence to performance standards by some low performing providers and CSBs.

During the next review period, the Independent Reviewer will prioritize studying the status of the Commonwealth's progress in achieving the following:

- Creation of waiver slots;
- Individual and Family Support Program;
- Case Management services;
- Crisis Services;
- Peer to Peer/Family to Family and Guidelines for Families;
- Serving individuals in the most integrated setting, including children in nursing facilities and the largest ICFs;
- Serving individuals with intense behavioral needs; and
- Training Center discharge and transition planning.

In these studies, the Independent Reviewer will use the compliance indicators agreed upon by the Parties and/or established by the Court to determine the compliance rating.

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

II. SUMMARY OF COMPLIANCE

Settlement Agreement Reference	Provision	Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	**Compliance ratings for the eleventh, twelfth, thirteenth, fourteenth, and fifteenth periods are presented as:** 11th period 12th period (13TH period) *14th period* **15th period**	**Comments include example(s) to explain the ratings and status. The Findings Section and attached consultant reports include additional explanatory information re: indicators of compliance.** ***The Comments in italics below are from a prior period when the most recent compliance rating was determined.***
III.C.1.a.i-viii	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community ... vii. In State Fiscal Year 2019, 35 waiver slots	Compliance Compliance *Compliance*	*The Commonwealth created sixty Community Living waiver slots during FY 2019, twenty-five more than the minimum number required for individuals to transition from Training Centers.*
III.C.1.b.i-viii	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) ... vii. In State Fiscal Year 2018, 325 waiver slots.	Non Compliance Non Compliance *Compliance*	*The Commonwealth created 568 new waiver slots in FY 2019 exceeding the total required for the former ID and IFDDS slots.* *The Independent Reviewer will consider the effectiveness of the discharge and transition process at NFs and ICFs as an indicator of compliance for III.D.1.*
III.C.1.c.i-viii	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) ... viii. In State Fiscal Year 2019, 25 waiver slots"	Non Compliance Non Compliance *Compliance*	*The Commonwealth created 568 new waiver slots in FY 2019 exceeding the total required for the former ID and IFDDS slots.* *The Independent Reviewer will consider the effectiveness of the discharge and transition process at NFs and ICFs as an indicator of compliance for III.D.1.*

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

Settlement Agreement Reference	Provision	Rating	Comments
III.C.5.c	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	Non Compliance Non Compliance (Non Compliance) *Compliance* **Compliance**	The Individual Services Review studies during the tenth, eleventh, twelfth, thirteenth and fifteenth periods found that case managers had offered choices of residential and day providers. The offer of a choice of case managers is now documented as part of the ISP process and was documented for 53 of 54 (98.1%) of the individuals studied in the fourteenth and fifteenth periods.
III.C.5.d	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	Non Compliance (Non-Compliance) **Non Compliance**	Licensing protocols continue to not include a review of the adequacy of case management services, including a review of whether case managers are fulfilling their responsibilities to determine whether services are being delivered appropriately and remain appropriate to the individual.
III.C.6.a.i-iii	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall: i. Provide timely and accessible support ... ii. Provide services focused on crisis prevention and proactive planning ... iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual ...	Non Compliance Non Compliance (Non Compliance) *Non Compliance*	*This is an overarching provision. Compliance will not be achieved until the Commonwealth is in compliance with the components of Crisis Services, as specified in the provisions of the Agreement.*
III.C.6.b.i.A	The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	Compliance Compliance (Compliance) *Compliance*	*CSB Emergency Services are utilized. REACH hotlines are operated 24 hours per day, 7 days per week, for adults and for children with IDD.*

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

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

Settlement Agreement Reference	Provision	Rating	Comments
III.C.6.b.iii.G.	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	Non Compliance Non Compliance *Non Compliance*	*The Commonwealth determined that it is not necessary to develop additional "crisis stabilization programs" for adults in each Region. It has decided to add two programs statewide to meet the crisis stabilization/transitional home needs of adults who require longer stays. Children's crisis stabilization programs are also planned, but developments have again been delayed.*
III.C.7.a	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	Non Compliance (Non Compliance) **Non Compliance**	This is an overarching provision. Compliance will not be achieved until the component provisions of integrated day, including supported employment, are in compliance.
III.C.7.b	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in the ISP. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.	Non Compliance Non Compliance (Non Compliance) **Non Compliance**	The Qualitative Review study found that: • the discussions required by (3) had not occurred for 27 percent of eligible individuals studied. • The ISP checked box, where the case manager self-reports that this discussion occurred, did not consistently indicate that a discussion, or an adequate discussion, had occurred. The data from the checked boxes were reported to DBHDS. • Other than the ISP checked boxes, the Individual Services Review study did not find case manager notes indicating that employment services and goals were developed and discussed. The Commonwealth did not have an employment service coordinator during the fifteenth Review period.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.7.b.i.	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreation opportunities, and other integrated day activities.	Non Compliance (Compliance) Compliance	The Commonwealth had previously developed plans for both supported employment and for integrated community activities. It has reviewed, revised and improved its implementation plans.
III.C.7.b.i.A.	Provide regional training on the Employment First policy and strategies through the Commonwealth.	Compliance (Compliance) Compliance	DBHDS continued to provide regional training.
III.C.7.b.i. B.1.	Establish, for individuals receiving services *through the HCBS waivers*, annual baseline information regarding:	Compliance (Compliance) Compliance	The Commonwealth has sustained its improved method of collecting data. For the third consecutive full year, data were reported by 100 percent of the employment service organizations. They continue to report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a, b, c, d, and e below.
III.C.7.b.i. B.1.a.	The number of individuals who are receiving supported employment.	Compliance (Compliance) Compliance	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.b.	The length of time individuals maintain employment in integrated work settings.	Compliance (Compliance) Compliance	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.c.	Amount of earnings from supported employment;	Compliance (Compliance) Compliance	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.d.	The number of individuals in pre-vocational services.	Compliance (Compliance) Compliance	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.e.	The length-of-time individuals remain in pre-vocational services.	Compliance (Compliance) Compliance	See answer for III.C.7.b.i.B.1.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.7.b.i. B.2.a.	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	Non Compliance (Non Compliance) **Non Compliance**	The Commonwealth set targets to meaningfully increase the number who enroll. Its quality improvement program has not been sufficient to identify and plan to address systemic obstacles to increasing employment for individuals with waiver-funded.
III.C.7.b.i. B.2.b	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	Compliance (Compliance) **Compliance**	Of the number of individuals who were employed in June 2018, 90 percent had retained their jobs twelve months later in June 2019, which exceeded the 85 percent target set in 2014.
III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. ... shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly ... Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	Compliance (Compliance) **Compliance**	The RQCs continue to meet each quarter, to consult with the DBHDS Employment staff, both members of the SELN (aka E1\AG), and to review progress toward targets. Continuing compliance will require evidence that the RQC's consult with providers.
III.C.7.d.	The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.	Compliance (Compliance) **Compliance**	In FY 2019, the five RQCs all reviewed employment data and targets.
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	Non Compliance **Non Compliance**	DMAS/Broker successfully implemented many improvements. The rate of complaints by users with IDD regarding late pickup and delivery are substantially higher than for individuals without disabilities and for the MCOs transportation. The transportation quality improvement program is not sufficient to identify and address this most significant issue/outcome for IDD users.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.8.b.	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access	Non Compliance *Non Compliance*	*DBHDS has continued to make progress, but has not yet implemented components of its multi-part plan for publishing guidelines.*
III.D.1.	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	Non Compliance *Non Compliance*	*Implementation of the redesigned waivers has increased options. However, there are not enough "most integrated settings", or providers, to serve:* *▪ individuals with intense needs,* *▪ individuals wanting increased independence, and/or* *▪ children who are growing up living in institutions without an integrated out-of-home family-like residential option.*
III.D.2.	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources.	Compliance *Compliance*	*As of 3/31/19, the Commonwealth had created new options for 925 individuals, now living in their own homes, exceeding its targeted goal for 6/30/19 of 796. Its Outcome-Timeline schedule is to provide independent community-based housing to 1866 individuals by the end of FY 2021.*
III.D.3.	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	Compliance *Compliance*	*The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies.*

Settlement Agreement Reference	Provision	Rating	Comments
III.D.3.a.	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ...	Compliance *Compliance*	*A DBHDS housing service coordinator developed and updated the plan with these representatives and with others.*
III.D.3.b.i-ii	The plan will establish for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and recommendations to provide access to these settings during each year of this Agreement.	Compliance *Compliance*	*The Commonwealth estimated the number of individuals who would choose independent living options. It has revised the Housing Plan with new strategies and recommendations.*
III.D.4	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing from a one-time fund of $800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii.	**Compliance and Completed**	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds received permanent rental assistance.
III.D.5	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	Non Compliance Non Compliance *Non Compliance*	*Peer to peer and family-to-family programs were not active for individuals who live in the community and their families.*
III.D.6	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	Non Compliance Non Compliance (Non Compliance) **Non Compliance**	Although DBHDS has sustained and added substantive process improvements and Case Managers submitted a higher percent of RST referrals on-time, too many continue to be submitted late (after or concurrent with the individual's move), which nullifies the purpose of the RST review.

Settlement Agreement Reference	Provision	Rating	Comments
III.D.7	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home ...	Compliance (Compliance) *Compliance* **Compliance**	The Commonwealth included this term in the performance contracts, developed and provided training to case managers and implemented an ISP form with education about less restrictive options.
III.E.1	The Commonwealth shall utilize Community Resource Consultant ("CRC") positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office...The CRCs shall be a member of the Regional Support Team ...	Compliance (Compliance) *Compliance* **Compliance**	Community Resource Consultants (CRCs) are located in each Region, are members of the Regional Support Teams, and are utilized for these functions.
III.E.2	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	Non Compliance (Compliance) **Compliance**	DBHDS has sustained improved RST processes. When case managers submit timely referrals, CRCs and the RSTs continue to fulfill their roles and responsibilities and the Regional Support Teams frequently succeed at their core functions.
III.E.3.a-d	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	Compliance (Compliance) **Compliance**	DBHDS established the RSTs, which meet monthly. The CRCs continue to refer cases to the RSTs as required.

Settlement Agreement Reference	Provision	Rating	Comments
IV	**Discharge Planning and Transition**	**Compliance ratings for the twelfth and fourteenth periods are presented as:** 12th period *14th period*	**Note: The Independent Reviewer gathered information about individuals who transitioned from Training Centers and rated compliance during the first, third, fifth, seventh, ninth, twelfth and fourteenth review periods.** ***The Comments in italics below are from the period when the compliance rating was determined.***
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	Compliance *Compliance*	*The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It has continued to implement improvements in response to concerns identified by the Independent Reviewer.*
IV.A	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	Non Compliance *Non Compliance*	*This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Discharge section are determined to be in compliance.*
IV.B.3.	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	Compliance *Compliance*	*The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.*
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	Non Compliance *Non Compliance*	*Discharge plan goals did not include measurable outcomes that promote integrated day activities. Two (8.3%) of the 24 individuals studied were offered integrated day opportunities and one (3.7%) had typical days that included regular integrated activities. Eighteen (66.7%) of the 27 studied did not have day programs five to nine months*

Settlement Agreement Reference	Provision	Rating	Comments
			after moving to the community.
IV.B.5.	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan will be developed within 30 days prior to discharge.	Compliance *Compliance*	*The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans are well documented. All individuals studied had discharge plans.*
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	Compliance *Compliance*	*The documentation of information provided was present in the discharge records for 72 (100%) of the individuals studied during the ninth, twelfth, and fourteenth review periods.*
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	Compliance *Compliance*	*The discharge plans included this information.*
IV.B.5.c.	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	Compliance *Compliance*	*For 122 of 124 individuals (98.4%) studied during the fifth, seventh, ninth, twelfth and fourteenth review periods, the discharge records included these assessments.*
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	Compliance *Compliance*	*The PSTs select and list specific providers that provide identified supports and services.*

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	Compliance *Compliance*	*The Training Centers document barriers in six broad categories as well as more specific barriers.*
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	Compliance *Compliance*	*The severity of the disability has not been a barrier in the discharge plans.*
IV.B.5.e.ii.	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	Compliance *Compliance*	*DBHDS has identified the factors that led to readmission and has implemented steps to support individuals with intensive needs.*
IV.B.6	Discharge planning will be done by the individual's PST...Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	Non Compliance *Non Compliance*	*The Individual Services Review Study found that the discharge plans lacked recommendations for services in integrated day opportunities and such opportunities were not provided. The fourteenth period ISR study also found that 18 of 27 (67%) individuals did not have any day service five to nine months after moving, and that only 1 of 27 (3.7%) had a typical day that included regular integrated activities*
IV.B.7	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	Compliance *Compliance*	*The Commonwealth's discharge plans indicate that individuals with complex/intense needs can live in integrated settings.*
IV.B.9.	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	Compliance *Compliance*	*The Individual Services Review studies during the fifth, seventh, ninth, twelfth, and fourteenth review periods found that 124 (100%) of individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST.*
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	Compliance *Compliance*	*Discharge records included evidence that the Commonwealth had offered a choice of providers.*

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the ... community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	Compliance *Compliance*	*The ninth, twelfth and fourteenth individual services reviews found that 39 of 45 individuals (86.7%) and their ARs did have an opportunity to speak with individuals currently living in their communities and their family members. All (100%) received a packet of information with this offer, but discussions and follow-up were not documented for four individuals.*
IV.B.9.c.	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	Compliance *Compliance*	*PSTs and case managers assisted individuals and their Authorized Representative. For 100 percent of the 72 individuals studied in the ninth, twelfth and fourteenth ISR studies, providers were identified and engaged; provider staff were trained in support plan protocols.*
IV.B.11.	The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	Compliance *Compliance*	*During the fifth, seventh, ninth, twelfth and fourteenth review periods, the reviews found that 116 of 124 individuals /Authorized Representatives (93.5%) who transitioned from Training Centers were provided with information regarding community options.*

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.11.a.	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	Compliance *Compliance*	*The Independent Reviewer confirmed that training has been provided via regular orientation, monthly and ad hoc events at all Training Centers, and via ongoing information sharing.*
IV.B.11.b.	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches ... will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	Compliance *Compliance*	*The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training. All Training Centers have person-centered coaches. DBHDS reports that regularly scheduled conferences provide opportunities to meet with mentors. An extensive list of trainings was provided and attendance is well documented.*
IV.B.15	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	Compliance *Compliance*	*See Comment for IV.D.3.*

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.1	Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.	Compliance *Compliance*	*The Independent Reviewer found that for the ninth, twelfth, and fourteenth ISR studies, residential staff for all 72 individuals participated in the pre-move ISP meeting and were trained in the support plan protocols.*
IV.C.2	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	Compliance *Compliance*	*During the fifth, seventh, ninth, twelfth, and fourteenth periods, the Independent Reviewer found that 121 of 124 individuals (97.6%) had moved within 6 weeks, or reasons were documented and new time frames developed.*
IV.C.3	The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	Compliance *Compliance*	*The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions. During the fifth, seventh, ninth, twelfth and fourteenth review periods, the ISR studies found that for 124 (100%) individuals, PMM visits occurred. The monitors had been trained and utilized monitoring checklists. The look-behind process was maintained during the seventh period.*
IV.C.4	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	Compliance *Compliance*	*The Individual Services Review studies during the ninth, twelfth and fourteenth review periods found that:* *For 71 of 72 individuals (98.6%), the Commonwealth updated discharge plans within 30 days prior to discharge.*

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.5	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential. supports are in place at the individual's community placement prior to the individual's discharge.	Compliance *Compliance*	*The reviewers confirmed that the Personal Support Teams (PSTs), including the Authorized Representative, had determined and documented, and the CSBs had verified, that essential supports to ensure successful community placement were in place prior to placement.*
IV.C.6	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.	Compliance *Compliance*	*The discharge records reviewed in the ninth, twelfth, and fourteenth review periods indicated that all twenty-six individuals (100%) who moved to settings of five or more did so based on their informed choice after receiving options.*
IV.C.7	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	Compliance *Compliance*	*The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans.*
IV.D.1	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	Compliance *Compliance*	*Community Integration Managers (CIMs) are working at each Training Center.*
IV.D.2.a	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	Compliance *Compliance*	*CIMs reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals.*

Settlement Agreement Reference	Provision	Rating	Comments
IV.D.3	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	Compliance *Compliance*	*During the twelfth period, there were improvements in the timeliness of referrals to the RST, which is essential to allow sufficient time for the CIM and RST to resolve identified barriers. During the fourteenth period, the ISR study of individuals who moved from Training Centers, found that 11 of 12 (91.3%) were referred timely.*
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	Compliance *Compliance*	*The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.*
V.	Quality and Risk Management	**Compliance ratings for the eleventh, twelfth, thirteenth, fourteenth, and fifteenth periods are presented as:** 11th period 12th period (13TH period) *14th period* **15th period**	***The Comments in italics below are from a prior period when the most recent compliance rating was determined.***
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	Non Compliance (Non Compliance) **Non Compliance**	This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Quality section are determined to be in compliance.
V.C.1	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	Non Compliance (Non Compliance) **Non Compliance**	The Commonwealth does not yet have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks.

Settlement Agreement Reference	Provision	Rating	Comments
V.C.2	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	Compliance (Compliance) **Compliance**	DBHDS implemented a web-based incident reporting system. Providers report 89 percent of incidents within one day of the event. Some duplicate reports are submitted late.
V.C.3	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	Non Compliance (Compliance) **Compliance**	DBHDS revised its regulations, increased the number of investigators and supervisors, added expert investigation training, created and Investigation Unit, includes double loop corrections in CAPs for immediate and sustainable change, and requires 45-day checks to confirm implementation of CAP s re: health and safety.
V.C.4	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	Non Compliance (Non Compliance) **Compliance**	DBHDS has provided guidance and in-person training. The DBHDS regulations now require that licensed providers to use Root Cause Analysis in internal investigations for Level II and III incidents.
V.C.5	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The ...mortality review team ... shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death; ... (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems ... and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	Non Compliance (Non Compliance) **Non Compliance**	A Mortality Review Committee (MRC) has significantly improved its data collection, data analysis, membership, and attendance with improved processes and quality of mortality reviews. It has begun a quality improvement program. The MRC completed only 44 percent of its reviews within 90-days during FY 19, but 91.8 percent during the final three months. The newly recruited member, who is independent of the State, attended only 4 of 17 (24%) of the MRC meetings.

Settlement Agreement Reference	Provision	Rating	Comments
V.C.6	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider.	Non Compliance (Non Compliance) **Non Compliance**	DBHDS cannot consistently use available mechanisms to sanction providers, beyond use of Corrective Action Plans to require consistent provider compliance with minimum standards.
V.D.1	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	Non Compliance (Non Compliance) **Non Compliance**	This is an overarching provision that requires effective quality improvement processes to be in place at the CSB and State level, including monitoring of participant health and safety.
V.D.2.a-d	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement.	Non Compliance (Non Compliance) **Non Compliance**	DBHDS quality and risk management system does not yet have consistently reliable and valid data throughout its system.
V.D.3.a-h	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	Non Compliance (Non Compliance) **Non Compliance**	DBHDS has not resolved significant challenges with the reliability and validity of the data still throughout the system.

Settlement Agreement Reference	Provision	Rating	Comments
V.D.4	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	Non Compliance (Non Compliance) **Non Compliance**	This is an overarching provision. It will be not be rated in compliance until reliable data are provided from all the sources listed and cited by reference in V.C. and in V.E-G.
V.D.*5*	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	Non Compliance (Non Compliance) **Non Compliance**	DBHDS shared and RQCs reviewed data including: employment, OLS, OHR, and other data. The RQCs, however, had limited and frequently unreliable data available for review. See comment re: V.D.*5*.b. below.
V.D.*5*.a	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	Compliance (Compliance) **Compliance**	The five Regional Quality Councils include all the required members.
V.D.*5*.b	Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	Non Compliance (Non Compliance) **Non Compliance**	The RQCs met quarterly, but had limited discussion. The RQC members do not have the training, tools or reliable and valid data to full the RQC role. The DBHDS Quality Improvement Committee directed the RQCs work.
V.D.6	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability ... and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	Non Compliance (Non Compliance) **Non Compliance**	DBHDS has not yet implemented its plans for public reporting .
V.E.1	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program including root cause analysis that is sufficient to identify and address significant issues.	Non Compliance (Non Compliance) **Non Compliance**	The Commonwealth has approved new Regulations that require providers to have QI programs, and has issued guidance, including how DBHDS will monitor compliance. No reports were yet available regarding whether and

Settlement Agreement Reference	Provision	Rating	Comments
			to the extent providers have implemented QI programs.
V.E.2	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	Non Compliance (Non Compliance) **Non Compliance**	The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS revised Licensing Regulations require providers to have risk management and QI programs, and Licensing has issued guidance. The Commonwealth has not reported the measures or the extent to which CSBs and providers are complying with risk management and QI reporting.
V.E.3	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	Non Compliance **Non Compliance**	The Commonwealth has paused its QSRs until it completes an RFP process and selects a new vendor.
V.F.1	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	Compliance Compliance (Compliance)	*The eleventh period case management study and the thirteenth ISR study found that 44 of the 47 case managers (93.6%) were in compliance with the required frequency of visits. DBHDS reported data that some CSBs are below target.*

Settlement Agreement Reference	Provision	Rating	Comments
V.F.2	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs....	Non Compliance *Non Compliance*	*See comment for III.C.5.b.i.*
V.F.3.a-f	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	Compliance Compliance *Compliance*	*The ninth, twelfth, and fourteenth ISR studies found that the case managers had completed the required monthly visits for 72 of 73 individuals (98.6%).*
V.F.4	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	Non Compliance Non Compliance **Non Compliance**	DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to assess CSB compliance with their performance standards relative to case manager contacts.
V.F.5	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	Non Compliance Non Compliance	*DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to capture case manager/support coordinator findings regarding the individuals they serve.*

Settlement Agreement Reference	Provision	Rating	Comments
V.F.6	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	Compliance	*The Commonwealth developed the curriculum with training modules that include the principles of self- determination. The modules are being updated.*
V.G.1	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	Compliance (Compliance) **Compliance**	OLS regularly conducts unannounced inspection of community providers.
V.G.2.a-f	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Compliance (Compliance) **Compliance**	OLS has maintained a licensing inspection process with more frequent inspections.
V.G.3	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	Non Compliance Non Compliance (Non Compliance) **Non Compliance**	The DBHDS licensing process has not yet incorporated protocols that include assessing the adequacy of the individualized supports and services provided.
V.H.1	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	Non Compliance (Non Compliance) **Non Compliance**	The Commonwealth developed and improved the statewide competency-based curriculum, and approved new waiver regulations that require DSP and supervisors in waiver-funded services to receive this training. It has not effectively monitored or enforced provider adherence to the requirement that all staff complete core-competency training.
V.H.2	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	Non Compliance (Non Compliance) **Non Compliance**	Same as V.H.1 immediately above.

Settlement Agreement Reference	Provision	Rating	Comments
V.I.1.a-b	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	Non Compliance (Non Compliance)	As of 7/1/19, the Commonwealth has paused use of the QSRs. It has since issued an RFP with plans to revamp and has renew the required annual QSR process once it selects a new vendor. The Independent Reviewer's annual review of the status of the Commonwealth's progress toward achieving the requirements of the QSR provisions was postponed because the Commonwealth acknowledged that it would not have a QSR provider under contract during the second half of the fifteenth review period.
V.I.2	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting .	Non Compliance (Non Compliance)	Same as V.I.1. immediately above
V.I.3	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	Non Compliance (Non Compliance)	Same as V.I.1. immediately above.
V.I.4	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	Compliance (Compliance)	Same as V.I.1. immediately above.
VI	**Independent Reviewer**	**Rating**	**Comment**
VI.D.	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with the, ... shared with Intervener's counsel.	Compliance Compliance (Compliance) *Compliance* Compliance	DBHDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.
IX	**Implementation of the Agreement**	**Rating**	**Comment**

Settlement Agreement Reference	Provision	Rating	Comments
IX.C.	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented ...	Non Compliance Non Compliance (Non Compliance) *Non Compliance* **Non Compliance**	The Independent Reviewer has determined that the Commonwealth did not maintain sufficient records to document proper implementation of the provisions, including integrated day services and case management.

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

III. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

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

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

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

- Services for Individuals with Intense Behavioral Needs;
- Integrated Day and Supported Employment;
- Regional Support Teams;
- Transportation;
- Investigations: Offices of Licensing and Human Rights;
- Mortality Review;
- Training; and
- Quality Assurance/Quality Improvement.

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

For the fifteenth time, the Independent Reviewer utilized his Individual Services Review (ISR) study process to evaluate the status of services for a selected sample of individuals. Previous Individual Services Review studies, including the seven studies of individuals who transitioned from Training Centers, included individuals with intense behavioral needs; for the third time, the Individual Services Review study during the fifteenth period focused only on individuals with such needs. By utilizing the same questions over several review periods, for different subgroups and in different geographical areas, the Independent Reviewer has identified findings that include positive outcomes as well as areas of concern. The size of the selected sample allows findings to generalize to the cohort (i.e., by studying 27 randomly selected individuals, findings can generalize to the cohort of 42 individuals with a 90 percent confidence factor). After carefully reviewing these findings, the Independent Reviewer has identified and reported themes.

To determine the ratings of compliance for the fifteenth period (April 1, 2019 through September 30, 2019), the Independent Reviewer considered information provided by the Commonwealth for the period prior to November 15, 2019. The Independent Reviewer also considered the findings and conclusions from the consultants' studies, the Individual Services Review study, the Commonwealth's planning and progress reports and documents, as well as other sources. The Independent Reviewer's compliance ratings are best understood by reviewing the comments in the Summary of Compliance table, the Findings section of this Report, and the consultant reports, which are included in the Appendices. For each study, the Commonwealth was asked to provide any additional records that document the proper implementation of the provisions being reviewed. Information that was not provided for the studies is not considered in the consultants' reports or in the Independent Reviewer's findings, conclusions, and compliance determinations. If the Commonwealth was not able to provide, or informed the Independent Reviewer that there was not, sufficient information to demonstrate that the indicators of compliance for a provision had been achieved, then the Independent Reviewer determined a rating of non-compliance.

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

B. Compliance Findings

1. Serving Individuals with Intense Behavioral Needs

The Individual Services Review study during the fifteenth period studied the service outcomes for 42 individuals with intense behavioral service needs. The cohort for this study was comprised of all the individuals who:

- Live in community-based settings in Region II (Northern), Region III (Southwestern), or Region V (Eastern);
- Are receiving HCBS waiver-funded services;
- Were placed in level seven (Intense Behavioral Support Needs), the highest level, based on the results of their Support Intensity Scale assessments; and
- Had their most recent ISP start date from April 2, 2019 through May 31, 2019.

Twenty-seven individuals were selected randomly from the list of 42, which provides a 90 percent confidence factor that the study's findings can be generalized to the cohort. The themes that emerged from this Individual Services Review (ISR) study are reported below. Tables with the specific findings from the completed Monitoring Questionnaires that were completed as part of this study are included in Appendix A. The ISR Monitoring Questionnaires completed for each individual were provided to the Commonwealth under seal as they include private contact and health information. By March 31, 2020, DBHDS will provide written responses to the concerns that the independent ISR review teams identified related to the services for each individual in the selected sample. The next section of this Report to the Court, Behavioral Programming and Supports, includes the findings of the Independent Reviewer's more in-depth study of a subset of eight of the 27 individuals who were randomly selected for the ISR study.

Themes from the ISR Study of Individuals with Intense Behavioral Needs

Although there were individual exceptions, the ISR study identified themes regarding the positive outcomes and areas of concern:

Positive Outcomes

More individuals lived in more integrated settings. Of the 17 individuals who did not live in their own home, leased apartment, or family's home, 14 (83%) lived in more integrated community-based settings of four or fewer individuals.

Overall, the individuals' support plans were current and person-centered (i.e., individualized). Case Managers offered annual education about less restrictive services and a choice of providers, including case management, and typically made the required onsite Enhanced Case Management monthly face-to-face visits, including to the individuals' homes.

Residential staff were able to describe the individual's likes and dislikes, talents and contributions and what's important to and important for the individual, as well as the individual's health related needs and their role in ensuring the needs are met.

The families of the individuals with intense behavioral needs who were living at home provided love, support and exhibited great strength to ensure their family member's health, safety and well-being.

There were many positive healthcare process outcomes for virtually all the individuals studied. All but one of the individuals had a physical exam within a year and their Primary Care Physicians' recommendations were implemented within the prescribed timeframes. All individuals had physician ordered diagnostic consults completed as ordered and within the recommended time frame. All but two had their medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist.

Areas of concern

Structured behavioral programming and supports were not provided to, or available for, most of the individuals. These individuals displayed aggressive, dangerous, and disruptive behaviors that negatively impacted their quality of life and that disrupted their households and other community settings. The behavioral programing that was provided was substantially inadequate. Not one of the eight individuals whose behavioral supports were studied in depth was receiving the elements of the behavioral programming that are essential for adequate behavioral programming.

Neither of the Agreement's two required external monitoring systems identified that behavioral services were frequently not available, or if available, were inadequate and/or were not being implemented appropriately. DBHDS's Office of Licensing has not implemented, as part of its licensing process, an assessment of adequacy of individualized services and none of these individuals' Case Managers had identified that the behavioral services that were in place were not being implemented appropriately.

Staff at the group, or sponsor, homes for seven of 16 (43.8%) individuals had not received competency-based training (i.e., training that provides knowledge of performance expectations and that requires staff to demonstrate the skills learned), as required by the Agreement.

The difficulty experienced by service providers and families in recruiting and retaining Direct Support Professionals (DSPs) to work with individuals with challenging behaviors who lived in their families' homes undermined the adequacy and continuity of needed and planned services.

Integrated day opportunities, including supported employment, were not being implemented effectively. Only two of the 20 adults were receiving Community Engagement services and none had supported employment. There were too few Community Engagement providers available. Case Managers did not typically develop and discuss goals with individuals and their Authorized Representatives to help them to better understand the options for, and paths to, achieving supported employment.

Once again, for individuals prescribed psychotropic medications, a combination of concerns was found that could contribute to serious negative health consequences. At the residential settings where these medications were administered, there was a lack of documentation of informed consent and of the intended side effects of the medications. There was no evidence in the records that the individuals' nurses or psychiatrists conduct monitoring using a standardized tool for the detection of tardive dyskinesia side effects for 22 percent of individuals receiving psychotropic medications.

For many of the individuals studied, the Case Managers did not fulfill certain requirements of the Agreement, as follows:

- The outcomes in ISPs were not specific and measurable; therefore, accomplishment could not be determined and reported reliably;
- Employment service goals were not developed *and* discussed; and
- Case Managers did not identify that behavioral programming was not being appropriately implemented.

2. Behavioral Programming and Supports

The Independent Reviewer retained an independent expert (Ph.D.,BCBA-D) consultant to study in greater depth the behavioral programming and supports for eight of the 27 individuals with intense behavioral needs who were randomly selected for the fifteenth Individual Services Review study. Based on interviews with caregivers and providers, and a review of documentation, the consultant compared the behavioral programming and supports that were in place with generally accepted standards and practice recommendations with regard to the components of effective behavioral programming and supports.

These standard components included:

- Level of need (i.e., based on behaviors that are dangerous to self or others, disrupt the environment and negatively impact his/her quality of lifer and ability to learn new skills and gain independence);
- Functional Behavior Assessment (FBA);
- Behavioral Support Plan (BSP) that is developed and overseen by a qualified clinician;
- Behaviors targeted for decrease;
- Functionally equivalent behaviors targeted for increase;
- Care provider and staff training; and
- Ongoing data collection, including regular summary and analysis with revision as necessary.

The individuals sampled had significant maladaptive behaviors that were not under control. Specifically, of the eight individuals sampled:

- Eight (100%) engaged in behaviors that injured self or others;
- Eight (100%) engaged in behaviors that disrupted the environment;
- Eight (100%) engaged in behaviors that impeded their ability to access a wide range of environments; and
- Eight (100%) engaged in behaviors that impeded their abilities to learn new skills or generalize already learned skills.

The Individual Services Review study found that most of the families and residential programs were managing the selected individuals' behaviors in most situations. However, the independent review teams determined that two of the individuals were in imminent risk of harm. There were also very concerning exceptions that involved assault, property destruction, eloping, injury to self and others, police involvement, and admissions to psychiatric hospitals. Overall, there were very few examples of plans being implemented effectively to eliminate and replace maladaptive behaviors, which is a central purpose of behavioral programming.

The following areas of concern were documented by the in-depth study of behavioral programming and supports for the subset of eight individuals:

- Of these eight individuals, only three (37.5%) were receiving formal behavioral programming through the implementation of comprehensive Behavior Support Plans (BSPs) at the time of the on-site visits. One individual, however, was receiving ABA services in the home that did not include the implementation of a BSP. Overall, all eight (100%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence; all had significant maladaptive behaviors that had dangerous and disruptive consequences to these individuals and to their households. Meeting these criteria for maladaptive behaviors is a strong indication that most of the eight individuals would likely benefit from behavioral programming or other therapeutic supports implemented within their homes or residential programs.

- Of the eight individuals reviewed, only one (12.5%) had a Functional Behavioral Assessment considered current (i.e., implemented or updated within the last 12 months). Three (37.5%) individuals had BSPs. Of these three, only one (33%) individual had a BSP that was considered current (i.e., implemented or updated within the last 12 months). In addition, only one (33%) individual had a BSP that was currently overseen by the author or other qualified behavior clinician.

- As cited above, three individuals had BSPs. Upon examination, however, the prescribed behavioral programming appeared inadequate. For example, although all of the BSPs identified target behaviors for decrease, none (0%) of the BSPs clearly identified and operationally defined specific functionally equivalent replacement behaviors (FERB). In addition, evidence of adequate data collection and review was found – for behaviors clearly identified in the BSP – for only one (33%) of the individuals sampled. None (0%) of the BSPs appeared to have all of the currently accepted elements of generally accepted practice.

- Furthermore, for the three (38%) individuals who had BSPs implemented at the time of the onsite visits, there was no evidence found that any of their support staff had successfully completed competency-based training related to the BSP.

Conclusions

- All of the sampled individuals demonstrated unsafe behavior that placed them and others at risk and, as reported, negatively impacted their quality of life. The Independent Reviewer's Individual Services Review study and expert consultant identified concerns and determined that further review is needed by the Commonwealth, which should include an examination of the adequacy and appropriate implementation of behavioral support and programming for six of the eight (75.0%) individuals whose services were selected for in-depth study.

- Only three of the sampled individuals were receiving formal Behavior Support Plans to address unsafe and disruptive behavior as well as skill deficits that would likely improve their independence and quality of life. And, of those who did have BSPs, most were outdated and were not currently supervised by qualified behavior clinicians.

3. Integrated Day Activities and Supported Employment

In the Settlement Agreement, the Commonwealth committed, "To the greatest extent practicable, ... to provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment." (III.C.7.a.)

To evaluate the Commonwealth's progress toward achieving this overarching provision, and the 12 sub-provisions that comprise the integrated day activities and supported employment section (III.C.7) of the Agreement, the Independent Reviewer retained the same consultant who completed six previous reviews. This period's study included two parts. The first focused on the Commonwealth's performance and progress during the full Fiscal Year 2019; the second was an in-depth qualitative review of the day and employment services for 100 individuals, who were randomly selected from ten of the 40 CSBs (25%). During this period, the Individual Services Review study also reviewed the day services participation for 27 individuals with intense behavioral needs.

Policy, Plan, Organizational and Operational Requirements

As reported previously, the Commonwealth had achieved compliance with several of the Agreement's requirements related to increasing integrated day activities, including supported employment. During this review period, the Independent Reviewer confirmed that the Commonwealth has sustained its compliance with several of the Settlement Agreement's requirements that comprise the foundation of the statewide and systemic effort to increase integrated day opportunities.

These provisions include:

- Reviewing annually and refining its implementation plan;
- Maintaining its membership in the State Employment Leadership Network, which is now called the Employment First Advisory Group (E1AG);
- Continuing a statewide Employment First policy;
- Including and requiring the Employment First policy in its CSB Performance Contract; and
- Providing training on the Employment First Policy and strategies.

During the fifteenth review period, the Commonwealth did not fulfill the requirement to employ an Employment Services Coordinator to monitor implementation of Employment First practices.

The Agreement also requires that "employment services and goals must be developed and discussed at least annually ... and included in ISPs." (III.C.7.b) During the fifteenth review period, the Independent Reviewer again found that boxes checked by Case Managers to indicate that employment services and goals were developed and discussed are not consistently accurate or reliable indicators that the required discussions occurred. This conclusion was confirmed by the consultant's Qualitative Review of 100 individuals (see Appendix C, Part Two). Based on interviews with the Case Managers, the consultant found that meaningful discussions occurred with only 73 percent of the sample; whereas, almost all of these individuals had an ISP checked box that "an employment conversation" occurred. DBHDS reported in its Semiannual Employment Report that these discussions occurred with 93 percent of individuals in Fiscal Year 2019. The Individual Services Review study found the ISP box checked for almost all individuals aged 18 through 64, but that almost no Case Manager's notes included descriptions of a meaningful conversations.

To fulfill the requirement of the Agreement, and to consider employment as the first and priority services option, as required by the Commonwealth's and CSB's Employment First policies, a meaningful discussion is a critical component of service planning for individuals who have not had any employment or have not had a positive work history. This is especially so for those with challenging behaviors and medical needs. The development and discussion of potential paths to employment, and of the barriers to an individual's or their Authorized Representative's interest, prompts inquiry, which can frequently resolve misunderstandings and myths, including the impact of supported employment on benefits.

The Independent Reviewer has determined that the Commonwealth has not effectively implemented the requirement that Case Managers develop and discuss employment services and goals, and include them in the ISP, at least annually. In 2018, to establish its expectations, the Commonwealth, in consultation with the CSBs, developed and distributed "Employment Options Discussions." During this fifteenth review period, however, the Individual Services Review study and the qualitative study of integrated day services found that, in some CSBs, Case Managers frequently check the verification

box in the ISP regardless of whether meaningful minimally acceptable employment discussions occurred. In addition, interviewed Case Managers in the CSBs that performed poorly did not know what constituted an acceptable discussion. This period's qualitative study found that only 73% of the 100 individuals reviewed had a discussion of employment options that included the individual's interest; the identification and plans to address barriers; the development of goals and educational strategies.

Of the ten CSBs studied, two (Eastern Shore and Harrisonburg-Rockingham) held meaningful discussions with 100% of the individuals reviewed. This is very positive, and a powerful indication of what is possible in Virginia. In contrast though, in three of these CSBs (Southside, Crossroads, and Colonial), meaningful annual discussions occurred with the individuals reviewed in only 40%, 47% and 50% respectively. Continued poor performance by some CSBs indicates inadequacies, such as in leadership, training, and supervisory areas, as well as in the Commonwealth's ability to monitor and/or take effective action to ensure improvements in CSB performance meet Agreement requirements.

With input from the E1AG, DBHDS has again assessed and produced a status report of its progress in achieving the goals in its Fiscal Year 2016 – 2018 Employment Plan, which included updates through the third quarter of Fiscal Year 2019. The Independent Reviewer's consultant's full report with findings, analysis, conclusions and recommendations is included in Appendix C. Her report includes highlights of the status of the Employment Plan's implementation, as of March 31, 2019, and the DBHDS Semiannual Report of Employment, as of June 30, 2019.

Prior to the fifteenth review period, the Commonwealth had completed, with the contributions of many stakeholders, most of the initial actions in its Plan. It expected that accomplishing its planned goals would significantly increase the number of individuals employed and that it would meet its employment targets for those with HCBS waiver-funded services. To achieve its goals and targets, the Commonwealth implemented both revised and new service definitions, modified payment rates, created provider incentives, generated meaningful and consistent data reporting, and provided initial training. These changes, which were developed and implemented with interagency collaboration, especially between DBHDS and DARS, did result in significant increases in employment for citizens of Virginia with IDD. For those with waiver-funded services, however, increases fell significantly below the employment targets that DBHDS set in 2014.

During the past year, the Commonwealth's interagency work group, the E1AG (Employment First Advisory Group), continued to implement several planned actions. However, overall, progress stagnated on important planned actions. The planned actions that were implemented resulted in progress developing and implementing training for providers to become qualified to offer Customized Employment; family Listening Sessions were conducted throughout the Commonwealth; the E1AG continued to develop videos of successful employment; and DBHDS began to use feedback from a previously reported survey of employment providers to engage providers regarding existing barriers to providing integrated services. The planned actions that were not initiated or not completed included work with Virginia's Department of Education to develop a guide for children and their families to initiate employment planning and preparation; the development of a structure to showcase videos and other employment resources for stakeholders; the lack of final regulations for HCBS waiver services, including for employment and community engagement; the identification of trends in recent years' Semiannual Employment Report; and changed E1AG membership to include all disability groups.

During Fiscal Year 2019, DBHDS and E1AG accomplished fewer of its plans to advance employment policy, to conduct training, and to use data to identify trends in employment and other integrated day activities. This significant slowdown seems attributable to two causes. First, DMAS has not yet issued final regulations for the waiver programs. This has caused other delays, including not issuing the Provider Manual and provider competencies, as well as other work by the E1AG Policy Subgroup. Second, since February 2018, DBHDS has not had an Employment Services Coordinator, a position required by Section III.C.7.b. It is evident that the loss of someone to provide coordination, expertise, and staff capacity in this vital role has negatively impacted the work of the E1AG, provider capacity building, employment training offered, and the Commonwealth's ability to fulfill timely the requirements of the Agreement.

Establishing Baselines and Targets to Increase Supported Employment

The Agreement requires that the Commonwealth's plan shall establish the following annual baseline information for individuals receiving HCBS waiver-funded services:

- The number of individuals receiving supported employment;
- The length of time individuals maintain employment in integrated work settings;
- The amount of earning from supported employment;
- The number of individuals in pre-vocational services; and
- The time individuals remain in pre-vocational services.

The Commonwealth's Employment First policy, however, applies to all individuals in the target population, not only those with waiver slots. Therefore, in addition to setting the required employment targets for the "number of individuals receiving HCBS waiver-funded services", the Commonwealth also set employment targets for the larger group of all individuals with IDD who are receiving employment services through all Commonwealth-funded programs. Both sets of targets include the number of individuals who enroll in supported employment in each year and the number who remain employed for at least twelve months.

Since 2014, DBHDS has worked in partnership with DARS to refine its data collection and to ensure data are reported by all of the Commonwealth's Employment Service Organizations (ESOs). Now, and for the third full Fiscal Year, the DBHDS Semiannual Report on Employment, through June 30, 2019, includes data based on a 100 percent response rate from the ESOs. DBHDS also continues to gather data from a second source for both Employment Reports, which helps to make comparisons between reporting periods.

Comparing the much larger number of individuals with IDD who were employed as of June 2018 to June 2019, shows that the number employed in:

- Independent Supported Employment (ISE) increased by 155 from 3,092 to 3,247;
- Group Supported Employment (GSE) decreased by 44 from 1,128 to 1,084; and
- Sheltered Workshops decreased by 261 from 957 to 696.

For the larger group, as of June 2019, an additional 111 individuals were in supported employment compared with a year earlier. The gain occurred in ISE. (Note that supported employment occurs in integrated settings; therefore, those working in congregate sheltered workshops are not counted.) The above numbers reflect the total number of individuals with IDD reported as employed across all Commonwealth-funded employment programs and the number of individuals in HCBS waiver-funded employment services. More of the smaller group, the subset of individuals with waiver-funded services whose disabilities are on-average more significant, were also employed: 1078 in June 2019, compared to 972 in June 2018, an increase of 106 (+11%) in Fiscal Year 2019.

Based on the 100 percent response rate from its ESOs, the Commonwealth reported the average hours worked, the length-of-time at the current job, and earnings from employment. It is very positive to continue to have data that include all individuals with IDD who are employed. The increase of 155 individuals in ISE is particularly noteworthy in the year between June 2018 and June 2019.

The Commonwealth has maintained compliance with III.C.7.b.i, III.C.7.b.i.A., III.C.7.b.i.B.1,a, b, c, d, and e. The Commonwealth remains in non-compliance with Section III.C.7.b.

Setting Employment Targets

In March 2014, DBHDS set the required employment targets (Table 1) for the smaller group, individuals with waiver-funded services who, overall, have more significant disabilities. During the past two years, although the number of these individuals receiving employment services increased, DBHDS's progress toward achieving its targets fell significantly short of, and further from, its target. While 146 more individuals were participating in ISE and GSE waiver-funded services in June 2018 than one year earlier, and 106 more individuals were receiving these services in June 2019, these actual totals respectively represented only 74.9 percent of and 325 fewer individuals than the 2018 target of 1297 as well as 64.9 percent and 583 fewer than the target of 1,661.

In its Semiannual Employment Report through June 2019, DBHDS significantly reduced the employment targets for the number of individuals in waiver-funded programs. The Agreement included a provision for deciding how to adjust the employment targets upward (i.e. "the Regional Quality Councils ... shall work with providers and the SELN in determining whether the targets should be adjusted upward"). DBHDS did not provide or document a strong rationale or explanation for changing its employment targets.

TABLE 1 Reduced Employment Targets for the HCBS Waiver Programs Fiscal Years 2016-2020						
End of FY	**ISE**	***ISE (new)***	**GSE**	***GSE (new)***	**Total**	***Total (new)***
16	211		597		808	
17	301		631		932	
18	566		731		1297	
19	830	***661***	831	***550***	1661	***1211***
20	1095	***936***	931	***550***	2026	***1486***
Total Increase '16-'20	+884	***+725***	+334	***(-47)***	+1218	***+678***
Reduction from previous targets		***(-159)***		***(-381)***		***(-540)***

TABLE 2 Number of Individuals Employed in the HCBS Waiver-funded Programs Fiscal Years 2016-2019			
End of FY	**ISE**	**GSE**	**Total**
16	225	665	890
17	305	521	826
18	422	550	972
19	555	523	1078
Total Increase FY 2016 - 2019	***+330***	***(-142)***	***+188***

Although the Commonwealth significantly reduced it employment targets for individuals in waiver-funded services, it fell short of these reduced targets for ISE or GSE for Fiscal Year 2019. It is the Independent Reviewer's considered option that the Commonwealth's inability to achieve its original or its reduced targets is directly related to the on-going systemic barriers to increasing employment. There is broad agreement among individuals and families, service providers, CSBs, and state officials that these barriers undermine the Commonwealth's abilities to achieve, or at least move much closer toward, its targets and that these obstacles remain substantially unaddressed.

For example, non-medical transportation was established by the Commonwealth with the expectation and intent to significantly increase employment of members of the target population. However, it was structured with built-in constraints that prevent its effective use for all but a very small percentage of individuals in the target population. A majority of employment service providers and other stakeholders continue to report that the lack of available transportation is a major barrier to employment, and, therefore, to achieving the targets established by DBHDS.

The other broadly accepted systemic barriers to increasing employment for individuals with waiver-funded services, which must be addressed to fulfill the Commonwealth's Settlement Agreement commitments, include:

- The lack of provider capacity to develop and operate supported employment programs, especially for individuals with intense needs;
- Misperceptions among case managers, individuals and families regarding the impacts of earned wages on benefits;
- Families need much more information about practicable paths to employment; and
- CSB Case Managers' inadequate implementation of the requirement to develop and have meaningful discussions of employment services and goals, at least annually.

In addition, although the Commonwealth has made progress in the past year, it has not completed many of the actions that it planned to increase employment and included in its Implementation Plan 2016-2018.

On December 30, 2016, for the larger group of all individuals with IDD who receive employment services funded by the Commonwealth, DBHDS set a target for employment in both ISE and GSE. Its target was that by June 30, 2019, 4,218 individuals would be employed. This target was determined as 25 percent of the total number of individuals with IDD between the ages of 18 and 64 who are either on the waivers or on the waiting list (16,871). As of June 2017, 3,806 of these individuals were so employed, which was 23 percent of this total number. As of June 2018, 4,262 individuals were employed, which achieved the target goal one year earlier than DBHDS had set for June 2019.

It is concerning that the General Assembly passed legislation supporting continued funding of sheltered work and pre-vocational programs. This legislation undermines the Commonwealth's commitment and approach to effective implementation of its Employment First Policy. This policy requires that individuals will be assessed first for employment, discuss possible goals to achieve employment, or otherwise consider employment as the first and preferred option. This legislation allows families to directly access DARS funds that are allocated to sheltered workshop providers without first being educated about the values of, and considering optional paths to, achieving supported employment. This legislation, therefore, creates an obstacle to the Commonwealth's ability to achieve, within the planned schedule of the Agreement, the provisions to which the Commonwealth committed. This legislation will undermine the Commonwealth's timely transition of individuals to community-based integrated employment opportunities from these large congregate sheltered work and pre-vocational settings that segregate and isolate individuals from their communities.

There are also no records that Case Managers provide ongoing opportunities for the individual and family to learn more about employment or how employment providers or staff could help address barriers. DBHDS still has not demonstrated that it has the ability, through its performance contracts, to require CSBs to take effective corrective actions that address and resolve supported employment-related performance that has been consistently below acceptable standards.

The Commonwealth has fulfilled the requirement for setting targets to meaningfully increase the number of individuals who enroll in supported employment each year. The Commonwealth,

however, is not yet in compliance with Section III.C.7.b.i.B.2.a., as its quality improvement program has not been sufficient to identify and plan to address the above described systemic obstacles to increasing employment for individuals with waiver-funded services to achieve its employment targets. Although increased, the number employed is only 64.9 percent of the Commonwealth's original employment target for the end of Fiscal Year 2019, and 89.0 percent of the reduced target that it set six months earlier.

Average length of time at current job

The Commonwealth established the expectation that 85 percent of individuals will maintain their jobs for at least 12 months. Overall, 90% of the employed population who were employed twelve months ago retained employment This exceeds the expectation that 85% of individuals with I/DD will maintain their job for twelve or more months. Ninety percent (90%) of individuals in both ISE and GSE worked for more than twelve months.

The Commonwealth has continued to achieve compliance with Section III.C.7.b.i.B.2.b. by setting and exceeding its goal to have individuals who are in ISE remain employed for 12 or more months.

Integrated Community Activities

To make substantive and sustained progress toward achieving the goals of the Settlement Agreement, including its commitment to provide individuals in the target population receiving services under this Agreement with integrated day opportunities, the Commonwealth created Community Engagement and Community Coaching Services. These services, which were created as part of the Commonwealth's redesign of its HCBS waiver programs, were structured to provide inclusive community-based day activities, rather than group day support in congregate and segregated settings. Community Engagement was designed as a service option for individuals who were of retirement age or were not ready for or otherwise not interested in employment. It was also created to enhance the lives of individuals who participated in part-time employment. Community Engagement was not intended to replace employment for individuals who are capable of and interested in working.

The Plan for Increasing Integrated Day Opportunities

During the first two years of planning and implementing the Agreement's requirements, the Commonwealth focused its work and activities on increasing employment opportunities for individuals with IDD. Because the Commonwealth was equally responsible to create integrated day activity services, the Independent Reviewer directed DBHDS to develop the required implementation plan for these services by March 31, 2014. DBHDS created the required plan, and during this review period, submitted its most recent and revised Community Engagement Plan FY2016-FY2018, which included implementation updates through June 30, 2019.

The Commonwealth established its foundation for Community Engagement in its redesigned HCBS waiver programs, which were approved for implementation as of September 2016. For individuals with IDD waiver slots, the redesign offered newly defined integrated day activity in Community Engagement, Community Coaching, and other related services; these services had newly developed reimbursement rates to incentivize providers to create the new services throughout Virginia. To guide the implementation of these newly defined services, DBHDS, with the input of the Community Engagement Advisory Group (CEAG), developed a comprehensive Community Inclusion Policy. This policy sets the direction for and clarifies the values of community inclusion for all individuals with IDD, regardless of the severity. The policy requires the involvement of both the DBHDS and the CSBs to:

- Establish outcomes with specific percentage goals;
- Identify strategies to address barriers;
- Expand capacity of providers;
- Collaborate with the State Department of Education (and schools to promote transition planning); and
- Conduct a statewide education campaign about Community Engagement.

Implementation required DBHDS to:

- Provide training and consultation;
- Work with DMAS to incorporate these services in the waivers;
- Continue the role of the CEAG;
- Develop an implementation plan;
- Maintain membership in the national SELN; and
- Maintain an Employment Services Coordinator to monitor and support implementation.

The DBHDS Community Engagement Plan, which was revised on December 29, 2015, was updated as of April 15, 2019 to reflect the status of achieving the six goals. Its updates on the status of each goal are described in Appendix C.

DBHDS implemented some of the planned activities. These include training providers in two Regions and offering requested technical assistance to providers in a third Region. It created collaboration with selected providers to assist with sustaining Community Engagement services. Providers completed a self-assessment; DBHDS utilized these to offer guidance to service providers who had not met expectations. However, DBHDS reported that it had not completed, or it had discontinued, many of the actions that it had planned to increase and sustain the new integrated community activity services. For example, the Commonwealth's work on the Provider Manual continued but was not completed or distributed; DBHDS's effort to review providers' practices on collecting data, which was reported as underway in June 2018, was discontinued.

The results of the Commonwealth's efforts to create integrated community-based activities to the greatest extent practicable are mixed and, therefore, have fallen far short of what it planned and expected.

In June 2018, DBHDS projected that it would produce quarterly reports summarizing demographic data, successes, barriers, and the average number of hours of participation in Community Engagement and Community Coaching, with data separated for urban and rural areas. As of September 2019, these reports have not been produced. DBHDS needs data that provide information on the hours of involvement and the type of activities offered. During a period of rapid program growth, it is especially important that DBHDS can monitor the effectiveness of this program and the satisfaction of its participants. The Quality Improvement Program that is required for all services under the Agreement cannot be effectively implemented without data. The likelihood of increased success will be enhanced once DBHDS has and can analyze valid and reliable performance data.

The numbers of licensed providers and provider locations for Community Engagement have both declined. Fifteen additional providers of CE and a total of In June 2018, 198 licensed provider locations were reported, whereas, only 111 providers of CE services in 171 locations, in June 2019, a decrease of twenty-seven (13.6%).

The rate of individuals transitioning from receiving services in large group congregate and segregated settings (i.e. Group Day Support) to more individualized services in integrated community-based settings has slowed dramatically. With more individuals with waiver slots, and 275 more authorizations for Community Engagement than one year earlier, there are more individuals (6,545, +7.4%) authorized to receive Group Day Support services in June 2019 than there were three years earlier in June 2016 (6,095).

The number of authorizations for Community Engagement and Community Coaching continue to increase, which reflects continuing interest by individuals and families. However, the pace of increase has slowed dramatically. In June 2018, there were 2,375 approved authorizations for individuals to receive Community Engagement, compared to 1,588 in June 2017, an increase of 787 (+50%). Community Engagement, There were 239 approved authorizations compared to 120 in June 2017, an increase of 139 (+99%). However, in the most recent year reported, the number of individuals in Community Engagement increased by only 275 (11.6%), and the number enrolled in Community Coaching by 44 (+18.4%). The Independent Reviewer's consultant's Qualitative Review (Appendix C, Part Two) found that the Commonwealth has not developed sufficient provider capacity. This is directly related to the reduced number of licensed providers and locations for Community Engagement services and may, in part, reflect provider reports that the current rate reimbursement structure for these services is not adequate to sustain these services.

The DMAS regulations for the waiver programs are reported to have been drafted, but have not been finalized. This delay is the reason cited for the Provider Manual not being completed.

In summary, the Commonwealth's accomplishments to-date are substantial and impressive. The guidance from DBHDS and DMAS has been especially important and helpful; it will become even more important as the participation in Community Engagement and Community Coaching continues to increase. DBHDS needs data that provide information on the hours of involvement and the types of activities that are offered. During a period of rapid program growth, it is especially important that DBHDS can monitor the effectiveness of this program and the satisfaction of its participants. Its process with DMAS may achieve this goal. The likelihood of success will be enhanced with data to analyze.

Regional Quality Councils

The Agreement requires that DBHDS's Regional Quality Councils (RQCs) review data regarding the extent to which the employment targets identified in Section III.C.7.b. are being met. It also requires the RQCs to consult with providers and the SELN (now the E1AG) regarding the need to take additional measures to further enhance the services and to determine whether the targets should be adjusted upward. All five of the RQC's met quarterly and were provided employment data. The RQCs met with DBHDS senior employment staff, who also serve on the SELN/E1AG, to hear and discuss presentations regarding the data included in the DBHDS semi-annual employment report. Not all RQCs had meaningful discussions, nor is there evidence that the RQCs routinely work with providers to review the targets identified in III.C.7.b.i.B.2., as is required by III.C.7.d. Some of the Councils had more in-depth discussions and also made recommendations. The RQCs also discussed progress achieving the employment targets. Each of the RQCs has had challenges achieving consistent attendance at one or more meetings during the reporting period.

The Commonwealth has maintained compliance with Sections III.C.7.c and d, but to continue compliance it must provide sufficient documentation that RQCs are working with providers.

4. Regional Support Teams

During this fifteenth review period, the Independent Reviewer's consultant completed a follow-up to his 2018 review, his fifth study of the Commonwealth's status in fulfilling the Regional Support Team (RST) requirements of the Agreement. As described and required by the Agreements' related provisions, the RST process is a system. The purpose and core functions of the RST system are to:

- Identify, address and resolve barriers and ensure placement in the most integrated setting;
- Redirect individuals to more integrated settings prior to placements in nursing homes, intermediate care facilities and other congregate settings of five or more individuals; and
- Promote quality improvements in discharge planning and the development of community-based services.

The Agreement's provisions related to the RST system clearly define the roles and responsibilities for the system's three components: the Case Managers, the Community Resource Consultants (CRCs), and the five Regional Support Teams. The effective functioning of each component is essential to the RST system being able to fulfill its purposes. In his 2018 assessment, the consultant found that, except for untimely submission of referrals by some CSB Case Managers, the RSTs were functioning consistent with the Agreement's related provisions. However, each late referral largely nullifies the purpose and essential functions of the RST for that individual; there was an unacceptably high number and percentage of late referrals. In fact, since DBHDS created the RSTs more than five years ago, late referrals by Case Managers have been an ongoing obstacle to the effective functioning of the RSTs.

During the thirteenth period review, one year ago, the consultant reported that DBHDS had, with input from CSBs, implemented multiple significant process improvements to enhance the efficiency and effectiveness of the RST system. At that time, and for the first time, the Independent Reviewer determined that the CRCs and the RSTs were fulfilling their roles and responsibilities and that the RSTs frequently succeed at their core functions, except when Case Managers submit late referrals.

This fifteenth period's review found that the problem of CSB Case Managers submitting late referrals (after or concurrent with an individual's move) has continued despite DBHDS's implementation of significant process improvements. As depicted in Table 3 below, the statewide timeliness rate for Fiscal Year 2019 averaged about 71 percent (298/420). Although, the trend is positive, failure to submit timely referrals for approximately three of every ten individuals is significantly below acceptable standards and is not sufficient to achieve compliance

TABLE 3
Referral Timeliness Rates across CSBs during Fiscal Year 2019

Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	FY19 Total
65% (55/84)	65% (57/88)	70% (78/111)	79% (108/137)	71% (298/420)

During 2019, DBHDS, Division of Developmental Services (DDS), again reorganized the RST process. The changes and restructuring currently underway will include the incorporation of RST referral and tracking information into the WaMS service authorization system later this year, if funding is available. Utilizing the WaMS system will allow for the electronic management of the RST information, which DBHDS expects will lead to improved effectiveness. In addition, DBHDS began a quarterly notification process. This notification process involves sending a "Letter of Compliance" to each CSB regarding its adherence to DBHDS's RST expectations. If followed up timely and effectively enforced, this process should lead to improved CSB compliance.

During 2018, to promote quality improvements in discharge planning and the needed development of community-based services, DBHDS generated a more centralized approach to addressing service gaps and new provider development. Startup funding, called Jump-Start Funding, is one-time monies designed to encourage collaboration among providers and to stimulate the growth of needed services and supports by illustrating to providers where growth opportunities and gaps exist. In Fiscal Year 2018, an estimated $80,000 of Jump-Start Funding was committed to providers. To date in Fiscal Year 2019, about $25,000 has been committed.

The Commonwealth is now doing Network Development and Planning as evidenced by the data captured and reported in the DDS Provider Data Summary. During the past year, waiver slots dedicated to more integrated living opportunities have increased by eight percent. When an eight percent concurrent decline in the use of non-integrated settings is considered, it is clear that the Commonwealth is on a positive trajectory and that the provider development activities may be acting as an accelerant.

The absence of final policies and the Commonwealth's regulations governing waiver services that are less restrictive and more integrated may be contributing to some providers' reluctance to expand into integrated services. A provider designation process, which allows agencies to declare/market their specialization, should make it easier for more providers to expand. In addition, an on-boarding process for providers interested in expanding into the delivery of integrated services has been initiated and will be repeated semi-annually. This too should encourage and motivate more providers to engage in providing these services, regardless of the uncertainties of the regulatory environment.

Finally, a new website is under development on the Aging and Disability Resource Center website. This disAbility Navigator platform should better enable consumers to research and locate providers who can serve them, whether in the waiver or not. It will also enable providers interested in expanding to market their availability and their specialties (via the provider designation process).

Conclusion

The Commonwealth has maintained compliance with Sections III.E.1 – 3. It has made some improvements in the timeliness of Case Manager referrals; however, it has not yet achieved compliance.

5. Transportation

The Independent Reviewer retained the expert consultant who has previously conducted multiple reviews of the Commonwealth's community transportation services for individuals with IDD who receive HCBS waiver-funded services. The goal of this fifteenth period review was to determine whether the Commonwealth has implemented and demonstrated a functioning and effective quality improvement program related to the services for these users.

The essential elements for a quality improvement program (QIP) is one which:

- Gathers relevant performance information;
- Identifies priority problems for users;
- Establishes goals to address the prioritized problems;
- Implements targeted improvements;
- Confirms the extent to which the expected positive impact was achieved; and
- Determines whether further actions are needed to achieve acceptable performance.

Four years ago, in December of 2015, the Independent Reviewer requested a plan from the Commonwealth to address improvements needed "to ensure that its transportation services are of good quality, appropriate, available and accessible to the target population." DMAS subsequently issued a new Request for Proposals (RFP) for transportation services. Reportedly, due to administrative complications, the RFP had to be reissued. Because this delayed the awarding of a new contract, in December 2017, the Independent Reviewer again reported to the Court that the Commonwealth was in non-compliance with the transportation requirements of the Agreement. At that time, the Commonwealth had implemented some previous recommendations made by the Independent Reviewer, but had not yet implemented a quality improvement program focused on

transportation services for individuals in the Agreement's target population who were receiving waiver-funded services. In 2018, DMAS awarded a new contract to LogistiCare.

During this fifteenth period review, the consultant confirmed that DMAS had implemented four of the eight recommendations made in the Independent Reviewer's report from December of 2015:

- Ensure that more representatives of users from the IDD (Intellectual and Developmental Disabilities) Waiver are included on the LogistiCare regional Advisory Boards;
- Analyze the LogistiCare databases using the IDD Waiver as a sub-group for assessment of their differing needs;
- Encourage the use of GPS, tablets and other technology in matching drivers with users;
- Encourage LogistiCare to develop a Network Development Plan to eliminate/reduce gaps in transportation at the community level.

DMAS also included the above recommendations as specialized requirements in the RFP and new LogistiCare contract, along with statistically valid customer satisfaction surveys from IDD Waiver users, and 'trip recovery' technology (i.e., software designed to redirect drivers in real time when another driver is unable to make a ride). The current use of GPS by Logisticare's drivers will facilitate future monitoring by Logisticare and DMAS of actual on-time pickup and delivery.

Currently, the Commonwealth's Non-Emergency Medical Transportation (NEMT) continues to be administered by DMAS (Department of Medical Assistance Services) through a brokerage system to a multi-state private sector contractor, LogistiCare, now with the new contract requirements. Overlapping this contract change and transition to managed care, DMAS delegated responsibility for transportation to medical services to six Managed Care Organizations (MCOs).

It is notable that the large majority of transportation services required by users of the IDD Waivers (80%) are still provided by LogistiCare. IDD Waiver users of LogistiCare have averaged about 5,400 individual riders per month during 2019. In addition, providers of HCBS waiver-funded services also supply transportation that is secondary to the delivery of their residential and day services; costs are generally, but not always, included as part of their reimbursement rates. Some providers may also access mileage reimbursement directly from DMAS for individuals with extraordinary circumstances. And finally, some individuals receiving HCBS services may access DMAS funded bus passes for the use of public transportation.

The consultant's fifteenth period review found that DMAS/LogistiCare had made significant improvements in several areas. These include greater attention by LogistiCare to the regional Advisory Boards, cameras in over 500 vehicles operated by LogistiCare providers, GPS in all vehicles, complaint and survey data available from users of the IDD Waivers, review of subcontracted providers with high rates of complaints, Network Development Planning, reduced instances of No Vehicle Available (NVA), additional options for independence, debit card mileage reimbursement for users of the IDD Waivers, availability of a mobile app to track scheduled trips, and a transportation dashboard.

DMAS/LogistiCare's extracted complaint findings for individuals with IDD waiver services continued to show 'provider late' or 'no show' as the most frequent issues that users call about. The caveat for the rate at which complaints are filed are multiple reports that suggest the actual number of complaints are substantially higher and is suppressed. For example, providers and

families report having stopped using LogistiCare due to problems encountered. Others report fears that users who complain will be labeled a problem, fears of retaliation through the loss of a specific driver's services, and the conclusion that complaining does no good. Transportation sub-contractors have financial incentives to have low rates of complaints filed and try to avoid customers who file complaints.

However, since IDD Customer Satisfaction Surveys consistently show that late or no-show drivers make up 75-85 percent of all IDD user complaints, complaint free trips has been and remains a bona fide proxy outcome measure for on-time performance and an indicator of a significant issue for users. No complaint rate system ever includes all those who experience problems, but the financial structure of some systems result in a suppressed number of complaints being filed. To be helpful to its quality improvement program, LogistiCare's complaint data must be compared with other transportation systems and be normalized in a way that allows the measurement of change. For example, the rate of complaints from IDD users of LogistiCare was 483 per 100,000 trips for the three month period studied. This compares to 26 per 100,000 trips for the second quarter in 2019 for MCO transportation in Virginia and to a rate of ten to fifteen complaints per 100,000 trips for NYC taxis, a ten-year average. Normalizing data involves finding bench marks to tell stakeholders, providers and internal transportation staff whether the current rate of complaints is acceptable or not, and implementing targeted improvements to improve substandard performance.

The DMAS/Logisticare quality improvement program has the complaint data and the results of satisfaction surveys, as well as recent information segregated for IDD users regarding the impact of past efforts to reduce rates of filed complaints. This information is sufficient to identify that on-time performance is the priority for improvement efforts. Previously for IDD users, since 2015, unfulfilled trips due to No Vehicle Available (NVA) have been a significant issue. LogistiCare's written reports to DMAS suggest dramatic recent improvements with reductions in what has previously been a long-standing and fundamental problem. For example, although reflecting a comparatively brief period of time, NVA data reported for all users dropped from 1,882 trips in June 2019 to 102 trips in August 2019. Time will tell whether this is a sustainable change, but DMAS believes that targeted initiatives led by new program managers have made this improvement possible. This may point to the conclusion that most significant problems faced in IDD user transportation are amenable to quality improvement efforts. A similar management effort should be directed toward addressing "provider late" or "no show" experiences for IDD waiver service recipients.

Current encounter billing data do not permit a direct measure of on-time driver performance, which now limits LogistiCare information about on-time performance to complaint information.

As soon as practicable, on-time performance should be measured by actual on-time data, including the experiences of all users, free from skewing by financial incentives related to the number of complaints filed.

Complaint data during the period January to August 2019 indicate a slight positive trend of complaint free trips as a percent of all trips for all users and a slightly lower rate for IDD users. These trends are positive and suggest, if DMAS/LogistiCare targeted improvement efforts are sustained and enhanced, IDD waiver users will experience improved outcomes.

Conclusion

DMAS and LogistiCare have demonstrated commitment with actions. They have addressed needed quality improvements, which is resulting in improved metrics and outcomes for users. If LogistiCare management's efforts are sustained, these improvement could become permanent. However, the rate of complaints, especially for no-shows and late pick-ups, appears excessive. Regional Advisory Board members support similar anecdotal reports. Multiple Individual Services Review studies, in interviews with individuals, families and caregivers, report transportation problems with LogistiCare transportation; some cited praise for the driver as the reason never to file a complaint regardless of whether he was late. The percent of complaints filed and the anecdotes align. Together, they suggest strongly that many users who experience problems do not file complaints and that on-time performance is the most significant issue that should be prioritized for targeted quality improvement initiatives.

If DMAS/LogistiCare's quality improvement program is to work effectively, it needs to reach out assertively to solicit feedback from current IDD waiver users and initiate actions to improve on-time pickup and delivery. As soon as practicable, on-time performance should be measured by actual on-time data, rather than the number of complaints filed. Actual on-time data would be a much better more accurate and useful measure. It would reflect the experiences of all users equally and would be free from skewing by financial incentives and other personal factors related to the number of complaints filed.

Other current DMAS and LogistiCare quality improvement activities that should continue or be enhanced include accountability and correction of sub-contracted transportation providers/drivers' performance, software development that should ultimately lead to individual vehicle tracking and real time driver ratings, tracking of driver training, vehicle safety monitoring, the Extra Mile Driver incentive award program, and weekly/monthly meetings between DMAS and LogistiCare. Other issues remaining for DMAS and LogistiCare include more transparency in data sharing with Advisory Boards, attention to callbacks for complainants, enforcing complaint rates among providers/drivers as a quality measure, and, overall, improving on-time performance generally.

The Commonwealth remains in non-compliance with III.C.8.a. for the provision of community transportation services. These services for individuals with IDD waiver-funded services have improved. Compliance will be achieved when DMAS demonstrates that the improvements are sustained, that its quality improvement program is reviewing the impacts of targeted improvement, and that acceptable outcome rates of no-show and late pick-ups have been achieved.

6. Investigations: Office of Licensing/Office of Human Rights

During the fifteenth review period, the Independent Reviewer retained an independent consultant to complete his sixth annual review of the Office of Licensing (OL) and his fifth review of the Office of Human Rights (OHR). The purpose of these reviews is to assess the status of the Commonwealth's compliance with the Agreement's Quality and Risk Management provisions related to licensing and human rights investigations. These entities represent the Commonwealth's primary system for ensuring the basic health, safety and wellbeing of individuals receiving services.

The provisions related to OL and OHR include incident reporting, investigations, corrective actions and management system. Licensed providers report incidents to DBHDS through its Computerized Human Rights Information System (CHRIS). Last year, the OSIG (Office of the State Inspector General) conducted a review of the DBHDS incident management system. The OSIG Report resulted in the Department undertaking an overhaul of the CHRIS reporting system including its definitions and its accessibility. In response to the OSIG report, and with an infusion of funding for additional staff, OL has created a specialized Investigations Unit and a specialized Incident Management Unit. With these recent changes, and built on a management structure which in the past two years increased the number of investigators, added regional managers, implemented expert investigation training, began routinely including double loop corrections, and confirming implementation of remedial actions for health and safety violations within 45 days, the Office of Licensing is ensuring:

- Improved consistency in incident management;
- Enhanced effectiveness at discovering patterns and trends in incident data;
- Heightened scrutiny of marginal providers; and
- More robust documentation that will better withstand administrative and legal appeals.

While OL has strengthened its management structure, it has also continued to conduct unannounced licensing visits and more frequent inspections of licensed providers. Its trending reports suggest, as is reflected in Table 4, that again in 2019, nine out of every ten reports of serious incidents are submitted within 24 hours.

TABLE 4
Timely SIR Reporting

2016	2018	2019
88%	92%	89%

The OL has continued its practices of compiling summary reports of compliance patterns and trends. These reports indicate that in Fiscal Year 2019, OL placed one IDD provider setting on provisional status, three providers voluntarily relinquished their licenses under "heightened scrutiny," and one provider's license was "summarily suspended" and closed. This "summary suspension" of a provider license reflects OL's use of a sanction tool that has previously existed, but rarely used. Its effective use in this one instance clarified a strategy that OL could implement effectively for other urgent citation issues. As noted in previous reports, however, it is unlikely that OL's use alone of these approaches to ensuring minimum quality standards will be sufficient for the minority of providers who deliver marginal services. OL's assignment of "provisional status" to a license or "heightened scrutiny," which results in a voluntary relinquishment of a license, continue to be the most likely OL response to providers who have not been able to modify their practices pursuant to a Corrective Action Plan. To improve and strengthen its ability to require consistent provider compliance with minimum standards, OL reports that it is currently assessing the available regulatory tools to force improvements among substandard providers and to eliminate providers who have demonstrated a refusal or inability to improve their services. Reportedly, additional enforcement activity pursuing enhanced legal and administrative hearing resources is being considered.

The Agreement requires, within 12 months of its effective date, that the Commonwealth ensures that the DBHDS licensing process assesses the adequacy of the individualized services and supports ... "in each of the eight domains listed in Section V.D.3." Although compliance with this provision was required in 2013, the Commonwealth determined that it was not able to fulfill this commitment until its Licensing Regulations were revised; and, even then, its licensing process would be able to complete the required assessments as part of the licensing process only if there are applicable regulations to cite as the basis for violations. Eventually, effective September 2018, the Governor approved the revised DBHDS emergency Licensing regulations for implementation.

One year later, and six years after this external monitoring mechanism was to be functioning, DBHDS has not incorporated these required assessments into its licensing process. DBHDS reports, however, that its OL is developing case management checklists that will be included in the licensing process. It also reports that for two of the eight domains (i.e., stability and provider capacity), the Commonwealth does not have applicable regulations; it will therefore use data from assessments of adequacy by processes other than licensing. One of only two monitoring systems external to the service provider and required by the Agreement, the OL's assessments of the adequacy of the supports and services that individuals receive are critical to ensuring that minimum quality service expectations are in place. Although the primary assurance of good quality services is a competent staff working for a caring and effective service provider, it is the considered opinion of the Independent Reviewer that effective implementation of external monitoring systems is essential to ensuring that service recipients receive adequate and appropriate services that comply with, at least, minimum performance expectations.

As reported to the Court a year ago, DBHDS had made several important improvements in the effective functioning of OHR. As an oversight mechanism, retrospective look-behinds of a sample of internal provider investigations were being completed semiannually. These case reviews were distributed across providers in all process five Regions; and, to ensure reliability of findings, an inter-rater reliability assessment component was added to the ongoing look-behind process. The look-behind reviews had identified problems and, based on OHR findings, DBHDS implemented corrective actions. These OHR findings were also used to revise the DBHDS "New Provider On-Boarding" process approach to human-rights related review and to revisions of OHR monitoring protocols.

In his fifteenth review period assessment, the consultant found that the OHR retrospective look-behind process had continued to mature and is now on a four to six month review cycle with technical assistance being delivered to the provider samples. Technical Assistance, which is provided by the OHR Regional Advocates, is now provided at the time of the look-behind review. The OHR look-behind process is a well-done, quality review which has become increasingly effective at discovery and remediation efforts.

OHR has continued to find that significant numbers of providers are continuing to have timely reporting problems and are failing to archive evidence from investigations. The continuing problem of late reporting may be a relate to the DBHDS practice of accepting provider Corrective Action Plans that are insufficient and that more consistent, predicable and effective sanctions may be needed. The failure of providers to archive evidence from investigations indicates a lack of standards, monitoring or enforcement regarding minimum quality standards for how investigations should be implemented and documented. DBHDS should take sufficient actions to ensure these problems are corrected.

This year the OHR implemented several improvements. It implemented a best practice Case Study approach to providing source information to the DBHDS's Risk Management Review Committee (RMRC). System improvements appear to have been generated through this process, which indicates that the RMRC has a path to effecting change in the service delivery system. To address the historically high rate of human-rights citations in OL reports, OHR has increased efforts to educate individuals receiving services as to their rights and options. Self-advocacy is an effective tool to minimize the occurrence of abuse, neglect or exploitation.

The Independent Reviewer has been encouraged by the investments and actions undertaken by the Commonwealth to improve the effectiveness of both the Office of Licensing and the Office of Human Rights. These efforts contribute to ensuring that basic minimum quality expectations are in place. The Commonwealth's failure to implement assessments of adequacy as part of the licensing process undermines this effort and should be addressed and resolved as soon as possible.

The Commonwealth is in compliance with V.C.2. and has sustained recently achieved compliance with V.C.3, which was first achieved in my fourteenth Report to the Court.

DBHDS remains in non-compliance with V.C.6. Although DBHDS has increased taking "appropriate action" with agencies which fail to timely report, it does not use the sanction tools it has available to ensure that providers consistently meet standards or effectively implement CAPs.

DBHDS continues to be in compliance with Section V.G.1. and 2, but in non-compliance with the requirements of Section V.G.3. The DBHDS licensing process does not include the assessment of the adequacy of services in the eight domains at Section V.D.3.

7. Mortality Review

The Independent Reviewer again retained the same independent consultant to complete his fourth study to assess the status of the Commonwealth's progress related to the Mortality Review requirements of the Agreement. The assessment included the Commonwealth's planning, development, and implementation of the Mortality Review Committee's membership, process, documentation, reports, and quality improvement initiatives. The consultant's complete report, which includes background information, findings, analysis and conclusions from review of nearly a full year of progress and change (October 2018 - August 2019), is included in Appendix G.

One year ago, at the end of the thirteenth review period, the consultant reported that the Mortality Review Committee (MRC) had made significant advances, but that significant challenges remained. The MRC had implemented newly written standard operating procedures, had created and filled a new MRC Coordinator position, and had developed and implemented a schedule for posting documents needed to complete mortality reviews. These and other improvements had resulted in progress that included: sustained increase in MRC meeting frequency and attendance; increased clarity regarding the documents needed and tracked; improved data accuracy and integrity; a streamlined review process with more complete clinical reviews: improved tracking of recommendations; new leadership; and an increased rate of processing mortality reviews.

The consultant's thirteenth period review also found that the MRC was not fulfilling the specific requirements of the Agreement. Reviews were rarely being completed within 90 days; the MRC did not have a member with clinical experience who was independent of the State; data fields in its tracking system were incomplete; and some lacked definitions. It also did not have a process in place to rapidly review unexpected deaths to determine whether inadequately delivered supports or neglect might have contributed, and, if so, to ensure DBHDS reviews were immediately instituted to ensure that the individual's housemates were safe. Some of the MRC review meetings did not include the clinical staff critical to quality reviews and the MRC had not made any recommendations to the Quality Improvement Committee during the previous year.

In his assessment for this report, at the end of the fifteenth review period, the consultant again found that during the past year, the MRC had made additional, important and needed progress in several areas. There were also indications of progress addressing some stubborn problems with positive results. To achieve improved results, the DBHDS added clinical and support resources to the MRC. In addition to expanding the MRC membership with individuals with new and different perspectives and benefiting from improved attendance, the MRC utilized a streamlined, two-tier mortality review process to increase the rate of reviews. It also improved the processes for collecting, documenting, organizing, and making available needed documents; it updated the

Mortality Review Form to ensure that all essential components are reviewed and succinctly documented. The MRC members were also authorized to interview Case Managers.

Table 5 below shows the impact of the MRC's revised and improved processes as of September 2019, the final month of the Settlement Agreement's fifteenth review period. Specifically, the consultant found that the MRC had completed an increased number of mortality reviews while reducing the number of cases with outcomes that remained pending or not documented. This table also shows the positive results from the MRC Coordinator closely tracking mortality review documents and activities.

Table 5
Mortality Review Committee
Cases – Outcomes - Pending

Calendar Year**	# cases reviewed	Outcome pending	Outcome blank	Pending resolved	Action steps/alerts, etc.
2015	307	48	15	31	75
2016	295	9	57	4	80
2017* (Jan-Mar)	50	2	9	0	23
2017 (Apr-Sep)	91	8	3	5	52
Oct 2017-August 2018	243	26	7	25	125
Oct 2018-August 2019	351	1	0	31	64*

*A list of alerts which were developed during the current review period from OIH were not submitted, hence this number may be inaccurate. There were at least 63 action steps listed through the MRC meeting minutes. One example of an action alert was submitted.
** Note: not all rows include data for a full year

Table 6 below shows the improved availability of documents for review by the MRC. The MRC Coordinator also continued tracking the timeliness of submission of required documentation. The consultant's review found that during the fourteen and fifteenth periods, the MRC had sustained adherence to some of the measurable mortality review compliance indicators. The MRC held meetings in each month and averaged two meetings per month. The expanded membership of the MRC contributed to an increase in attendance, which averaged ten to eleven members per meeting. Either the Chief Clinical Officer (MD) or the MRC co-chair (DNP) attended each of 22 MRC meetings (100%) and both attended 18 MRC meetings (81.8%), which has improved the clinical quality and efficiency of the reviews.

Table 6 Mortality Review Committee Documents Reviewed									
Year	# Cases	Case Manager Progress notes	Medical Record	Doctor's notes	Nurse's notes	Incident Reports	ISP	Physical Exam record (most recent)	Death Certificate
2014	226	NR****	0	0	0	0	0	0	4
2015	289	NR	1	1	1	100%	3	0	2
2016*	164	NR	1	1	2	98%	2	1	9%
2017**	108	NR	16%	14%	6%	98%	21%	13%	6%
2017***	138	NR	42%	21%	26%	99%	55%	32%	5%
2017-18^	243	95%	NR	7%	12%	97%	95%	26%	27%
2018-19^^	351	94%	NR	25%	25%	72%	94%	29%	34%

*1/1/2016-6/30/2016, **7/1/16-12/31/16, ***1/1/17-6/27/17, **** Not Recorded
^October2017-August2018, ^^ October2018-August2019

During the prior reporting period, mortality reviews occurred four to six months following the death of the individual. The process for timely completion of the mortality reviews has improved during the current review period. Overall, from October 2018 through August 2019, 44 percent of MRC reviews were completed within 90 days. However, for the most recent three months of the period reviewed (June through August 2019), 90 of 98 (91.8%) deaths were reviewed by the MRC within 90 days. The combination of the MRC two-tier review process, increased staff resources and coordination, and having more of the needed documents available has resolved the backlog, which has allowed the MRC to complete mortality reviews within 90 days of death, as required by the Agreement.

The MRC is in the process of implementing other improvements. In September, the MRC was in the final stage of revising and formalizing its charter. The Office of Licensing is reported to be hiring a nurse to provide guidance to Licensing Specialists, as part of a rapid response team approach after an unexpected death, to insure others in the home are safe. The MRC has also defined criteria for a potentially preventable death and has begun collecting related data.

There are long standing and significant challenges that remain that the MRC must address and resolve to achieve compliance. The MRC process has continued to be challenged in collecting needed data and records, especially in regards to medical information. For example, for the 11 months recently reviewed, the individual's most recent physical exam was available for only 29 percent of the those who died; and the death certificates, all of which are in the custody of the Commonwealth, were only provided for 34 percent of the mortality reviews. Doctor's and nurse's notes were available for less than 30 percent of mortality reviews.

The MRC has facilitated implementation of quality initiatives to address identified problems. However, the MRC quality improvement program lacks basic elements which are essential to its ability to succeed and to fulfill the Agreement requirement "to reduce mortality rates to the fullest extent practicable." There is no evidence that the MRC or the OIH have conceptualized, described,

or implemented a process to determine the extent to which its improvement initiatives are effective, i.e. the problem that it has identified as potentially contributing to an avoidable death has been addressed and resolved by implementing the improvement initiative. Without collecting data about the impact of its improvement initiatives, and without evaluation to determine the extent to which the initiatives were and were not successful, the Commonwealth will not able to able to determine whether additional initiatives are needed or what additional actions are necessary "to reduce mortality rates to the fullest extent practicable."

The Commonwealth remains in non-compliance with Section V.C.5. The MRC has made significant progress. If it sustains this progress, and if these other significant challenges are addressed and resolved, compliance could be achieved in the next year.

8. Provider Training

The Independent Reviewer retained an independent consultant to review the status of the Agreement's requirements regarding the development and implementation of a "statewide core competency-based training curriculum for all staff who provide services" under the Agreement.
The current version of the statewide core competency-based training curriculum was initiated three years ago. This curriculum includes Orientation Training to Direct Support Professionals (DSPs) and Supervisors, *Supporting People in their Homes and Communities,* and its ancillary training approaches to ensure adequate coaching and supervision. It also includes content areas, including: characteristics of developmental disabilities, IDD waivers, person-centeredness, positive behavioral supports, effective communication, health risks and their interventions, and values-based best practices supporting people with developmental disabilities. Additional "advanced" competencies are required for DSPs who work with individuals with autism, those with challenging behaviors, and those needing intensive health related supports. The competency-based trainings are online in a website that is held by Virginia Commonwealth University's Center on Excellence in Developmental Disabilities, but are managed, maintained, and kept current by the DBHDS, Division of Developmental Services (the Division).

Each DSP and supervisor providing DBHDS licensed services under the Agreement must pass a written test with 91 questions "before providing reimbursable supports." There is also an associated checklist of 48 competencies that a newly hired DSP must demonstrate via observation by their supervisor within 180 days of hire. All competencies, the entire 27 items, must be verified for proficiency by the supervisor within 180 days of the staff hire date. The supervisor verification requires dating and initialing the checklist. The supervisors must have also shown proficiency on the same 27 items.

The training competencies verification form now includes an Observation/Indicator column that facilitates observability or measurability. In addition, DBHDS and DMAS are currently revising their assessment strategies surrounding supervisor evaluation of DSP and supervisor competencies. When implemented, the supervisor evaluation will include a record of:

- How the "training" was delivered (i.e., 1:1, group, formal classroom);
- "Observations" of skills being trained (e.g. demonstration, language used, relates individual needs and plan, etc.);
- "Implemented skills" (i.e., supervisor's direct observations); and
- "Proficiency confirmation" (i.e., supervisor verification that the employee is competent and requires minimal or low amounts of supervision).

Requiring supervisors to specify how trainings were delivered and competencies were demonstrated is important. In Virginia's community-based service system, the Independent Reviewer's studies have found many examples of boxes checked on forms when the activity verified had not in fact occurred, or had occurred but inadequately. Given that the Commonwealth's only current mechanism to monitor provider's compliance with the competency-based training requirements is by a review only every two to three years and by documents, it is critical to verify that supervisors specify the basis for checking the box that the staff's competencies were in fact demonstrated and observed

The Commonwealth has added responsibility to the DMAS Quality Management Review (QMR) process to ensure that the competency-based training requirements have been properly implemented. The QMR audits samples of each provider agency's training records every two to three years. The QMR monitoring process includes reviews of the Assurance items listed in Table 7 below, among other performance measures. Findings from the DMAS QMR reviews are processed quarterly with DBHDS as a way of ensuring the Commonwealth's "Assurances" to the Center for Medicaid and Medicare Services (CMS), which approved them as part of its approval of the Commonwealth's HCBS IDD waiver program.

Table 7 shows that the most significant challenge for provider agencies reviewed by DMAS in Fiscal Year 2019 was assuring that DSPs meet training competencies requirements. This is understandable, and expected, since meeting Assurance C8 is validated by a written test with multiple choice and true/false questions, whose answers are available publicly; whereas, meeting the competency requirements, Assurance C9, entails direct supervisor observation and signoff. During Fiscal Year 2019 (January 1, 2019 to March 31, 2019), the QMR audit determined 85.8 percent of provider agency staff "met" the orientation training requirement versus determining only 57.2 percent met the core-curriculum competency requirements. The QMR audits did not indicate a positive trend toward achieving competency-based training for "all staff providing services under the Agreement."

Table 7 Fiscal Year 2019 Performance Measures for HCBS Waiver Sub-Assurances C8 and C9					
Assurance	**Q1**	**Q2**	**Q3**	**Q4**	**FY 2019**
C8. Number and percent of provider agency staff meeting provider *orientation* training requirements.	36/37 97%	58/58 100%	121/155 78%	112/131 85%	327/381 85.8%
C9. Number and percent of provider agency DSP staff meeting *competency* training requirements.	19/29 66%	44/56 79%	78/137 57%	46/105 44%	187/327 57.2%

In the considered opinion of the Independent Reviewer, there is no more important factor in ensuring the health, safety and personal growth of the individuals served than staff who are required periodically to demonstrate the competencies necessary to meet job expectations. The consultant's review determined that the content of the trainings is appropriate. However, the Commonwealth has not yet demonstrated that it has an adequate mechanism or process to ensure that provider staff have completed the required trainings and demonstrated the required competencies.

Two years after DBHDS's deadline for all staff to have completed the competency-based training, the DMAS QMR found that a significant percentage of provider staff have not met these requirements. The Commonwealth's current monitoring and enforcement mechanisms have not ensured acceptable provider performance.

Formerly, the Division warned in supervisor training that DMAS could request paybacks (recoupment, retraction) for those services provided by DSPs and DSP supervisors who failed to pass the orientation test or demonstrate competencies as required. This latter contingency was infrequently enforced, reportedly due to workload issues at the DMAS Program Integrity Division. For competency-based training, the current DBHDS draft instructions indicate that: "From the date of that initial 180 day review, DMAS shall not reimburse for those services provided by DSPs or DSP supervisors who failed to pass the orientation test or demonstrate competencies as required." It is the Independent Reviewer's considered opinion that a monitoring and enforcement process will very likely be inadequate at ensuring compliance when it occurs only every two to three years, is based only on document reviews, and when substantive violations are found, sanctions are only enforced infrequently. In addition, DBHDS's current warning, when enforced, could worsen the problem, as it reduces funds available to providers to pay DSPs. DSP low pay rates and few benefits contribute to existing high staff turnover, which in turn may cause residential managers to assign newer staff, or those who have not yet passed the trainings, to deliver needed services prior to completing required competency-based training. The Independent Reviewer's related recommendations are included in Section V. Recommendations.

The Agreement's requirement that all staff be trained and can demonstrate competence fulfilling the expectations is a cornerstone in building a service system with programs that consistently provides good quality services. There is broad agreement that the Commonwealth should have the tools and the ability to ensure the health, safety, and personal growth of the individuals served by

its community-based service system. Timely and effective enforcement is not necessary to achieve these outcomes for the many providers who fulfill their responsibilities consistently, but is essential for providers who don't. Virginians with IDD and their families deeply appreciate and express being indebted to the former, and would be better off with fewer of the latter. The QMR audit results to-date have confirmed that many service providers have staff providing services needed to ensure health, safety, and personal growth who have not demonstrated the competencies necessary to fulfill these expectations.

Conclusion

The Commonwealth has made substantial progress in continuing to improve and refine its statewide competency-based curriculum. The content of the competency-based trainings is appropriate. The DMAS QMR monitoring process, however, is not at all adequate to ensure that provider agency DSP staff and supervisors meet the *competency* training requirements. It is the considered opinion of the Independent Reviewer that much more frequent monitoring, the provision of more technical assistance, if needed, but especially more timely and effective enforcement is necessary for the Commonwealth to ensure that all staff have demonstrated the required competencies and to achieve compliance with the Agreement requirement.

The Commonwealth remains in non-compliance with Section V.H.1-2.

9. Quality and Risk Management

The Agreement requires the Commonwealth to develop and implement a Quality and Risk Management System to "identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement." (V.B.). To assess the status of the Commonwealth's efforts and achievements to comply with the quality and risk management provisions, the Independent Reviewer's consultant completed the seventh annual review of the provisions listed below, which require the Commonwealth to:

- establish uniform risk triggers and thresholds and provide guidance and training to providers to proactively identify (V.C.1.);
- adhere to the CMS (Centers for Medicare and Medicaid Services)-approved waiver quality improvement plan (V.D.1.);
- offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions (V.C.4.);
- collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services (V.D.2.);
- collect and analyze consistent, reliable data in key quality domain (V.D.3.);
- collect and analyze data from specific available sources (V.D.4.);
- implement Regional Quality Councils (V.D.5.); and,
- implement and ensure effective provider quality improvement strategies (V.E.).

The consultant's full report (attached at Appendix H) includes references to the findings and recommendations from the previous studies. Prior to initiating this review, the Commonwealth had not attested to its compliance and did not dispute the Independent Reviewers' conclusion that its implementation of newly revised plans has not been sufficient to achieve compliance. The primary purpose of this review, therefore, was to obtain updates and to identify areas where the Commonwealth's current plans, if implemented effectively, are likely to achieve compliance. Unlike previous studies, this review did not include Quality Service Reviews (QSR) because the Commonwealth had paused its QSR implementation while it completes a Request for Proposal process. After selecting a new vendor, the Commonwealth will recommence its QSR assessments.

In recent years, the Commonwealth's approaches to its quality and risk management system have undergone frequent revisions between reviews. This was the case this time. Since the previous review, the Commonwealth had again engaged in substantial efforts of self-assessment related to its quality and risk management system and, as a result, had initiated and/or was planning many systems improvements to address identified needs. Much of the self-assessment described in this report was internal to DBHDS. It resulted in the development of a revised quality and risk management organizational structure, which is described in the recently completed *DBHDS Quality Management Plan FY 2020,* (dated September 13, 2019) as well as in its analytical reports on the topics of CSB quality improvement needs and data quality, reliability and validity.

DBHDS's revised plans were influenced by the Commonwealth's Office of the State Inspector General (OSIG) review and December 2018 report, *Department of Behavioral Health and Developmental Services: Review of Serious Injuries Reported by Licensed Providers of Developmental Services*. The OSIG report criticized DBHDS incident management processes with regard to serious injuries and made several recommendations for systems improvement. The OSIG Report's criticisms identified deficiencies and made recommendations to address isuues including the quality, consistency and reliability of reports with regard to serious injuries. The OSIG report also identified limitations in DBHDS Quality Improvement Committee's and Regional Quality Councils' abilities to analyze serious injury data, identify patterns and trends or prioritize the highest risk injuries for performance improvement initiatives.

Overall, the Independent Reviewer's consultant's study found that DBHDS has made progress with regard to designing quality and risk management structures, such as re-defining its quality management framework, including principles, structures and data collection and analysis methodologies. The *DBHDS Quality Management Plan FY 2020*) was not yet complete, but once all components have been developed as envisioned, this plan should provide a mechanism which can be used to demonstrate how DBHDS will properly implement and comply with the quality and risk management indicators described above. At the time of this review, DBHDS has also not yet finalized development and/or implementation of many of the other strategies that it intends will bring the Commonwealth into compliance. Some strategies, such as replacing the incident management system technology, are still in the early formative stages.

At present, as described in detail in the consultant's report, the overall functionality of the framework continued to be severely hampered by the lack of valid and reliable data across much of the system. In December 2018, after the thirteenth review period, the Independent Reviewer urged DBHDS to create a comprehensive data quality improvement plan, with specific action steps and milestones, to expand and improve the quantity and quality of data to measure performance and to provide a structure for greater accountability of effort. DBHDS staff were keenly aware of the continuing need to make improvements in this area, and were either engaged in, or planning, improvement initiatives. However, DBHDS still needs to develop a comprehensive and specific data quality improvement plan to tie its efforts together in a cohesive manner. The recently-developed *Data Quality Plan* and *CSB Quality Reviews* (April 26, 2019) will provide a good foundation for this effort.

Risk Triggers and Thresholds

In interviews with the consultant, DBHDS staff indicated that they were continuing to examine how to implement risk triggers and thresholds in a systematic way and had not yet settled on an approach. It appears that DBHDS staff need additional guidance and technical assistance to effectively plan and implement such a system. The consultant's attached report offers some suggestions and raises some serious concerns.

At the individual level, a system of risk triggers and thresholds begins with a risk assessment. This identifies an individual's disposition toward a higher likelihood of certain adverse events (for example, a diagnosis of dysphasia predisposes an individual to aspiration). As the thirteenth period study found, DBHDS continues to assess options for a uniform approach to health risk assessment. In Virginia, the managed care organizations (MCOs) are required by their contracts with the Commonwealth to complete an annual Health Risk Assessment (HRA); and DBHDS Support Coordination training recommended that the Support Coordinator/Case Manager "can and should request a copy of this each year and use this as a resource to update the essential information, identify changes in status and determine if there are previously unidentified risks i.e. unidentified health or behavioral support needs." However, DBHDS staff and CSB staff continue to report that each MCO had its own proprietary tools and that these assessment results were not readily accessible to the individual's Case Manager or residential provider. This is a serious and systemic flaw and obstacle to compliance for the Commonwealth's Support Coordinators/Case Managers and residential service providers not have access to health risk assessments. It is also unclear why this flaw cannot be resolved when both entities work under contract to the Commonwealth and have shared missions to ensure that risks are addressed.

As DBHDS examined how to implement risk triggers and thresholds, it continued to develop educational resources to address some of the risk trigger topics. The Office of Integrated Health (OIH) website currently offers provider education resources on health risk topics, including immunizations, falls prevention, skin integrity, bowel obstruction, aspiration, seizures, gastroesophageal reflux disease (GERD), and dehydration.

The falls prevention resources came about as a result of an Risk Management Review Committee (RMRC) quality improvement plan (QIP) on that topic, which, in turn, had been prompted by recommendations from the OSIG report criticizing DBHDS's incident management processes with regard to serious injuries. That report identified that falls and urinary tract infections (UTIs) were among the most frequently reported adverse events, and it recommended that DBHDS develop targeted performance improvement initiatives related to these two priority health and safety issues as a starting point for its quality management efforts. It is positive to see that DBHDS has responded to this identified need. However, their slow and incomplete response to the OSIG notification highlights two significant concerns with the current status and functioning of the DBHDS quality and risk management system.

The first concern is that DBHDS did not act with the needed degree of urgency to address known systemic identified risks. The OSIG report was released in December 2018, yet the falls training was not posted until eight months later, a significant lag time for known risk to individuals' health and safety. In addition, based on the documentation submitted for this review, DBHDS has not yet developed a quality initiative to address UTIs.

According to the *DBHDS Quality Management Plan FY 2020,* DBHDS uses the Plan-Do-Study-Act quality improvement model. This model relies heavily on data-based decision making, in which a clear measurement strategy for the proposed intervention is developed as an integral part of the planning stage, and data are rigorously collected during the implementation of the intervention. These data are then studied to determine whether the intervention had the planned and desired impact. For this fall prevention QIP, DBHDS does not appear to be collecting any data regarding related provider competencies, or another means, to measure the extent to which the initiative was successfully implemented. The problem of DBHDS not gathering information about the impact of its quality improvement initiatives is a significant weakness that has also been identified in other components of its quality and risk management systems.

Root Cause Analysis

In April 2019, DBHDS provided training to its licensed providers entitled *Root Cause Analysis (RCA): The Basics*. This presentation included an overview of the regulatory requirements for CSBs and providers with regard to the purpose of RCA, when to conduct an RCA, and the three components of an RCA required by DBHDS licensing regulations. The presentation also described how the DBHDS Office of Licensing would monitor providers adherence to the requirements. The DBHDS regulations also now require providers to implement Quality Improvement programs and OL has provided guidance. The DHBDS Office of Integrated Health provides guidance, training and technical assistance to providers regarding harms and risks of harms.

The Commonwealth has achieved compliance with V.C.4. for the first time. It has provided the necessary guidance and training required, and it has gone even further. DBHDS regulations now require that providers actually utilize Root Cause Analysis during its internal investigations for all Level II and Level III incidents.

Case Management as an Integral Function of Risk Management

In previous reviews, the DBHDS's Quality Improvement Plan conceptualized the Case Manager as the "system's trip wire for quality assurance." The Agreement requires Case Managers to fulfill functions that are integral to risk management for the individuals they serve. DBHDS's current conceptualization of its quality and risk management system, as presented in the *DBHDS Quality Management Plan FY 2020*, did not provide a specific emphasis on the role of the Case Manager. It seems incongruent and a systemic flaw to envision and develop a Risk Management System that does not specifically include the many critical roles that the Agreement requires Case Managers to fulfill related to the management of the individual's risks and to subsequent required reporting to the DBHDS Risk Management processes.

The Agreement requires Case Managers to identify the individual's needs and risks, convene the Individual Support Plan team to design individual service plans to address identified needs and risks, and assist the individual to access needed services that, if implemented appropriately, address the risk. The Case Manager should also visit the individual regularly, and, during visits, assess for previously unidentified risks, for changes in status, and for whether ISP goals remain appropriate and are being implemented appropriately. If the Case Manager's assessment identifies a change in the individual's status, needs, or risks, or that services are not being implemented appropriately, then the Case Manager is required to document the issue, convene the individual's service planning team to address it, and document its resolution. Subsequent to fulfilling these functions, the Case Manager provides information regarding availability and accessibility of services, quality of services received, and effective processes to monitor participant health and safety, which is reported to the Commonwealth for its Quality and Risk Management system. It is important for DBHDS's Quality Improvement Plan to describe how the Agreements' requirements related to Case Management will relate to the DBHDS plan for quality improvement.

The continuing obstacles that Case Managers must overcome to obtain both critical incidents and injuries information about individuals on their caseloads are indicative of a system that excludes them from their essential role in risk management required by the Agreement. The current DBHDS incident management system still presents significant obstacles to Case Managers effectively performing their assigned functions. The Independent Reviewer's December 2018 Report to the Court identified that Case Managers did not have direct access to the CHRIS reports of critical incidents for the individuals they serve. These reports are typically submitted to DBHDS by the private providers whose services the Case Manager is responsible for assessing to determine whether these services are being properly implemented.

DBHDS states that it has addressed this concern. However, during this current study period, CSB staff again reported that due to various continuing obstacles, Case Managers still do not have direct or timely access to the CHRIS reports. Below are some examples of obstacles cited:

- CSBs can only pull data from the CHRIS system for their own providers;
- Case Managers/Support Coordinators cannot obtain copies of CHRIS reports directly, but only by a request to a supervisor;
- Some CSBs only provide copies of CHRIS reports on a monthly basis, and not closer to real time;
- The DBHDS system requires that CHRIS reports be requested solely by the date submitted, rather than by the name of the individual. This makes it extremely difficult to access a single individual's full incident history, and undermines the Case Manager's ability to maintain an acceptable risk management plan; and
- There is no uniform system across CSBs to govern access to CHRIS reports. Each CSB has its own method.

These obstacles to Case Managers receiving "real time" information about risks and injuries to individuals they support significantly impairs their ability to gather a full risk profile, and so to fully understand and be responsive to an individual's service planning needs. The Independent Reviewer previously recommended that DBHDS seek to remove the obstacles to a case manager accessing CHRIS incident reports for individuals on their caseload. The Commonwealth has not yet addressed this sufficiently. In addition, the Independent Reviewer has not received results of any quality improvement review of the effectiveness of the Commonwealth's actions taken to date regarding the retrieval of CHRIS report information. Further, the Commonwealth has not provided plans to address and resolve remaining systemic obstacles.

In summary, Case Managers are unable to effectively fulfill their job expectations, and so the Commonwealth is not meeting the related requirements of the Agreement.

It is unclear why DBHDS has conceptualized its quality and risk management system without emphasizing how the required functions of the Case Managers will be included. This is a significant gap in the DBHDS risk management system.

Quality Improvement Plan

The first provision of this section of the Agreement (V.D.1.), Data to Assess and Improve Quality, requires the Commonwealth to operate in accordance with the CMS-approved quality improvement plan. The thirteenth review period study found that DBHDS's high-level description of the structure of its quality management program did not include sufficient information to determine whether the Commonwealth's HCBS waivers were being operated in accordance with the CMS-approved quality improvement plans.

For this current Report, the Independent Reviewer's consultant reviewed the Commonwealth's Quality Improvement Strategy Appendix (see Appendix H) to its HCBS waiver applications and the most recent CMS waiver evidence report which details the status of the Commonwealth's compliance with the waiver assurances and sub-assurances. The consultant's study also reviewed the processes in place to ensure that the Commonwealth's review of data occurred at the local and

state level, by the CSBs and by DBHDS/DMAS respectively. Local review is required by the Agreement and by CMS. The following provides a summary of findings.

The *DBHDS Quality Management Plan FY 2020* described a state-level collaborative and cross-agency Quality Review Team (QRT) responsible for the oversight of the quality improvement strategy as described in the waiver programs.

The Agreement's provision V.D.1. regarding its CMS-approved waiver quality improvement plan also requires a review of data at the local level. The Commonwealth has not provided documents that give a clear picture of the CSB's role in the review of data with regard to the waiver performance measures and sub-assurances.

In order to evaluate the status of DBHDS' performance for this section, the consultant reviewed the Appendix H for the Community Living Waiver, Family and Individual Support Waiver, and the Building Independence Waiver. In these documents, the Commonwealth described a process for quality improvement that appeared to be consistent with the description in the *DBHDS Quality Management Plan FY 2020*.

The consultant also requested to review the waiver evidence reports. CMS renewal of an existing waiver is contingent upon a CMS review of waiver data, or evidence, to determine if the state has met the assurances. Based on this review and findings, CMS will issue a report to the state summarizing its findings and conclusions concerning the operation of the waiver.

In February 2018, CMS issued the most recent evidence report indicating that the Commonwealth did not demonstrate the assurance for Health and Welfare. For four performance measures across three sub-assurances, DBHDS did not collect and/or provide the required data. For this study, to assist in the evaluation of the thoroughness and efficacy of the required state-level data review process, the consultant also requested the Commonwealth's Quality Review Team's meeting minutes. However, DBHDS did not provide these records.

The Commonwealth remains in non-compliance with V.D.1.

Collecting and Analyzing Reliable Data

The Data to Assess and Improve Quality provisions of the Agreement (V.D.2.-4) define the purpose, the domains of individuals' lives, and the sources of reliable data that the Commonwealth shall collect and analyze, as follows:

V.D.2. defines that the purpose is to:

- Improve the availability and accessibility of services; and
- Improve the quality of services.

V.D.3. identifies the eight *domains* of individuals' lives as:

- Safety and freedom from harm;
- Physical, mental, and behavioral health and wellbeing;
- Avoiding crises;
- Stability;
- Choice and self-determination;
- Community inclusion;

- Access to services; and
- Provider capacity.

V.D.4. identifies the sources of data as including the:

- Risk management system;
- Providers;
- Case Managers;
- Quality Services Reviews; and
- Licensing.

The review of these Quality and Risk Management provisions during the thirteenth period found that the Commonwealth had made limited and intermittent progress. It had developed a Quality Management Framework that described roles and responsibilities, begun to develop valid measures for the domains (i.e. Key Performance Areas), and had updated its Incident Management Report. Significant work remained, however, in each of these areas, and importantly, the Commonwealth had not yet developed a structured plan to guide its efforts to collect, ensure the reliability of, or analyze relevant data to evaluate and improve services.

The fifteenth period review found that the Commonwealth has continued to make modifications to its Quality Management Framework. This includes additional definition of the roles and responsibilities of the QIC and RMRC in the development, implementation and oversight of processes to collect and analyze valid and reliable data. In September 2019, DBHDS promulgated the *DBHDS Quality Management Plan FY 2020*, which defined three broad categories aimed at addressing the availability, accessibility and quality of services. The plan chartered three Key Performance Area (KPA) workgroups, one for each domain, and charged them with the proposal and development of measures, which would be reviewed and approved by the QIC. It had also cross referenced the eight domains (above) with its performance measure template and with its waiver assurances, and incorporated many of the recommendations from previous Reports.

The Commonwealth is also currently collecting data on a variety of metrics from various sources. These include serious incidents from its CHRIS system, licensing data, and a range of case management data through its performance contract with CSBs. The Commonwealth also collects a wide range of data as a participant in the National Core Indicators, but its collection of data from Quality Services Reviews (QSRs) has been paused while it revamps that process.

This study found that, while DBHDS collected considerable data from various sources, significant challenges with the reliability and validity of the data still exist throughout the system. These issues hamper the ability of DBHDS staff to complete meaningful analyses of the various data collected and/or to implement needed improvements. It was positive, though, that DBHDS staff had identified many of these concerns and were either engaged in or planning initiatives to rectify them. The consultant's full report (Appendix H) describes some of the concerns and the steps that DBHDS has taken or are planned.

Since the last report during the thirteenth review period, DBHDS engaged in a period of self-assessment with regard to several of its data source systems. In 2019, during the fifteenth review period, DBHDS examined data quality concerns for various data sources. Its draft *Data Quality Plan* identified data validity and reliability issues with regard to the DBHDS's major services

related information systems: CHRIS serious incident and death reporting system, the CHRIS human rights reporting system, the OLIS, and the Regional Support Team data. In each case, the report examined the current status to identify specific concerns and described improvements needed as well as any existing or planned initiatives toward resolving those concerns.

These concerns, which frequently relate to reliability, are similar to problems found previously. They include the lack of clear definitions for reportable incidents and the insufficient quality, consistency and reliability of reports used by DBHDS relevant to serious injuries. The inadequate system design prevents DBHDS staff and its Regional Quality Councils and Quality Improvement Committees from using the data to identify systemic needs for preventative, remedial or improvement interventions. The data issues identified in DBHDS's draft *Data Quality Plan* were largely consistent with, and affirmed by the OSIG examination and report related to DBHDS' critical incident management system. That OSIG report recommended "review the efficiency and effectiveness of DBHDS' QIC and RQCs relevant to serious injuries reported by providers serving individuals with developmental disabilities to identify actual and potential risk points and make recommendations to improve the process and individuals' overall safety and freedom from harm."

DBHDS had been actively addressing some of these issues even prior to the OSIG report. DBHDS had promulgated emergency amendments to its licensing regulations with incident definitions and reporting requirements which includes categorizing incidents by severity. DBHDS has also implemented updates to the CHRIS system, and published guidance regarding refined system protocols that had led previously to inaccuracies in the data.

However, DBHDS staff have also long recognized that these changes would not address all of the concerns presented with the legacy CHRIS system and are currently developing an RFP to obtain a new system for critical incident management. At the time of this review, the specifications for the new system was not sufficiently developed to share.

DBHDS has also identified data reliability issues within CCS 3, another system DBHDS uses to collect data with regard to quality and availability of services, service gaps and accessibility of services. DBHDS performance contracts require the CSBs to provide monthly CCS 3 extracts that report these service and case management data to DBHDS. In April 2019, in response to its Quality Improvement Committee request, DBHDS issued *CSB Quality Reviews*, a report regarding the quality, accuracy and completeness of case management data. This report includes the concerning findings that:

- The CCS 3 was developed to collect data related to services for federal grant purposes and was unlikely to support future data reporting demands;
- Most CSBs did not currently have the technical expertise or capability to develop or generate specific reports related to the case management data metrics;
- CSBs who did could generate reports could not replicate DBHDS aggregate reporting numbers and were unable to reconcile the reports to improve data quality; and,
- DBHDS's generated reports did not allow for timely correction of issues identified due to the lag time between data submission and report generation.

The CSBs and DBHDS must improve their limited capabilities to identify and correct errors in data reporting and to process in a timely manner. These improvements are necessary for the CSB s and DBHDS to effectively monitor performance measurements.

Conclusion

DBHDS continued to collect data in many areas relevant to the Agreement's requirements, and had made some incremental progress with regard to development of related measures. However, the efforts of DBHDS staff to conduct any meaningful analysis continued to be severely hampered by the lack of valid and reliable data across much of the system. DBHDS staff were keenly aware of the need to make improvements in this area, and were either engaged in, or planning, improvement efforts. DBHDS still needs to develop a comprehensive and specific data quality improvement plan to integrate its efforts together in a coherent and cohesive manner. At the time of the previous Quality and Risk Management Systems study for the thirteenth review period, the Independent Reviewer had urged DBHDS to create a comprehensive data quality improvement plan, with specific action steps and milestones, to expand and improve the quantity and quality of data to measure performance and to provide a structure for greater accountability of effort. The recently-developed *Data Quality Plan* and *CSB Quality Reviews* (April 26, 2019) provided a good foundation for moving forward on this recommendation.

The Commonwealth remains in non-compliance with V.2, 3 and 4.

Regional Quality Councils

At the time of the thirteenth period review, RQCs were operational and consistently held meetings each quarter in each of the five Regions. While meeting minutes reflected some specific discussion on data reports for certain topics, (e.g. employment and housing report), they were inconsistent with regard to identifying specific feedback and recommendations from the regional participants.

The fifteenth review found that the *DBHDS Quality Management Plan FY 2020* described the roles and responsibilities of the RQCs, prescribed the membership and issued a charter, including that:

> "RQCs are to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and evaluate data to identify and respond to trends to ensure continuous quality improvement. RQCs review and assess state and regional data related to quality indicators (performance measure indicators) for developmental disability services...Each RQC reviews and evaluates the data, trends and monitoring efforts."

The consultant's attached report details the progress which DBHDS has achieved as well as continuing concerns. The RQCs have continued to meet regionally each quarter. Their minutes continue to reflect similar activities and concerns to those reported previously. The OSIG report of December 2018 found that RQC members had not received any training in quality management or performance improvement. As a result, on August 22, 2019, with the assistance of a community partner agency, DBHDS convened a much needed joint training session for all five RQCs that included a review of the DBHDS quality management structure, understanding the big picture of the role of quality councils, roles and responsibilities of a Quality Council and using data to improve system performance. Additional training is needed in Quality Management (QM) principles and performance improvement.

The OSIG report also found that data presentations provided to the RQCs did not facilitate the members' ability to track, trend or identify serious-injury patterns in their respective Regions, make comparisons of serious injuries by quarter, or develop targeted performance improvement regional plans. For this review, RQC minutes continue to indicate that the members did not yet have a clear picture of the data they would receive, but had made some specific requests to receive data that were both regionalized and relatively current. DBHDS staff commented that, due to constraints with the data collection processes, it is not yet able to consistently provide current, and therefore actionable, data to the either CSB or regional level trend data. DBHDS staff should consider these limitations and how to address them when finalizing its RFP for a redesigned incident management system.

Overall, based on interviews with DBHDS staff and some stakeholders, a general consensus was that the RQCs lacked a clear value-added purpose in their current format. DBHDS leadership indicated they planned to continue discussions with stakeholders about the role of the RQCs and how to move forward. It was notable, though, that DBHDS staff reported it had been difficult to sustain RQC membership and attributed this in part to a lack of clarity about purpose and expectation, even with the recently issued charters. It was therefore interesting that CSB staff interviewed reported finding the meetings valuable and informative. As much as anything, it is possible that the perceived lack of functionality of the RQCs has as much to do with the lack of needed tools to undertake their assigned tasks (i.e., current and regionalized data, training and expertise, etc.). These factors should be considered as the discussions about the future of the RQCs move forward.

Public Reporting

At the time of the thirteenth review period, DBHDS had not yet developed the functionality for the required Public reporting, due in part to issues with its website operations. For this fifteenth period review, DBHDS staff did not provide any documentation to demonstrate that it had provided pubic reporting on the availability and quality of supports and services in the community, gaps in services, or on recommendations for improvements.

The Commonwealth remains in non-compliance with V.D.6.

Providers

At the time of the thirteenth period report, DBHDS:

- Had revised regulations to required providers to develop and implement quality improvement programs and to conduct, at least annually, systemic risk assessment reviews that incorporated uniform risk triggers and thresholds; and,
- Had not developed clear criteria and expectations for the requirements for a provider risk management system to serve as guidance and to allow DBHDS to consistently monitor providers' and CSBs' implementation and adherence to the requirements.

For this fifteenth period report, the Independent Reviewer's consultant reviewed the Commonwealth's emergency regulations that require licensed providers to develop and maintain quality improvement programs (QIPs). Effective September 1, 2018, these regulations, required

providers to implement QIPs programs and risk management systems and specified the expectations below.

Each provider's quality improvement plan must:

- review and update its QIP, at least annually;
- establish measurable goals and objectives;
- include and report on statewide performance measures;
- utilize standard quality improvement tools, including root cause analysis;
- regularly evaluate progress toward meeting established goals and objectives;
- incorporate any corrective action plans;
- include put from individuals and their authorized representatives, and
- implementation of improvements, when indicated.

In November 2018, DBHDS also issued a guidance document (*Office of Licensing Guidance for a Quality Improvement Program*) to providers regarding these requirements. This guidance indicated that DBHDS did not require a specific template for the quality improvement plan, but provided some additional detail with regard to the subsections of the regulation.

For this fifteenth period review, DBHDS did not provide any records to document the Office for Licensing (OL) protocol for monitoring whether, and the extent to which, CSBs and providers have implemented the quality improvement program regulations. Once implemented, the initial results of the OL monitoring process will provide information needed to determine what additional actions are necessary for the Commonwealth to ensure that CSBs and providers are fulfilling these requirements. DBHDS' communication of its expectations regarding the subsections was a good and important start. DBHDS will need an organized methodology and protocol to monitor and gather information of effective implementation to provide records that demonstrate that the Agreement's QIP requirements have been properly implemented. As has occurred with implementation of other Agreement requirements that include the development and implementation of new systems, some CSBs and providers will likely need considerably more guidance, technical assistance, and potentially enforcement to ensure that these requirements are effectively implemented.

During the fifteenth period, the Independent Reviewer postponed conducting an independent study of the status of the Commonwealth's progress toward fulfilling the requirements to utilize annual Quality Service Reviews. Based on its own analysis, the Commonwealth planned to not continue with its previous QSR contract agency as of July 1, 2019, and to post an RFP for a new vendor, which occurred on September 6, 20119. As a result, the Commonwealth would not have a QSR provider under contract during the second half of the fifteenth review period and its newly revised approach would not yet be in place.

Conclusion

DBHDS is fully aware that it is not yet gathering valid and reliable data and that this is essential to the effective functioning of its Quality and Risk Management system and to achieving compliance

with the requirements of the Agreement. Accordingly, DBHDS should continue to focus on building the capacity and infrastructure to collect valid and reliable data.

The Commonwealth remains in non-compliance with V.E.1 and 2.

IV. CONCLUSION

During the fifteenth review period, the Commonwealth, through its lead agencies DBHDS and DMAS, and their sister agencies, continued to achieve compliance with the provisions of the Agreement that it had previously accomplished.

In addition, it took important steps in some areas, due to its ongoing implementation of three strategic initiatives to reform and restructure its community-based service system for individuals with intellectual and developmental disabilities. Examples of these areas include mortality review, transportation, and offering Root Cause Analysis and related training and guidance to providers. However, despite this much-needed progress, the Commonwealth has not yet made sufficient headway for a determination of compliance.

In other critical areas, the Commonwealth's pace of meaningful progress has remained sluggish, especially in the development of a functioning and effective Quality and Risk Management System. Some vitally important elements of this system, such as Quality Services Reviews, will take 18 to 24 months of effective implementation before compliance can be achieved for the first time, and an additional six months to demonstrate sustained compliance. The Commonwealth's lack of progress and continued ratings of non-compliance are frequently due to one or more of six systemic obstacles. These are widely known yet remain substantially unaddressed or unresolved. These obstacles include a long standing and fundamental lack of valid and reliable data, no substantive implementation of the two external monitoring mechanisms regarding the adequacy and appropriateness of services provided, and the complete absence of standards for behavioral support services.

During this fifteenth period, the Independent Reviewer positively notes that the parties negotiated and agreed on compliance indicators for additional provisions of the Agreement.

Commonwealth leaders have continued to meet regularly, to communicate effectively with DOJ, and to collaborate with stakeholders. In its efforts to achieve compliance, the Commonwealth has continued to develop plans to address needed improvements. It has also expressed strong ongoing commitment to fully implementing the remaining provisions of the Agreement, which will then fulfill its promise made to all the citizens of Virginia, especially to those with IDD and their families.

V. RECOMMENDATIONS

The Independent Reviewer's recommendations to the Commonwealth regarding services for individuals in the target population are listed below. The Independent Reviewer requests a report regarding the Commonwealth's actions to address these recommendations and the status of implementation by March 31, 2020. The Commonwealth should also consider the recommendations and suggestions in the consultants' reports, which are included in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the seventeenth review period (April 1, 2020 – September 30, 2020).

Behavioral Programming and Support

1. The Commonwealth should assess and determine actions to address:
   - The current shortage of behavioral specialists;
   - Inadequate behavioral support services; and
   - The lack of existing standards for both the Office of Licensing's monitoring assessments of adequacy and Case Managers' assessments of appropriate service implementation.

2. The Commonwealth should give guidance to providers and Case Managers/Support Coordinators regarding minimum expectations for behavioral services.

3. The Commonwealth should give guidance to providers and CSB Case Managers/Support Coordinators regarding how the Office of Licensing will:
   - Monitor and assess the adequacy of behavioral services; and
   - Determine the adequacy of Case Manager assessments for appropriate implementation of behavioral services.

Integrated Day Activities and Supported Employment

4. The Commonwealth should enhance its efforts across all Regions to ensure a sufficient number of provider agencies are operational, each with the commitment and expertise needed to offer more integrated models of service, including Community Engagement and Supported Employment.

5. The Commonwealth should ensure that:
   - Individuals and their families have ongoing opportunities to learn more about employment; and
   - Case Managers/Support Coordinators communicate that provider agencies can help address barriers to employment.
   - Misconceptions among Case Managers/Support Coordinators are eliminated regarding the impacts of earned wages on benefits.

Regional Support Teams

6. DBHDS should design enhanced reporting and accountability measure. These should then be tested with CSBs who do not submit 90 percent timely referrals for two successive quarters.

7. RSTs should review the barriers in their respective Regions that they have already identified as preventing individuals from gaining access to most integrated settings for residential and day services. They should then make recommendations to remove these barriers.

Transportation

8. DMAS should re-evaluate performance standards in the next NEMT contract, reauthorization or amendment cycle to promote a higher standard of complaint-free rides, including Unfulfilled Trips.

9. As soon as possible, DMAS/LogistCare should measure on-time performance by actual on-time data, and not by the number of complaints filed.

Mortality Review

10. At the time the MRC develops recommendations to reduce avoidable deaths, it should identify measures that will indicate successful implementations. These measures will allow a determination at a later date of whether additional initiatives are needed "to reduce mortality rates to the fullest extent practicable."

Provider Training

12. The DMAS method of monitoring provider agencies to ensure successful implementation of the Commonwealth's required competency-based training curriculum should be improved. The Commonwealth should consider implementing a more effective process that includes increased monitoring frequency and escalating, more reliable and meaningful consequences.

Quality and Risk Management

13. DBHDS should develop a structured plan that specifies goals, objectives, tasks and timelines, and provides guidance to identify, define, collect, analyze, report, and effectively use relevant, valid and reliable data to evaluate and improve services.

14. DBHDS should ensure that its incident management RFP should specify the structured plan elements and how to address them.

15. DBHDS should ensure that Case Managers are notified of all reports of serious incidents and injuries experienced by those individuals for whom they are responsible for "assessing previously identified and unidentified risks, injuries, or other changes in status."

I. APPENDICES

APPENDIX A.

INDIVIDUAL SERVICES REVIEW
Individuals with Complex Behavioral Needs

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

Individual Services Review Study
Individuals with Complex Behavioral Needs
Fifteenth Review Period

Demographic Information

Sex	n	%
Male	17	63.0%
Female	10	17.0%

Age ranges	n	%
Under 21	7	25.9%
21 to 30	3	11.1%
31 to 40	4	14.8%
41 to 50	8	29.6%
51 to 60	3	11.1%
61 to 70	1	3.7%
71 to 80	1	3.7%
Over 80	0	0.0%

Levels of Mobility	n	%
Ambulatory without support	21	77.8%
Ambulatory with support	5	18.5%
Total assistance with walking	1	3.7%
Uses wheelchair	0	0.0%

Type of Residence	n	%
ICF-ID	0	0.0%
Group home	8	29.6%
Sponsored home	8	29.6%
Family/Own home	10	37.0%
Crisis Therapeutic Home	1	3.7%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	22	75.9%
Limited spoken language, needs some staff support	3	10.3%
Communication device	0	0.0%
Gestures	4	13.8%
Vocalizations, Facial Expressions	0	0.0%

Behavioral Needs and Supports

Behavioral Needs Items				
Item	*n*	*Y*	*N*	*CND*
Has there been police contact?	27	18.5%	81.5%	0.0%
Has there been a psychiatric hospitalization?	27	11.1%	88.9%	0.0%
Has there been the use of physical, chemical, or mechanical restraint?	25	12.0%	88.0%	0.0%
Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others?	27	88.9%	11.1%	0.0%
Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment?	27	88.9%	11.1%	0.0%
Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)?	27	70.4%	29.6%	0.0%
Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills?	27	77.8%	22.2%	0.0%
a. Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence?	27	96.3%	3.7%	0.0%

Behavioral Programming Items				
Item	*n*	*Y*	*N*	*CND*
If the individual engages in behaviors that negatively impact his/her quality of life and greater independence:				
Is there a functional behavior assessment in the current setting?	26	26.9%	73.1%	0.0%
Is there a written plan to address the behavior?	26	38.5%	61.5%	0.0%
If there is a written plan to address the behavior:				
Are there target behaviors for decrease?	10	20.0%	80.0%	0.0%
Are there functionally equivalent replacement behaviors/new adaptive skills targeted for increase?	10	60.0%	40.0%	0.0%
Does the plan specify the data to be collected, summarized and reviewed to determine whether planned interventions are working?	10	40.0%	60.0%	0.0%
Have the data been collected, summarized and reviewed by a qualified behavior clinician?	10	20.0%	80.0%	0.0%

Individual Support Plan

Individual Support Plan Items – positive outcomes				
Item	*n*	*Y*	*N*	*CND*
Is the individual's support plan current?	27	96.3%	3.7%	0.0%
Did the Case Manager/Support Coordinator provide education annually about less restrictive services?	21	95.2%	4.8%	0.0%
Was the individual or family given a choice of service providers, including the Case Manager/Support Coordinator?	26	96.3%	3.7%	0.0%
Is there evidence of person-centered planning?	27	100.0%	0.0%	0.0%
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her individual support plan?	27	96.3%	3.7%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	27	96.3%	3.7%	0.0%
Medical	27	100.0%	0.0%	0.0%
Recreation	26	88.5%	11.5%	0.0%
Mental Health (psychiatry)	23	100.0%	0.0%	0.0%
Transportation	27	92.6%	7.4%	0.0%
Does the individual require adaptive equipment?	27	44.4%	55.6%	0.0%
If yes, is the equipment available?	12	91.7%	8.3%	0.0%
If available, is the equipment in good repair and functioning properly?	10	100.0%	0.0%	0.0%
For individuals who require adaptive equipment, is family and/or staff knowledgeable and able to assist the individual to use the equipment?	12	100.0%	0.0%	0.0%
Is family and/or staff assisting the individual to use the equipment as prescribed?	12	100.0%	0.0%	0.0%

Individual Support Plan Items – areas of concern				
Item	*n*	*Y*	*N*	*CND*
Are all essential supports listed?	27	74.1%	25.9%	0.0%
Is the individual receiving supports identified in his/her Individual's Support Plan/Plan of Care?				
Dental	27	81.5%	18.5%	0.0%
Mental Health (behavioral supports)	24	41.7%	58.3%	0.0%
Communication/assistive technology, if needed	7	71.4%	21.6%	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?	3	33.3%	66.7%	0.0%
Does the individual's support plan have specific and measurable outcomes and support activities that lead to skill development or other meaningful outcomes?	27	11.1%	88.9%	0.0%
If applicable, were employment goals and supports developed and discussed?	20	15.0%	85.0%	0.0%
Does typical day include regular integrated activities?	27	29.6%	70.4%	0.0%

Community Residential Services

Residential Staff – positive outcomes Items				
Item	*n*	*Y*	*N*	*CND*
Is residential staff able to describe the individual's likes and dislikes?	15	100.0%	0.0%	0.0%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	16	93.8%	6.2%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's talents/contributions and what's important to and important for the individual?	15	100.0%	0.0%	0.0%
Does the individual require adaptive equipment?	27	44.4%	55.6%	0.0%
If yes, is the equipment available?	12	91.7%	8.3%	0.0%
If available, is the equipment in good repair and functioning properly?	10	100.0%	0.0%	0.0%
Is the residential support staff present, knowledgeable and able to assist the individual to use the equipment?	7	100.0%	0.0%	0.0%
b. Is the residential support staff present, assisting the individual to use the equipment as prescribed?	7	100.0%	0.0%	0.0%
Do you have your own bedroom?	21	100.0%	0.0%	0.0%
Do you have privacy in your home if you want it?	22	90.9%	9.1%	0.0%

Residential Staff – areas of concern				
Item	*n*	*Y*	*N*	*CND*
Is it documented that the support staff/sponsor home provider successfully completed competency-based training related to the adaptive equipment prescribed?	27	44.4%	55.6%	0.0%

Healthcare

Healthcare Items - positive outcomes				
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?	27	92.6%	7.4%	0.0%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	25	96.0%	4.0%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	25	88.0%	12.0%	0.0%
Is lab work completed as ordered by the physician?	26	100.0%	0.0%	0.0%
If applicable per the physician's orders, Does the provider monitor fluid intake?	8	100.0%	0.0%	0.0%
Does the provider monitor food intake?	11	100.0%	0.0%	0.0%
Does the provider monitor bowel movements	4	75.0%	25.0%	0.0%
Does the provider monitor weight fluctuations?	12	100.0%	0.0%	0.0%
Does the provider monitor seizures?	3	100.0%	0.0%	0.0%
If applicable, and the individual does not live in his/her own or family home, is there documentation that caregivers/clinicians: Did a review of bowel movements?	11	100.0%	0.0%	0.0%
Made necessary changes, as appropriate?	4	100.0%	0.0%	0.0%
If applicable, and the individual does not live in his/her own or family home, is there documentation that caregivers/clinicians:				
Did a review of food intake?	14	85.7%	14.3%	0.0%
If applicable, is the dining plan followed?	3	66.7%	33.3%	0.0%
Is there evidence of a nourishing and healthy diet?	27	92.6%	7.4%	0.0%
If the individual receives psychotropic medication:				
Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	19	94.7%	5.3%	0.0%
Is there any evidence of administering excessive or unnecessary medication(s) (including psychotropic medication?	27	0.0%	85.2.	14.8%

Healthcare – continued

Healthcare Items – areas of concern				
Item	***n***	***Y***	***N***	***CND***
If ordered by a physician, was there a current psychological assessment?	5	60.0%	40.0%	0.0%
If applicable, is the dining plan followed?	3	66.7%	33.3%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	27	70.4%	29.6%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	17	82.4%	17.6%	0.0%
Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	10	80.0%	20.0%	0.0%
Are there needed assessments that were not recommended?	27	37.0%	63.0%	0.0%
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?				
Psychology	9	55.6%	44.4%	0.0%
If applicable, and the individual does not live in his/her own or family home, is there documentation that caregivers/clinicians:				
Did a review of fluid intake?	12	83.3%	16.7%	0.0%
Made necessary changes, as appropriate?	9	77.8%	22.2%	0.0%

Healthcare Items –Psychotropic Medications - areas of concern				
Item	***n***	***Y***	***N***	***CND***
If the individual receives psychotropic medication:				
Is there documentation of the intended effects and side effects of the medication?	23	60.9%	39.1%	0.0%
Is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	24	66.7%	33.3%	0.0%
Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?	18	55.6%	27.8%	16.7%

Integration

Integration items – areas of concern				
Item	*n*	*Y*	*N*	*CND*
Do you live in a home licensed for four or fewer individuals with disabilities and without other such homes clustered on the same setting?	*9*	*66.7%*	*33.3%*	*0.0%*
Were employment goals and supports developed and discussed?	20	15.0%	85.0%	0.0%
If no or n/a, were integrated day opportunities offered?	25	36.0%	64.0%	0.0%
Is the individual engaged in supported employment?	19	0.0%	100.0%	0.0%
Does typical day include regular integrated activities?	27	29.6%	70.4%	0.0%
Have you met your neighbors?	20	75.0%	25.0%	0.0%
Do you go out primarily with your housemates as a group?	12	58.3%	41.7%	0.0%
If attending religious services is important to you/your family, do you have the opportunity to attend a church/synagogue/mosque or other religious activity of your choice?	20	65.0%	35.0%	0.0%

APPENDIX B.

BEHAVIORAL SUPPORTS AND PROGRAMMING

To: Donald J. Fletcher

From: Patrick F. Heick, Ph.D., BCBA-D, LABA, Manager, PFHConsulting, LLC

RE: UNITED STATES v. VIRGINIA, CIVIL ACTION NO. 3:12cv59-JAG

Date: October 18, 2019

The following *Summary* and *Addendum* were prepared and submitted in response to the Independent Reviewer's request to summarize a small sample of reviews completed as part of his larger Individual Services Review (ISR) Study. More specifically, the following summary is based upon the reviews of the behavioral services for eight individuals, a sample selected from a larger sample (N=27) by the Independent Reviewer. These reviews compared the behavioral programming and supports that are currently reported to be in place with generally accepted standards and practice recommendations with regard to components of effective behavioral programming and supports – these components included: level of need; Functional Behavior Assessment (FBA); Behavioral Support Plan (BSP) including targeted behaviors for decrease and functionally equivalent behaviors for increase; care provider and/or staff training; ongoing data collection, including regular summary and analysis; and, revision of programming, as necessary. It should be noted that the Reviewer does not intend to offer these components as reflective of an exhaustive listing of essential elements of behavioral programming and supports. Furthermore, these reviews were based on the understanding that all existing documents were available onsite and/or provided in response to the Independent Reviewer's initial and/or subsequent request.

This Summary is submitted in addition to Individual Services Review (ISR) Monitoring Questionnaires (Attachment 2) that were completed for each of the eight individuals sampled as well as Data Summaries (Attachment 1). The ISR Monitoring Questionnaires were submitted separately and under seal as they contact private health information. It should be noted that the following Summary as well as data summaries within the Addenda are based upon the ISR study's Monitoring Questionnaires which were completed using information obtained during on-site visits, including observations and interviews with care providers, brief off-site phone calls with care providers and others, as well as review of documentation provided in response to the Independent Reviewer's document requests (Attachment 3).

Summary

Findings

1. Based on a review of the completed individuals' service records and other provided documentation as well as the completed ISR Monitoring Questionnaire, all of the individuals sampled demonstrated maladaptive behaviors that had unsafe and disruptive consequences to themselves and their households, including negative impacts on the quality of their lives and their ability to become more independent. Meeting these criteria is a strong indication that these individuals would likely benefit from formal behavioral programming (or other therapeutic supports) implemented within their homes or residential programs. More specifically, of those sampled, eight (100%) engaged in behaviors that could result in injury to self or others, eight (100%) engaged in behaviors that disrupt the environment, and eight (100%) engaged in behaviors that impeded his or her ability to access a wide range of environments. In addition, of those sampled, eight (100%) engaged in behaviors that impeded their ability to learn new skills or generalize already learned skills. Overall, all eight (100%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence. Consequently, it appeared that all of these individuals would likely benefit from behavioral programming or other therapeutic supports. However, of those sampled, only three (38%) individuals were receiving behavioral programming through the implementation of comprehensive Behavior Support Plans (BSPs) at the time of the on-site visit (see Figure 1). The Reviewer noted, however, that one other individual (#3) had intensive ABA therapy in the home that reportedly did not include the implementation of a BSP. It should be noted that the family of one individual (#2) explicitly stated that they did not want behavioral programming in their home and the home providers for two other individuals (#4 & #6) reported that they did not believe behavioral programming was needed or likely to be beneficial. With respect to the wishes and beliefs of these families and care providers, the Reviewer nonetheless acknowledged that further review was prudent for six (75%) individuals given the observed need for – or inadequacy of – formal behavioral programming, this included the three individuals with BSPs (see Figure 2).

2. As noted above, of the eight individuals sampled, three (38%) individuals had BSPs implemented at the time of the onsite visits. Of these three, only one (33%) individual had a BSP that was considered current (i.e., implemented or updated within the last 12 months). In addition, only one (33%) individual had a BSP that was currently overseen by the author or other qualified behavior clinician. Lastly, two (67%) of the BSPs were developed and implemented by a Board Certified

Behavior Analyst (see Figure 3). The Board Certified Behavior Analyst (BCBA) is the nationally accepted certification for practitioners of applied behavior analysis. This certification is granted by the Behavior Analyst Certification Board (BACB), a nonprofit corporation established to develop, promote, and implement a national and international certification program for behavior analyst practitioners. As noted above, the Reviewer identified one individual (#3) who was receiving intensive in-home ABA therapy, that did not include a BSP, developed and supervised by a BCBA.

3. As noted above, of the eight individuals sampled, three (38%) individuals had BSPs implemented at the time of the onsite visits. Of these, three (100%) had a Functional Behavior Assessments (FBA) completed. Of these, only one (33%) individual had an FBA that was considered current (i.e., completed or updated within the last 12 months). Lastly, two (67%) of the FBAs were completed by a Board Certified Behavior Analyst (see Figure 4).

4. Upon closer examination of the BSPs, it was noted that prescribed behavioral programming appeared inadequate (see Monitoring Questionnaires for specific information). For example, although all (100%) of the BSPs identified target behaviors for decrease, none (0%) of the BSPs clearly identified, operationally defined, and tracked functionally equivalent replacement behaviors. It was noted, however, that all (100%) of the BSPs included adaptive skills to be learned. In addition, evidence of adequate data collection and review was found – for behaviors clearly identified in the BSP – for only one (33%) of the individuals sampled. Lastly, the BSP appeared to be updated or revised, as necessary, for only one (33%) of the individuals (see Figure 5). Overall, of the individuals with BSPs, zero (0%) appeared to have all of the currently accepted elements of generally accepted practice targeted by the Monitoring Questionnaire.

5. As noted above, of the eight individuals sampled, three (38%) individuals had BSPs implemented at the time of the onsite visits. Evidence that support staff had successfully completed competency-based training on the BSP was found for zero (0%) of the individuals sampled. Evidence that residential staff were able to adequately describe the individual's behavior related needs and their role in ensuring that their needs were met was found for two (100%) of two individuals sampled. It should be noted that the Reviewer was unable to interview staff for the third individual. And, although none (0%) of the BSP were found to be adequate, one (33%) of the BSPs appeared to be implemented as written (see Figure 6).

Conclusions – Areas of Concern:

1. All of the sampled individuals demonstrated unsafe behavior that placed them and others at risk. In addition, all sampled individuals displayed behaviors that were unsafe, disruptive, and likely to negatively impacted their quality of life. And, all of the sampled individuals demonstrated behavior that impeded their ability to access diverse community settings and that limited their ability to learn new skills. Given the current supports in place, the Reviewer acknowledged that further review, including the provision of behavioral support and programming, was prudent for three-quarters of the individuals sampled.

2. Only three of the sampled individuals were receiving formal behavior support plans to address unsafe and disruptive behavior as well as skill deficits that would likely improve their independence and quality of life. And, of those who did have BSPs, most were outdated and were not currently supervised by qualified behavior clinicians. One of the sampled individuals was receiving intensive ABA therapy.

3. For those individuals currently identified as receiving formal behavior support plans, behavioral programming did not meet standards of generally accepted practice and were determined to be inadequate.

4. For those individuals currently identified as receiving formal behavior support plans, two received supports from a BCBA.

Respectfully submitted by,

Patrick F. Heick, Ph.D., BCBA-D, LABA
Manager, PFHConsulting, LLC

Attachment 1

Data Summaries:

Figure 1

Name	item 212	item 213	item 214	item 215	item 216a	item 216b
1	1	1	1	1	1	1
2	1	1	1	1	1	0
3	1	1	1	1	1	0
4	1	1	1	1	1	0
5	1	1	1	1	1	0
6	1	1	1	1	1	0
7	1	1	1	1	1	1
8	1	1	1	1	1	1
total (N=8)	8	8	8	8	8	3
percentage	100%	100%	100%	100%	100%	38%

Figure 2

Name	item 216b	item 138
1	1	1
2	0	1
3	0	0
4	0	0
5	0	1
6	0	1
7	1	1
8	1	1
total (N=8)	3	6
percentage	38%	75%

Figure 3

Name	BSP	BSP is Current	Overseen by Author	Overseen by Clinician	BCBA
1	1	0	0	0	1
7	1	1	1	1	1
8	1	0	0	0	0
total (N=3)	3	1	1	1	2
percentage	100%	33%	33%	33%	67%

Figure 4

Name	BSP	FBA	FBA is Current	BCBA
1	1	1	0	1
7	1	1	1	1
8	1	1	0	0
total (N=3)	3	3	1	2
percentage	100%	100%	33%	67%

Figure 5

Name	item 217b	item 217c	item 217d	item 217e	item 217f	item 217g
1	1	0	1	1	0	0
7	1	0	1	0	1	1
8	1	0	1	0	0	0
total (N=3)	3	0	3	1	1	1
percentage	100%	0%	100%	33%	33%	33%

Figure 6

Name	BSP	item 52	item 53	item 56
1	1	0	0	1
7	1	1	0	1
8	1	0	0	na
total (N=3)	3	1	0	2
percentage	100%	33%	0%	100%

Attachment 2

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 1: DEMOGRAPHICS/OBSERVATIONS

1. **Individual's Name**:

2. **Age Range**:

   ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80 ☐ 81-90 ☐ 91+

3. **Gender**: ☐ Male ☐ Female

4. **Mobility Status**:

   ☐ Ambulatory without support
   ☐ Uses wheelchair
   ☐ Ambulatory with support
   ☐ Confined to bed

5. **Residential Provider**:

6. **Address**:

7. **Telephone Number**:

8. **Type of Residence**:

   ☐ Family/Own Home
   ☐ Sponsor Home
   ☐ Supported Apartment
   ☐ Group Home
   ☐ ICF
   ☐ Other (please specify):

9. **Brief description, as observed of the individual, setting and circumstances** (rather than from documents or interviews)

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 3: INDIVIDUAL'S SUPPORT PLAN

52.	Is the family or support person supporting the individual as detailed (consider the individual's Behavior Support Plan or regarding the level of support needed)?	☐Yes ☐No ☐NA
53.	If applicable, is there evidence the family or support person has successfully completed competency-based training on the desired outcome and support activities of the Individual's Behavior Support Plan? a. If Yes, what was the date of the training?	☐Yes ☐No ☐NA

56.	a. Is residential staff able to describe the individual's behavior related needs and their role in ensuring that the needs are met?	☐Yes ☐No ☐NA

SECTION 7: SUMMARY QUESTIONS

137.	Is there any evidence of actual or potential harm, including neglect? If Yes, cite:	☐Yes ☐No
138.	In your professional judgment, does this individual require further review? If Yes, identify the issue here and explain further on the Issues Page:	☐Yes ☐No

SECTION 9: SUPPLEMENTAL QUESTIONS

212.	Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
213.	Does the individual engage in behaviors (e.g., screaming, tantrums, etc.)	☐Yes ☐No

	that disrupt the environment? If Yes, describe the behavior and how often it occurs:	
214.	Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
215.	Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
216.	Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence? If Yes, describe the behavior and how often it occurs: If Yes, is there a written plan to address the behavior?	☐Yes ☐No ☐Yes ☐No
217.	If there is a written plan to address the behavior: a. Is there a functional behavior assessment in the current setting? If Yes, list the date when the assessment was completed? b. Are there target behaviors for decrease? c. Are there functionally equivalent replacement behaviors targeted for increase? d. Are there new adaptive skills identified to be learned? e. Does the plan specify the data to be collected, summarized and reviewed to determine whether planned interventions are working? f. Have the data been collected, summarized and reviewed by a qualified behavior clinician? g. Were necessary changes made, as appropriate?	 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No

REVIEWER'S NOTES

ISSUES

(Use only for issues related to the individual reviewed that require follow-up or for issues that were resolved and commendation is warranted.)

Reviewer's Name / Title:

Date(s) of Review:

APPENDIX C.

INTEGRATED DAY AND SUPPORTED EMPLOYMENT

2019 REVIEW OF THE INTEGRATED DAY AND EMPLOYMENT SERVICES REQUIREMENTS OF THE US v COMMONWEALTH OF VIRGINIA'S SETTLEMENT AGREEEMENT

REVIEW PERIOD: OCTOBER 1, 2018– SEPTEMBER 30, 2019

SUBMITTED TO DONALD FLETCHER
INDEPENDENT REVIEWER

BY: KATHRYN DU PREE, MPS
EXPERT REVIEWER

November 19, 2019

TABLE OF CONTENTS

I. OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer, has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the integrated day and supported employment services requirements of the Settlement Agreement for the time period 10/01/18 – 9/30/19. The purpose of the review is to determine the Commonwealth's progress implementing plans to comply with the requirements of the Settlement Agreement focused on integrated day activities and employment. Virginia has been implementing progressive changes to its employment service array for individuals with intellectual and developmental disabilities (I/DD) since 2012. This is the second review that covers a twelve-month period of time. The Independent Reviewer determined it is more useful to review the relevant data over a twelve-month, rather than a six-month, period. Comparing year-to-year data also provides a more longitudinal view of trends and a greater understanding of the advances that are being made from the Commonwealth's efforts to address challenges and implement policy and funding changes. The report from this period will include data and findings of the Commonwealth of Virginia's progress toward achieving the following requirements:

The review will determine the Commonwealth of Virginia's compliance with the following requirements:

7.a. To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this agreement with integrated day opportunities, including supported employment.

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

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

- *A. Provide regional training on the Employment First policy and strategies throughout the Commonwealth; and*
- *B. Establish, for individuals receiving services through the HCBS waivers:*
  - *1. Annual baseline information regarding:*
    - *a. The number of individuals receiving supported employment;*
    - *b. The length of time people maintain employment in integrated work settings;*
    - *c. The amount of earnings from supported employment;*
    - *d. The number of individuals in pre-vocational services as defined in 12 VAC 30-120-211 in effect on the effective date of this Agreement; and*
    - *e. The lengths of time individuals remain in pre-vocational services*
  - *2. Targets to meaningfully increase:*
    - *a. The number of individuals who enroll in supported employment in each year; and*
    - *b. The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment*

III.C.7.c. Regional Quality Councils, described in Section V.D.5 below, shall review data regarding the extent to which the targets identified, in Section III.C.7.b.i.B.2 above, are being met. These data shall be provided quarterly to the Regional Quality Councils and the Quality Management system by the providers. Regional Quality Councils shall consult with those providers and the SELN regarding the need to take additional measures to further enhance these services.

III.C.7.d. The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN.

II. PURPOSE OF THE REVIEW

This review will build on the review completed last fall by the Expert Reviewer for the review period 10/01/17 through 10/30/18 and the related recommendations the Independent Reviewer made in his 12/13/18 Report to the Court.

This review will cover all areas of compliance related to integrated day opportunities, including supported employment services to make sure that the Commonwealth has sustained compliance in areas achieved during the previous reporting period. The focus of this review will be on:

- The refinement of the implementation plan to increase integrated day activities for members of the target population including the strategies, goals, action plans, interim milestones, resources, responsibilities, and a timeline for statewide implementation;
- The expectation that the individuals in the target population are offered employment as the first option by Case Managers and their teams during the individual planning process in which they discuss and develop employment goals;
- The Commonwealth's success meeting the FY 2019 targets it established for the number of people who receive HCBS waiver-funded services in supported employment, the number who remain employed for at least twelve months, the hours worked per week, and the average earnings for those in supported employment;
- The exchange of information regarding employment accomplishments and barriers between the RQCs and the E1AG; and
- The Commonwealth's progress offering and providing Community Engagement and Community Coaching to individuals who do not work or as a supplement to employment.

III. REVIEW PROCESS

To complete this review and determine compliance with the requirements of the Settlement Agreement, I reviewed relevant documents and interviewed key administrative staff of DBHDS, and members of the Employment First Advisory Group (E1AG), previously known as the SELN-Virginia. In July 2019, prior to initiating this review, a kickoff meeting was held with the Independent Reviewer, the Expert Reviewer, Heather Norton, Peggy Balak and Jenni Schodt to review the process and to clarify any components. Of the review and the qualitative study. The Commonwealth was also asked to provide any additional documents that it maintains to demonstrate that it is properly implementing the Settlement Agreement's provisions related to integrated day and employment services.

Document Review: Documents reviewed include:

1. VA DBHDS Employment First Plan: FY 2016-2018, updated through FY19 Q4.
2. DBHDS Semiannual report on Employment (draft): 10/03/2019.
3. Employment First Advisory Group (E1AG) Work Group meeting minutes relevant to the areas of focus for this review. The Community Engagement Advisory Group (CEAG) is no longer active as it completed its activities and accomplished its goals.
4. Regional Quality Council (RQC) meeting minutes and recommendations for implementing Employment First.
5. Community Engagement Plan FY2016-2018, updated through FY19 Q4.
6. Employment Provider Barrier Survey Results (survey issued in FY18 Q1).
7. Extended Employment Services (EES) and Long-Term Employment Support Services (LTESS)Statistics 2017-2019.
8. E1AG Data Trend Graphs Draft 10/10/19
9. DMAS Proposed HCBS Waiver regulations: 01/19

Interviews: The Expert Reviewer interviewed members of the E1AG and Heather Norton, Assistant Commissioner, Division of Developmental Services, DBHDS. Numerous Case Managers and one CSB IDD Director were also interviewed as part of the Qualitative employment study.

This review also includes a qualitative study of the CSBs requirement to hold meaningful discussions about employment and community engagement (CE), and specifically to develop and discuss employment related goals and to include them in the individuals support plan for individuals who are interested in employment after a meaningful discussion of the possibilities. The SA expects these conversations will occur prior to the individual or their AR being asked for a decision whether to consider the offer of pursuing a path to participation in supported employment. The Commonwealth has set the targets for both a discussion about employment and setting employment goals. Although the parties have not yet agreed to measurable indicators of compliance for this requirement of the Agreement, DBHDS has established standards which expects Case Managers (CMs) to have discussions with 100% of the adults who have an Individual Service Plan (ISP), and to set employment goals for 35% of the adults. The Qualitative Employment Study includes a random selection of 100 individuals who had their annual ISP meeting in June 2019 and who reside in ten CSBs. The ten selected CSBs represent all five Regions. The qualitative study is further explained and its findings are presented in a separate report to the Independent Reviewer.

I appreciate everyone's willingness to participate in interviews and for the work of the CSB and DBHDS staff to provide numerous individual plans and reports for review. All of the interviews provide information that contribute to a more robust and complete report. The graphs in this report are taken from DBHDS' Semiannual Employment Report through June 2019.

IV. THE EMPLOYMENT IMPLEMENTATION PLAN

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

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

DBHDS, with the input of the E1AG (formerly the SELN-VA Advisory Committee) has revised the FY16-FY18 plan to increase employment opportunities. I was provided with the Status Report as of 8/18/19: ***3rd Quarter Update FY19***. The Plan includes five goal areas, each of which has sub-goals.

Goal 1: Align licensing, certification, accreditation, data collection, and other activities between state agencies that facilitate employment for individuals with disabilities.
Status: The interagency work through FY19Q4 continued for DBHDS, DARS and VDOE. The focus of their work during this review period has been in the development and implementation of training for employment providers and staff to become qualified to offer Customized Employment. The Legislature provided funding for this second round of training. DBHDS and DARS are collaborating to develop a milestone payment methodology for Customized Employment services. DBHDS is finalizing work with VDOE to guide young children and their families to initiate employment planning and preparation.

Goal 2: Education and training of stakeholders, providers and state agency staff.
Status: Eleven Family Listening Sessions were conducted throughout the Commonwealth with approximately 100 families attending. The information was compiled by the Partnership (Partnership for People with Disabilities, Virginia's University Center for Excellence in Developmental Disabilities at Virginia Commonwealth University (the Partnership) and shared with stakeholders, including the Regional Quality Councils (RQC). The E1AG training subcommittee continued to develop videos including interviews with individuals and family members discussing the benefits of employment. Various organizations including CSBs have developed videos to illustrate successful employment for individuals with I/DD. These videos are to be available on the DBHDS website, but the agency needs to identify a structure to showcase these and provide other resources about employment for individuals and families. To date, all of these educational resources have not been made available to families, individuals, providers and Case Managers.

Goal 3: All employment services are in alignment with evidence based/informed best practice and federal/state regulatory requirements.
Status: There was not activity to advance this goal in this reporting period. The Policy Committee did not meet. The policy work is on hold until DMAS completes the regulations for HCBS waiver services including employment and community engagement. There is no progress reported on the status of issuing the waiver regulations. A draft was issued and provided for public comment in FY19. The Attorney's General Office is reviewing final proposed changes. The E1AG issued a provider survey during the previous reporting period. DBHDS shared the results of this survey by issuing a report summarizing the data. Forty-nine providers responded to questions about barriers to employment. Thirty-eight providers responded serving between two

and 247 individuals. Of the providers who responded 63% provide job development, assessment and training; 57% provide situational assessments; 26% offer workplace assistance; 21% offer community engagement and 13% offer community coaching. The majority of respondents (60%) have a goal to increase the number of waiver recipients participating in their services and another 30% indicated they may increase the number of waiver recipients served. Providers who intend to expand their waiver services plan to do so within four years, with 40% planning to realize these increases within two years. A separate question was asked about the provider's interest in providing employment services under the waiver. This question was answered positively by 25% of the respondents with most planning to accomplish this expansion within two years. Providers were asked to identify their concerns about providing employment waiver services. Concerns focused on rates of reimbursement; documentation and billing requirements; attitudinal barriers to employ individuals with significant disabilities; the requirement to pay individuals at least minimum wage; and a lack of job opportunities in parts of Virginia. Providers were also able to identify the types of information and technical assistance their organizations need. Providers want assistance to better understand documentation and billing requirements; a better understanding of the impact of employment on benefits; and the chance for interchange with other waiver-funded employment services providers. DBHDS is already starting to use this feedback. Laura Nuss, Deputy Commissioner and Heather Norton, Assistant Commissioner Developmental Services, held a forum with providers on October 9, 2019 to discuss general barriers to providing inclusive services available under the Waiver, including employment support.

Additionally, the survey asked specific questions about transportation as a barrier to inclusive employment. Fifty-one percent (51%) reported transportation as one of the top three barriers and 22% reported it as the primary barrier to employment. Thirty percent (30%) reported trying innovative solutions and over 50% reported individuals have access to transportation through a local public or private partnership.

It is encouraging that more providers are planning to offer employment services and/or increase the number of waiver recipients to whom they offer employment services. Transportation is a challenge to securing employment for individuals with I/DD nationally. In Virginia, employment related transportation is not a reimbursable service under Medicaid or the waivers, unless a job coach or other staff are accompanying the individual. In addition, employment related transportation occurs during a day in which another Medicaid billable service in addition to transportation was provided. This precludes reimbursement for transportation for individuals who work without constant staff support or who are otherwise able to independently commute to work.

Goal 4: Virginia will have a system wide data collection and performance measurement system and procedures for employment data for people in supported employment.
Status: The data subgroup is working on trending information from the Semiannual Employment Reports that have been produced over the past few years. This was not completed in this reporting period, but a draft was issued in early October 2019. All ESOs continue to report data regarding employment to DBHDS for inclusion in the Semiannual Employment Reports. There is no report on the development of a performance measurement system which is part of Goal 4.

Goal 5: Virginia's Employment First Advisory Group will have a formalized structure with clearly defined roles and responsibilities for members.
Status: Membership was to change in the FY19 year so that all disability groups are represented. However, this has been delayed to FY20. Recently DBHDS has asked existing E1AG members to reapply and is seeking individuals who represent behavioral health to apply for membership.

Conclusion and Recommendations: DBHDS is meeting the regional training requirements of *7.b.i.A.* DBHDS and DARS partnered with the Partnership to continue Customized Employment Training. The Partnership offered a series of Family Listening events. The Partnership is sharing the information gathered from these sessions with the E1AG, RQCs, and DBHDS. This information should be used to inform further work of the policy and training subgroups.
This is a critical time in the Commonwealth's implementation of its employment first initiative. The Commonwealth, with the contributions of many stakeholders, completed much of the work that it planned to support its efforts to achieve its employment targets: rate changes, service definitions, provider incentives, meaningful and consistent data reporting, initial training, and interagency collaboration, especially between DBHDS and DARS. These changes were all intended, at least in part, to contribute to significant increases in the number of HCBS waiver-funded participants in supported employment. The Commonwealth is realizing an increase in the number of participants in Individual Supported Employment (ISE), which is discussed in greater detail in Section V of this report. The Memorandum of Agreement (MOA) between DARS and DBHDS, signed in FY18 is having positive impact on increasing the number of individuals entering waiver-funded employment services. E1AG members are concerned, that if, in the future, DARS lifts its Order of Selection, this would require new individuals with I/DD to first seek employment support through DARS, rather than immediately through the waiver, as now occurs as a result of the MOA. Stakeholders report that such a change would extend the time it takes for assessment and job coaching support, and likely reduce the number of individuals entering waiver-funded employment services. This eventuality should be discussed by the E1AG Policy subgroup, which should make recommendations for the E1AG, DBHDS and DARS to consider.

There have been fewer results accomplished by the E1AG and DBHDS this year to advance employment policy, conduct training and use data to identify trends in employment and other integrated day activities. This stagnation seems attributable to two causes. First, DMAS has not yet issued the regulations for the waiver programs which is delaying issuance of the Provider Manual and provider competencies, as well as other work by the E1AG Policy Subgroup. Second, since February 2018, DBHDS has not had an Employment Services Coordinator, a position required by Section III.C.7.b. It is evident that the loss of someone to provide coordination, expertise, and staff capacity in this vital role has negatively impacted the work of the E1AG, provider capacity building and the employment training offered throughout the Commonwealth.

7.b.i.B.1.a-e: The Commonwealth is to develop an employment implementation plan to increase integrated day opportunities for individuals in the target population including supported employment, community volunteer activities, and other integrated day activities. The plan shall establish, for individuals receiving services through the HCBS waivers:
Annual baseline information regarding:
a. The number of individuals receiving supported employment;
b. The length of time individuals maintain employment in integrated work settings;
c. The amount of earning from supported employment;
d. The number of individuals in pre-vocational services; and
e. The lengths of time individuals remain in pre-vocational services.

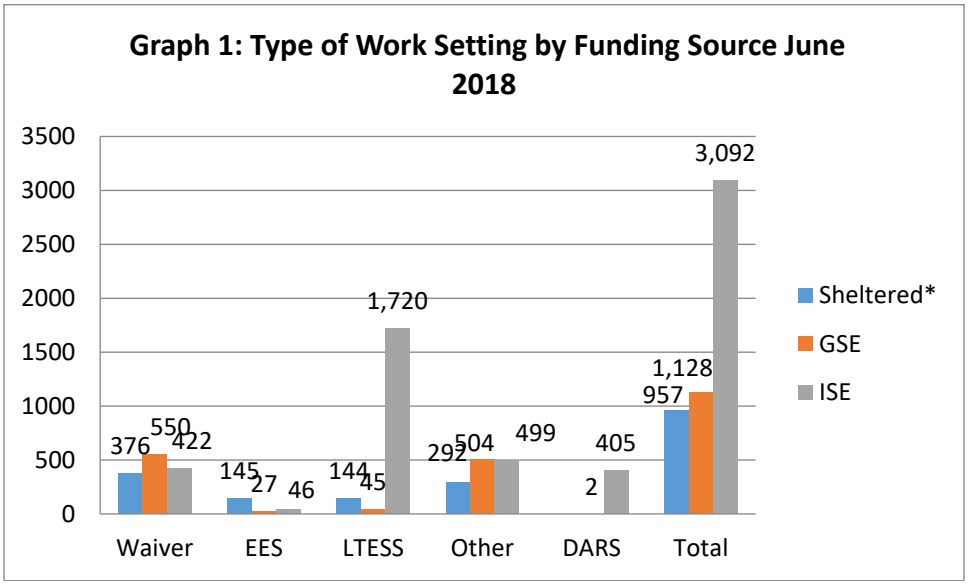
DBHDS has worked in partnership with the DARS to refine its data collection since October 2014. At that time, DBHDS had a response rate of 44% from ESOs. For this review, the DBHDS submitted two semiannual reports on employment. One summarizes December 2018 data and the other summarizes June 2019 data. The most recent DBHDS Semiannual Report on Employment, dated 10/03/19, is the seventh semiannual reporting period for which responses were received from 100% of the ESOs.

DBHDS continues to gather data from a second source for its employment reports. DBHDS used its data sharing agreement with DARS to gather data regarding individuals with developmental disabilities who receive employment support from DARS funded services including Extended Employment Services (EES) and Long-Term Employment Support Services (LTESS). The consistency of data reporting from both DARS and the ESOs allow comparisons to be made between reporting periods.

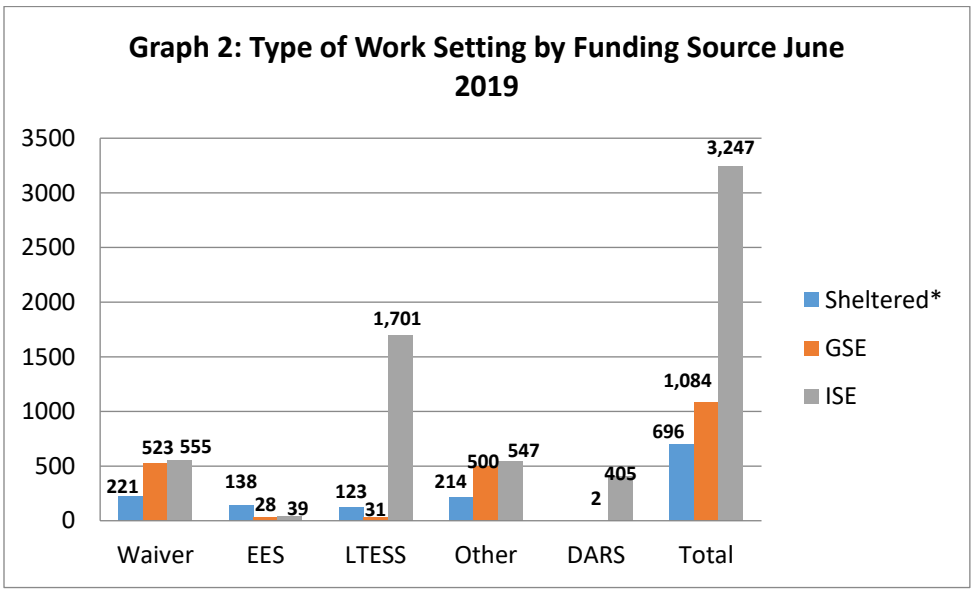
Statewide Employment Data Analysis-This report compares the achievements in June 2018 to the achievements in employment in June 2019 to provide comparison over a full year. The data in Graph 1 below for June 2018 indicates that total of 4,220 individuals were employed; 3,092 individuals were in Individual Supported Employment (ISE) services and 1,128 were in Group Supported Employment (GSE) services. (Note: an additional 957 people were receiving services in sheltered workshops. The individuals in sheltered workshops are not counted toward the DBHDS employment targets.) As of June 2019, the total number of individuals employed was 4,331, which is 111 (+2.6%) more than in the previous June. The changes in these three situations, including sheltered work, compared to June 2018 are as follows:

- 155 more individuals were employed in ISE
- 44 fewer individuals were employed in GSE
- 261 fewer individuals in sheltered work

Overall, of the additional 111 individuals in supported employment, the gain realized was in ISE. These numbers reflect the total number reported as employed across all employment programs including the programs offered by DARS as well as the HCBS waiver-funded employment services. This increase is far lower than the additional 414 achieved in the previous year that ended June 2018. Graph 1 illustrates the status of employment in June 2018, while Graph 2 illustrates the status of employment in June 2019



Graph 2 depicts the status of employment for individuals with disabilities in June 2019. Overall, 4,331 people are employed with supports from ISE and GSE, which is an increase of 111 people from the data reported in June 2018. It also indicates that 1078 individuals on the waiver are employed representing (8%) of all 13,955 individuals on the waiver. This is also an increase from the previous year when DBHDS reported that 972 of the individuals enrolled in a waiver were employed. It is important to note that the increase of 133 people (from 422 to 555) in waiver-funded ISE employment is a 32% increase in ISE for waiver participants during the past twelve- month period. During the previous year there was a 38% increase in ISE. Overall participants in the waiver program who were employed in both ISE and GSE increased from 972 at the end of June 2018 to 1078 participants in June 2019. This is an overall increase in employment of 11% for individuals in the waiver-funded programs in the most recent twelve-month period compared to the 17% increase in the previous twelve-month period.

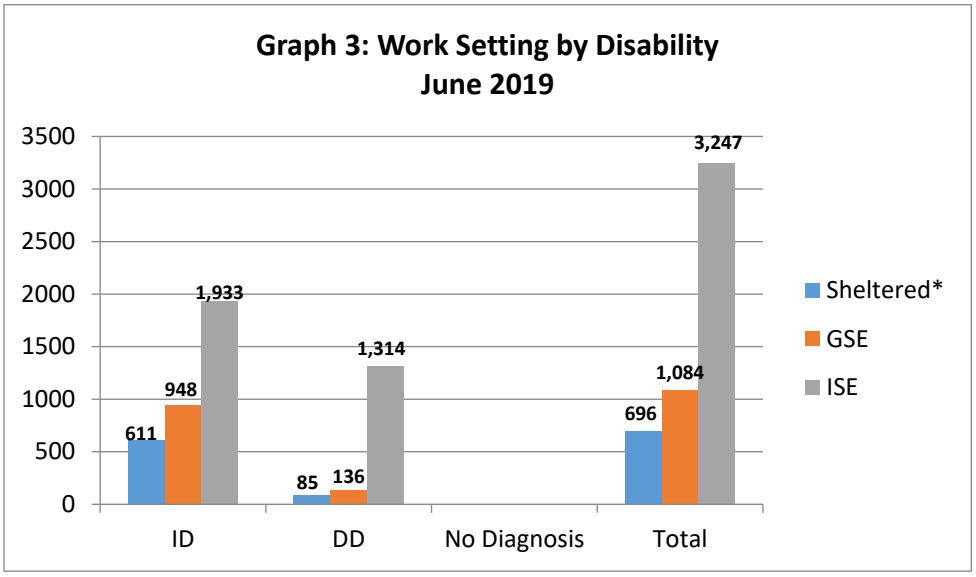


DBHDS has been able to sustain the accuracy and comprehensiveness of the employment data in terms of the overall number of individuals with developmental disabilities who were employed. Once again 100% of the ESOs reported on the number of individuals employed who were waiver participants.

DBHDS continues, as it should, to report on the number of individuals employed in ISE and the number in GSE. The long-term goal of the Settlement Agreement, however, is to have individuals employed through ISE and eventually competitively employed. Overall, of the individuals in supported employment in June 2019, in either ISE or GSE, 75% were employed in ISE, compared to 73% in June 2018 and 69% in June 2017. Again, the DARS LTESS program funds the majority of individuals in ISE. Of the total number of individuals in ISE, 17% compared to14% in June 2018 and 12% in June 2017 are participating in the HCBS waiver-funded employment services as of June 2019. Of individuals in HCBS waiver-funded ISE, the number increased by 155 individuals between June 2018 and June 2019. This number compares favorably to the previous year in which the increase in Waiver ISE participants was 117. During this most recent period, the number of individuals in GSE decreased by forty-four individuals across all of the employment programs. The decrease in the number of GSE participants is a trend. The participation in GSE also decreased in the waiver program.

The number of individuals in the sheltered workshops (SW) is not counted by DBHDS towards the employment target goals. However, it is important to track the changes in utilization of sheltered workshops. Fewer individuals should be in SWs as a result of the changes DBHDS made in the waiver service definitions. The Commonwealth did not plan to have SWs in the waiver at all by July 2019 to make sure Virginia was fully compliant with the federal Workforce Innovation and Opportunity Act (WIOA). While we have seen an increase in the use of sheltered workshops in past reports, it is heartening to see a second consecutive year of decrease in the number of individuals in sheltered workshops overall and in the waiver program, specifically. The number of individuals in sheltered workshops decreased overall by 261 people compared to a decrease of 109 in the previous year. Most notable was the decrease of 155 individuals with waiver-funded services in sheltered workshops. Sheltered work decreased in the DARS funded ESS and LTESS programs in addition to the waiver program but did increase in the "Other" category lessening the overall reduction in the total number of people in sheltered workshops. This is a similar trend as was evidenced in June 2018 compared to June 2017.

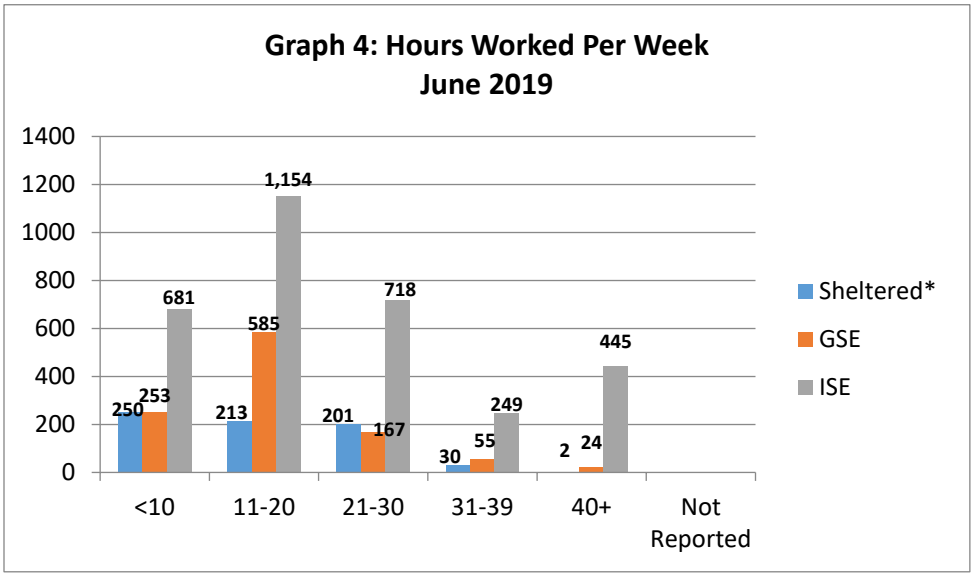
Employment of individuals by disability group- Overall, there are increases in the numbers of individuals employed with either ID or DD (other than ID) between June 2018 and June 2019. There was an increase of eighty-six individuals with DD who were employed by June 2019, and an increase of twenty-five individuals with ID who were employed at the same point in time. This represents a 19% increase in employment for individuals with DD, and a 7% increase in the employment of individuals with ID. Both disability groups decreased their use of GSE. Overall 46 fewer individuals used GSE. Also, fewer individuals were in sheltered workshops. The decrease in sheltered work is significant for individuals with ID. The number in sheltered work decreased by 270 individuals from 881 in June 2018 to 611 in June 2019. There was a slight increase of nine individuals, (from 76 to 85) using sheltered workshops who had DD.
Graph 3 shows the employment involvement of individuals by disability group: individuals with Intellectual Disabilities (ID) and those with Developmental Disabilities (DD), other than ID, as of June 2019.



Average hours worked- The Commonwealth no longer reports on these data, broken down by ID and DD target groups or by Region. Previously individuals with DD worked more hours on average than did their counterparts with ID. In the past, comparisons of both data sets have been useful as they provide more detailed information. For example, only by identifying areas of underemployment and geographic disparities for subgroups of the target population can obstacles be determined and addressed to the extent practicable. Graph 4 below details hours worked by service type in the DBHDS Semiannual Employment Report as of June 2019.

There has been an increase in the number of individuals who receive employment support whose wages are reported. An additional 144 individuals' wages were reported in June 2019 compared to June 2018. The percentage of individuals who work twenty hours or less per week comparing the data from June 2018 to the data from June 2019 indicates a slight reduction of 2% from 58% to 56% of the total number of individuals working. This is the same percentage reported of individuals working twenty of fewer hours per week in June 2017. However, the percentage of individuals in GSE working twenty or fewer hours increased from 71% to 77% of the total number of individuals with I/DD working in GSE, while the percentage for individuals in ISE decreased slightly from 58 to 56% of all individuals with I/DD working in ISE.

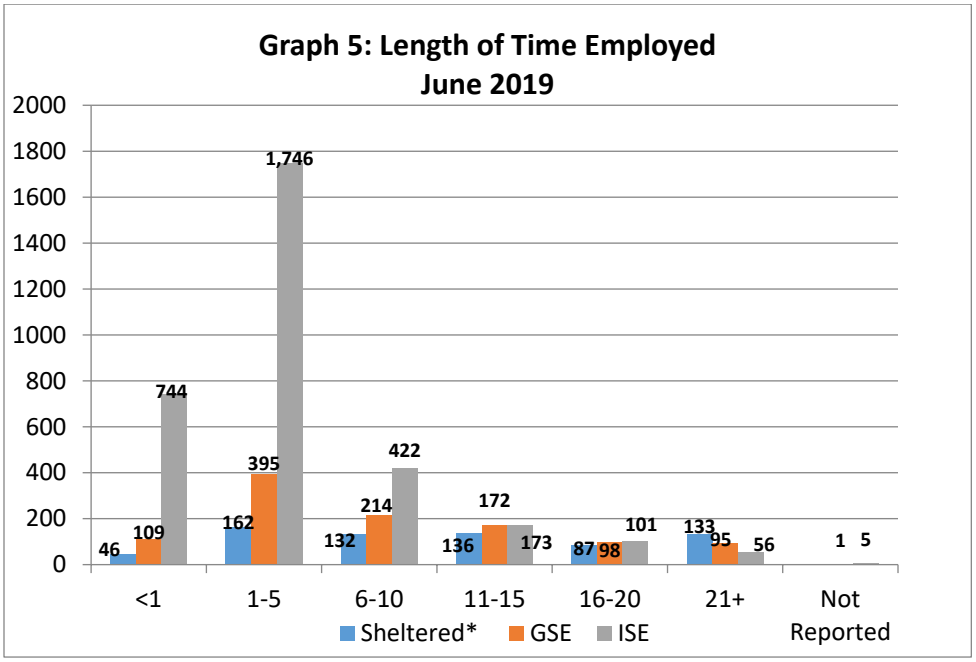
The percentage of individuals reported working more than thirty hours per week in ISE increased from 20% to 22% but decreased from 9% to 7% in GSE. However, the number of individuals in ISE working either 31-39 or forty or more hours per week *increased* by twenty-one and forty individuals respectively between June 2018 and June 2019 DBHDS still does not report on whether individuals are working the number of hours they want to be employed. Many of the individuals may be underemployed. This likely conclusion is based on the fact that 62% (2673 of 4331 individuals) are working no more than twenty hours per week, which is the same overall percentage as was reported in June 2018.



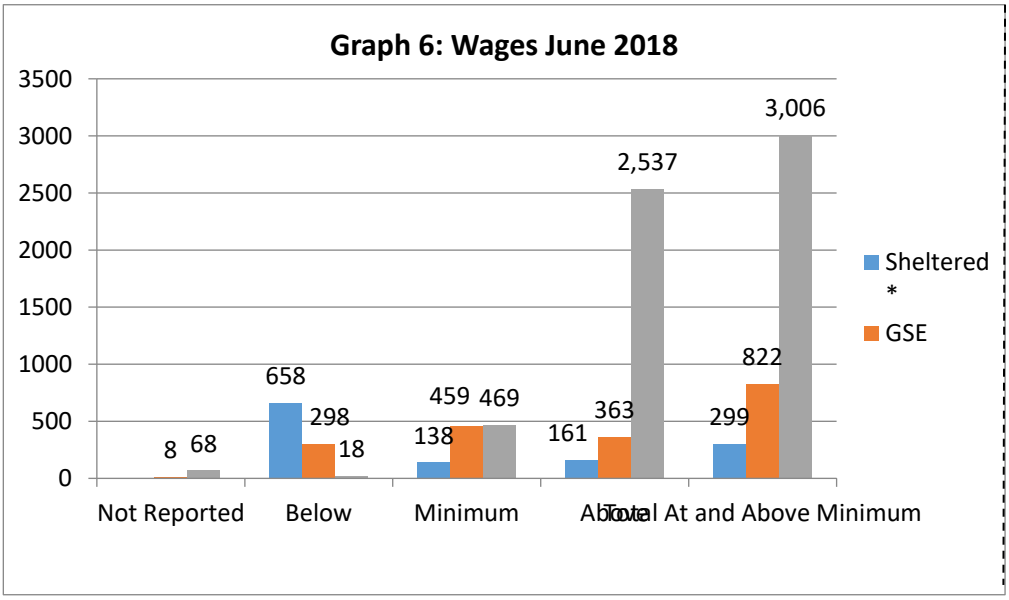
Average length of time at current job- these data are no longer specific to disability group, and, therefore, reviewers cannot compare the length of time individuals with ID versus DD, other than ID, maintain jobs. The expectation is that 85% of individuals will maintain their jobs for at least twelve months.

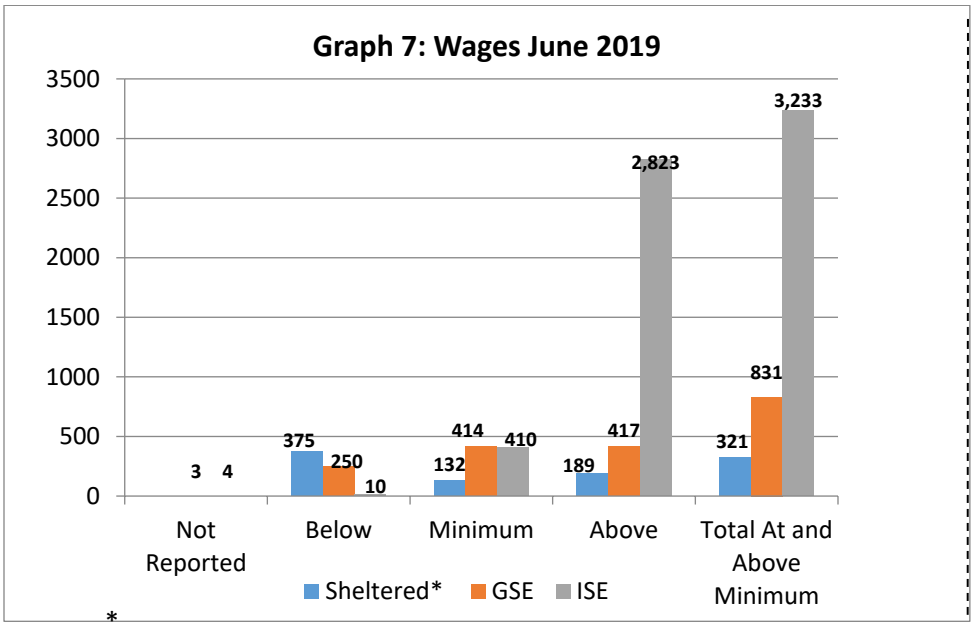
Overall, 90% of the employed population who were employed twelve months ago retained employment. This exceeds the expectation that 85% of individuals with I/DD will maintain their job for twelve or more months. Ninety percent (90%) of individuals in both ISE and GSE worked for more than twelve months. To determine this percentage the number of individuals entering employment for the first time in the current twelve-month period must be subtracted as they could not have worked for twelve months since June 2018. During the twelve months between June 2018 ad June 2019 a total of 510 individual became employed: 105 through ISE waiver programs and 405 through DARS programs (reference Graph 2). Therefore, of the 4331 individuals who were employed in June 2019, 3821 had the opportunity to be employed for twelve months or longer. Of these 3821 individuals 3427 of them have been employed for at least twelve months which is 90% of the total number of individuals employed.

Graph 5 displays this information for June 2019.



Earnings from supported employment- DBHDS collected information regarding wages and earnings. The two graphs below depict the number of individuals that earned above or below minimum wage by employment program type for June 2018 (Graph 6) and June 2019 (Graph 7). All but ten individuals in ISE earn at least minimum wage as of June 2019 compared to eighteen earning less than minimum wage in June 2018. The number of individuals in GSE, earning less than minimum wage has decreased from 298 in June 2018 to 250 in June 2018. Overall, 94% of individuals working in either ISE or GSE make at least minimum wage. It is impressive that, of individuals in ISE, 87% in June 2019 compared to 82% in June 2018 are paid more than minimum wage.





Conclusion and Recommendations: The DBHDS is meeting the expectations set forth in *7.b.i.B.1.a, c, d, and e.* In this reporting period it did not meet the expectation that 85% of individuals would maintain their employment for at least twelve months (*B.1.b*). Its data reflects information from 100% of all providers including the providers who offer HCBS waiver funded services and all employment related data from DARS relevant to the I/DD population.

It is very positive to continue to have data that include all individuals with ID and DD who are employed. DBHDS now has more accurate information about both the ID and DD populations related to employment with complete reporting for seven semi-annual reporting periods. The Commonwealth continues to increase the number of individuals in ISE although the increase is less than was achieved in the previous year.

V. SETTING EMPLOYMENT TARGETS

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

DBHDS has set employment targets at two levels. A target was set on December 30, 2015 for 25% of the total number of individuals with I/DD 18-64 years old on the waivers or the waiting list (16,871), to be employed, in both ISE and GSE, by June 30, 2019, for a total of 4,218 individuals. This target has been revised to reflect the total number of individuals with DD on the waivers or waiver waiting list as of 6/30/19, which is 17,964. Therefore, the Commonwealth committed to a total of 4,491 being employed as of June 30, 2019. There were 4,331 individuals employed in either GSE or ISE as of June 30, 2019, compared to 4,262 employed in June 2018. This represents 24% of the total number of individuals with I/DD on the waivers or the waiver waiting list.

The second goal is to increase the number of individuals who are employed through waiver-funded programs. DBHDS has slowed its rate of progress toward the employment targets it established for increases in employment for individuals in the HCBS waiver in this reporting period. However, it has again increased the number of individuals actually participating in HCBS employment services. A total of 146 waiver recipients were newly employed as of June 2018 whereas an additional 106 waiver recipients were newly employed as of June 2019. This slower rate of progress is due in part to a reduction of twenty-seven individuals in GSE compared to an increase of 133 individuals employed through ISE. ***Table 2*** depicts the overall employment changes in waiver programs from FY16 - FY19. In the past four years, an additional 330 individuals are employed in ISE programs. The overall increase in the number of individuals employed in waiver-funded programs is only 188 because of a significant decrease in the number of individuals employed through GSE.

DBHDS set employment targets with the input of the EIAG (then SELN) in March 2014. Based on these targets, DBHDS expected that a total of 1661 individuals would be employed through waiver programs as of June 30, 2019, with 830 in ISE and 831 in GSE. The Semiannual Report on Employment issued October 2019, reports only 1078 individuals are employed through the waiver. In the Semiannual Report issued for the previous reporting period through December 2018, DBHDS has significantly revised the employment targets for the waiver programs. GSE targets have been reduced to reflect fewer waiver recipients selecting this employment option. However, the ISE targets have also been revised. Overall DBHDS projects serving more individuals than they originally planned but indicates the agency will accomplish this new target of 1135 individuals by the end of FY21 rather than the original projection of FY20. DBHDs increases the target for ISE from 1095 to 1135, an increase of forty individuals employed in ISE. However, the overall number of individuals now targeted to be employed through waiver programs is significantly fewer than was originally projected because the number in GSE was adjusted downward from 931 to 550, which is a decrease of 381 individuals.

DBHDS plans to extend its employment initiative by an additional year through FY21, but targets 341 fewer individuals to be employed using waiver programs. DBHDS has not provided a strong rationale or explanation for the changes in employment targets for the waiver program. Last year DBHDS reported it would revise the employment goals because of the advent of Community Engagement (CE). However, this program is not increasing at its previous rate and will be discussed later in this report. Also, all individual should have an opportunity to be employed and engage in non-work community activities during other parts of the day and week, rather than have CE substitute for meaningful employment.

It is curious that these reductions have been recommended at a time when the waiver programs are able to immediately enroll individuals seeking employment services as a result of the MOU between DARS and DBHDS. This MOU was explained in last year's Employment Report. It stipulates that waiver recipients can immediately access employment support from waiver providers at any time when DARS' Order of Selection is active. ***Table 1*** illustrates and compares the original targets to the revised targets set in 2019.

Table1: Employment Targets for the HCBS Waiver Programs FY16-21						
End of FY	**ISE**	**ISE (new)**	**GSE**	**GSE (new)**	**Total**	**Total (new)**
16	211		597		808	
17	301		631		932	
18	566		731		1297	
19	830	**661**	831	**550**	1661	**1211**
20	1095	**936**	931	**550**	2026	**1486**
21	NP	**1135**	NP	**550**	NP	**1685**
Total Increase '16-'21	*884*	***924***	*334*	***(-47)***	*1218*	***877***

Table 2: Number of Individuals Employed in the HCBS Waiver Programs FY16-19			
End of FY	**ISE**	**GSE**	**Total**
16	225	665	890
17	305	521	826
18	422	550	972
19	555	523	1078
Total Increase '16-'19	***330***	***(-142)***	***188***

Comparison of the Targets- As of June 2019, 1078 individuals were participating in ISE and GSE waiver-funded services, an increase of 106 individuals since June 2018. This is 533 fewer individuals than the original target of 1611 individuals that DBHDS had set to reach by the end of FY19, and 133 fewer than the revised target of 1211 set this year. DBHDS has not met its target for employment participation in the waivers for FY19.

Individuals in Supported Employment **-**the Commonwealth's current goal is to reach 85% of the total number of individuals who are in ISE to remain employed for twelve or more months. This is reported earlier in the report and it is noted that the Commonwealth has not achieved this percentage even when the methodology is adjusted to exclude the number of individuals in the totals who have become employed in the past twelve months and therefore have not been employed for a sufficient period of time to work for more than twelve months. Once that adjustment is made, 83% of individuals employed have retained their employment for at least twelve months. This is a reduction from FY18 when 91% retained their employment for at least twelve months, adjusted for individuals who had just started working in the previous twelve months.

The Commonwealth is reporting that more individuals are employed throughout the Commonwealth's employment programs, representing 24% of all individuals with DD on the waiver waiting list of participating in a waiver. The Commonwealth's overall employment target is 25% of this population. More significantly the Commonwealth has not met the target it established for employment for individuals with waiver-funded services (i.e. "for individuals receiving services through the HCBS waivers). This is despite an increase of individuals in ISE of 106 individuals in the year ending June 2019. This is fewer than the 117 increase in ISE participants as of June 2018. There has been a continued decline in the number of individuals in GSE, this June totaling almost twenty-seven individuals. The continued decline in the selection of GSE by waiver participants would indicate more individuals would be selecting ISE but the slower growth in ISE does not support this hypothesis.

Members of the E1AG anticipated the inclusion of transportation supports for employment related travel under the waiver would have a positive impact on increasing the number of waiver participants who become employed. Although, this planned service has been established, its constraints does not allow its effective use and service providers and other stakeholders continue to report that the lack of available transportation is one of the major barriers to employment, and to achieving the targets established by DBHDS. Currently, transportation can only be reimbursed under the waiver when a staff person is accompanying the individual, or when a waiver service is billed during that day. So, if the individual is taking transportation independently or with a family member and work without a staff on a particular day, transportation cannot be billed under the waiver.

DBHDS initially set ambitious goals for the end of FY19 for both ISE and GSE waiver participation. However, the Commonwealth has failed to even meet the revised reduced waiver targets for ISE, GSE and overall employment during FY19.

There is a table in DBHDS's Semiannual Employment Report that captures the number of unique individuals who have a service authorization for each day service in the HCBS waiver including ISE and GSE. This graph is included in this report as Graph 8: Total Number of Unique Individuals, which is more fully discussed later in this report regarding community engagement.

The number of individuals authorized for ISE and GSE differ from the number of individuals employed in ISE and GSE. In June 2018, 458 ISE and 604 GSE authorizations were awarded versus 422 ISE and 550 GSE individuals employed as of June 2018. The number of authorizations versus the number of individuals actually employed in 2019 follows a similar pattern: 789 ISE authorizations versus 555 individuals employed, and 552 GSE authorizations versus 523 GSE individuals employed. Both authorization numbers are higher than the number reported as actually employed through waiver ISE and GSE services, which is understandable as many individuals may still be receiving assistance finding a job. It is interesting to note that the GSE authorizations have been decreased in the year to reflect actual participation. The number of authorizations does not match the original target of 830 for ISE but is in excess of the revised ISE target of 661.

In June 2019 only 70% of the ISE authorizations were utilized compared to 92% of the authorizations in 2018 utilized. The GSE authorizations continue to be utilized at a rate over 90%, reaching 95% in June 2019. It is of interest that the number of authorizations for ISE and GSE in June 2019 totals 1341 which is an increase of 279 authorizations since June 2108 when there were 1062 authorizations. However, this is significantly below the original target set for waiver employment of 1661 for the end of FY19, which is June 2019. It is higher than the new target proposed of 1211 individuals. DBHDS has now revised its target to be lower than the number of employment opportunities that are authorized which reflects a more accurate picture of the pattern of utilization of these programs.

CE was designed to provide inclusive community options for individuals who were not ready or interested in employment and to enhance the lives of individuals with part-time employment. It was not intended to replace employment for individuals capable of and interested in working. These data will need further analysis in future reporting periods to determine if there are trends and unintended consequences on employment growth by offering this new service option.
In order for the Commonwealth to reach its employment targets in future fiscal years, especially in ISE for individuals in the HCBS waivers, the DBHDS will need to concentrate on increasing provider capacity. Its plan to provide training and technical assistance to providers to offer employment support to individuals with more significant disabilities should prove helpful to increase the number of waiver participants who are employed. Later in this report I will discuss the themes from the qualitative study in which 100 individuals' ISPs were reviewed to determine if Case Managers held meaningful discussions that explore and determine employment goals, and then include employment goals in the ISP for individuals interested in pursuing employment. From this study, after reviewing these ISPs and interviewing case managers, it is evident that families need much more information about paths to employment and employment and particularly the impact of employment income on individuals' benefits; case managers need training to assist individuals with behavioral, medical or physical needs to feel more confident exploring employment, and DBHDS and CSBs need to address the significant barrier of transportation if the number of individuals employed is to increase in any significant way.

Conclusions and Recommendations: The Commonwealth has not met the target it set for the percentage of individuals with I/DD who would be employed by 2019 across all of the DARS and DBHDS waiver employment programs which responds to Section *7.b.i.B.2.a.* The Commonwealth has reduced its targets to meaningfully increase the number of individuals receiving services through the waivers. These revised targets have not been achieved even though the number of individuals employed in the waiver program has increased between June 2018 and June 2019. The increase in the number of individuals employed in the waiver remains positive but the rate of increase does not demonstrate that the Commonwealth can achieve its new targets by the end of FY21 for waiver participants. The Commonwealth has exceeded the expectation of retaining employment for at least twelve months for 85% of participants when analyzed to only include individuals employed prior to June 2018.

I support the recommendations the DBHDS made in the Semiannual Employment Report draft. Continued efforts to fully implement these recommendations would further DBHDS's efforts to achieve its employment goals. Recommendations include:

1. *DBHDS needs to continue collaborating with CSBs to ensure that accurate information about the different employment options is discussed with individuals in the target population and that these discussions are documented.*
    a. *Work with the SELN to develop a video that shows the conversation between a case manager and individual and their family to show how to have a better conversation. (not done)*
2. *Increase the capacity of the Commonwealth's provider community to provide Individual Supported Employment services to persons with intellectual and developmental disabilities by providing technical assistance and training to existing and potential new providers.*
    a. *Report the number of waiver providers offering Individual Supported Employment and Group Supported Employment. (Update: 43 ESO's offer ISE, compared to 39 ESOs in June 2018; and 35 ESO's offer GSE compared to 23 in June 2018 of the 66 ESO's in Virginia.)*
    b. *Training for providers to support people with more significant disabilities. (Update: DBHDS reports this will be addressed in FY19, but it does not appear sufficient training was offered in this reporting period.)*
    c. *Competency development: (Update: while originally projected for 6/30/2018 completion, DBHDS reports this is still underway.)*
    d. *Find out from ESO's additional services offered/subcontracted to identify potential combination of services that would help providers be better able to support people with specialized needs. (No update.)*
3. *Increase capacity in parts of the Commonwealth that have less providers and employment options. Create a map of the service providers in each of the Regions and the services provided so we can track increase in capacity. (Update: Provider Survey complete with 49 respondents.)*
4. *Continue to collaborate with DARS, Employment Service Organizations, and DMAS to collect and report on employment data. (Done semiannually.)*

Do a comparison in future reports of employment discussions and employment goals to evaluate the impact on the percent of people employed per region. (Update: DBHDS reports the data is sufficiently consistent to initiate this review and has the staff resources to accomplish the task. It is not anticipated that this review will occur before January 2020)

   a. *DBHDS will follow up with the CSBs who have data reporting concerns around the discussion of employment and goals to address barriers to employment.*

5. *Create data tables around the waiver data according to old slots, new slots, and training center slots. (Update: Raw data is being analyzed by the E1AG and reported out in the next reporting period.)*
6. *Implement recommendations from the Regional Quality Councils. (Ongoing)*
   a. *Create success stories of employment that identify individuals according to the current support level as indicated by their support's intensity scores. (Update: Completed and need to be publicized.)*
   b. *Develop tools/training for individuals and families by using the trend reports for targeted training (Update: Listening sessions all conducted throughout VA spring of 2019 and recommendations shared with DBHDS and the E1AG.)*
   c. *Gather transportation data (Update: survey summarized and shared with stakeholders.)*
   d. *Improve communication with DOE around transition age youth and employment services and supports. (No update.)*
7. *Monitor the number of transition age youth entering non-integrated work settings to determine potential future intervention. (Done semiannually.)*
8. *Develop additional detail regarding individuals who are earning subminimum wage by age and job type to determine if any trends exist. Use current data to establish baseline data and present to Advisory Group for refinement*. (*Update: Plan to review at the December 2019 meeting.)*
9. *Develop a trend report based on the previous four semiannual reports for*: *unemployment rates; NCI data; individuals working fewer than ten hours per week; individuals retaining employment for less than five years; low wage earners earning tips; and the reasons for the decreases in GSE participation. (Update: NCI data not used by DBHDS for trend reporting but the NCI data was shared with RQCs in September 2019. The data subgroup of the E1AG is developing trend data and a draft was developed 10/19.)*

It would be helpful if DBHDS could report on the impact new waiver funding has in each fiscal year on increasing its waiver opportunities for ISE and GSE and to analyze the impact of new resources on the employment targets. The new waiver slots are allocated to individuals based on the urgency of their need. Older individuals or youth with behavioral challenges may need many of the available slots. Unlike other states, the Commonwealth does not target any of its newly created waiver slots for supported employment, particularly for school graduates. If new funding is not sufficient to achieve the targets set for each fiscal year, changes will need to focus on transitioning individuals who have waiver slots but are receiving services in sheltered workshops and congregate day support programs toward employment supports. This will require re-education of families and case managers and more vigorous implementation of the Commonwealth's Employment First Policy.

It is concerning that the General Assembly passed legislation supporting continued funding of sheltered work and pre-vocational programs. This legislation will negatively impact, and undermine the Commonwealth's ability to fulfill its commitments to pursue the goals of the Agreement by implementing an Employment First Policy to transition individuals from these large congregate settings that segregate and isolate individuals from their communities to community–based integrated employment opportunities. This legislation undermines the ability of the Commonwealth to implement its Employment First Policy because it allows families to directly access ESS and LTESS funds that are allocated to sheltered workshop providers without first being assessed for employment, discussing possible goals to achieve employment, or considering employment as the preferable option.

I continue to recommend that the Commonwealth further refine its employment targets by indicating the number of individuals it hopes to provide ISE from the following groups: individuals currently participating in GSE or pre-vocational programs; individuals in the target population who are leaving the Training Centers; and individuals newly enrolled in the waivers during the implementation of the Settlement Agreement.

I am pleased that the E1AG has also made the recommendation to refine its employment targets; however the Commonwealth has not yet undertaken an analysis more than one year after the E1AG made the recommendation.

Creating these sub-groups with specific goals for increased employment for each will assist DBHDS to set measurable and achievable goals within the overall target and make the undertaking more manageable and strategic. By refining its targets, and by measuring actual performance against these goals, the Commonwealth will learn about the obstacles that must be addressed to fulfill its commitment to provide "*individuals with DD integrated day opportunities, including supported employment, to the greatest extent practicable*". Realistic and successful marketing and training approaches to target these specific groups can be developed through discussions between the DBHDS and the E1AG. A collaborative outreach effort to families, case managers, CSBs, Training Center staff, and ESOs will assist the DBHDS to achieve its overall targets, and the goals of its Agreement, in each of the next two fiscal years. I think it is very positive that DBHDS and the E1AG have developed competencies for employment providers and plan to offer to enhance their staffs' competencies to assist individuals with more severe disabilities to work.

VI. The Plan for Increasing Opportunities for Integrated Day Activities

7.a. To the greatest extent practicable the Commonwealth shall provide individuals in the target population receiving services under this agreement with integrated day opportunities, including supported employment.

Integrated Day Activity Plan: The DBHDS is required to provide integrated day activities, including supported employment for the target population. The Settlement Agreement states: *To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under the Agreement with integrated day opportunities, including supported employment.*

Since the Commonwealth of Virginia entered into the Settlement Agreement with the US DOJ, DBHDS focused its work and activities on increasing employment opportunities for individuals with ID and DD, other than ID. The Independent Reviewer directed DBHDS to develop a plan by March 31, 2014 to describe its approach to create integrated day activity capacity throughout its provider community and ensure that individuals in the target population can participate in these integrated activities as the foundation of their day programs. During this review period, DBHDS submitted the revised Community Engagement Plan FY2016-FY2018, which includes updates through FY19 Q4. The foundation for community engagement is included in the HCBS waiver as redesigned to offer community engagement, community coaching, and related services with reasonable rates.

DBHDS, with the input of the CEAG, drafted a comprehensive Community Inclusion Policy. This policy sets the direction and clarifies the values of community inclusion for all individuals with intellectual and developmental disabilities, regardless of the severity. The policy requires the involvement of both the DBHDS and the CSBs:

- to establish outcomes with specific percentage goals;
- to identify strategies to address barriers;
- to expand capacity of providers;
- to collaborate with the State Department of Education (and schools to promote transition planning); and
- to conduct a statewide education campaign about Community Engagement.

Implementation requires DBHDS to provide training and consultation; to work with DMAS to incorporate these services in the waivers; to continue the role of the CEAG; to develop an implementation plan; to maintain membership in the national SELN, and to maintain an Employment Services Coordinator to monitor and support implementation.

The DBHDS Community Engagement Plan, as revised December 29, 2015, was updated to reflect the status of achieving the six goals as of April 15, 2019.

1. There is an overall goal to develop a common understanding and philosophy among stakeholders, providers, and state agencies of Community Engagement (CE) based on accepted national standards and in compliance with federal regulations.
Status- DBHDS created the CEAG with broad stakeholder membership. All of the originally planned actions have been completed. As a result. the CEAG has been disbanded. DBHDS continues to offer training and technical assistance. During this review period, 100 provider staff in northern Virginia were trained in community integration. DBHDS offered training on community engagement for seventy-five providers in the Rockbridge area. Technical assistance was provided individually to providers who requested it in western Virginia. DBHDS reports this goal has been fully achieved.

2. Policies are in place to promote and encourage CE Activities.
Status-The CEAG had developed new material about CE for the Provider Manual by the end of the fourteenth review period. The CEAG continued to develop these best practice guidelines during FY19 Q1 in consideration of the DMAS regulations. However, during the year that this review studied, DMAS did not finalize new regulations and the Provider Manual was not completed or distributed. DMAS and DBHDS convened a meeting in September 2019 to reinitiate this effort. Staff at DBHDS reported the intention of finalizing the Provider Manual.

3. Develop funding sources that promote and encourage implementation of CE.
Status- DBHDS established a HCBS Business Acumen Business Development Learning Collaborative that involved thirty employment providers chosen to participate in a process of following through on a plan made in the previous year. The purpose was to assist providers to develop sustainable community engagement services. Rates for CE have been established. Providers have expressed concern regarding whether the rates are adequate to attract and new and sustain existing providers.

4. Structures, at both the state and provider levels, will support delivery of CE in the least restrictive and most integrated settings that are appropriate to the specific needs of the individual as identified through the person-centered planning process.
Status- This goal is related to Goal 2. No progress has been made this year because the DMAS waiver regulations have been modified and have not been finalized. The modifications have been shared for public comment

5. Ensure CE services are being offered and provided to individuals across the state in the most integrated community settings based on the needs of the individual as determined through the person-centered planning process.
Status- There were 198 licensed provider locations of community engagement (not center-based day) services in June 2018, an increase of fifteen since the previous reporting period. Now there are 111 CE providers offering this service in 171 locations throughout Virginia. This is a decrease of twenty-seven locations or 14% within a year. There are 2,650 approved authorizations for individuals to receive CE, compared to 2375 in June 2018 and 283 approved authorizations for Community Coaching (CC) compared to 239 in June 2018, an increase of 44. CE authorizations have increased by 275. These data are as of June 2019. This is an increase in CE participation of 12% compared to an increase of 50% in 2018, and of 18% in CC, in addition to 99% in 2018. *(See Graph 8 on page 27).* The dramatically slower rate of transitions from congregate to integrated day services is very concerning as there was an increased number of individuals (+7.8%) in congregate group day settings in June 2019 (6,545) than there were when

the redesigned waiver and Community Engagement services began to be implemented in September 2016 (6,095). See graph 8 below.

6. Ensure that there is an increase in meaningful CE for each individual. Virginia's vision is to have an array of integrated service opportunities available for individuals with disabilities and wants individuals to be able to choose to have services delivered to them in the least restrictive and most integrated setting.
Status- In June 2018 DBHDS reported that DBHDS and the CEAG were reviewing providers' practices on collecting data and plan to use National Core Indicator (NCI) and Quality Service Review (QSR) data. However, DBHDS reports that, as of June 2019, it is not using the NCI or QSR data. Providers completed a self-assessment and DBHDS, in collaboration with DMAS, reviewed and have followed up to provide greater guidance to providers who did not demonstrate compliance with DBHDS's expectations. DBHDS did not share for this review any results or specific data. No additional information was available to this reviewer as of the June 2019 semiannual report except that Commonwealth officials who were interviewed reported that most providers were in partial compliance or compliant and that DBHDS will be working with providers to identify minimal requirements.

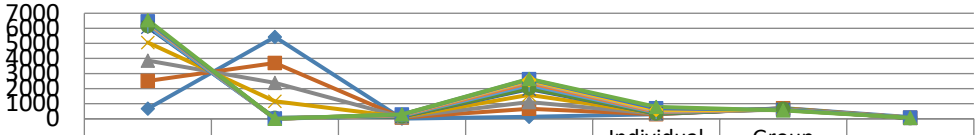
DBHDS needs data that provide information on the hours of involvement and the type of activities that CE offers. It is also essential that DBHDS monitor the effectiveness of the CE program and the satisfaction of its participants.

The DBHDS cannot ascertain whether it achieves its stated goal of assuring consistent practice among CE providers and participant satisfaction without data and analysis. This reviewer made this same recommendation in 2018. However, still DBHDS has not gathered or provided any qualitative data for their or this review regarding the providers' implementation practices related to CE services.

Individuals Participating in Day Service Options

DBHDS has provided data, which is depicted in Graph 8 below, that allows for comparison and growth of CE and CC from 9/30/16 through 6/30/19. This information reflects the number of individuals authorized for each service type.

Graph 8: Total of Unique Individuals through June 2019



	Group Day 97150	Group Day 97537	Community Coaching 97532; 97127	Community Engagement T2021	Individual Supported Employment H2023	Group Supported Employment H2024	Workplace Assistance H2025
9/30/2016	668	5427	7	130	295	701	108
12/31/2016	2504	3698	79	658	300	695	63
3/31/2017	3859	2378	106	1109	328	684	41
6/30/2017	5059	1160	120	1588	346	674	34
9/30/2017	6077	53	150	1969	353	638	40
12/31/2017	6145	53	162	2020	356	647	40
3/31/2018	6161	2	203	2230	413	627	60
6/30/2018	6339	0	239	2375	458	604	70
9/30/2018	6383	0	261	2491	526	585	77
12/31/2018	6431	0	278	2563	598	577	78
3/31/2019	6453	0	279	2619	691	584	72
6/30/2019	6545	0	283	2650	789	552	69

e

Overall between 9/30/16 and 6/30/19 there has been an increase in the number of individuals served in congregate day support programs from 6,095 to 6545 (+7.4%). Day Support and other programs in large congregate settings tend to isolate individuals from their communities. However, because more individuals are receiving waiver-funded services there are also increases in the number of individuals who are being supported in integrated settings. For example, in the twelve-month period, 6/30/18 and 6/30/19, there was an increase of forty-four individuals authorized for Community Coaching (CC), compared to 119 in the previous twelve-month period. The authorization for individuals in Community Engagement (CE) increased by 275 to a total of 2,650 individuals authorized for CE. The increase in authorized CE slots was 787 in the previous year. While the increase in CE is lower than the previous year, CE continues to have more authorizations than Group Day . Group Day had 206 authorizations between June 2018 and June 2019 while CE had 275 authorizations in the same time period. This continues to indicate greater preference for, and choice of day supports that are more focused on employment or community engagement options.

Authorization for GSE reduced by fifty-two individuals between June 2018 and June 2019, continuing the trends of decreasing utilization of GSE services, while increasing authorizations more for ISE, by 331 for the year reviewed. This is significantly higher than the increase in ISE authorizations of 112 in the previous twelve months. There was no increase in authorization for Workplace Assistance.

These employment and day support programs had 10,888 individuals authorized as of 6/30/19 compared to 10,085 as of 6/30/18. The percentage of individuals authorized for CC, CE, GSE and ISE increased from 36% in June 2018 to 39% of the individuals authorized for some type of day support service in June 2019. This results primarily from the steady increase in the number in CE and significant increase in the number of individuals in ISE resulting in a percentage increase of 12% in CE and 72% in ISE. The increase in ISE authorizations far exceeds the actual increase in the number of individuals in ISE who are employed rather than still in job development. This increase does demonstrate a continued commitment by the Commonwealth to fund its employment initiative although not at the level projected in the employment targets that it originally established.

Conclusion and Recommendations: The DBHDS and the CEAG have previously developed a robust definition of Integrated Day Activities, which the Commonwealth now calls Community Engagement. These services have been approved by CMS and offered to waiver participants since September 2016. There is a total of 10,888 individuals authorized for waiver-funded day services, including center-based group day services. Unfortunately, the Commonwealth continues to fund increased capacity for Group Day non-integrated settings.

As of 6/30/19, 2,933 (27 %) of the individuals authorized for all day-services are authorized for CE and Community Coaching (CC). This is an increase in the number of authorizations and the same overall percentage CE authorizations represented in June 2018. It illustrates a continuing interest among individuals and families. The percentage of participants compared to the percentage in center-based day settings has not grown in the past year; and there has been a reduction in the number of CE locations across the state. It is evident from the qualitative employment study of 100 individuals during this reporting period that there is not a sufficient number of CE providers in all parts of the Commonwealth. Based on interviews with Case Managers, there appears to be concerns among providers about the viability of providing CE within the current rate structure. The loss of twenty-seven CE locations during the past year may well validate this concern. There are far more ESOs providing GSE and ISE for fewer individuals than there are CE providers for significantly more participants. There are forty-three ESO providers serving 789 ISE participants and thirty-five of the ESOs serving 552 GSE participants compared with **111** CE providers for 2,650 participants.

DBHDS is exploring the development of CE services being offered by residential providers. These providers may be more suited to match individual interests and support meaningful community participation for individuals after work and on weekends, when more typical adults are also involved in community activities.

During this past year, DBHDS projected that it would produce quarterly reports summarizing demographic data, successes, barriers and the average hours of participation in CE and community coaching by urban and rural areas this year. These reports have not been produced, but would be extremely useful in helping DBHDS determine how best to increase participation

in CE and to encourage more providers to offer CE. I recommend that DBHDS initiate these reports during the next reporting period so there are specific data to better determine the success of this initiative longitudinally.

During the one-year period reviewed for this study, DBHDS continued to increase the availability of Community Engagement services by 275 more individuals. This is in addition to, but a significantly lower increase than in the previous reporting period when 787 individuals started receiving CE services. Groups Supported Day continue to increase participants as well, having 6545 individuals in Group Day as of June 30, 2019. It is this reviewer's opinion that many of these individuals would likely switch from group day programs in large congregate setting to Community Engagement services if such services were available nearby and if the benefits were well explained and understood.

There appears to be a need to further education of Case Managers to explain CE to individuals and families and to help them address any barriers to the participation of the individual. DBHDS also needs to assure there is a sufficient number of providers in all Regions, so families do not find the travel time to be a deterrent to the participation of their sons or daughters. I support the DBHDS plan to further engage residential providers in offering CE and CC. I again suggest the Commonwealth develops participation targets for CE as it does for employment; articulates its expectations for hours of participation; and monitors the provision of these services to assure they are meaningful for the individuals.

VII. Review of the SELN and the Inclusion of Employment in the Person-Centered ISP Planning Process

III.C.7.b. The Commonwealth shall:

- ✓ *Maintain its membership in the SELN established by NASDDDS.*
- ✓ *Establish a state policy on Employment First (EF) for this target population and include a term in the CSB Performance Contract requiring application of this policy.*
- ✓ *The principles of the Employment First Policy include offering employment as the first and priority service option; providing integrated work settings that pay individuals minimum wage; discussing employment options with individuals through the person-centered planning process at least annually.*
- ✓ *Employ at least one Employment Services Coordinator to monitor the implementation of the employment first practices.*

Virginia has maintained its membership in the SELN and issued a policy on Employment First. There has not been an Employment Services Coordinator since February 2019; however, DBHDS has recently sought and was granted permission to refill this position.
The Settlement Agreement requires the Commonwealth to ensure that individuals in the target population are offered employment as the first day service option. DBHDS included this requirement expectation in its Performance Contracts with the CSBs starting in FY15.
The CSB Performance Contract requires the CSBs to monitor and collect data and report on these performance measures:
I.C. The number of employment aged adults receiving case management services from the CSB whose case manager discussed integrated, community-based employment with them during their annual ISP meeting, and
I.D. The percentage of employment-aged adults in the DOJ Settlement Agreement population whose ISP included employment-related or employment-readiness goals.

The Commonwealth expects that 100% of individuals with I/DD with a case manager will have "employment services and goals developed and discussed at least annually" by 12/30/15, and that 35% of these individuals will have an employment or employment-related goal in the Individual Service Plan (ISP).

Employment Discussion with Individuals- DBHDS reports that a total of 8,915 adults' case managers conducted annual ISP meetings or updates in this reporting period. However, 12,151 individuals between the ages of 18-64 receive case management, all of whom should have annual ISP meetings. CSBs report that ISP meetings were conducted for 75% of the total number of individuals who should have had an ISP meeting. DBHDS believes this is an issue of inaccurate and unreliable data rather than an indication that CSBs are not convening teams annually for many individuals' ISP meetings. Of these 8,915 individuals, their case managers checked a box that indicated that a total of 8,270 individuals had discussed integrated, community-based employment during their annual ISP meetings. This indicates that for 93% of the individuals who had an ISP meeting, the case manager checked a box that stated that employment had been discussed at some level. However, when comparing the number of individuals who were reported to have had a conversation about employment to the total number who have case managers and should have had an ISP meeting that included the development and discussion of employment goals, the percentage decreases to 68%. Neither of these percentages should be accepted as a reliable measure because DBHDS has no process to determine if the employment discussions are actually meaningful.

Six (15%) of the CSBs had employment conversations with all of their waiver participants, which was the same number achieving 100% during the last reporting period. The number of CSBs reporting these employment conversations with at least 90% of individuals decreased from twenty-seven to twenty-two, for a total of 55% of all CSBs. Of those in the 90-99% category, fifteen report having held the conversations with at least 95% of the individuals.

It is important to look at the data specific to each of the forty CSBs. The following table, Table **3**, provides a breakdown of the percentage of individuals by CSB who were engaged in an employment discussion.

Table 3- Tracking Employment Conversations

Number of CSBs June 2017	Number of CSBs June 2018	Number of CSBs June 2019	% of Employment Discussion
5	6	6	100%
20	27	22	90-99%
5	3	7	80-89%
2	1	1	70-79%
0	1	2	60-69%
2	0	1	50-59%
1	0	0	40-49%
2	0	0	30-39%
1	2	0	20-29%
0	0	1	10-19%
2	0	0	0%

The twenty-one CSBs that reported having discussed employment with 95% or more of individuals having ISP meetings are: Alexandria, Alleghany, Chesapeake, Colonial, Cumberland Mountain, Eastern Shore, Fairfax-Falls Church, Goochland-Powhatan, Hanover, Harrisonburg-Rockingham, Henrico, Highlands, Horizon, Mount Rogers, New River Valley, Norfolk, Northwestern, Rappahannock-Rapidan, Region 10, Southside and Virginia Beach.

For a total of 2,825 of the 8,270 individuals in June of 2019 compared to 2,879 of the 7,008 individuals in June 2018, the case manager's reported having employment or employment related goals in their ISP. This results in a statewide average of 32% of individuals reported to have had an annual ISP review in this reporting period who have an employment or an employment-related goal in their ISP. This compares to 38% in June 2018. This decline to a smaller percent of individuals with employment goals in their ISPS also reflects fewer individuals were reported to have had an employment goal in June 2019 compared to in June 2018. Only thirteen CSBs in June 2019 compared to twenty-one CSBs in June 2018, reported having met the expectation to have employment goals for at least 35% of their consumers. One CSB did not report employment goals for any waiver participant and another four reported employment goals for 15% or less. Five CSBs set employment goals for at least 50% of waiver individuals and one CSB, Alexandria, set goals for 74% of the individuals for whom they convened the ISP meeting.

Only thirteen CSBs set employment goals for at least 35% of the individuals who had ISP meetings, which is a decrease of eight CSBs when compared to June 2018. These are: Alexandria, Alleghany-Highlands, Chesterfield, Hanover, Harrisonburg-Rockingham, Henrico, Horizon, Loudon County, Northwestern, Prince William County, Rappahannock, Rappahannock-Rapidan, and Southside. The Parties are discussing what the appropriate percent of individuals with employment goals should be to indicate compliance for employment services.

The full DBHDS report of the CSB effort to meet these two target goals is in Attachment 1.

This issue has been only minimally discussed and by only some of the Regional Quality Councils. It has not been discussed by the E1AG. The DBHDS efforts to date are still focused on improving the accuracy of the reporting, but not on how to monitor that the employment discussions occur, and employment goals are established for individuals in the individual support plans. Later in this report, I summarize the related findings and conclusions from the employment qualitative study. It is not apparent from this study that meaningful discussions occur as often as expected or that there is consistent follow up by the Case Managers and teams to educate individuals and families about employment or to identify and address barriers.

DBHDS continues to report that it has worked with the Case Management Coordinator and Performance Contracting staff to retrain all CSB case managers on these data elements. The E1AG and DBHDS have worked together to develop both written materials and a video for case managers to build their competencies to conduct employment discussions and develop meaningful employment goals for individuals. Materials and FAQ's are also completed for families.

DBHDS reported last year that they can more readily have their agency's quality monitoring and enhancement staff review a sample of ISPs to determine the meaningfulness of the employment conversations and the suitability of the employment goal now that data entry is more reliable and consistent. However, this review by DBHDS Quality Improvement (QI) staff has not yet been initiated. Currently CSB Case Management Supervisors audit the ISPs. The data will not be available to DBHDS until January 2020, after which time DBHDS projects QI staff will undertake quality reviews. The E1AG has also recommended that DBHDS review employment outcomes for individuals compared to the employment discussions and goal setting to determine if the opportunities for employment are increased as a result of more in-depth employment discussions and whether the ISPs include measurable employment goals.

The Commonwealth report having improved its performance regarding its target of having employment discussions, which it achieved for 93% of those individuals who had an ISP meeting convened in the year ending June 2019 compared to 92% in June 2018. As discussed above, the accuracy and reliability of these data has not yet been established. In this same time period DBHDS did not meet, its target of having employment goals in at least 35% of the ISPs. It reported having achieved employment goals for only 32% of the individuals who had annual ISP meetings between June 2018 and June 2019, which is a 16.8% decline compared to 38% who reported having employment goals in their ISPs in the previous reporting period. In determining compliance with *III.C.7.b* the fact, and/or the reliability, that ISPs were convened or reliably reported on for 75% of those who should have had these ISP meetings convened and reported, must also be considered.

There is also considerable range in the levels of compliance across the forty CSBs. The percent of annual ISPs convened ranges from 10-98%. The percent of employment discussions ranged from 18-100%; and the percent of ISPs that include employment goals ranged from 0-74%. The Commonwealth has demonstrated improvement in its effective and sustained implementation of its Employment First policy by the CSBs in terms of employment discussions reported but has dropped in the percentage of ISPs that include an employment goal. This decline is of greater concern in the findings of the employment qualitative study that was conducted in this review period of 100 individuals served by ten CSBs. The qualitative study found a lack of evidence in the plans or in interviews with Case Managers that meaningful discussions actually took place at all during ISP annual meetings. Rather the study found that it is more typical for the Case Manger to ask if the individual or Authorized Representative wants employment considered and a list of providers is offered. There is no evidence that the benefits of employment, the person's interests, skills and challenges, or possible employment related goals are thoroughly discussed first, or at all, or whether the plans then address these issues. There are also no records that the CM provides ongoing opportunity for the individual and family to learn more about employment or how employment providers or staff could help address barriers. DBHDS has still not demonstrated that it has the ability through its performance contract to require CSBs to take effective corrective actions that address and resolve repeated performance related to employment that is consistently below acceptable standards.

The Engagement of the SELN - The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, to assist setting the targets for the number of individuals in the target population who will be employed, and to provide ongoing assistance to implement the plan and the Employment First Policy. The SELN Advisory Group was renamed the Employment First Advisory Group. Its members are appointed for two-year terms. The E1AG is taking applications for membership both for existing members to be reappointed and for new members to apply. The E1AG will be expanding to include members representing behavioral health. It includes self-advocates, family members, advocacy organization representatives, CSB staff, educators, employment providers, and representatives of the following state agencies: DBHDS, DMAS, DARS, and VDOE. A new member from VDOE joined in the past year after a gap in representation from the VDOE.

This Advisory Group has several sub-committees: membership, training and education, policy, and data. I reviewed the E1AG meeting minutes for two meetings that occurred during the review year. Heather Norton reports that two additional meetings were held, but minutes were not available. These might have been conducted as virtual meetings rather than in-person. The membership of the group was planned to expand in January 2019 to include individuals who represent the needs of individuals served by DBHDS who have mental health challenges and other disabilities to ensure all disability groups are included in the mission of the Advisory Group. These representatives are applying now and will be appointed this fall.

DBHDS had formalized the work of the Community Engagement Advisory Group (CEAG). This Advisory Group was disbanded since its mission has been fulfilled and its objectives have been met. Any future issues regarding CE policy, rate setting, or capacity will be addressed by the E1AG.

The E1AG remains active in its advisory capacity to DBHDS regarding its employment initiatives. I interviewed five members of the E1AG for this reporting period to gain perspective on the work of the advisory group and the progress the Commonwealth is making to meet the Settlement Agreement requirements for employment.

1.***The operation of the SELN and the opportunity afforded its members to have input into the planning process -***most of the members who I interviewed continue to report that the E1AG is active and has a diverse and effective membership. Members report that they have the opportunity for meaningful input. They appreciate the structure of the sub-committees for policy, training and data. However, there were fewer meetings of the subgroups in this reporting period. The structure is for the full E1AG to meet bimonthly and for both sub-committees to meet during alternate months. There have been fewer meetings of the sub-committees in general and some of the full committee meetings were not in person. In part, this decline seems to be due to: the vacant Employment Services Coordinator position since last February; various departures and temporary reassignments of leadership responsibilities at DBHDS; delays in subgroup work waiting for the DMAS waiver regulations to be finalized and issued; and much of the original sub-committee work having been completed.

Members are pleased that decisions are more data driven, but there is some concern that this year the E1AG, which received data from DBHDS, did not always engage in a meaningful and substantive review of the data. The data sub-committee is reported to becoming re-engaged and to be undertaking trend analysis.

The proposed changes in membership are being embraced by the membership and the DBHDS. In terms of the evolution of employment development, members believe it is a good time to expand the work of the E1AG to consider the needs of other target populations in addition to I/DD. Some recommend that the policy sub-committee be maintained to solely address the policy issues that impact the I/DD population. The members report satisfaction that data are still being used to drive decisions. In addition, most members report that the data the E1AG and its subcommittees' review is more robust. The data sub-committee is developing a trend analysis of the key data elements to facilitate comparisons and understanding of progress over the past few years. None of the members interviewed report discussing the proposed employment compliance indicators, although the minutes of the E1AG September 2019 meeting reference the indicators as an agenda topic.

2. ***Review of the Employment Targets***- Members appreciate the continued progress to increase the number of individuals who are employed, both overall and in the waiver programs, while acknowledging that the targets for individuals in waiver-funded employment services are not being met. The June 2019 Semiannual Employment Report had not been shared with the E1AG as of the interviews for this report, but the employment report was planned to be shared at the October E1AG meeting. The comments members made were based on the December 2018 employment report. Members who were previously encouraged that transportation will be a full-fledged waiver service for employment (non-medical) transport effective January 2019, are still reporting transportation as a key barrier to employment because of the imitations of this waiver service as discussed earlier in this report. They are pleased that this was included in the Provider Survey and hope the data and responses can be used to determine better systems solutions. They report that addressing transportation is critically necessary for the number of individuals with I/DD to attain and retain employment, a core goal of the Agreement.

DBHDS reviewed the changes the department made in the employment targets for the waiver-funded programs described in the Semiannual Employment Report through December 2018 during this reporting period. These changes were discussed with the E1AG at the December 2018 meeting. One member reports the E1AG was in agreement with the proposed change in employment targets for waiver participants.

3. ***Review of CSB Targets-*** E1AG meetings have not focused on the review of these targets. Members of the E1AG think that Case Managers will benefit from continued training on employment to fully embrace the principles, intent, and policy direction, as well as the importance of their role to improve employment outcomes for individuals with I/DD. Case Managers need a greater understanding of their role in the ISP planning to assist families and individuals to seriously consider employment as the first and priority option. The E1AG has been involved with DBHDS to develop training material for the CSB CMs. These training materials include employment scripts, answers to frequently asked questions, and employment discussion videos. Members report that the training efforts of DBHDS, including the production of videos, are focused and positive. However, not all of this training material has been made available to CSBs and their CMs. Some of the individuals who were interviewed for this study expressed concern that the workload of CMs limits their ability to work effectively with families to meaningfully consider employment for their adult children with I/DD or to be able to facilitate productive discussions to address barriers to employment. The Partnership staff at VCU conducted a survey of CMs that indicates many individuals find their role to be highly stressful.

4. Provider Capacity and Training- Members are encouraged that more individuals are employed and that more individuals are receiving employment support from ESO waiver programs as a result of the Memorandum of Agreement (MOA) between DARs and DBHDS. They continue to acknowledge that more training is needed for providers to assist individuals with more significant disabilities to become meaningfully employed. Provider competencies have been developed, but are still being finalized to reflect provider feedback. DBHDS reported that the competencies will be reviewed through the QSR process starting this fiscal year. The Commonwealth's participation as a state in the Business Acumen Learning Collaborative may help achieve better provider capacity and ability to sustain employment supports for the target population. This Collaborative project was undertaken in FY19 with ten providers, but the results have not yet been shared with the E1AG.

5. Review of the RQC Recommendations- The recommendations of the RQCs are shared with the E1AG. The E1AG embers report that similar concerns are expressed by the various RQC's as well as from one reporting period to the next. The E1AG members agree with the general concerns and believe that the E1AG and DBHDS staff are working to address the issues of training, capacity, waiver service access, and transportation.

6. Interagency Initiatives- The members of the E1AG who I interviewed continue to be positive about the interagency cooperation between DBHDS and DARS that resulted in the new MOA that was issued in 2018. It allows waiver providers to provide employment support to waiver participants directly at any time that DARS is under its Order of Selection. An Order of Selection places a hold on authorizing DARS support for new applicants and in reality, creates a waiting list for these vocational supports. E1AG report this has been incredibly helpful to increase employment support for individuals with I/DD. They are positive that VDOE has replaced its original member who no longer served in this capacity.
7. Transportation- Members fully support adding non-medical transportation as a waiver service and see it as addressing a critical barrier for many individuals to be able to work. DBHDs' willingness to pilot this enhancement before implementing it as a waiver service was also viewed as a positive effort. It has not as yet had the intended outcome because it is only available for individuals' transportation when they are accompanied by staff.

Conclusion and Recommendation: The DBHDS continues to meet the Settlement Agreement requirements to maintain the SELN, has set goals for the CSBs in the performance contracts, but has not fully met the provisions of *III.C.7.b.* The CSBs have not consistently offered employment as the first and priority option or developed and discussed employment service goals annually, a target that was anticipated to be achieved by June 2015. In addition, DBHDS has been without an Employment Services Coordinator since February 2018, which includes the entire fifteenth review period. Members of the E1AG report that leaving this position unfilled has delayed some of the employment initiatives because there are not sufficient staff resources to assign to these responsibilities. This position needs to be filled so that the E1AG and its subgroups can continue their work activities in a more uninterrupted manner so that manuals, policies and other written materials can be issued in a timely way, and training can once again be more routinely provided. Many of the positive activities and products underway this year including the provider manual; provider competencies; expanded case management and family training; and the results of the family listening sessions have not been issued as a result of this important position being vacant for eight months.

VIII. Regional Quality Councils

III.C.7.c. Regional Quality Councils, [described in Section V.D.5 below,] shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly to the Regional Quality Councils and the Quality Management system by the providers. Regional Quality Councils shall consult with those providers and the SELN regarding the need to take additional measures to further enhance these services.

III.C.7.d. The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.

RQC Regional Meetings

The minutes for the Regional Quality Councils (RQC) were shared for all five Councils. These meetings occurred for each RQC in FY19Q2, FY19Q3, FY19Q4 and FY19 Q1. Heather Norton or other DBHDS staff discussed employment targets with each RQC, highlighting the data in the Semiannual Employment Report of December 2018. During this reporting period, as of September, the data from the June 2019 report was not yet available for discussion.
DBHDS staff provided updates on employment for each RQC meeting. During FY18Q2 and FY18Q3 some of the RQCs had more in-depth discussions and subsequently made recommendations. These discussions focused on training for CMs; clarification of reporting expectations; addressing the employment needs of individuals with more significant disabilities; the need for transportation; and the need to build employment provider capacity. These recommendations and concerns were all shared with the E1AG in timely fashion. They are areas of consistent discussion and recommendation by all RQCs.

The RQCs' meeting minutes reflect that DBHDS consistently made presentations about employment. It does not appear that DBHDS discussed the reductions it made in the employment targets for the waiver with any of the RQCs.

None of the RQCs had all of their members attend any of the meetings as was also noted in this reviewer's last employment report. Many of the RQC meetings were held without a representative for an employment service provider, a day program provider representative, an individual with I/DD or a family representative. None of the RQCs appear to have CE providers as members. Attendance at these meetings is routinely low, making it difficult for DBHDs to receive feedback that is truly representative of the community and its stakeholders.

The RQCs had a joint meeting in FY19Q1 with outside presenters and a facilitator. Presenters were from external groups including NASDDDS and HSRI. The focus was to present how to use data for policy discussions and decision making, and how to determining program and quality of life recommendations. The presenters also discussed the role and responsibilities of quality councils. There was much better attendance at this joint meeting by all RQCs than was evident at any of the previous RQC meetings during this reporting period. Attendance and meaningful review and discussion of data have been consistent challenges for the RQCs. This planned joint learning opportunity was well planned and will hopefully result in more meaningful engagement by the RQCs. I have recommended in the past that the DBHDS converse with these Regional committees to determine the reasons for the lack of engagement of individuals, families and employment providers in committee meetings. Their attendance is important to ensure local and regional concerns and recommendations for quality improvement are established and brought to the attention of the Commonwealth. This collaborative meeting has the potential to reengage the RQCs.

The Commonwealth is responding to the requirement of involving the RQCs because the meetings were held, and employment was at least presented. Targets are expected to be reviewed by the RQCs on an annual basis and were reviewed during this reporting period, but not yet for the June 2019 Semiannual Employment Report.

Conclusions and Recommendations: DBHDS fulfilled the requirements of III.C.7.d because the employment target for sustaining employment for twelve months was reviewed by the five RQCs in the reporting period. DBHDS also fulfilled the requirements of III.C.7.c because there were quarterly reviews of employment data. All five Regions' RQCs held meetings during all four quarters. However, not all RQCs have meaningful discussions, nor is there evidence the RQCs are routinely working with providers as is required by *III.c.7b.i.B.2.* I continue to recommend that the RQCs be only required to review employment semiannually to align with the availability of the Semiannual Employment Report and that each RQC make recommendations for consideration by the E1AG so all parts of the state have the opportunity for input that may lead to policy change.

IX. SUMMARY

DBHDS continues to make gains during this reporting period to increase employment and in its efforts to implement community engagement. Its progress towards achieving its multi-year employment targets is mixed. The Commonwealth has increased the number of individuals who are employed, but has not met its overall employment target or its revised, and substantially reduced, target for waiver employment services. Although not a requirement of the Agreement, the Commonwealth is close to meeting its overall target of achieving 24% versus the 25% expected for employment of individuals on the waiver or the waiver waiting list. There is a significant increase in participation of individuals with I/DD in Community Engagement activities, but the rate of increase is not matching the increases over the previous two reporting periods. This may be a factor and contribute to the concern that there appears not to be sufficient provider capacity of CE to offer this as a service in all parts of Virginia.

The Commonwealth has continued to support customized employment training, has added benefits planning to the waiver and has implemented the MOA between DARS and DBHDS. These accomplishments, all of which are important features of a robust employment initiative, have assisted ESOs to engage individuals on the waiver in employment services more quickly.

The Commonwealth has not achieved its employment targets related to case management services provided by the CSBs. The expectation that employment goals would be set for at least 35% of individuals who have ISPs was not achieved in this reporting period. The CSBs report having done better facilitating employment conversations with waiver participants but have fallen for short of the target of 100%.

The Stakeholders who are part of the E1AG remain interested and positive about the Commonwealth's progress and achievements. It will be useful for DBHDS to provide sufficient support to the E1AG throughout the next reporting so its data analysis, training efforts and plans to include other disability groups can all be successfully undertaken. This can be more readily accomplished once the Employment Services Coordinator position is refilled.

Attachment 1

CSB Performance Summary

DBHDS has worked to develop new measures as part of the CSB performance contract, which specifically collects data on:

1. Discussing employment with individuals receiving case management services, and
2. Developing individual employment related and/or readiness goals.

Tracking Employment First Conversations:

DBHDS has worked to develop new measures as part of the CSB performance contract, which specifically collects data on:

1. discussing employment with individuals receiving case management services, and
2. developing individual employment related and/or readiness goals.

Tracking Employment First Conversations:

DBHDS has worked to develop new measures as part of the CSB performance contract, which specifically collects data on:

1. discussing employment with individuals receiving case management services, and
2. developing individual employment related and/or readiness goals.

The results of the data collection are presented below for the fiscal year of FY19

Employment (All columns ages 18 through 64 only) Jul 1, 2018 - Jun 30, 2019	Receiving DD CM	F2F Mtg	%	Total Discussions	% Discussions	Total Outcomes	% Outcomes
Chesterfield	888	618	71%	575	93%	230	37%
Crossroads	189	18	10%	17	94%	6	33%
District 19	302	183	58%	150	82%	35	19%
Goochland-Powhatan	63	45	68%	44	98%	12	27%
Hanover	177	142	78%	137	96%	52	37%
Henrico Area	535	354	67%	348	98%	143	40%
Richmond	418	380	90%	335	88%	131	34%
Southside	188	172	93%	172	100%	65	38%
Central Region	**2760**	**1912**	**71%**	**1778**	**93%**	**674**	**35%**
Chesapeake	261	204	75%	204	100%	52	25%
Colonial	152	116	77%	113	97%	34	29%
Eastern Shore	110	90	84%	90	100%	11	12%
Hampton-Newport News	523	377	73%	351	93%	88	23%
Middle Peninsula-Northern Neck	224	134	60%	105	78%	20	15%
Norfolk	457	393	89%	383	97%	104	26%
Portsmouth	221	195	98%	159	82%	44	23%
Virginia Beach	693	595	85%	594	100%	169	28%
Western Tidewater	245	213	87%	180	85%	64	30%
Eastern Region	**2886**	**2317**	**81%**	**2179**	**94%**	**586**	**25%**

Alexandria	88	27	33%	26	96%	20	74%
Arlington	145	127	88%	106	83%	38	30%
Fairfax-Falls Church	1023	813	80%	794	98%	246	30%
Loudoun County	231	197	84%	183	93%	89	45%
Northwestern	368	266	74%	255	96%	100	38%
Prince William	443	275	62%	247	90%	158	57%
Rappahannock Area	506	311	61%	264	85%	158	51%
Rappahannock-Rapidan	238	194	82%	185	95%	86	44%
Northern Region	**3042**	**2210**	**74%**	**2060**	**93%**	**895**	**40%**
Blue Ridge	405	302	74%	281	93%	57	19%
Cumberland Mountain	158	143	89%	143	100%	47	33%
Danville-Pittsylvania	322	238	78%	159	67%	53	22%
Dickenson	21	11	52%	2	18%	1	9%
Highlands	132	101	77%	98	97%	21	21%
Mount Rogers	290	202	68%	196	97%	0	0%
New River Valley	242	217	85%	211	97%	72	33%
Piedmont	264	185	74%	174	94%	17	9%
Planning District I	164	38	23%	24	63%	6	16%
Southwestern Region	**1998**	**1436**	**73%**	**1288**	**90%**	**274**	**19%**
Employment (All columns ages 18 through 64 only) **Jul 1, 2018 - Jun 30, 2019**	**Receiving DD CM**	**F2F Mtg**	**%**	**Total Discussions**	**% Discussions**	**Total Outcomes**	**% Outcomes**
Alleghany-Highlands	53	19	35%	19	100%	8	42%
Harrisonburg-Rockingham	186	165	87%	161	98%	86	52%
Horizon	579	320	55%	312	98%	168	53%
Region Ten	327	279	83%	272	97%	71	25%
Rockbridge Area	53	40	87%	12	30%	12	30%
Valley	267	224	81%	193	86%	53	24%
Western Region	**1465**	**1047**	**71%**	**969**	**93%**	**398**	**38%**
Statewide Total	**12151**	**8915**	**75%**	**8270**	**93%**	**2825**	**32%**

Integrated Day Activities and Supported Employment
Part two: Qualitative Review Summary
15th Review Period

At the request of the Independent Reviewer, a qualitative review of employment and community engagement was undertaken in this review period. The purpose of the review was to determine if there were meaningful discussions about employment interests and options and about increasing opportunities for engaging in community-based activities on a regular basis; and whether an individual employment or employment readiness goal and/or community engagement goal were established for the individuals. The Individual Support Plans (ISPs) for 100 individuals who had face-to-face ISP planning meetings in June 2019 were selected for the review.

The study included a review of the written plans and any other documentation related to employment and Community Engagement (CE) discussions during the face-to-face ISP meetings, and interviews with the individuals' case managers.

DBHDS provided the complete list of adults with I/DD who are supported by CSBs who had their annual ISP meetings during June 2019. These meetings were face-to-face and conducted by the Case Managers (CM). I selected individuals from two CSBs in each region to review. The sample included all of the individuals in these ten CSBs who had their annual planning meetings in June 2019.

One hundred adults were selected as the sample for this qualitative review of employment and CE, the two primary waiver-funded services in Virginia that comprise integrated day activities. The sample included 25% of the forty CSBs and 100 of the individuals whose ISP annual meetings were convened in June 2019. The CSBs included by Region and the number of individuals in the sample from each CSB are:

Central Region (25):	Crossroads 15 and Southside 10
Eastern Region (16):	Eastern Shore 4 and Colonial 12
Northern Region (16):	Alexandria 3 and Rappahannock/Rapidan 13
Southwestern Region (25):	PD1 14 and Cumberland 11
Western Region (18):	Harrison-Rockbridge 13 and Rockbridge 5

The reviewers reviewed ISPs including the Part V section and interviewed CMs to determine:

- Did the individual's planning team meaningfully discuss employment with the individual at the annual ISP meeting?
- Did the team identify and address any barriers to employment?
- Did the team with the participation of the individual and guardian, set an employment goal or employment readiness goal for the individual?
- If the individual or guardian was not interested in employment at this time did the team develop strategies to educate the individual and family about the benefits of employment?
- Did the individual's planning team meaningfully discuss community engagement with the individual at the annual ISP meeting?
- Did the team identify and address any barriers to community engagement?
- Did the team with the participation of the individual and guardian, set a community engagement goal for the individual?
- If the individual or guardian was not interested in community engagement at this time did the team develop strategies to educate the individual and family about the benefits of community engagement?
- Is the individual engaged in meaningful integrated day activities that reflect the individual's preferences, needs and goals?

In order to make these determinations we considered the following issues when reviewing both documents and interviewing CMs:

1. Is there documentation of the employment discussion?
2. Were the individual's and/or guardian's opinions, desires, and concerns included in the discussion?
3. Did the discussion include determining what the individual's interests and skills are?
4. Did the discussion include any challenges or barriers to employment that the individual is experiencing?
5. Did the discussion include an explanation of the employment options that are available to the individual?
6. Did the team review the impact of employment on the individual's benefits if the individual was interested in working?
7. If the individual is interested in working did the team recommend related assessments if not already done?
8. Was an employment or employment readiness goal created?

9. Does the goal reflect the employment discussion (strengths, preferences, needs and barriers)?
10. Does the goal include an outcome?
11. Does the plan include goals, objectives and activities to promote the individual's participation in integrated day activities?
12. Do these integrated day activities reflect the strengths, preferences and needs of the individual?
13. Do these integrated day activities promote active participation for the individual in the community?

The reviewers contacted every CM who had one or more individuals in the sample. The reviewers sought to schedule a telephone interview of approximately thirty minutes. Reviewers asked questions related to the plan review elements in cases where the plan documentation was not sufficient to confirm if the element had been addressed by the team and to have a more in-depth understanding of the individual. The reviewers received the ISPs in September, so the documents reviewed do not reflect a full year of progress implementing the employment and integrated day activity goals, objectives and activities. Case Managers were asked to address the current and relevant implementation of the ISP in these two areas: employment and CE. The response rate by CMs was quite high and for most CSBs all of the CMs responded. One CM was on medical leave and the Supervisor participated in the interview. We greatly appreciate the time these CMs gave so the reviewers were better informed.

Case Management Interviews- The review included individuals served by sixty-three Case Managers. The Case Managers were from the following CSBs: Alexandria (3), Colonial (6);Crossroads (15); Cumberland (10); Eastern Shore (2); Harrisonburg-Rockingham (6); PD1 (7), Rapidan- Rappahannock (7); Rockbridge (2); and Southside (5). All charts were reviewed for the 100 individuals in the sample, and interview requests were sent to all Case Managers. Fifty-six (56) CMs and one Supervisor responded to the request for an interview and were scheduled. There were three CMs who did not respond to the reviewer's call for the scheduled interviews, and one did not respond to a second request for interview. Attempts were made to speak to four other CMs who initially responded but who were never interviewed. Three had client emergencies and one could not be reached due to a technical issue with the CSB telephone and could not re-schedule. Two CMs in Southside were no longer employed, but the CMs who were interviewed for this CSB addressed these individuals' plans as best they could. This process resulted in the reviewers interviewing fifty-two of the

Case Managers, an 82.5% interview rate. Although all could not be interviewed for the reasons stated above, we appreciate that all but four of the CMs responded who were still employed by the CSBs.

The vast majority of CMs interviewed were professional, courteous and conveyed their appreciation to be included in the review process. They provided valuable information that was not captured in the chart review. Others, while professional in their demeanor, demonstrated, either by acknowledgment or their answers to interview questions, that they were not familiar with the individual in the sample.

Case Manager Training- The Case Managers who report feeling well trained to have employment and CE discussions with individuals and families or ARs report the training has been primarily provided by their Supervisors. Many of these CMs report that employment is a regular topic of staff meetings. One CM described in great detail the training she received from her supervisor, which covered all aspects of the expected discussions about Integrated Day Activities (IDA) including employment. This particular CM's interview exemplified the benefit of her training as was evidenced by how well prepared she was for the interview and the level of knowledge she had of IDA, which she used to create IDA opportunities for the individuals on her caseload.

The range of responses from CMs about the IDA training they received varied tremendously. Some reported no training while others found their training excellent. Some did not recall if they participated in training. Most CMs reported the training to be adequate, but not in sufficient depth. Few CMs reported receiving training to explain the impact of employment on individual's benefits. CMs report referring individuals to DARS for benefits planning and support. Many of the CMs did not feel confident to have in-depth discussions with families who express disinterest, or who are adamant that their adult child should not pursue employment. CMs report that the most useful training was the training provided by their Supervisors.

It was clear from the interviews that not all CMs understand the value of employment for everyone or how to engage families and individuals in meaningful discussions that include a discussion about strengths, interests, skills, challenges and barriers. Some believed incorrectly that the work activities at group day programs were examples of competitive employment; one CM reported that if the individual wanted competitive employment it was the person's responsibility to find it; and many reported that their discussions consisted of only asking annually if the individual was interested in being employed. It was evident from the interviews that some of the CMs are less familiar with CE than employment. These CMs thought the limited community activities offered by group day support programs could constitute CE. The majority of CMs did not report formal training on holding discussions with individuals, families, or Authorized Representatives about CE. Although, not in formal training sessions, some reported this topic was addressed in supervisory sessions. These CMs credited their supervisor for excellent practical as well as theoretical training about CE.

Those CMs who reported having participated in more extensive training possessed:

- knowledge and ability to introduce the topics of employment and CE on an individualized basis
- an ability to navigate refusals by individuals and families by introducing skill building activities that would benefit the individual with a plan to return to the topic of employment and CE as skill building progressed
- a thorough understanding of employment providers and how to access them
- an understanding of how CE and employment could be used to complement each other to create an integrated day for the individual
- knowledge of both employment and CE providers that allowed them to match individuals appropriately
- a solid understanding of CE and what comprised an integrated day and the steps needed to assist individuals to experience meaningful community integration

A concern common for many of the CMs was the inability to develop goals with measurable objectives. Some asked for guidance that was provided using an individual on their caseload who was in the sample. Some CMs reported providers do not develop goals with measurable objectives for employment or CE.

Case Managers Initiating Employment Services- All CMs serving individuals who are employed cited that when DARS was involved it took a number of months to finalize the authorization; and, at least an entire year from the date of receiving authorization for the service to the start of employment. CMs reported much shorter timeframes for authorization and securing employment when directly working with providers through the waiver-funded programs. The findings of this review confirmed that many individuals in the waiver programs were employed within a few months. CMs spoke very positively about the provider Stand Up, an employment service provider. Stand Up often secures employment for waiver participants within three months. Those CMs who had experience with Stand Up spoke positively about this organization's efforts for others on their caseload as well as the individual in this sample. They find Stand Up's Discovery Program, very helpful for individuals to gain confidence and secure the right employment match for the individuals' skills and interests.

Addressing the implication of employment on benefits- All but two Case Managers utilize a Benefits Counselor from Social Security, DARS or an employment provider. The two CMs who report explaining benefits themselves did not have any individual on their caseload who was employed. Both were aware that a benefits counselor could be utilized.

Community Engagement Provider Capacity- The majority of CMs report a lack of a sufficient number of CE providers, either in their entire CSB geographic area or in portions of the CSB. These CMs either report there has never been sufficient capacity or that providers of CE have discontinued this IDA service. CMs report that providers do not find the reimbursement rates for CE to be sufficient to maintain this type of HCBS waiver-funded service. In these CSB areas, it is much less likely the CMs have an extensive conversation because, if the individuals and families express interest, there is no provider to meet this interest or need. In some areas residential providers are offering CE which is positive, but these residential providers only offer CE to individuals in their residential programs.

Case Managers cited the following information about CE capacity:

- ***Alexandria***-has a sufficient number of CE providers
- ***Colonial***-does not have sufficient providers throughout the counties; and transportation is difficult to get to the providers who do offer CE. Some residential providers are considering becoming CE providers
- ***Crossroads***- has only two CE providers within its seven counties
- ***Cumberland***-has access to only two CE providers located just outside of the CSB area, but these providers are used
- ***Eastern Shore***-has only two CE programs, both operated by the CSB
- ***Harrisonburg-Rockingham***- reports sufficient capacity with at least eleven CE providers , only one of which has no vacancies. Six of these CE programs are offered by the CSB
- ***PD1***-has one to three CE programs available depending on where the individual lives
- ***Rappahannock/Rapidan-*** has only two providers including the CSB that offered CE programs
- ***Rockbridge***- has only one day program in the CSB area that provides CE. Residential providers are becoming involved with providing CE.
- ***Southside***- has only one provider for its three-county geographic area. CE is successfully provided by this provider, but the distance is too far for many portions of the CSB area.

CMs report that only Alexandria and Harrisonburg-Rockingham have sufficient CE capacity

All of the CMs who commented on CE talked about the difficulty providers were having hiring staff due to the low rates of pay and subsequently cannot accept more participants or expand their programs to other areas.

ISP document review- DBHDS provided the ISPs for the individuals and included the Part V section completed by the CMs. The section of the ISP that addresses employment and CE is comprised of check off boxes for each service related to the discussion by the team; the individual's interest; whether the person is deciding to retire; a listing of barriers; and whether there is a plan to further educate the individual and family about employment and CE. There is no area in the ISP that provides an opportunity for the CM to enter information that would validate what comprised these discussions; what was being done to address the barriers; or how the CM and team planned to provide further education and information about employment or CE for individuals who were not interested at

the time of the meeting. The Section V of the ISPs that were shared were the Part V's completed by the CM. The Section Vs submitted did not provide information about any team discussion nor reflected goals with measurable objectives. Overall, this study found that the goal statements were weak, very general and for the most part reflected basic rights. CMs report that providers do not routinely include specific or measurable outcomes in the goals that they develop for their respective portions of the ISP. Subsequent determinations reported by the CMs regarding whether such outcomes are met, cannot be made reliably.

Although, for this review, all records were requested that demonstrate the Commonwealth's proper implementation of the provisions being reviewed, the Section V's for integrated day activities and supported employment services were not provided. In mid-October, I learned that these documents existed but had not been provided. I then requested these be shared for the individuals in the sample who were employed or expressed an interest in employment, but the timing was such that these were not provided. Therefore, we cannot comment on the status of vocational assessments, actual employment goals, or whether providers are developing measurable objectives related to these goals.

Employment Discussions and Goal Setting

Table 1 below summarizes the findings by CSB for the employment expectations. This Table includes discussing employment; determining the individual's interest; identifying and addressing barriers to employment; setting employment goals and planning to further educate individuals who are not currently interested in employment.

Employment Discussion- DBHDS expects that CSB CMs will have employment discussions with 100% of the individuals on their caseloads at the ISP annual meeting. DBHDS reported in its Semiannual Employment Report that these discussions were held for 93% of all individuals during FY19. Our study found that these discussions were held for 73% of the selected sample overall. The range across the ten CSBs in the study was from 40%-100% with three CSBs achieving 100%: Eastern Shore, Harrisonburg-Rockingham, and Rockbridge. Rappahannock-Rapidan held employment discussions for 92% of its individuals in the sample.

Almost all of the ISPs included a checkmark that an employment conversation occurred. In making our determinations we expected to see evidence that a meaningful discussion occurred including a discussion of the person's interests and history of employment; their skills related to employment; and the barriers that they or their family felt existed to successful employment. Much of this information was gleaned from interviews with the CMs. We rated that no employment discussion occurred if it was evident that the CM only asked the question if the individual or family wanted to consider employment and/or shared the written form that lists employment options.

Setting an Employment Goal- We made this determination based on the number of individuals who expressed an interest and therefore needed a goal. We did not include individuals with no interest in employment or the few who had worked for a long time, were happy with their work and did not need a goal in this area who are identified in the sample as RR3 and CU6, or who chose to retire. Seven individuals chose to retire. Using this methodology, 70% of the individuals who expressed an interest also have an employment goal. CSBs range in achieving this expected outcome from 0%-100%. The CSBs with 100% are: Eastern Shore, Rapidan-Rappahannock, Alexandria, and Cumberland. However, DBHDS calculates this based on everyone who has an employment discussion. Using DBHDS' methodology and not subtracting the individuals who do not express an interest in employment, the percentage of individuals with an employment goal included in their ISPs is only 19%.

Interest in Employment and Plans to Educate Individuals and Families- The interest of the individual or family is noted only by a check off box on the ISP. Often it is noted if it is the family who objects. We noted twenty-three families who have strong objections to either employment and/or CE. (These individuals are noted in the Tables with two asterisks.) These families do not include the six individuals in the sample whose loved ones have significant health or physical considerations that impact their employability. This include individuals who have quadriplegia; are frequently suctioned and use a ventilator; or whose medical fragility preclude them from being out of their home settings because of fear of infection or lack stamina to engage in activities.

Overall only 26% of the individuals expressed an interest in employment and 74% expressed that they did not have interest at this time. The Commonwealth's and CSB policy requires employment to be the first and priority service option for individuals' day service option. To be the priority service option, this study expects that educational plans would be developed for those individuals who are not interested in employment, unless an educational plan was unnecessary. We determined that an educational plan was unnecessary for individuals who had previously worked or volunteered and wanted to retire, and for those individuals who had significant medical and/or physical challenges that affected their interest and seemed a legitimate reason for them to not want to consider employment. Overall, seven individuals wanted to retire and six have significant health and/or physical issues. The seven who are retired are identified in the sample as CR1, CR2, C11, R2, R3, RR4, and CU3; and those with a health or physical concern are identified as CR7, ES1, A2, S5, S6 and CU7.

Of the remaining individuals who were not interested in employment, only 25% (18) individuals have a plan to further educate them about employment. Many CMs reported that their plan was merely to ask them each year if they were interested in employment. We determined that there was a plan in place to educate an individual when the CM could be specific about strategies they would use to further the individual and family's interest and comfort with employment That may be to link them to a benefits counselor, have then visit an employment provider, or research transportation.

Identifying and Addressing Barriers- CMs did a good job of identifying barriers to employment for individuals on their caseload who are in the sample. Overall 77% of the individuals had barriers identified in their ISPs`. The only individuals excluded from needing barriers identified were those who have retired, and one person employed for a long time without any barriers. Cumberland identified barriers for 100% of its participants in the sample. However, there is only evidence that barriers are being addressed for 45% of the remaining individuals in the sample. We did not include individuals to rate this category who are retired; whose teams identified they did not have any barriers to employment; or who are currently uninterested in employment and have a significant health or physical consideration that makes employment difficult.

It is critical that teams become proficient in both identifying barriers and developing specific strategies to address and overcome barriers if more individuals are going to be confident and interested in pursuing paths to employment. Many of the individuals in this sample participate in group day programs and have some work activities. These are individuals who may have fewer barriers to individualized employment and whose teams could concentrate on assisting them to understand the benefits of integrated employment and to address whatever barriers or hesitancies may exist that is keeping them from actively pursuing employment opportunities.

Community Engagement Discussions and Goal Setting

Table 2 summarizes the findings by CSB for the Community Engagement expectations. This includes discussing CE; determining the individual's interest; identifying and addressing barriers to community engagement; setting community engagement goals and planning to further educate individuals who are not currently interested in CE about its benefits.

Community Engagement Discussion- DBHDS set a goal in the Outcome-Timeline submitted to the Court in January 2016 that 100% of individuals would have an annual discussion about CE. Our study found that these discussions were held for 74% of the sample overall. The range across the ten CSBs in the study was 47%-100% with three CSBs achieving 100%: Eastern Shore, Harrisonburg-Rockingham, and Rockbridge. Rappahannock-Rapidan held CE discussions for 92% of its individuals in the sample. These four CSBs achieved these same high percentages for employment discussions for these same individuals. This is not surprising as the CMs who were knowledgeable of IDA in general held more robust discussions about both employment and CE. As was true for employment we expected to find evidence of meaningful discussions that included discussing skills, interests, challenges and barriers in order to find that a meaningful discussion occurred.

Setting a CE Goal- We made this determination based on the number of individuals who expressed an interest and therefore needed a goal. We did not include the six individuals in the study with no interest in CE; or who had meaningful engagement in community activities of their choosing, did not need staff or a program to assist them and therefore did not need a goal in this area. This individuals are CR1, CR2, CR10, CR11, RR3 and RR4.

Using this methodology, 69% of the individuals who expressed an interest also have a CE goal. CSBs range in achieving this expected outcome from 0%-100%. The CSBs with 100% are: Rapidan-Rappahannock, PD1, and Harrisonburg-Rockingham. However, this only includes twenty-six of the individuals in the sample because there were so many who expressed not having an interest in CE. DBHDS calculates this percentage for employment goals based on everyone who has an employment discussion. Using the same methodology DBHDS uses to calculate this percentage for determining the percentage of individuals with an employment goal, the percentage of individuals with a CE goal is only 26%.

Interest in CE and Plans to Educate Individuals and Families- The interest of the individual, family or Authorized Representative (AR) is noted by a check off box on the ISP. Often interest is noted if it is the AR who objects. Twenty ARs in this sample who have strong objections to either employment and/or CE. This number of ARs does not include those whose loved ones have significant health or physical considerations that impact their employability.

Overall, 46% of the individuals expressed an interest in CE compared to 26% expressing an interest in employment, and 54% who expressed not having an interest in CE at this time. DBHDS expects that educational plans will be developed for individuals who are not interested in CE. For some of these individuals, we determined that an educational plan was unnecessary. We concluded this for one individual who was already actively involved in integrated community activities of their choosing, and for those individuals who had significant medical and/or physical challenges that affected their interest and seemed a legitimate reason for them to not want to consider CE. Four individuals have significant health and/or physical issues. These individuals are CR7, ES1, A2, and CU7. Of the remaining individuals who were not interested in CE, only 19% (10) of individuals have a plan to further educate them about employment.

Many CMs reported that their plan was merely to ask each year whether the individuals, family or AR were interested in CE. We determined that there was an acceptable plan in place when the CM could be specific about strategies they would use to further the individual and family's interest and comfort with, and understanding of CE. Such a strategy may be to explore the individual's or family's interests as they relate to participating in community groups, functions and activities including volunteering. Many of these individuals are attending congregate group day programs. They already volunteer, but on a limited basis and in large groups. The volunteer work is not individualized to their interests.

CMs report that group day programs offer limited weekly community outings as well but few of them give the individuals the opportunity to substantively interact, or develop relationships, with others in their communities, make contributions, learn new skills or pursue interests outside of shopping, dining out and attending sporting events or concerts. The ISP teams could use this level of activity and community presence to assist individuals to transition to CE.

Identifying and Addressing Barriers- CMs did a good job of identifying barriers to employment for individuals on their caseloads who are in the sample. Overall, CMs identified barriers for 76% of the individuals in the sample. Eastern Shore and Rockbridge identified barriers for 100% of their participants in the sample and Cumberland and Rappahannock-Rapidan identified barriers for over 90% of their sample. However, there is only evidence that barriers are being addressed for 43% of the individuals in the sample. We excluded from these percent calculations individuals whose teams identified that the individual did not have any barriers to CE, or those who are currently uninterested in CE and have a significant health or physical consideration that makes meaningful CE difficult.

It is critical that ISP teams become proficient in both identifying barriers and developing specific strategies to address and overcome barriers if more individuals are going to be interested in transitioning from their congregate day programs to become more meaningfully engaged in their communities. Many of the individuals in this sample participate in group day programs and have some community-based activities as discussed earlier. These are individuals who may have fewer barriers to CE and whose teams could concentrate on assisting them to understand the benefits of CE and addressing whatever barriers or hesitancies may exist that is keeping them from becoming engaged in community life.

Earlier in this report, I discuss the feedback from CMs about the lack of a sufficient number of CE providers to meet the needs and interests of individuals on their caseloads in less populated areas of Virginia. This is a systemic barrier that the Commonwealth must address for its IDA initiative to be successful. CMs cannot be asked to present CE as an available service when it is not accessible in reasonable proximity to where individuals reside.

Achieving an Integrated Day- Using the information about individuals' participation in employment, volunteer work, or participating in other community activities of their choosing, we indicated how many have a current opportunity for meaningful community participation and inclusion. This includes individuals who work, participate in CE programs, or who on their own participate meaningfully in community activities and interact with community members. This type of day and routine is only realized for 27% of the individuals in the sample. The range is 10%-60% of the sample across the CSBs, which reflects this achievement for twenty-seven individuals.

Conclusions and Recommendations

The findings of this study do not conclude that the targets DBHDS set for both IDA discussions and IDA goals are being met. Only seventy-three (73%) individuals had a meaningful employment discussion and seventy (70%) individuals had a meaningful discussion of CE. Many Case Managers do not discuss employment but rather ask if there is an interest and share written materials about employment service options and providers. In these cases, there is no evidence that there is a conversation about interests, skills and what individuals and ARs may perceive are barriers.

The interest in employment and CE is surprisingly low with only 26% of individuals and ARs expressing an interest in employment and 46% of individuals and ARs expressing an interest in CE. Twenty-three ARs do not want at least employment explored for their family member, some also do not want to explore CE. They represent individuals who do not have a significant health of physical reason why employment cannot be pursued. These ARs need much more information about employment in order to more seriously consider it as the first and priority option for their family members. To view employment as a realistic option for their adult children, families may need opportunities to observe other individuals with similar characteristics. The findings of this study also indicate that CMs need to be more prepared to have initial discussions about the impact of wages on existing benefits, so families are more comfortable seeking more information about this critical issue rather than dismissing employment as even an option at the ISP meeting.

CSBs are not training or expecting the CMs to develop strategies to educate individuals who are uninterested in employment or CE to learn more about it, CMs have educational plans in place for only 25% and 27% respectively for individuals who are not currently interested in employment or CE. This indicates a high percentage of individuals who are not interested in IDA. CMs need training to be able to both educate these ARs and individuals and develop more concrete plans to address the barriers to employment and CE that are identified if individuals are to select IDA rather than congregate day programs that offer limited opportunities for community integration and inclusion. Only twenty-seven individuals (27%) have an active integrated community-based routine of the 100 individuals in the sample.

DBHDS has developed a number of training modules regarding the IDA initiative for CMs. The E1AG has contributed significantly to this effort. The interviews with the CMs in this study indicate that this training has not prepared many of them to meaningfully engage individuals and ARs in discussions to promote employment and CE. Supervisors are most likely the key to advancing cultural change via a more consistent training process for new CMs and continued mentoring of existing CMs work in this area. DBHDS may want to work with the CSBs that are more proficient at achieving the discussion and goal targets to identify best practice for CM training and supervision. Training should include detailed technical training, and shadowing by supervisor for monthly visits and annual ISP meeting to offer timely technical assistance. CMs who demonstrate these competencies over time may be paired with newly hired CMs especially important because there is turnover in these positions. CMs need more training to make goals more specific and to develop measurable objectives to be able to reliably determine progress. CMs report employment and CE providers also need this training.

To make substantive progress, the lack of provider capacity to offer CE must be addressed. There is not a sufficient number of these providers in many geographic areas of Virginia. This may contribute to the reduced rate of enrollment in these programs, as reported in the June 2019 Semiannual Employment Report. CMs cannot reasonably be expected to offer CE when it is not available in proximity to where individuals reside; they may also avoid discussions about interest. CMs report satisfaction when residential providers offer CE. This supports DBHDS' plan to expand the availability of this service through residential providers statewide.

The Parties are negotiating compliance indicators for employment and CE discussions and goal setting. It will be important that the criteria and methodology for determining if the targets are reached be clarified during these negotiations. In this study, as noted earlier in this report, we did not consider that individuals who expressed not being interested in employment or CE should have goals in these areas, but that they should have education plans. This criterion and methodology results in a much different percentage of individuals with goals than the current methodology used by DBHDS, which just compares the number of individuals with goals compared to the number of individuals who had a discussion about employment.

DBHDS needs an internal CSB supervisory review, and an external review, process to ensure that the CSB CMs understand how to have, and actually do have, meaningful discussions, which lead to creating goals, and developing education strategies about IDA for individuals who express not having a current interest in these services. Currently, DBHDS is relying on data reported from the CSBs that does not include a qualitative review of these expectations.

Table 1 Employment Summary and Table 2 Community Engagement Summary-
The findings of the qualitative study are presented in Tables 1 and 2 below. Each topic area related to employment and community engagement discussions; interest; barrier identification and address; goal setting and educational strategies are rated as being present, noted by a Yes or not present noted by a No. The percentages have been calculated for each CSB and then for the overall total of the sample.

TABLE 1: EMPLOYMENT SUMMARY						
	Employment Discussion	Interest	Identified Barriers	Addressed Barriers	Employment Goal	Plan to Educate
CENTRAL REGION						
Crossroads						
CR1*	YES	NO	N/A	N/A	N/A	N/A
CR2*	YES	NO	N/A	N/A	N/A	NO
CR3	NO	NO	NO	NO	N/A	NO
CR4	NO	NO	NO	NO	N/A	NO
CR5	NO	NO	NO	NO	N/A	YES
CR6**	YES	NO	YES	NO	N/A	NO
CR7***	NO	NO	YES	N/A	N/A	NO
CR8**	YES	NO	YES	NO	N/A	YES
CR9**	YES	NO	YES	NO	N/A	NO
CR10	YES	YES	YES	YES	YES	N/A
CR11	YES	NO	YES	YES	N/A	YES
CR12b	NO	NO	YES	NO	N/A	NO
CR13b	NO	NO	YES	NO	N/A	NO
CR14b	NO	NO	NO	NO	N/A	NO
CR15b	NO	YES	YES	NO	NO	N/A
CSB COMPLIANCE PERCENTAGE	47%	13%	69%	17%	50%	17%
Southside						
S1	NO	NO	YES	NO	N/A	NO
S2	YES	NO	NO	YES	N/A	NO
S3	NO	NO	NO	NO	N/A	YES
S4	NO	NO	YES	NO	N/A	NO
S5***	YES	NO	YES	N/A	N/A	NO
S6***	YES	NO	YES	N/A	N/A	NO
S7**	NO	NO	YES	NO	N/A	NO
S8**	NO	NO	YES	NO	N/A	NO
S9	NO	NO	YES	YES	N/A	NO
S10	YES	YES	NO	NO	NO	N/A
CSB COMPLIANCE PERCENTAGE	40%	10%	70%	25%	0%	11%

EASTERN REGION						
Colonial						
C1**	NO	NO	NO	NO	N/A	NO
C2	YES	NO	YES	NO	N/A	NO
C3	YES	YES	NO	NO	NO	N/A
C4	NO	NO	NO	NO	N/A	NO
C5	NO	NO	NO	NO	N/A	NO
C6	NO	NO	YES	NO	N/A	NO
C7	YES	NO	YES	YES	N/A	YES
C8	YES	NO	YES	N/A	N/A	NO
C9	YES	NO	YES	YES	N/A	YES
C10	YES	YES	YES	YES	NO (d)	N/A
C11*	NO	NO	NO	NO	N/A	NO
C12	NO	NO	YES	NO	N/A	NO
CSB COMPLIANCE PERCENTAGE	50%	17%	58%	27%	0%	20%

Eastern Shore						
ES1***	YES	NO	YES	NO	N/A	NO
ES2**	YES	NO	NO	NO	N/A	NO
ES3	YES	YES	YES	YES	YES	N/A
ES4	YES	YES	YES	YES	YES	N/A
CSB COMPLIANCE PERCENTAGE	100%	50%	75%	50%	100%	0%

NORTHERN REGION						
Rap Rap						
RR1	YES	YES	YES	YES	YES	N/A
RR2	YES	NO	YES	YES	N/A	YES
RR3	YES	YES	N/A	N/A	N/A	N/A
RR4*	YES	NO	N/A	N/A	N/A	N/A
RR5	YES	NO	YES	NO	N/A	NO
RR6	YES	NO	NO	NO	N/A	NO
RR7**	YES	NO	YES	YES	N/A	YES
RR8**	YES	NO	YES	YES	N/A	NO
RR9	YES	YES	YES	YES	YES	N/A
RR10**	YES	NO	NO	NO	N/A	YES
RR11	YES	YES	YES	YES	YES	N/A
RR12	YES	NO	YES	YES	N/A	YES
RR13	NO	NO	YES	YES	N/A	NO
CSB COMPLIANCE PERCENTAGE	92%	31%	82%	82%	100%	50%
Alexandria						

A1	NO	NO	NO	NO	N/A	NO
A2***	YES	YES	YES	YES	YES	N/A
A3	YES	NO	YES	N/A	N/A	NO
CSB COMPLIANCE PERCENTAGE	67%	34%	67%	50%	100%	0%

SOUTHWESTERN REGION						
PD1						
PD1**	YES	NO	YES	NO	N/A	NO
PD2**	YES	NO	NO	NO	N/A	NO
PD3	YES	NO	YES	NO	N/A	NO
PD4**	YES	NO	YES	NO	N/A	NO
PD5	YES	YES	YES	YES	YES	N/A
PD6**	YES	NO	YES	NO	N/A	NO
PD7**	YES	NO	YES	NO	N/A	YES
PD8	YES	YES	YES	YES	YES	N/A
PD9b	YES	YES	YES	YES	YES	N/A
PD10b	NO	NO	NO	NO	NO	NO
PD11b	YES	NO	YES	YES	N/A	NO
PD12b**	YES	NO	NO	NO	N/A	YES
PD13b	NO	NO	YES	NO	N/A	NO
PD14b	NO	NO	NO	NO	NO	NO
CSB COMPLIANCE PERCENTAGE	79%	21%	71%	29%	60%	18%

Cumberland						
CU1a	YES	YES	YES	YES	YES	N/A
CU2**	YES	NO	YES	YES	N/A	YES
CU3*	YES	NO	N/A	N/A	N/A	N/A
CU4**	YES	NO	YES	YES	N/A	YES
CU5	YES	NO	YES	YES	N/A	YES
CU6	YES	YES	YES	YES	N/A	YES
CU7***	YES	NO	YES	N/A	N/A	N/A
CU8**	YES	NO	YES	YES	N/A	YES
CU9	YES	YES	YES	YES	YES	N/A
CU10b	NO	NO	YES	NO	N/A	NO
CU11b	NO	NO	YES	NO	N/A	NO
CSB COMPLIANCE PERCENTAGE	82%	27%	100%	78%	100%	71%

WESTERN REGION						
Harrisonburg-Rockingham						
H1	YES	YES	YES	YES	YES	N/A
H2	YES	YES	YES	YES	NO	N/A
H3	YES	YES	YES	YES	YES	N/A
H4	YES	YES	YES	YES	YES	N/A
H5**	YES	NO	YES	YES	N/A	NO
H6**	YES	NO	YES	NO	N/A	NO
H7	YES	YES	YES	YES	YES	N/A
H8	YES	YES	YES	YES	YES	N/A
H9	YES	YES	YES	YES	YES	N/A
H10**	YES	NO	YES	NO	N/A	NO
H11**	YES	NO	YES	NO	N/A	NO
H12**	YES	NO	NO	NO	N/A	NO
H13	YES	NO	YES	YES	N/A	YES
CSB COMPLIANCE PERCENTAGE	100%	54%	92%	69%	86%	17%

Rockbridge						
R1	YES	NO	NO	NO	NO	NO
R2*	YES	NO	YES	N/A	N/A	NO
R3*	YES	NO	YES	N/A	N/A	NO
R4	YES	YES	YES	YES	YES	N/A
R5	YES	NO	YES	N/A	N/A	NO
CSB COMPLIANCE PERCENTAGE	100%	20%	80%	50%	50%	0%
OVERALL COMPLIANCE PERCENTAGE	73%	26%	77%	45%	70%	25%

KEY:
* Retired due to longevity or health
** Parent/Guardian does not want employment or CE
*** Physically or medically unable to participate

a. Authorization for employment was 3 months or more and employment start date exceeded 11 months from authorization.
b. Case Manager did not respond to interview request.
c. Individual was in community coaching; the program closed and no others in the area; CM working to find a CE program.
d. CM has referred individual for employment assessments DARS did not find her suitable for competitive employment and CM having difficulty finding a waive provider.
e. This individual is blind and has mobility issues. Although she has been encouraged to consider IDA, she is adamant that she does not want any involvement.

TABLE 2: COMMUNITY ENGAGEMENT SUMMARY							
CENTRAL REGION							
Crossroads	CE Discussed	Interest	Identified Barriers	Addressed Barriers	CE Goal	Plan to Educate	IDA Reflected
CR1*	YES	YES	YES	N/A	N/A	N/A	YES
CR2*	YES	YES	YES	N/A	N/A	N/A	YES
CR3	NO	NO	NO	NO	N/A	NO	NO
CR4	NO	YES	NO	NO	NO	N/A	NO
CR5	NO	NO	NO	NO	N/A	NO	NO
CR6**	YES	NO	YES	NO	N/A	NO	NO
CR7***	NO	NO	YES	N/A	N/A	NO	NO
CR8**	YES	YES	YES	NO	NO	N/A	NO
CR9**	YES	NO	YES	NO	N/A	NO	NO
CR10	YES	YES	YES	N/A	N/A	N/A	YES
CR11	YES	YES	YES	N/A	N/A	N/A	YES
CR12b	NO	NO	NO	NO	N/A	NO	NO
CR13b	NO	NO	NO	NO	N/A	NO	NO
CR14b	NO	NO	NO	NO	N/A	NO	NO
CR15b	NO	NO	NO	NO	N/A	NO	NO
CSB COMPLIANCE PERCENTAGE	47%	40%	53%	0%	0%	0%	27%

Southside							
S1	YES	YES	YES	YES	YES	N/A	YES
S2	YES	YES	NO	NO	NO	N/A	NO
S3	NO	YES	YES	N/A	NO	N/A	NO
S4	NO	NO	YES	YES	N/A	YES	NO
S5***	NO	NO	YES	N/A	N/A	NO	NO
S6***	YES	NO	YES	YES	N/A	YES	NO
S7**	YES	NO	YES	NO	N/A	NO	NO
S8**	NO	NO	YES	NO	N/A	NO	NO
S9	YES	YES	YES	YES	YES	N/A	NO
S10	NO	YES	NO	NO	NO	N/A	NO
CSB COMPLIANCE PERCENTAGE	50%	50%	80%	50%	40%	40%	10%

EASTERN REGION							
Colonial							
C1**	NO	NO	NO	NO	N/A	NO	NO
C2	YES	NO	YES	NO	N/A	NO	NO
C3	YES	YES	NO	NO	YES	N/A	YES
C4	NO	NO	NO	NO	N/A	NO	NO
C5	NO	NO	NO	NO	N/A	NO	NO
C6	NO	NO	YES	NO	N/A	NO	NO
C7	YES	NO	YES	YES	N/A	YES	NO
C8	YES	YES	YES	YES	NO	N/A	NO
C9	YES	YES	YES	YES	YES	N/A	NO©
C10	YES	YES	YES	YES	YES	N/A	YES
C11*	NO	NO	YES	NO	N/A	NO	NO
C12	NO	NO	YES	NO	N/A	NO	NO
CSB COMPLIANCE PERCENTAGE	50%	33%	67%	33%	75%	13%	17%

Eastern Shore							
ES1***	YES	NO	YES	YES	N/A	NO	NO
ES2**	YES	YES	YES	YES	NO	N/A	NO
ES3	YES	YES	YES	YES	YES	N/A	YES
ES4	YES	YES	YES	YES	YES	N/A	YES
CSB COMPLIANCE PERCENTAGE	100%	75%	100%	100%	67%	0%	50%

NORTHERN REGION							
Rap Rap							
RR1	YES	YES	YES	YES	YES	N/A	YES
RR2	YES	NO	YES	NO	N/A	NO	NO
RR3	YES	YES	YES	N/A	N/A	N/A	YES
RR4*	YES	YES	YES	N/A	N/A	N/A	YES
RR5	YES	NO	NO	NO	N/A	NO	NO
RR6	YES	YES	YES	YES	YES	N/A	YES
RR7**	YES	NO	YES	YES	N/A	YES	NO
RR8**	YES	YES	YES	YES	YES	N/A	NO
RR9	YES	YES	YES	YES	YES	N/A	YES
RR10**	YES	YES	YES	YES	YES	N/A	NO
RR11	YES	YES	YES	N/A	N/A	N/A	YES
RR12	YES	YES	YES	YES	YES	N/A	NO
RR13	NO	NO	YES	YES	N/A	NO	NO
CSB COMPLIANCE PERCENTAGE	92%	69%	92%	80%	100%	25%	46%

Alexandria							
A1	NO	YES	NO	NO	NO	N/A	NO
A2***	YES	NO	YES	N/A	N/A	N/A	NO
A3	YES	YES	YES	N/A	YES	N/A	YES
CSB COMPLIANCE PERCENTAGE	67%	67%	67%	0%	50%	0%	33%

SOUTHWESTERN REGION							
PD1							
PD1**	YES	NO	YES	NO	N/A	NO	NO
PD2**	YES	NO	NO	NO	N/A	NO	NO
PD3	YES	NO	YES	NO	N/A	NO	NO
PD4**	YES	NO	YES	NO	N/A	NO	NO
PD5	YES	YES	YES	YES	YES	N/A	YES
PD6**	YES	NO	YES	NO	N/A	NO	NO
PD7**	YES	NO	YES	NO	N/A	YES	NO
PD8	YES	YES	YES	YES	YES	N/A	YES
PD9b	YES	YES	YES	YES	YES	N/A	YES
PD10b	NO	NO	NO	NO	N/A	NO	NO
PD11b	YES	NO	NO	YES	N/A	NO	NO
PD12b**	YES	NO	NO	NO	N/A	YES	NO
PD13b	NO	NO	YES	NO	N/A	NO	NO
PD14b	NO	NO	NO	NO	N/A	NO	NO
CSB COMPLIANCE PERCENTAGE	79%	21%	64%	29%	100%	18%	21%

Cumberland							
CU1a	YES	YES	YES	YES	YES	N/A	YES
CU2**	YES	YES	YES	YES	YES	N/A	NO
CU3*	YES	YES	YES	N/A	N/A	N/A	YES
CU4**	YES	NO	YES	YES	N/A	YES	NO
CU5	YES	YES	YES	YES	YES	N/A	NO
CU6	YES	YES	YES	YES	YES	N/A	YES
CU7***	YES	NO	YES	N/A	N/A	N/A	NO
CU8**	YES	NO	YES	YES	N/A	YES	NO
CU9	YES	YES	NO	NO	NO	N/A	NO
CU10b	NO	NO	YES	NO	N/A	NO	NO
CU11b	NO	NO	YES	NO	N/A	NO	NO
CSB COMPLIANCE PERCENTAGE	82%	55%	91%	67%	80%	50%	27%

WESTERN REGION							
Harrisonburg-Rockingham							
H1	YES	NO	YES	YES	N/A	YES	NO
H2	YES	YES	YES	YES	YES	N/A	NO
H3	YES	YES	YES	YES	YES	N/A	YES
H4	YES	YES	YES	YES	YES	N/A	YES
H5**	YES	NO	YES	NO	N/A	NO	NO
H6**	YES	NO	NO	NO	N/A	NO	NO
H7	YES	NO	YES	NO	N/A	NO	NO
H8	YES	NO	YES	NO	N/A	NO	NO
H9	YES	NO	YES	NO	N/A	NO	NO
H10**	YES	NO	YES	NO	N/A	NO	NO
H11**	YES	NO	NO	NO	N/A	NO	NO
H12**	YES	NO	NO	NO	N/A	NO	NO
H13	YES	NO	YES	YES	N/A	YES	NO
CSB COMPLIANCE PERCENTAGE	100%	23%	77%	38%	100%	20%	15%

Rockbridge							
R1	YES	YES	YES	YES	YES	N/A	YES
R2*	YES	YES	YES	YES	YES	N/A	YES
R3*	YES	YES	YES	N/A	NO	N/A	NO
R4	YES	YES	YES	NO	NO	N/A	YES
R5	YES	YES	YES	NO	NO	N/A	NO
CSB COMPLIANCE PERCENTAGE	100%	100%	100%	50%	40%	N/A	60%

OVERALL COMPLIANCE PERCENTAGE	74%	46%	76%	43%	69%	19%	27%

KEY:

* Retired due to longevity or health

** Parent/Guardian does not want employment and/or CE

*** Physically or medically unable to participate

a. Authorization for employment was 3 months or more and employment start date exceeded 11 months from authorization.
b. Case Manager did not respond to interview request.
c. Individual was in community coaching; the program closed and no others in the area; CM working to find a CE program.
d. CM has referred individual for employment assessments DARS did not find her suitable for competitive employment and CM having difficulty finding a waive provider.

APPENDIX D.

REGIONAL SUPPORT TEAMS

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

Regional Support Team
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

November 20, 2019

Executive Summary

The Independent Reviewer for the *US v. Commonwealth of Virginia* Settlement Agreement (SA) requested a follow-up to the 2018 review of the Regional Support Team (RST) requirements of the Agreement.

During this past summer the Division of Developmental Services (DDS) again reorganized the RST process under Provider Development. Another round of change and restructuring is underway, which will include the incorporation of RST referral and tracking information into the WaMS service authorization system later this year if funding is available. A Quarterly CSB notification Letter of Compliance with RST expectations was also initiated this past summer and should, if enforced, lead to improved CSB compliance.

This study found that the problem of late referrals (after or concurrent with an individual's move) has continued after the last round (2018) of changes in RST process. The timeliness rate for FY19 statewide averaged about 71% (298/420). With late referrals, the RSTs were not able to fulfill the purposes for which they were created. When referrals were submitted by CSBs timely, the RSTs were again not always able to divert individuals from placement in group homes 5-persons or larger (GH5), nursing facilities (NF) or intermediate care facilities (ICF/IDD).

During 2018 DBHDS generated a more centralized approach to addressing service gaps and new provider development. Startup funding, called Jump-Start Funding, is one-time monies designed to encourage collaboration among providers and to stimulate the growth of needed services and supports by illustrating to providers where growth opportunities and gaps exist. In FY18 an estimated $80,000 was Jump-Start Funding was committed to providers. Year- to-date FY19 about $25,000 has been committed.

The Commonwealth is now doing Network Development and Planning as evidenced by the data captured and reported in the DDS Provider Data Summary. During the past year, waiver slots dedicated to more integrated living opportunities has increased by 8%. When an 8% concurrent decline in the use of non-integrated settings is considered, it is clear that the Commonwealth is on a positive trajectory and that the provider development activities may be acting as an accelerant.

The absence of final policies and DBHDS regulations governing services that are less restrictive and more integrated is one element that may be making some providers reluctant to expand into integrated services. A provider designation process, which allows agencies to declare/market their specialization, should make it easier for more providers to expand. In addition, an on-boarding process for providers interested in expanding into the integrated services has been initiated and will be repeated semi-annually.

Finally, a new website is under development on the Aging and Disability Resource Center website. This disAbility Navigator platform should better enable consumers to research and locate providers who can serve them, whether in the Waiver or not. It will also enable providers interested in expanding to market their availability and their specialties (via the provider designation process).

Methodology

- Reviewed RST Quarterly Reports FY19;
- Reviewed RST referrals 'dashboard' for March 2019 to July 2019;
- Reviewed DBHDS Notification Letters to CSBs re: RST compliance August 2019;
- Reviewed HCBS residential settings report, 3.31.19;
- Reviewed DBHDS data change request for WaMS/RST;
- Reviewed RST referrals/ tracking docs from May 2019;
- Reviewed Provider Designation Process, 8.2.19;
- Reviewed Jump Start Funding report, 7.24.19;
- Reviewed Provider Data Summary, June 2019;
- Reviewed DDS Provider Development Annual Report FY19;
- Interviewed DBHDS leadership responsible for RSTs.

Findings

During this past summer the Division of Developmental Services (DDS) again reorganized the RST process and placed it under Provider Development. Another round of change and restructuring is underway. This will include the incorporation of the RST referral and tracking information into the WaMS service authorization system later this year if funding is available. The electronic management of the RST information is expected to lead to improved effectiveness.

The lack of timely referrals by case managers/support coordinators, and therefore timely reviews by the RST, were problems that have been identified in each of our previous reviews and now constitutes one compliance indicator for this area (Attachment A). DBHDS reports indicate the timeliness rates statewide are as in Table I below.

Table 1
Referral Timeliness Rates across CSBs

Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	FY19 Total
65% (55/84)	65% (57/88)	70% (78/111)	79% (108/137)	71% (298/420)

DBHDS's goal last year of reducing late referrals to 20% (80% timely) has not been achieved although the trend remains positive. DDS has established the precedent this summer of transmitting to each CSB a Letter of Compliance, which contains their agency compliance rates with RST requirements. If followed up consistently and timely and enforced effectively, the Commonwealth can meet the its previously established 80% timely goal and ultimately a higher percentage needed for compliance.

The RSTs were again not always able to divert individuals from placement in group homes 5-persons or larger (GH5), nursing facilities (NF) or intermediate care facilities (ICF/IDD). Indeed, one case of a 4 month old admitted to and remaining in an ICF/IDD is discouraging, as shift-based care is known to not be best for a young developing child. Disruptions in attachment and bonding processes are fairly predictable in infants and young children who do not have consistent, continuous and stable caregiving. These disruptions often lead to the costly challenging behaviors of adults who have been raised in congregate settings with shift-based staffing. The Commonwealth may be meeting the letter of the SA by improved tracking of ICF/IDD admissions, but it is in danger of missing the spirit, intent, and goals of the Agreement.

As stated in previous reports, given the known negative effects of institutional care on young children (Skeels & Dye, A study of the effects of differential stimulation on mentally retarded children, *Proceedings and Addresses of the American Association on Mental Deficiency*, 1939, 44, 114-136. Nelson et al, (2014) *Romania's Abandoned Children: Deprivation, Brain Development, and the Struggle for Recovery,* Cambridge, MA: Harvard University Press), CSBs appear to have no policy direction that indicates the Department's preference that young children belong, and are best served in a family setting, not in institutions. The VIDES process, with its hoped for intervention and diversion role, has not been as effective as OIH has been in diverting, following and ensuring timely discharge of children in nursing facilities.

During 2018, DBHDS generated a more centralized approach to addressing service gaps and new provider development, which included geo-mapping and self-calculating data displays. It also made data and startup funding available by Region to private sector providers willing to grow the system's services. The startup funding, called Jump-Start Funding, is one-time monies designed to encourage collaboration among providers and to stimulate the growth of needed services and supports by illustrating to providers where growth opportunities and gaps exist. In FY18 an estimated $80,000 was committed. Year to date FY19 about $25,000 has been committed. The Commonwealth is now doing Network Development and Planning as evidenced by the data captured and reported in the DDS Provider Data Summary. System gaps data for services and supports (RST data) is expected to be incorporated later this year

During the past year, waiver slots dedicated to more integrated living opportunities have increased from 10,514 (3.31.18) to 11,395 (3.31.19), which reflects an annual growth rate of 8%. When the 8% concurrent decline in the use of non-integrated settings is considered, it is clear that the Commonwealth is on a positive trajectory toward more integrated services and that the provider development activities may be acting as an accelerant. However, the absence of final policies and regulations governing services that are more integrated is one element that causing provider reluctance to invest and expand into integrated service models.

A provider designation process which allows agencies to declare/market their specializations will make it easier and should encourage more providers to expand. In addition, an on-boarding process for providers interested in expanding into the integrated services (PREP – Provider Readiness Education Program) has been initiated and will be repeated semi-annually. This too should encourage and motivate more providers to engage in providing these services, regardless of the uncertainties of the regulatory environment.

Finally, a new website under development on the disAbility Navigator platform (part of the family of websites that constitutes Virginia's ADRC – Aging and Disability Resource Centers) should better enable consumers to research and locate providers who can serve them, whether they are in the Waiver or not. The disAbility Navigator website should also enable providers interested in expanding to market their availability and their specialties (via the provider designation process). DBHDS hopes this will become the go-to "one stop shop" for providers and consumers interested in services.

Recommendations:
DBHDS should follow-up and demonstrate that it can and does enforce its RST compliance requirements for CSBs.

DBHDS should require CSBs that do not achieve 85% timely submission of non-emergency RST referrals to implement a Corrective Action Plan.

DBHDS should give policy direction to CSBs that indicates the Department's preference that young children belong in families, and that affirms its commitment to the goals of the Settlement Agreement to serve children in the most integrated setting. Everything else being equal, the family is the most efficient, compassionate service delivery system, and if the child cannot live with his/her biological family, an alternative community-based arrangement that allows the child to with a family and participate in community living is preferable.

DBHDS should prioritize for policy/regulation development the integrated services.

Suggestion for DBHDS Consideration:
DBHDS should consider labeling RST referrals that are submitted after the move has occurred as a 'default' rather than a 'late' referral to distinguish intentional and strategic late submissions.

APPENDIX E.

TRANSPORTATION

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

Transportation
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

November 14, 2019

Executive Summary

The Independent Reviewer for the *United States v. Commonwealth of Virginia* Settlement Agreement requested a follow up review of the 2015 and 2018 studies of Transportation requirements of the Agreement.

Non-Emergency Medical Transportation (NEMT) in Virginia is administered by DMAS (Department of Medical Assistance Services) through a brokerage system contracted to a multi-state private sector contractor, LogistiCare, and more recently through local area managed care organizations (MCOs), which are responsible for transportation to health and behavioral health appointments. DMAS awarded a new contract to LogistiCare in July 2018.

Overlapping this contract change, six MCOs took over responsibility for transportation to medical services. However, the large majority of transportation services required by users of the IDD Waivers (80%) are still provided by LogistiCare. IDD Waiver users of LogisitiCare have averaged about 5,400 individual riders per month during 2019.

Improvements noted in this review include greater attention by LogistiCare to the regional Advisory Boards, cameras in over 500 vehicles operated by LogistiCare providers, GPS in all vehicles, complaint and survey data available from users of the IDD Waivers, Network Development Planning, reduced instances of No Vehicle Available (NVA), additional options for independence, debit card mileage reimbursement for users of the IDD Waivers, availability of a mobile app to track scheduled trips, and a transportation dashboard.

Activities that should continue or be enhanced include accountability and correction of providers/drivers performance, software development that will ultimately lead to individual vehicle tracking and real time driver ratings, tracking of driver training, vehicle safety monitoring, Extra Mile Driver incentive award program, and weekly/monthly meetings between DMAS and LogistiCare.

Quality Improvement issues remaining for DMAS and LogistiCare include more transparency in data sharing with Advisory Boards, attention to callbacks for complainants, enforcing complaint rates among providers/drivers as a quality measure, and improving on-time performance.

Introduction:
The goal of this review was again to determine if the Commonwealth has made progress towards implementing a quality improvement program in Transportation services as identified in the Independent Reviewer's Report to the Court of December 6, 2015. Transportation requirements in the Settlement Agreement include:

III.C.8.a The Commonwealth shall provide transportation to individuals HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.

Non-Emergency Medical Transportation (NEMT) in Virginia is administered by DMAS (Department of Medical Assistance Services) through a brokerage system contracted to a multi-state private sector contractor, LogistiCare, and more recently through local area managed care organizations (MCOs). Service providers of HCBS waiver-funded services also provide transportation that is secondary to the delivery of their services (i.e. residential and day services); costs are generally, but not always, included as part of their reimbursement rates. Some providers may also access mileage reimbursement directly from DMAS for individuals with extraordinary circumstances. And finally, some individuals receiving HCBS services may access DMAS funded bus passes for the use of public transportation.

In December of 2015 the Independent Reviewer requested a plan to address improvements needed "to ensure that its transportation services are of good quality, appropriate, available and accessible to the target population". DMAS subsequently issued a new Request for Proposals (RFP) and an award of a new contract was made to LogistiCare in 2018. DMAS also began in 2018 to delegate Medicaid transportation to medical services to MCOs as part of a move to managed care.

DMAS adopted and implemented four of the eight recommendations/suggestions made in the Independent Reviewer's report from December of 2015:

- Ensure more representatives of users from the IDD (Intellectual and Developmental Disabilities) Waiver are represented on the LogistiCare regional Advisory Boards;
- Analyze the LogistiCare databases using the IDD Waiver as a sub-group for assessment of their differing needs;
- Encourage the use of GPS, tablets and other technology matching drivers with users;
- Encourage LogistiCare to develop a Network Development Plan to establish at the community level gaps in transportation.

DMAS also included these as specialized requirements in the RFP and new LogistiCare contract, along with statistically valid customer satisfaction surveys from IDD Waiver users, and 'trip recovery' technology' (i.e., software designed to redirect drivers in real time when another driver is unable to make a ride).

Methodology:

- Interviewed DMAS officials;
- Interviewed LogistiCare officials;
- Communicated with parent members of Advisory Boards via phone or email;
- Reviewed Summary Report, IDD trips, MCOs/FFS, Q2 2019;
- Reviewed quarterly regional Advisory Board meeting minutes, Feb. & May 2019;
- Reviewed Customer Satisfaction Surveys for IDD users, Jan. – June 2019;
- Reviewed LogistiCare complaints logs for May 2019; complaint summaries for Jan.-Mar. & Aug. 2019:
- Reviewed monthly minutes for Care Coordination/DMAS-LogistiCare meetings, July & Aug. 2019;
- Reviewed weekly minutes for Joint Operations Meetings (DMAS-LogistiCare) April-Aug. 2019;
- Reviewed DMAS Field Monitor Weekly Reports, Apr. –June, 2019;
- Reviewed Care Coordination tracking logs for 4th Quarter, 2019.
- Reviewed *Section VIII, Quality Review and Performance Standards and Penalties – SLA*, NEMT Contract.

Findings:

Mileage reimbursement, which is critical to resolving many individual transportation problems, can now be handled via debit card for speedier reimbursement. Parent Advisory Board members were unanimous in offering this as a significant improvement in facilitating reimbursement.

DMAS/LogistiCare extracted complaint findings for the IDD Waiver population which continue to show 'provider late' or 'no show' as the most frequent issues that users call about. For example, the IDD- only data for Jan-Mar 2019 shows 2,778 complaints for 575,079 trips or 99.5% with no-complaint filed. Good measurement requires normalizing the data in a way that permits the measurement of change, which might be, in this instance, 483 complaints per 100,000 trips. Finding benchmarks to tell stakeholders, providers and internal staff whether this rate of complaints is acceptable, then involves looking at comparisons; for example, compared to the same rate among the non-DD users of LogistiCare transportation; or examining trends over time; or looking at reports on complaint data for other transportation systems (e.g., NYC taxis have averaged 10-15 complaints per 100,000 trips over the past ten years)[1] All of this must be caveated by multiple reports that suggest the actual number of complaints may be higher and is suppressed due to fears of users who complain being labeled a problem, fears of retaliation through the loss of a specific driver's services, and the conclusion that complaining does no good.

Current encounter billing data does not permit a direct measure of on-time driver performance. However, since IDD Customer Satisfaction Surveys consistently show that the most issues are with late drivers or no-show drivers and since complaints of provider late or no-show make up 75-85% of all IDD user complaints, complaint free trips is a bona fide proxy outcome measure for on-time performance. LogistiCare has trended complaint free trips as a percent of all trips for all users and reported a high of 99.89% (i.e., 0.11% with complaints) and a low of 99.67% (0.33%) during the period Jan. 2019 to Aug. 2019 and a high of 99.71% (0.29%) and a low of 99.54% (0.46%) for IDD users during the same period. Table 1 below displays the performance benchmarks for complaints established in contract for all users and the penalties applied to LogistiCare if they fail to achieve these outcomes.

[1] See Scott Walston, *The Competitive Effects of the Sharing Economy: How is the Uber Changing Taxis?* Technology Policy Institute, 2015

Table 1 Complaint Measures, Performance Standards and Penalties Applied by DMAS	
Complaints shall be 0.85% of total net (assigned less canceled) trips measured on a monthly basis	**Graduated Penalties**: 0.85% or lower=no penalty 0.86% to 0.90%=$10,000 0.91% to 0.95%=$15,000 0.96% to 1.00%=$20,000

The rates reported by LogistiCare are all well within the contract performance standards range for acceptable (no penalty) complaint rates. However, the question arises, are these rates set at higher enough of a benchmark? The issue is moot for the duration of this contract cycle.

Closer examination of complaints for one month (May 2019) surfaced about two of logistiCare's subcontracted providers who received 28 complaints about their drivers (primarily late and no-show) and were re-educated by LogistiCare staff 23 times and a third provider who received 170 complaints about their drivers in the one month. LogistiCare appears to be appropriately addressing, correcting, and/or sanctioning these outlier providers. Complaint rates for the two providers dropped by almost 50% from May to August 2019; unfortunately, the provider that was the subject of 170 complaints in May has not shown substantial improvement through August 2019 and is reportedly the subject of continuing management scrutiny, liquidated damages, etc. Providers such as these are regularly discussed in monthly and weekly meetings between DMAS and LogistiCare.

Further review also suggested that five May complaints/incidents being tracked by LogistiCare were still open and not closed by September; four of those cases appeared to involve possible abuse of the user/passenger during the trip. DMAS follow-up resulted in closure and resolution notes for four of the five cases. The fifth case remains open awaiting an APS report, and one case resulted in the termination of a driver due to a history of allegations.

Unfulfilled trips due to No Vehicle Available (NVA) have been a concern since 2015. LogistiCare's written reports to DMAS suggest recent dramatic reductions in this fundamental problem. NVA data for all users dropped from 1,882 trips in June to 102 trips in August. Only time will tell whether this is a sustainable change, but DMAS believes new program managers have made this improvement possible. This may point to the conclusion that most problems faced in transportation are amenable to quality improvement efforts. LogistiCare leadership has engaged in systematic statewide Network Planning, which has also positively impacted these outcomes.

Although MCO transportation provided to IDD Waiver users is minimal volume (20%) compared to LogistiCare, complaint data tracked by DMAS suggests that MCO complaint rates (26 per 100,000, Q2 2019) are substantially better than LogistiCare complaint rates (483 per 100,000, Q3 2019). Obviously, MCO trips are more likely to be monthly or quarterly for each rider, rather than the daily trips LogistiCare makes.

Conclusions:

DMAS and LogistiCare appear committed to addressing needed quality improvements in services to users from the IDD Waiver, and their commitment is resulting in improved outcomes, as well as metrics, for users from the IDD Waivers. If LogistiCare management's efforts are sustained, these improvements could become permanent.

However, the rate of complaints, especially for no-shows and late pick-ups, appears excessive. Regional Advisory Board member reports, and anecdotal reports from stakeholders through multiple Individual Services Review studies, suggest strongly that many users may give up after initial complaints go unresolved or may refrain from reporting complaints due to the consequences of drivers withdrawing from services. This points out the need for DMAS/Logisticare to reach out assertively to current and users to solicit feedback.

Improvements noted in this review include greater respect and attention to the regional Advisory Boards, cameras in over 500 vehicles, GPS in all vehicles, complaint and survey data available from users of the IDD Waivers, Network Development Planning, reduced instances of No Vehicle Available (NVA), additional options for independence (i.e. Lyft as a limited option), debit card mileage reimbursement for users of the IDD Waivers, availability of a mobile app to track scheduled trips, and a transportation data dashboard.

Activities that should continue or be enhanced include accountability and correction of providers/drivers performance, software development that will ultimately lead to individual vehicle tracking and real time driver ratings, tracking of driver training, vehicle safety monitoring, Extra Mile Driver incentive award program, and weekly/monthly meetings between DMAS and LogistiCare.

Issues remaining for DMAS and LogistiCare include more transparency in data sharing with Advisory Boards, attention to callbacks for complainants, enforcing complaint rates among providers/drivers as a quality measure, and improving on-time performance generally.

Recommendations toward achieving full compliance:
DMAS should formalize report closure and update timelines for complaints and incidents, particularly when abuse or neglect is involved.

DMAS should re-evaluate performance standards in the next NEMT contract, reauthorization or amendment cycle to promote a higher standard of complaint-free rides, including Unfulfilled Trips.

When LogistiCare rolls out its planned vehicle tracking software next year, DMAS should establish benchmarks for acceptable on-time performance data.

Suggestions for DMAS Consideration:
Encourage LogistiCare to add more members to the Advisory Boards who are themselves users and individuals with disabilities.

Include in its quality improvement program the gathering of more direct information from users, such as focus groups, listening sessions, etc., with users and facilities from the IDD Waiver, in order to further identify real-time problems and the root causes for their complaints.

Share liquidated damages information with Advisory Boards.

Resolve the discrepancy between LogistiCare, who reports that complainant callbacks occur if requested, and Advisory Board members, who report that callbacks following complaints do not always occur, even when requested.

Examine complaints from Advisory Board members that a) non-English speaking drivers are assigned to IDD Waiver users and b) not all drop-offs require a signature documenting a handoff of the individual.

APPENDIX F.

OFFICE OF LICENSING/ OFFICE OF HUMAN RIGHTS INVESTIGATIONS

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

Licensing and Human Rights Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

November 19, 2019

Executive Summary

At the request of the Independent Reviewer, this writer conducted a sixth review of the Office of Licensing (OL) and a fifth review of the Office of Human Rights (OHR). These entities represent the Commonwealth's primary system for ensuring the basic health and safety of individuals receiving services.

OL reports indicate that one IDD provider setting was placed on provisional status during FY19, one provider's license was summarily suspended and closed, and three providers voluntarily relinquished their licenses under scrutiny. There is no evidence that unannounced annual survey inspection frequency has diminished.

Last year OSIG (Office of the State Inspector General) conducted a review of the DBHDS incident management system. Their report resulted in the Department undertaking an overhaul of the CHRIS reporting system, its definitions, and its accessibility. Further, due to an infusion of funding additional staff, OL has created a specialized Investigations Unit and a specialized Incident Management Unit. Built on a management structure which added regional managers and other middle managers in recent years, these more recent changes are ensuring a) improved consistency in incident management, b) enhanced effectiveness at discovering patterns and trends in incident data, and c) heightened scrutiny of marginal providers.

The OHR has implemented a Case Study approach to providing source information to the Department's Risk Management Review Committee (RMRC). System improvements appear to be generated through this process giving the RMRC a path to effecting change in the service delivery system. The OHR retrospective look-behind process has continued to mature and is now on a regularized cycle of four-six month reviews with technical assistance to provider samples.

This study found that OHR has increased efforts to educate individuals receiving services as to their rights and options are evident. These efforts address the historically high rate of human rights citations in OL reports. Self-advocacy is an effective tool to minimize the occurrence of abuse, neglect or exploitation.

This reviewer continues to be encouraged by the investments and actions undertaken by the Commonwealth to improve the effectiveness of both the Office of Licensing and the Office of Human Rights. These efforts are ensuring that basic minimum quality expectations are in place.

O**ffice of Licensing**

Methodology:

- Reviewed 23 incident investigations/CAPs for May-July, 2019;
- Reviewed OSIG, *DBHDS: Review of Serious Injuries Reported by Licensed Providers of Developmental Services,* Dec. 2018;
- Reviewed *CHRIS Modifications: Changes to Serious Incident Reporting*, July 2019;
- Reviewed Quality Improvement Committee (QIC) minute, 2019;
- Reviewed Risk Management Review Committee (RMRC) minutes, 2019;
- Reviewed QIC charter, 9.5.19, and RMSC charter, 9.5.19;
- Reviewed *Project Update, The Licensure Solution….CONNECT*, 6.24.19;
- Reviewed draft OL paper, *Ensuring Adequacy of Individualized Supports*, undated;
- Reviewed OL All Staff & SIU & Managers Meeting minutes, Jan.-July 2019;
- Reviewed draft CM Checklist: V.G.3 Adequacy of Services, undated;
- Reviewed OL Regulation Compliance summary report for training citations, FY19;
- Reviewed *OL High Health Risk Investigation Checklist,* 9.24.19;
- Reviewed OL memos regarding restructuring (7.10.19, 8.10.19), reporting SIRs (6.13.19), Mortality Review 7.12.19), 90-day Operating Expenses (6.13.19);
- Reviewed *CHRIS Modifications*, July 2019;
- Reviewed Provider License Status Report, undated;
- Reviewed internal OL guidance and procedural documents that underwent revision: *Summary Suspension & Imminent Danger*, *SIR investigations, Investigations Template, Death Investigations, Complaint Investigations, Investigative Procedures, Citing CSBs, Level 1 SIR Reviews*;
- Interviewed OL leadership.

Findings:

The Office of the State Inspector General (OSIG) completed a review of the DBHDS incident management in December of 2018. This report resulted in the Department undertaking an overhaul in the CHRIS reporting system, its definitions, and its accessibility.

In addition, during the fifteenth review period, with the support of an infusion of funding, OL has created a specialized Investigations Unit and a specialized Incident Management Unit. Built on a management structure which added regional managers and other middle managers in recent years, these more recent changes are ensuring:

1) improved consistency in incident management,
2) enhanced effectiveness at discovering patterns and trends in incident data,
3) heightened scrutiny of marginal providers, and
4) more robust investigation documentation that will better withstand administrative and legal appeals.

OL trending reports continue to suggest that timely reporting of serious incidents averages fairly reliably around 90%. Table 1 recaps data from the past three years.

Table 1 **Timely SIR Reporting**		
2016	2018	2019
88%	92%	89%

This reviewer selected a sample of twenty-nine (29) CAPs from the fifty-nine (59) closed by OL in the May-July 2019 quarter. All complaints and at least one investigation from each of the twenty (20) Licensing Specialists (LS) represented in the sample were selected for additional review. This review found that providers are being cited for failure to use a root cause analysis approach in their corrective action planning, a new OL regulatory expectation. Finally, in the selected sample of 29, LS staff accepted two CAPs, which indicated the agency plan was to promise 'not do it again' rather than taking an action (e.g. staff will work to ensure the health and safety of individuals - team members will communicate to ensure the best possible care - the home has adequate staffing - each ISP will be based on individual needs). Corrective Action Plans should reflect 'actions'. Promises 'not to do it again' reflect inadequate oversight, since providers have already assured at their licensure application that they would follow all rules.

OL summary reports from FY19 indicate that one IDD provider setting was placed on provisional status, three providers voluntarily relinquished their licenses under heightened scrutiny and one provider's license was summarily suspended and closed. This 'summary suspension' of a provider license reflects OLs use of sanction tools that have previously existed, but were rarely used. It also clarified a strategy that Licensing could use effectively for more urgent citation issues.

As noted in previous reports, it is unlikely that alone, OL's use of these approaches to ensuring minimum quality standards will be sufficient for the minority of providers who deliver marginal services. OL's assignment of provisional status to a license or heightened scrutiny to result in a voluntary relinquishment of a license continue to be the most likely OL response to providers who have not been able to modify their practices pursuant to a CAP. OL reports that it is assessing the available regulatory tools to force improvements among substandard providers and to eliminate providers who have demonstrated a refusal or inability to improve their services. There are also indications the Department is anticipating additional enforcement activity by pursuing enhanced legal and hearing resources.

Finally, there is no evidence that unannounced annual survey inspection frequency has diminished. Furthermore, case management checklists are being developed by OL to include an assessment of the "adequacy of individualized supports and services" for some of the areas, i.e. eight domains, listed in V.D.3 in the Agreement. Some components require fuller detailing, but the overall thrust of the drafts is positive. DBHDS reports that for two of the areas in V.D.3. (i.e., stability and provider capacity), it will utilize data from assessments of adequacy by processes other than licensing.

Recommendation:
OL should pilot test its use of the Adequacy assessment checklists to ensure that planned and expected outcomes are achieved (i.e. completeness and consistent interpretation and application by Licensing Specialists).

Suggestions for Departmental Consideration:
OL should consider developing a Licensing Specialist's toolbox of regulatory and other interventions to deal with providers who are not performing well.

OL should consider requiring regional manager review or sign-off on CAPS to ensure continuity and completeness:

> A number of investigations resulted in citations for timely failure to report obvious serious incidents; in the future LSs and their regional managers need to consider elevating some of these 'failure to timely report' to 'failure to report', which may indicate more deliberate omissions.
>
> A number of complaints triggered investigations, which do not include information as to whether the original complainant received a callback at closure. At closure LSs should note if original complainant was notified of closure and if not, why not. Alternatively, a written acknowledgement by OL to the complainant of the complaint's receipt, noting timelines and where follow-up information can be found, would be appropriate.
>
> A number of investigations resulted in citations for failure to maintain documentation about background and registry checks; in the future LSs and their regional managers need to consider elevating some of these 'failure to maintain documentation' to 'failure to conduct background and registry checks', which endangers the safety of those served.

Office of Human Rights

Methodology:

- Reviewed all allegations of sexual assault during May 2019;
- Reviewed DMAS Claims Data, May 2019 (Z04.41, T74.21XA, T76.21XA);
- Reviewed OHR Project: *Improving the Education & Understanding of Human Rights*, July 2019;
- Reviewed OHR Protocol 139*: A.I.M.,* March 2019;
- Reviewed OHR Protocol 143: *APS/CPS Tracking*, 6.24.19;
- Reviewed OHR Community Look Behind Report, July 2019;
- Reviewed OHR Case Reviews submitted to RMRC, 7.23.19, 8.20.19;
- Reviewed OHR summary report on A-N-E during FY18 and FY19, undated;
- Reviewed OIH training: *Falls – Review of Prevention Strategies*, undated, OIH *Falls Prevention Safety Alert*, Sept. 2019;
- Interviewed OHR leadership.

Findings:

OHR receives all initial reports of abuse-neglect-exploitation injury through the CHRIS electronic reporting system. Most investigations are carried out by the originating provider. Provider investigations are submitted to OHR for review and closure.

The OHR retrospective look-behind process for provider investigations has continued to mature and is now on a regularized cycle of four-six month review and technical assistance to provider samples. Technical assistance efforts to improve the quality of provider investigations are provided by the OHR regional advocates at the time of the look-behind. The OHR look-behind is a well-done, quality review which has become increasingly effective at discovery and remediation efforts.

OHR trend reports indicate that significant numbers of providers are continuing to have timely reporting problems and are failing to archive evidence from investigations. OHR also surfaced the practice that many providers shred written eye witness statements and reports of serious incidents or injury after the information is entered into CHRIS. This is an exceptionally poor practice by providers due to the need to file evidence with the investigation for follow-up, employee corrective actions, potential future litigation, etc.

OHR also implemented this year a best practice Case Study approach to providing source information to the Department's Risk Management Review Committee (RMRC). System improvements appear to be generated through this process giving the RMRC a path to effecting change in the service delivery system. For example, the RMRC has initiated efforts to clarify when CPR should be initiated by DSPs, as well as the timing of 911 calls.

In addition, at the urging of the State Inspector General, the RMRC sponsored provider training through OIH on falls prevention to those agencies that had reported at least one fall in the preceding month. Fifty-seven (57) agencies were offered the training in August-September. This training will continue monthly for the foreseeable future.

The fidelity of incident reporting was tested this cycle by reviewing all sexual assault allegation reports in CHRIS during the month of May 2019, and then cross-checking against May DMAS claims data for medical codes representing sexual assaults, usually in hospital

emergency rooms. Two sexual assault medical claims were paid by DMAS in May; corresponding reports to DBHDS were made in May via CHRIS – one that OHR reviewed and one that OL reviewed. The latter case was handled by OL because the alleged perpetrator was not an agency employee. Although a small sample, this assessment gives some assurance about the consistency of provider reporting, even if timeliness remains an issue.

Finally, efforts have been launched by OHR to a) educate individuals receiving services as to their rights to be free of from abuse, which addresses the historical high rate of human rights citations in OL reports; b) enhance follow-up and closure monitoring procedures for high priority cases, including sexual assaults, restraints, and physical abuse with injuries; these additional procedures should improve the verification and closure of investigation recommendations; and c) develop tracking mechanisms to better record and follow-up on reports transmitted from APS/CPS (Adult/Child Protective Services).

Recommendation:
OHR should issue instructions that clarify the period of time eyewitness statements and reports of serious incidents must be retained with the incident investigation file by the provider.

Suggestion for DBHDS consideration:
OHR should consider periodically conducting focus studies on topics of interest, such as fidelity checks against DMAS medical claims.

Attachment A
Settlement Agreement Requirements for OL and OHR

V.C.2. The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken. The Commonwealth shall be required to implement the process for investigation and remediation detailed in the Virginia DBHDS Licensing Regulations … and shall verify the implementation of corrective action plans required under these Rules and Regulations.

V.C.3. The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken. The Commonwealth shall be required to implement the process for investigation and remediation detailed in the Virginia DBHDS Licensing Regulations (12 VAC 35-105-160 and 12 VAC 35-105-170 in effect on the effective date of this Agreement) and the Virginia Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DBHDS Human Rights Regulations" (12 VAC 35-115-50(D)(3)) in effect on the effective date of this Agreement, and shall verify the implementation of corrective action plans required under these Rules and Regulations.

V.C.6. If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider pursuant to the DBHDS Human Rights Regulations (12 VAC 35-115- 240), the DBHDS Licensing Regulations (12 VAC 35-105-170), Virginia Code Section 37.2-419 in effect on the effective date of this Agreement, and other requirements in this Agreement.

V.G.1 The Commonwealth shall conduct regular, unannounced licensing inspections of community provider serving individuals receiving services under this Agreement.

V.G.2 Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals under this Agreement, including:

a. Providers who have a conditional or provisional license;
b. Providers who serve individuals with intensive medical and behavioral needs as defined by the SIS category representing the highest level of risk to individuals;
c. Providers who serve individuals who have an interruption of service greater than 30 days;
d. Providers who serve individuals who encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;
e. Providers who serve individuals who have transitioned from a Training Center within the previous 12 months; and
f. Providers who serve individuals in congregate settings of 5 or more individuals.

V.G.3. Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.

APPENDIX G.

MORTALITY REVIEW

To: Donald Fletcher, Independent Reviewer
From: Wayne Zwick, MD
Re: Mortality Review
Date: 11/19/19
Re: Review of the Mortality Review requirements in the Settlement Agreement, U.S. vs. Commonwealth of Virginia

This is the report of the 15th review period assessment of the status of the Commonwealth's planning, development, and implementation of the mortality review committee membership, process, documentation, reports, and quality improvement initiatives to comply with the mortality review provisions of the Settlement Agreement. The review encompasses nearly a full year of progress and change (October 2018 through August 2019).

Methodology

The findings and conclusions of this review are based on information obtained during interviews with administration and staff from DBHDS: Alexis Aplaska, MD, FAAP, Chief Clinical Officer; Patricia Cafaro, DNP, FNP-BC, Co-Chair of MRC, Mortality Review Clinical Manager; Robert Rigdon, RN MRC Reviewer, Susan Moon, RN, BSN, Care Consultant, Integrated Health Services; Whitney Queen, MRC Coordinator.

Additionally, the following documents were submitted for review during this review period:

Mortality Review Meeting Minutes: 10/18/18, 10/25/18, 11/15/18, 11/29/18, 12/13/18, 01/03/19, 01/17/19, 01/31/19, 02/14/19, 02/28/19, 03/14/19, 03/28/19, 04/04/19, 04/18/19, 05/02/19, 05/23/19, 06/13/19, 06/27/19, 07/11/19, 07/25/19, 08/08/19, 08/22/19.

For the above listed meetings, MRC Agenda, Sign-In Sheet, MRC minutes, the DBHDS Mortality Review Form/ Mortality Review Presentation Form for each individual reviewed.

Compliance Indicator Table – Mortality Review Committee (DBHDS revised V.C. proposal 8/27/19)
Annual Mortality Report: SFY 2018
Mortality Review Committee Charter September 2019, QIC approved September 5, 2019
Tracker Database SFY17 Death
Tracker Database SFY18 (July 2017-June 2018) Deaths
Tracker Database SFY19 Shell
MRC Action Tracking Log – Pending
Final Fall Prevention Presentation
September 2019 newsletter (OIH)
Falls Prevention Health and Safety Alert
MRC Process Flow Chart

Note: Documents submitted during prior review periods, which were used as baseline and reference information in interpreting the content of the above and progress of DBHDS in meeting the requirements of the SA, are included in the Attachment following this review.

Settlement Agreement Requirement

V. Quality and Risk Management System, C. Risk Management

> *3. The Commonwealth **shall have and implement a process to investigate reports of** suspected or alleged abuse, neglect, critical incidents, or **deaths and identify remediation steps taken**. The Commonwealth shall be required to implement the process for investigation and remediation detailed in the Virginia DBHDS Licensing Regulations (12 VAC 35-105-160 and 12 VAC 35-105-170 in effect on the effective date of this Agreement) and the Virginia Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DBHDS Human Rights Regulations" (12 VAC 35-115-50(D)(3)) in effect on the effective date of this Agreement, and shall verify the implementation of corrective action plans required under these Rules and Regulations.*

Findings

The following background review provides the baseline context for the changes and progress which have occurred in the mortality review process.

The DBHDS Annual Mortality Report for January 1, 2015 - June 30. 2016 outlines the process that it developed for mortality reviews. It also describes the population to be reviewed. The intent of the DBHDS mortality review process includes a review of deaths "of all individuals in training centers and individuals with developmental disabilities for whom a DBHDS licensed provider has direct or indirect oversight responsibility." The purpose of the DBHDS mortality review includes the following areas:

- identify immediate safety issues … requiring action … to prevent deaths, poor health outcomes, injury, or disability in other individuals served.
- Identify early warning signs in the change or deterioration of an individual's medical condition that may help to prevent other negative outcomes.
- Identify conditions contributing to an individual's death to determine if changes are needed to prevent negative outcomes in other individuals.
- Identify system trends or patterns that will serve as the basis for initiatives to improve the quality of care.
- Direct training needs to programs and services that serve individuals who are at high risk of injury, illness, or death.

The role of the Mortality Review Committee includes:

- Review individual deaths to identify safety issues that require action to reduce the risk of future adverse events.
- Analyze mortality data collected by DBHDS to identify trends, patterns, and problems at the individual service delivery and system levels.
- Recommend quality improvement initiatives to reduce mortality rates.

Providers of community-based licensed settings are required to report deaths to the Office of Licensing within 24 hours. Deaths in the Training Centers are expected to be reported to the DBHDS Central Office within 12 hours. The DBHDS process is designed to include a clinical review of all information available about the death and presentation of a summary of findings to the Mortality Review Committee. Based on this summary and other available information, the MRC categorizes the death as expected or unexpected. Based on the review, one or more action steps may occur:

- Request additional information
- Communication of identified issues to the provider
- Issuance of a Safety and Quality Alert to providers regarding an identified risk
- Establish a subcommittee to study or to take action regarding an identified risk
- Make recommendations to the Quality Improvement Committee to reduce the risk of death.
- Take other actions not further specified.

The DBHDS Mortality Review Committee is designed to provide these outcomes (findings, recommendations, etc.) to the Quality Management Committee and to the Commissioner for review and action.

The mortality review process during phase 1 of the eleventh review period was similar to the process outlined in 'DBHDS Annual Mortality Report 2014, except that the 2014 report indicated that the reviews were to occur within 90 days of the death. DBHDS subsequently removed this requirement from its next annual report. Additionally, the 'Mortality Review Committee Operating Procedures 2017 included the following statement: "If within the 90 day period sufficient information is not available to make a determination about the death, the case shall be closed and the minutes of the Mortality Review Committee shall document the lack of information." This guidance was intended to satisfy the SA requirement of completing of mortality reviews within 90 days of death, but did not focus on fulfilling the SA requirement to complete quality reviews to determine the necessary steps to ensure the health and safety of individuals – and to "reduce mortality rates to the greatest extent possible". The Departmental Instruction 315 (QM) 13 draft of 10/2017 included two statements which approached the requirements of the Settlement Agreement. Under '315-7 Procedures - Central Office Developmental Disability Mortality Reviews', documentation indicated: the mortality review shall be initiated within 90 days of the death." and later in this section: "The …Mortality Review Committee shall meet as often as necessary to ensure that the deaths of all individuals with a developmental disability are reviewed within 90 days of death." Although this indicated improvement in the understanding of the timeliness of mortality reviews, the wording suggested need for further review to accommodate the commitment made in the SA. The SA states clearly the requirement that the mortality reviews will be <u>completed</u> within 90 days with a report prepared and delivered to the DBHDS Commissioner.

A document entitled "Standard Operating Procedures for the DBHDS DD Mortality Review Committee", prepared 6/12/18, included several procedures which provided timelines for obtaining information for the mortality review; this would theoretically improve the timing of the completion of the mortality reviews to meet the requirements of the SA. DBHDS created and filled a new position (MRC Coordinator) which is responsible for preparing the annual calendar with specific due dates to meet the mortality review deadlines. A 'Master Document Posting Schedule' allows the tracking of documents, and a late documents log was created to track documents from all offices/department not received by the document posting deadline which was 60-69 days from the date of death. Once all

documents have been posted, the MRC Reviewer is notified in order for the review to begin. Required documentation of the content of the MRC proceedings is listed. The MRC Coordinator then takes recommendations made by the MRC and tracks them for completion on the "MRC Action Tracking log." The Standard Operating Procedures provided clarity to the process, as well as due dates to assist the MRC in reviewing deaths in a timely manner consistent with the SA requirement. Data on the impact of these ongoing procedures on timely completion of the mortality reviews will be provided later in this document.

DBHDS is in the final steps of revision of the Mortality Review Committee Charter, which was approved by the QIC on 9/5/19, and is pending approval by the Virginia Attorney General's Office. This charter appeared to be in response to the parties' discussions of compliance indicators, as a prior charter had not been submitted for prior review periods. Prior description/purpose of the Mortality Review Committee, however, had been described in the DBHDS Annual Mortality Reports. According to the proposed charter, the scope of authority focuses on monitoring and data analysis for identification of trends with recommendations to promote health, safety, and well-being of the individuals who received licensed service by DBHDS at the time of death. A case review is followed by MRC discussion and conclusion as to the cause of death; whether death was expected; whether death was preventable; relevant factors impacting the death; other findings affecting the health, safety and welfare of the individual; and potential actions/recommendations/ interventions to reduce identified risks. Components of the charter also include sections on the culture of quality, frequency of meetings, leadership responsibilities, standard operation procedures, voting and advisory membership, definition of quorum, and finally definitions of categories of death (expected/unexpected, unknown, other cause, and potentially preventable).

The following review of submitted documents and summary of interviews with DBHDS administrative staff provides an evidence-based synopsis of the quality, scope, and completeness of this process, as of September 2019, the final month of the Settlement Agreement's fifteenth review period.
The following data are derived from the contents of several years of Mortality Review Committee minutes:

Table 1 - Mortality Review Committee Cases - Outcomes – Pending

Calendar Year**	# Cases Reviewed	Outcome pending	Outcome blank	Pending resolved	Action steps/alerts, etc.
2015	307	48	15	31	75
2016	295	9	57	4	80
2017* (Jan-Mar)	50	2	9	0	23
2017 (Apr-Sep)	91	8	3	5	52
Oct 2017-August 2018	243	26	7	25	125
Oct 2018-August 2019	351	1	0	31	64*

*A list of alerts which were developed during the current review period from OIH were not submitted, hence this number may be inaccurate. There were at least 63 action steps listed through the MRC meeting minutes. One example of an action alert was submitted.
** Note: not all rows include data for a full year

Currently, an RN reviewer or the Mortality Review Clinical Manager completes a clinical review and summarizes findings on a standardized form (DBHDS Mortality Review Form). This information is then presented to the MRC. Since the information obtained from this review is sufficiently complete, when the requested documents are submitted and reviewed, this clinical review process has minimized the number of pending cases. Pending cases are often focused on providing additional information from other members of the MRC. (Office of Licensing, Community Integration, etc.). The current MRC process continues to be focused on gathering a standard packet of information and completing a review of this information in a timely manner (discussed in more detail later in this report). To reduce the backlog of reviews and ensure compliance with review by the MRC within 90 days of death, the review process included categorizing deaths into two tiers, with one tier which included review of the death by the Chair or Co-Chair of the MRC but not needing full MRC review (cause of death clearly identified, no quality of care, concerns, no corrective action plans as determined by the Office of Licensing, no lapse in care, and not considered potentially preventable), and a second tier in which all other deaths are brought to the MRC for discussion. This was a much more efficient review process compared to that noted in prior review periods. The current process has improved the rate of quality reviews within 90 days of death in which most reviews were not compliant at the start of the review period to being in compliance by the end of the review period.

In the past, the MRC process lacked a structure or process to rapidly review unexpected deaths. The Office of Licensing did not have the staff with sufficient clinical training and experience to rapidly identify safety issues that required immediate action to reduce the risk of future adverse events.

In the past, DBHDS was provided legal counsel guidance that only the DBHDS Office of Licensing has the authority to review another individual's records in the home. A prior Action Tracking Report July – Sept 2017 reflected this information. Additionally, a prior submitted document, the 7/19/17 MRC minutes indicated the need to discuss criteria for Licensing Specialists to use to determine if medical consultation is needed "to determine if other individuals in the home may be at risk." Although, providing clinical consultation rapidly to Licensing Specialists, when needed, could provide a rapid review that ensures the health and safety of housemates, there was no documentation that any action had been taken to implement this recommendation in prior reviews. The concern was that without the appropriate training and experience, Office of Licensing staff did not expand the review to include other individual's records in the home, nor focus on critical medical and nursing concerns.

Progress has been made in this area. The Office of Licensing has an Incident Management Team and an Investigation Team that work together to rapidly identify and resolve health and safety concerns in the provider systems. Discussion with the MRC support staff indicated the Office of Licensing now had a nurse or was in the process of recruiting a nurse to provide guidance in determining critical clinical concerns identified by the licensing staff. Although these steps were not verified with the Office of Licensing, a nurse on staff would provide quality guidance when urgent clinical concerns are determined by the licensing staff and a rapid response team approach would ensure others in the home are safe. Additionally, the Office of Integrated Health remains an informal nursing resource to the Office of Licensing for additional questions and concerns. The OIH focuses on technical assistance.

Settlement Agreement Requirement

V. Quality and Risk Management System, C. Risk Management

5. The Commonwealth shall ***conduct monthly mortality reviews for unexplained or unexpected deaths*** *reported through its incident reporting system. The Commissioner shall establish the monthly mortality review team, to include the DBHDS Medical Director, the Assistant Commissioner for Quality Improvement, and others as determined by the Department who possess appropriate experience, knowledge, and skills. The team shall have* ***at least one member with the clinical experience to conduct mortality reviews*** *who is otherwise* ***independent of the State.***

Table 2. - Expected vs Unexpected Deaths				
Year of MRC review**	**Total**	**Expected deaths**	**Unexpected deaths**	**Blank/unknown**
2013*	179	56	123 (68.7%)	
2014	226	75	151 (67.8%)	
2015	290	92	198 (68.3%)	
2016	325	109	212 (65.2%)	4
2017 (Jan-Mar)	50	17	28 (56%)	6
2017 (Apr-Sep)	91	25	61 (69%)	5
2017-18 (Oct-Aug)	243	91	144 (59%)	8
2018-19 (Oct-Aug)	351	167	178 (51%)	6

*From 2014 Annual MRC Report DRAFT

** Note: not all rows include a full year

Table 2 reviews the decisions by the Mortality Review Committee as to the categorization of each death reviewed as expected or unexpected. The average of unexpected deaths as a percentage of total deaths during the most recent period reviewed has declined by 8% as a percentage of total deaths from the prior review period.

The MRC has defined criteria for a potentially preventable death and has begun to collect data on potentially preventable deaths. The MRC determined that 3.7% of deaths reviewed were potentially preventable. However, the challenge is lack of information for several of the deaths. For 14.2% of the deaths, whether the death was potentially preventable or not could not be determined and was labeled as 'unknown'. Based on this large category of 'unknown', the range of preventable deaths was 3.7 - 17.9%.

Table 3 Mortality Review Committee Meetings		
Year	**# meetings**	**Months without meeting**
2015	12	Jan, Aug, Sept
2016	19	Apr, May
2017 (Jan – March)	5	None (all months had meetings)
2017 (April-Sept)	14	None (all months had meetings)
2017-18 (Oct-Aug)	32	None (all months had meetings)
2018-2019 (Oct-Aug)	22	None (all months had meetings)

DBHDS held at least one Mortality Review Committee meeting each month since June 2016. For the current review period (October 2018 through August 2019), there were 1 – 3 MRC meetings per month.

Table 4 Mortality Review Committee Meeting Attendance		
Year	**Attendance range at meetings**	**Average attendance**
2015	5-10	7.4
2016	6-12	7.5
2017 (Jan – March)	8-11	9.0
2017 (April – Sept)	7-10	8.5
2017-18 (October-August)	5-11	8.5
2018-19 (October-August)	8-13	10.6

Attendance at the Mortality Review Committee has increased due to the participation of other stakeholders and agencies, which provided additional expertise to the MRC (Office of Licensing, Medical Assistance, Pharmacy (DBHDS Chief Psychopharmacologies), Office of Human Rights, etc.). The increased average attendance rate during this review period improves the quality of the reviews, as well as the ability to resolve pending cases in a timely manner.

Table 5 Mortality Review Committee Member Expertise and Affiliations										
Year	**MD**	**NP**	**Clinical nurse**	**Admin nurse**	**Psych/ beh/ mental health**	**Data analyst**	**QA/QI/ risk mgmt.**	**Licensing**	**Other**	**No info**
2015	2	NR	2		2	2	2		1	6
2016	1	NR	4	2	1	2	3	2	2	3
2017 (Jan-Mar)	1	NR	2	2	1	2	2	1	2	1
2017 (April-Sept)	1	NR	4	2	1	2	4	2	5	0
2017-18 (Oct-Aug)	2	1	2	3	0	3	5	3	6	0
2018-9 (Oct-Aug)	2	2	2	2	0	4	3	6	6	0

The MRC meeting minutes continue to include the name of each attendee, along with the affiliation/ department which each represents. In the past, this important clarification was located in a separate document entitled 'Mortality Review Committee, membership/participation'. This information currently is located in each MRC minutes document for ready reference, if needed. This improvement is currently sustained, and reflected in the Table 5 above, as there was information concerning degree, and title/department designee for each participant. During the most recent period reviewed (October 2018 – August 2019), this information continued to be available in the minutes for each attendee.

It was noted that during the time period of this review (October 2018 through August 2019), the Chief Clinical Officer (MD) attended 18 of 22 (82%) MRC meetings. This was an improvement over the prior review period in which only 9 of 32 (28%) MRC meetings were attended by a physician. Additionally, the DNP co-chair/ Mortality Review Clinical Manager of the MRC attended 100% of the 22 MRC meetings during this review period.

DBHDS reported that the MRC has recruited "at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State." This position and role has changed 3 times during the current review period. The position was filled by an independent nurse practitioner from October 2018 through December 2018 (5 MRC meetings). This DPN then became a state employee with DBHDS, and has since been named co-chair and Mortality Review Clinical Manager of the MRC. There was no independent practitioner from January through April 2019. In May and June an independent NP attended 2 of 4 MRC meetings. An MD independent of the state has attended 4/4 MRC meetings in July and August 2019. In summary 11 of 22 (50%) MRC meetings have had an independent practitioner in attendance during the 15th review period, Currently, this position is filled and meets the requirements of the SA. Evidence of ongoing participation of an independent practitioner member on the MRC will be needed to ensure compliance.

Settlement Agreement Requirement

V. Quality and Risk Management System, C. Risk Management 5.
Within ninety days of a death, *the monthly mortality review team shall:*

(a) review, or document the unavailability of:
(i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death;
(ii) the most recent individualized program plan and physical examination records;
(iii) the death certificate and autopsy report; and
(iv) any evidence of maltreatment related to the death;
(b) interview, as warranted, any persons having information regarding the individual's care; and

Table 6 Mortality Reviews Completed within 90 days			
Year	**Within 90 days**	**Exceeds 90 days**	**% compliance**
2014	123	103	54%
2015	71	216	24%
1/1/2016-6/30/2016	37	127	23%
7/1/2016-12/31/2016	1	107	1%
1/1/2017-3/31/2017	1	72	1%
4/1/2017-9/30/2017	1	64	2%
10/01/17-8/31/2018	0	241	0%
10/1/2018-8/31/2019	155	207	43%

The process for timely completion of the mortality reviews has improved during the current review period. A process of a two tier review (previously described) has resolved the backlog and allowed for ongoing compliance with completion of MRC reviews within 90 days of death. During the prior reporting period, reviews did not occur until 4 to 6 months following the death of the individual. **For the current review period of October 2018 through August 2019, compliance was 43%. However, for the most recent 3 months of the review period (June through August 2019), compliance was 92% (90 of 98 deaths reviewed within 90 days).** If sustained in the next review period, compliance will be demonstrated.

Table 7 Mortality Review Committee Information Reviewed												
YR	**# cases**	**Progress notes**	**Med rec**	**Drs' notes**	**Nurses notes**	**IRs**	**ISP**	**Mal tx data**	**PE record**	**Death cert**	**Licensing data**	**Interview data**
2014	226	NR	0	0	0	0	0	0	0	4	NR	0
2015	289	NR	1	1	1	289	3	40	0	2	NR	0
2016*	164	NR	1	1	2	161	2	39	1	15	NR	3
2017**	108	NR	17	15	6	93	23	29	14	6	NR	4
2017***	138	NR	58	29	36	137	76	4	44	21	NR	0
2017-18^	243	231	NR	17	30	235	232	4	63	66	NR	0
2018-19^^	351	331	NR	88	87	251	329	4	103	121	187	0

*1/1/2016-6/30/2016, **7/1/16-12/31/16, ***1/1/17-6/27/17, ^Oct2017-August2018, ^^ Oct 2018-August 2019

There has been continued tracking of the timeliness of submitted required documentation by the MRC coordinator. This has allowed improvement in the quality and efficiency of the review.

Previous reviews found that the content of the Mortality Tracker database for all years reviewed included significant gaps in the availability of important information. Many of the columns were blank. The 2014 Mortality Tracker did not enter that Incident Reports were reviewed, when it would be difficult to review deaths without this essential information. The Mortality Tracker did not appear to capture information that was available to DBHDS. DBHDS also had access to the majority of the documents listed in the tracker for deaths at the Virginia Training Centers, as well as some information obtained through licensing reviews, but the MRC tracker database indicated that this information was

not available for the MRC reviews. In 2015, an Incident Report was submitted for every death, but this 100% compliance declined to 86% during the first quarter of 2017. A further clarification was needed in the MRC Tracker to understand the availability of maltreatment data. For this subject category, it was not clear whether the correct interpretation of the entry "no" meant that no data were collected, or that data were collected but indicated no maltreatment, two very different interpretations. In the review period ending in September 2017, additional changes and significant improvement were noted. DBHDS data analysts had created systems to review the data for completeness, accuracy, and consistency. To improve the completeness and integrity of the data available, DBHDS decreased the number of staff with privileges to enter/edit data, streamlined the review process, and added a layer of review to insure data reliability. There remained a need for definitions for each data field.
Additionally, DBHDS created a list of documents needed for the review of unexplained or unexpected ID/DD deaths during the review period 2016-17, with significant improvement in the availability of documents needed to complete a quality mortality review (reflected in the 2017 Mortality Review Tracker). The Office of Licensing obtained these documents for their own reviews and forwarded copies to the MRC nurse reviewer. This list, entitled 'Office of Licensing – DBHDS ID/DD Death Mortality Review Committee Required Documents/Reviews,' included 10 document categories (medical records for the 3 months preceding the death, physician case notes for 3 months preceding the death, nurse notes for 3 months preceding the death, most recent ISP, PCP assessment, quarterlies, other daily documentation, MARs, discharge summary, most recent physical exam, case management notes, any evidence of maltreatment related to the death, and, if available, autopsy reports and death certificates). Additionally, the MRC requested brief information as to any licensing issues (i.e., corrective action plans, and licensing investigation summary report). To collect complete documentation in a timely manner, MRC established posting periods (i.e., dates when documents and shared information must be posted), the meeting date when the MRC review is scheduled and the deadline for documentation to be available. The MRC posting schedule template included special status (individual resided in a state facility, SNF, etc.), and the identification of any offices that would potentially contribute to the document collection (i.e., licensing, community integration, integrated health services, etc.). The headings in the "Information Reviewed" (Table 7 above) above identify some of the documents that are required for review by the nurse reviewer.

In the prior review period (October 2017- August 2018) there was one part-time nurse reviewer. A part-time position for an MRC coordinator was also filled. The MRC coordinator position is responsible for ensuring the efficiency of the MRC process from collection of documents to recording and tracking of follow through of recommendations to completion. During this review period, the MRC coordinator position has been expanded to a full-time position (as of July 2019), and the part-time nurse reviewer position continues. The Co-Chair of the MRC assists in the nurse reviewer duties when that staff member is not available.

The Mortality Review Presentation Form was updated to the DBHDS Mortality Review Form during the current review period to ensure that all essential components are reviewed and succinctly documented. Such areas include demographic information, providing a narrative/ timeline of events, listing pertinent diagnoses and medications prescribed, completing a checklist of concerns/issues identified by the nurse reviewer, and determining whether required/requested documents were received, and separately whether these same documents were reviewed, whether hospice services were used, presence of advance directives, death certificate information, category of death (expected, preventable), whether a Corrective Action Plan had been issued and initial review date by the MRC and closure date by the MRC. In the past, a 'progress notes' category of documents received did not further break down the source of these notes (physician, nurse, QIDP, etc.). This has been resolved with the current form,

in which physician and nurse notes are separately tracked. Additionally, whether 3 months of documents per category are received (when applicable) is part of the template of the updated Mortality Review Form.

The ongoing process for preparation of documents for MRC review remains the responsibility of the MRC coordinator. A flow chart of the mortality review process was provided, which included the timing of communication with licensing, and other MRC participants. The flow chart includes the steps in preparation for the MRC, as well as actions to be taken based on decisions by the MRC (recommendations), with final closure of the process for each mortality review. An MRC Tracking Log is maintained until all recommendations are resolved. It appears to be a complex and thorough process, with the MRC Coordinator tracking each step in the process, with many steps occurring simultaneously. The success of this process is summarized by the findings in this report, specifically compliance with Settlement Agreement requirements, and compliance with the proposed indicators. That there has been significant advancement toward compliance in many areas indicates this process is effective and efficient.

Additionally, in the past only a few informal interviews were conducted, and MRC members did not have the authority to call case managers. However, this process has currently changed, and members are now able to conduct interviews.

Table 8
Mortality Review Committee
Documents reviewed (Part II)

Year	# Cases	CM Progress notes	Med Record	Doctor's notes	Nurses notes	Incident Reports	ISP	Physical Exam record	Death Certificate
2014	226	NR	0	0	0	0	0	0	4
2015	289	NR	1	1	1	100%	3	0	2
2016*	164	NR	1	1	2	98%	2	1	9%
2017**	108	NR	16%	14%	6%	98%	21%	13%	6%
2017***	138	NR	42%	21%	26%	99%	55%	32%	5%
2017-18^	243	95%	NR	7%	12%	97%	95%	26%	27%
2018-19^^	351	94%	NR	25%	25%	72%	94%	29%	34%

*1/1/2016-6/30/2016, **7/1/16-12/31/16, ***1/1/17-6/27/17, ^October 2017-August 2018, ^^ October 2018-August 2019

The MRC process has had continued challenges in data collection, especially in regards to medical information. Interpretation of privacy and confidentiality regulations by nursing homes, hospitals, etc., have not allowed access to clinical information in several cases. The CCO indicated legislation is being introduced to resolve this problem. In the meantime, the MRC has made advances in improved access to MD and nursing notes, and has maintained ability to receive copies of ISPs and QIDP progress notes. For 29%, the most recent physical exam was available, and for 34% death certificate information was available. There was a change in how incident reports are recorded in the MRC document folder. For the current review period, all deaths were followed by an incident report. However, the MRC requested information as to whether the individuals had other recent incident reports prior to death. The date was not reported when the change in recording this information occurred. As this statistic is in a transition phase, it cannot be interpreted during this review period. The 72% data point reflects the earlier data of the incident report availability for each death and the later data when this reflected additional incident reports during the months prior to death.

The Office of Licensing staff continues to obtain the majority of copies of the documents needed and a copy is provided to the MRC staff for review.

Settlement Agreement Requirement

V. Quality and Risk Management System, C. Risk Management

(c) ***prepare and deliver*** *to the DBHDS Commissioner a* ***report of deliberations, findings, and recommendations, i****f any.*

As background information, DBHDS finalized and published the annual report 'Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 – June 30, 2016. This "Annual Report", which included an eighteen-month period, included a review of available MRC data, analysis and a summary of findings. The Report also included several recommendations that were based on MRC findings and which provided direction for future initiatives. The MRC, however, did not include information in its "Annual Report" or in the Mortality Review Committee Tracking document to indicate what action steps have been taken (the Safety Alerts, the assistance/action steps taken in response to deaths in the provider agencies, etc.) to implement MRC's recommendations. The "Annual Report" did not prioritize needs that the DBHDS Commissioner should consider to facilitate implementation and completion of the MRC recommendations.

During a prior review period (October 2016-August 2017), a document was provided entitled 'Mortality Review Committee Quality Improvement Plan March 2017', in which, the MRC listed 8 goals that were based on the recommendations in the "Annual Report". Each of the goals had from one to eight action steps to be completed in order to achieve the goal. The plan included the office responsible for implementing the actions and the date when the action was expected to be completed. This "Improvement Plan" indicated that two of the action steps for one of the goals had been completed. An updated version, entitled 'Mortality Review Committee: Quality Improvement Plan Calendar Year' was subsequently provided. At the time of the November 2017 review, DBHDS reported progress on 3 of the goals, with dates of completion of one or more steps. No progress was reported to have been made on the implementation of any of the action steps listed for 5 other goals. A separate column entitled 'Notes/ Updates/ A DBHDS. Revisions' indicated that DBHDS was taking actions to implement 4 of these other 5 goals.

During the prior review period of Oct 2017 through August 2018, DBHDS released its third annual mortality report (The Annual Mortality Report for July 1, 2016 – June 30, 2017). Aggregated data included causes of death, causes of the 'other ' category of death, percent of deaths considered expected vs unexpected, use of hospice care, along with several other demographic indicators. There was a section which reviewed follow-up of recommendations from the prior SFY 2016 Report. Nine recommendations were listed, and progress or lack of progress was reported on each. The report included progress in 5 of these recommendations at the time of the final report. Also listed were several accomplishments of DBHDS, including development of several educational Alerts, listing the monthly educational meetings conducted by the Office of Integrated Health, a detailed process to obtain documents for review in a timely manner, as well as development of a standardized written format in presentation of death reviews at the MRC, expanding additional information collected for tracking and trending data analysis (such as safety, delay in action, regulations cited, missing/failed equipment, communications breakdown, lack of follow up, failure to provide care, etc.).

In September 2019, the 'Annual Mortality Report: SFY 2018' (July 1, 2017 - June 30, 2018) was released. There were 5 recommendations made. Due to the recent release of this document, DBHDS had not met to begin to develop or implement action steps to address these recommendations. The recommendations included: 1. Establishing a target of <10% of deaths reviewed to be classified as 'Unknown', 2. Develop quality improvement interventions to reduce potentially preventable deaths to less than 15% of the total DD deaths per year. 3-5. Develop quality improvement initiatives specifically targeted at decreasing the rate of preventable deaths due to 3. Aspiration, 4. Bowel obstruction, and 5. Sepsis. The most recent annual report is the 4th annual report provided to the DBHDS Commissioner, as well as the public.

The Quality Improvement Committee (DBHDS) currently meets quarterly. Included in review are any MRC recommendations. There were no recommendations forwarded by the MRC for review in the prior review period (October 2017 –August 2018), nor in the current review period (October 2018-August 2019), which resulted in action steps being taken. The MRC did make 5 recommendations reported in the 'Annual Mortality Report SFY 2018'.

Settlement Agreement Requirement

V. Quality and Risk Management System, C. Risk Management

4, The Commonwealth shall ***offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.***

The Office of Integrated Health Services continues to create Safety Alerts, which are distributed by email and are posted on the DBHDS website. Alerts listed in the State Fiscal Year 2017 Annual Report included the following: Breast Cancer Screening, Type I Diabetes, Type II Diabetes, Sepsis Awareness, Fall Prevention, Drug Recall Alert, Flu Season Reminder, and Adult Immunization Schedule, and Stroke. A list dated 8/8/18 included additional topics/updates for sickle cell anemia (undated), aspiration pneumonia (5/10/18), stroke update (5/10/18) congestive heart failure (5/10/18), pica, and recognizing constipation and bowel obstruction. A monthly newsletter provided information on a wide variety of topics important to the IDD population: wheelchair safety tips, transportation safety for individuals in wheelchairs, handwashing, inclusion, mobile dentistry program, foot care and diabetes, winter and extreme cold preparation, tips for wandering due to dementia, discharge planning, medication management, risks of cardiovascular disease, UTIs, nutrition and wound healing, and behavioral changes and underlying medical issues. The Alerts, which were of high quality, were written for easy understanding by the lay public, and included source references. The Office of Integrated Health Services also created one page, "in a nutshell", summaries of these alerts. The revised Alerts are an indication of a quality improvement approach: the periodic review of whether the implementation of policies and practices that address complex issue can be improved, and, if so to make needed revisions.

During the current interview process, OIH was requested to provide a list/and sample of the documents. The submitted information included a power point presentation on falls, a September 2019 newsletter highlighting discussion on preventing falls, and an in-depth Safety Alert on falls prevention (September 2019). To interest the community and engage their understanding of fall prevention a 'Jeopardy' game was created, During discussions with OIH, a review of additional topics were provided through alerts and newsletters: opioids use disorder, and an updated stroke alert. There was ongoing collaboration for an alert with focus on health education concerning when to call 911. Although a goal was to update all alerts every 3years, this remained a challenge. Measuring impact of the technical assistance and

ongoing training Alerts/newsletters has been elusive. A learning website has been created, and the staff from provider agencies registering for the website can be used/tracked to determine impact on the information learned in reducing falls in the home or by provider, based on the location of the staff who took the training. This has potential to determine the impact of the training. However, the development and implementation of this potential process in determining impact of technical assistance provided has not occurred. Additionally, an annual nursing conference is held. For technical assistance, regional nurses in OIH provide technical assistance in their respective region of the state.

Settlement Agreement Requirement

V. Quality and Risk Management System, C. Risk Management

The team also shall ***collect and analyze mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.***

-

Table 9 - Mortality Review Committee Cause of Death								
Year	**2014**	**2015**	**2016**	**07/16 - 12/16**	**01/17 - 03/17**	**04/17 - 06//17**	**10/17- 08/18**	**10/8- 08/19**
Total deaths	226	289	164	109	73	65	243	351
Pneumonia	14.2%	7.3%	10.4%	5.6%	23%		12.3%	7.1%
Cancer	10.6%	10.4%	17.1%	7.4%	1	1	8.2%	9.4%
Aspiration	7.5%	6.6%	2.4%	5.6%	1		4.1%	5.7%
Sepsis	8.8%	7.3%	11%	5.6%	1	3	5.8%	6.0%
GI	3.5%	2.8%	2.4%	1.9%	0		3.7%	3.1%
Respiratory	2.2%	6.6%	1.8%	6.5%	9.6%		8.2%	9.4%
Other	8.4%	6.6%	8.5%	7.4%	19%	1	12.3%	6.3%
Unknown	20.8%	20.1%	13.4%	11.1%	15%	2	7.0%	16.0%
Respiratory/pneumonia	16.4%	13.8%	12.2%	12.0%	233%	-	20.6%	16.5%
Cardiovascular	-	-	-	-	17.8%	-	16.9%	15.1%
Neurological	-	-	-	-	8.2%	-	7.8%	10.3%
Multiple medical	-	-	-	-	-	-	4.5%	2.6%
Renal	-	-	-	-	-	-	6.1%	2.6%
Congenital/ genetic								6.3%

The 'Mortality Tracker', the MRC minutes, and the Mortality Review Presentation Form included valuable data that provide information concerning the most common causes of death. The categories that the MRC are tracking had been expanded to include a category of "multiple medical conditions". In reviewing the findings in the submitted MRC minutes, the category of death was generally consistent with the information that was provided to the MRC.

The cause of death did not change significantly as a percentage of total deaths from prior review periods for several categories: cancer, aspiration, sepsis, GI, and cardiovascular. New categories included complications of congenital disorders, as well as complications of genetic disorder were added to the tracking database. As categories increase, the ‘other ‘ category is expected to decrease. The percentage of deaths with unknown causes has been a challenge to resolve, and equals the percentage of all death from 2014-2017 Areas of concern such as aspiration (choking), and sepsis have not been reduced significantly, despite Safety Alerts, training across the state by Integrated Health Services, and monthly newsletters, and will require ongoing surveillance and potentially new approaches. Tracking the number of “hits” or viewers of the OMRC ‘s IH website information indicating interest and value in the content has not been shown to impact outcome. It was interpreted as those reviewing the website were interested learners, but may not represent the staff needing the training the most in caring for the individual.

Quality Improvement Initiatives

The MRC has initiated some of the elements of a quality improvement program. The MRC’s current processes, however, lack essential elements. The MRC has analyzed information and made recommendations for individual and systemic improvements; however, it has not gathered information regarding the impact of its quality improvement initiatives that were prioritized for implementation. It has also not gathered or analyzed whether, or to what extent, the QI initiatives achieved the desired or expected outcomes. Without the data gathering and evaluation elements of a quality improvement program, the Commonwealth is not able to determine whether additional initiatives are needed or what actions will likely “reduce mortality rates to the fullest extent practicable”.

Recommendation follow-through

In the review ending September-October 2017, the quarterly review template entitled “Mortality Review Committee Action tracking Report July-Sept 2017“ was being tested in the second month of its development (October 2017). At that time, the results indicated that all MRC recommendations were being tracked until completion. Data from the following review period of October 2017 through August 2018 indicated that from July 2017 to August 2018, there were 125 MRC recommendations tracked in this document. As of September 2018, there were only 10 pending MRC recommendations (8%). The remainder had been closed (80%) or did not need additional follow up. It was noted that 50 of these MRC recommendations (40%) were systemic with impact to improve the quality, efficiency, and or effectiveness of the process, or impact to improve quality of life, health, and safety of the ID/DD population being monitored.

During the current review period October 2018 through August 2019, based on minutes of the 22 MRC meetings, there were 63 recommendations and action steps. There was one pending mortality review from the 8/22/19 MRC meeting and 3 additional action steps listed as pending in the MRC Action Tracking log. There was additionally one individual awaiting an autopsy report. The MRC coordinator closely tracks these recommendations and action steps to closure.

Summary Bullets

Advances

- MRC occurs monthly or more often as needed.
- Names of attendees with titles and department/ institution affiliation continue to be documented as part of the MRC minutes.
- Data accuracy, consistency, and integrity continues to be reviewed by data analysts.
- A list of documents that providers are required to submit to DBHDS licensing specialists continues to be utilized. Tracking included when the documents were received by MRC administrative staff. Timely inventory of received documents at periodic intervals continues to be part of the tracking process by an MRC Coordinator.
- The role of the MRC coordinator has been integral to the flow of documentation and timeliness of the many steps in the MRC process.
- A standardized format for mortality reviews continues to be utilized in providing essential information during MRC meetings.
- The MRC has been expanded to include other departments/agencies which contribute expertise to the mortality review process.
- Both Chair and Co-Chair of the MRC have clinical backgrounds.
- Deaths are reviewed and assigned to one of two tiers. A death review with no concerns, and clear diagnosis and which was not considered preventable, does not undergo full review. Deaths with concerns undergo a full review. This process has allowed the MRC to resolve the backlog of deaths to be reviewed. Although not compliant for the current review period, the most recent 3 months of review reflects potential compliance for the next review period.
- A new independent practitioner has been recruited as part of the MRC. If sustained through the next review period, this will meet compliance.
- The quality of the clinical reviews brought to the MRC is generally complete and of sufficient quality to allow the MRC to complete its duties.
- The MRC protocol continues to ensure quality mortality reviews.
- The current process of database management in populating the Mortality Tracker spreadsheets ensures integrity of the data.
- The MRC's tracking system to follow through on recommendations to closure continues.
- The Mortality Review Presentation Form has been updated to include other components relevant to the death review process.
- The Office of Licensing has created two teams to respond to urgent clinical concerns. A staff position with nursing experience will be a resource for the licensing staff for clinical questions.
- The MRC has defined criteria for a potentially preventable death and has begun to track data for this category of death.
- MRC members are now allowed to interview case managers/provider staff when needed.

Challenges

- Obtaining medical information has remained a challenge, and DBHDS has identified the need to resolve this issue, with additional steps already being taken to improve access to documents through impending legislation.
- Updating current Safety Alerts remained an ongoing challenge.
- OIH has not developed a methodology or data system to track impact of their technical assistance.
- The Quality Improvement Committee has not received any recommendations from the MRC to review this past year. Although there were no recommendations made to the Quality Improvement Committee, there were 5 systemic recommendations listed in the DBHDS Annual Report.
- DBHDS needs to review the quality and quantity of clinical documents received for review by the various residential settings. The provider residential settings Healthcare Plans/ Quality Care Plans need to be based on access to physician records, test results and hospital discharge summaries, with focus on critical diagnoses of the individuals in all residential settings. Quality of care plans may be inconsistent in quality and clinical depth across the various provider networks.
- Data gathering and evaluation elements of the Quality Improvement Program remain to be developed.

Attachment

Documents submitted during prior review periods which were used as baseline and reference information for this review:

Mortality Review Committee meeting minutes 2015: 2/11/15, 2/24/15, 3/11/15, 4/15/15, 4/17/15(2), 5/27/15, 6/10/15, 6/29/15, 7/10/15, 7/22/15, 10/14/15, 11/23/15, 12/2/15, 12/9/15, and 12/29/15.
2016: 1/27/16, 2/10/16, 3/9/16, 3/28/16, 6/8/16, 6/22/16, 6/30/16, 7/7/16, 7/13/16, 8/10/16, 8/24/16, 9/14/16, 9/21/16, 10/12/16, 11/9/16, 12/5/16, 12/9/16, 12/14/16, and 12/21/16.
2017: 1/11/17, 1/18/17, 2/15/17, 3/8/17. 3/22/17, 4/18/17, 4/26/17, 5/10/17, 5/24/17, 6/7/17, 6/14/17, 6/28/17, 7/19/17, 7/26/17, 8/9/17, 8/17/17, 8/23/17, 9/13/17, and 9/27/17, 10/25/17, 11/08/17, 11/27/17, 12/13/17, 12/27/17.
2018: (01/08/18), 01/10/18, 01/24/18, 02/01/18, 02/14/18, 02/22/18, 03/01/18, 03/08/18, 03/15/18, 03/29/18, 04/12/18, 04/26/18, 05/03/18, 05/10/18. 05/17/18, 05/24/18, 05/31/18, 06/07/18, 06/21/18, 06/28/18, 07/19/18, 07/26/18, 08/02/18, 08/09/18, 08/16/18, 08/23/18, and 08/30/18.
For the above listed meeting minutes, the MRPF reviews (Mortality Review Presentation Forms) for individuals discussed at these meetings.
2016 Mortality Tracker
2017 SFY Mortality Tracker (as of October 2017)
Draft Community DD Mortality Review Worksheet
'Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 –June 30, 2016'
Departmental Instruction 315 (QM)13 Reporting and Reviewing Deaths (draft)
Mortality Review Committee Operating Procedures 2017
Responses to Recommendations from the Independent Reviewer Report to the Court 12-23-16
Mortality Review Committee Membership/Participation (undated)
Numbered Recommendation Status Tracker
Mortality Review Committee tracking 3/15/17
Mortality Review Committee Interventions to Address Concerns
Form letter to Office of Vital Records for copy of death certificate (draft)
Form letter to provider organization requesting specific documents for review (draft)
DBHDS ID/DD Mortality 2013 Annual Report (May 2014 Draft)
DBHDS 2014 Annual Mortality Report (August 2015 draft): 'Mortality Among Individuals with an Intellectual Disability'
DBHDS Mortality Review Letter to Medical Practitioners (October 2015): "Reminding Medical Practitioners of High Risk Conditions"
Mortality Review Committee data tracking documents: 2014 Mortality Tracker, 2015 Mortality Tracker, and 2016 Mortality Tracker (to 6/30/16)
Action Tracking Report FY 18 (in testing): Mortality Review Committee Action Tracking Report July-Sept 2017
DBHDS Instruction (July 2016 Draft): Mortality Review
Mortality Review Committee: Master Document Posting Process (undated)
Copy of Master Schedule July 2017 (in testing): MRC Master Document Posting Schedule (MDPS) Posting Period July 2017; Date Master Schedule Posted August 2017
Mortality Review Presentation Form (Final) Form MRC #001, 08/11/17
MRC Master Document Posting Schedule (MDPS) with drop downs
DI (Department Instruction) 315 Reporting and Reviewing Deaths. Draft. Field Review 10/3/17: DI 315 (QM) 13 Attachment B: (Name of Facility) Mortality Review Worksheet
MRC Meeting Minutes Shell 10/16/17
Office of Licensing DBHDS: ID/DD Death Mortality Review Committee Required documents/reviews

Safety and Quality Alerts of the Office of Integrated Health Services: Recognizing Constipation, Type II Diabetes, Type I Diabetes, Sepsis Awareness, Scalding, Preventing Falls, Breast Cancer Screening, Aspiration Pneumonia – Critical Risk, 5/19/17 Drug Recall Alert
Mortality Review Committee: Quality Improvement Plan: CY 2017
Recommendations Status 3/14/17
Quality Improvement Committee Meeting Minutes 7/6/17
2017 Progress Report: Office of Integrated health
Training Data (Skin Integrity Training)
MRC: Action tracking Log: 9/2017 - 12/2018 Plus Outstanding Recommendations from Previous Tracker
Excerpt from the Office of Integrative Health Annual Report: Data ending April 30, 2017 report published June 2017
Virginia DBHDS Annual Mortality Report SFY 2017: Mortality Among Individuals with a Developmental Disability
Power Point Presentation: Death Certificates: Quarterly Data Presentation "Incorporating VDH Death Certificates Onto the MRC Tracker" August 2018, Virginia DBHDS
Standard Operating Procedures for the DBHDS DD Mortality Review Committee (prepared 6/12/18)
FY 2017 Mortality Discrepancy file
2018 SFY Mortality Discrepancy file
Mortality Review Tracking Tool FY18
Mortality Review Tracking Tool Oct 2017-Feb 2018
Mortality Review Presentation Form
MRC Samples of Data Warehouse Reports: DW-0064 Incidents, DW-0055 Mortality Report Detail, DW-0025 Death and Serious Injury reporting Time Detail
Action Tracking Log Sept 2017- Dec 2018 Plus Outstanding Recommendations from Previous Tracker
Action Tracking Log Oct 2017 – present.
13th Review MRC Health Alerts Developed as a Result of MRC Recommendations: Sickle Cell, Aspiration pneumonia, congestive heart failure, stroke,
Health Alerts Developed as a Result of MRC Recommendations (Alerts from Oct 2017 – 8/8/18)
Health Alerts Developed as a Result of MRC Recommendations (Newsletter Topics from Oct 2017 – present [September 2018]}
Newsletter (Virginia DBHDS) "Health Trends" for the following months with featured health alert/focused topics:
October 2017: Bowels: Constipation, C-diff, and Obstruction
November 2017: Diabetes management
December 2017: Aspiration
January 2018: Sickle Cell Anemia, Winter and Extreme Cold Preparation
February 2018: Seizures
March 2018: Congestive Heart Failure, Depression and Suicide, Medication Management
April 2018: Urinary Tract Infections, Safety for Individuals with Autism
May 2018: Stroke, Transportation Safety for individuals in Wheelchairs
June 2018: Choking, Behavioral Changes and Underlying Medical Issues
September 2018: Pica
Power Point Presentation: Tracking Health and Safety Alert Views: Mortality Review Committee, August 30, 2018, Virginia DBHDS

APPENDIX H.

TRAINING

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

Training
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

November 20, 2019

Executive Summary

The Independent Reviewer for the *US v. Commonwealth of Virginia* requested a review of the training requirements in the Settlement Agreement for all staff who provide services under the Agreement. This review focused on implementation of the Statewide Core Competency-based Curriculum (*Orientation Training to Direct Support Professional's (DSPs) and Supervisors: Supporting People in their Homes and Communities*) and its ancillary training approaches to ensure adequate coaching and supervision. Content areas include the characteristics of developmental disabilities, IDD waivers, person-centeredness, positive behavioral supports, effective communication, health risks and their interventions, and values-based best practices supporting people with developmental disabilities.

The current version is three years old and is an online power point held on Virginia Commonwealth University's Center on Excellence in Developmental Disabilities website but managed and maintained by the Division of Developmental Services. The content is appropriate and is kept current by the Division.

There is an associated test of 91 items, which must be passed at 80% criterion "before providing reimbursable supports", and there is currently an associated checklist of 48 competencies that a newly hired DSP must demonstrate via observation by their supervisor within 180 days of hire, which can be extended by DBHDS. Although not yet operational, newly drafted requirements include denial of Medicaid reimbursement to the provider for DSPs who do not show proficiency on the competencies within 180 days with no extensions. Currently, the Division warns that "DMAS shall not reimburse for those services provided by DSPs and DSP supervisors who have failed to pass the orientation test or demonstrate competencies as required." This latter expectation appears to be infrequently enforced, so compliance rates as determined by DMAS's Quality Management Review (QMR) review process show predictable variability across providers.

Additional "advanced" competencies are required for DSPs who work with individuals with autism, those with challenging behaviors, and those needing intensive health related supports. It is also required that all these competencies will be reassessed annually for DSPs by signed affirmation, which the QMR also evaluates in its reviews.

Introduction
The training requirements in the Settlement Agreement include:

V.H.1. The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.

V.H.2. The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.

This review focused on implementation of the Statewide Core Competency-based Curriculum (*Orientation Training to Direct Support Professional's (DSPs) and Supervisors: Supporting People in their Homes and Communities*) and its ancillary training approaches to ensure adequate coaching and supervision. Content areas include the characteristics of developmental disabilities, DD waivers, person-centeredness, positive behavioral supports, effective communication, health risks and their interventions, and values-based best practices supporting people with developmental disabilities.

Methodology
- Reviewed feedback from agencies piloting revised competencies curriculum;
- Reviewed licensing regulations and recent citations related to training requirements;
- Reviewed DMAS's QMR findings for training measures FY19;
- Reviewed the Commonwealth's orientation and training curricula: (*Orientation Training to Direct Support Professional's (DSPs) and Supervisors: Supporting People in their Homes and Communities*): (https://partnership.vcu.edu/DSP_orientation/index.html;
- Reviewed Licensing Regulation Compliance report, FY19: 440, 450, 460;
- Interviewed DBHDS and DMAS training coordinators.

Findings
The current version of *Orientation Training* is three years old and is an online power point of 97 slides held on Virginia Commonwealth University's Center on Excellence in Developmental Disabilities (Partnership) website but managed and maintained by the Division of Developmental Services (DDS). The overall organizational structure of the *Orientation Training* is easy to follow. The Orientation Manual is generally well organized. It is fairly clear who needs what training, the required timelines, the documentation requirements, and the level of competency. The competency checklists are well designed and easily completed for documentation. Supervisors documenting initial levels of competency with annual proficiency re-checks addresses the age-old training issue of didactic instruction not always translating into correct application. The content is appropriate and is comparable topically to other DSP curriculums published nationally. It is kept current by the Division of Developmental Services.

There is an orientation test of 91 items, which must be passed at 80% criterion "before providing reimbursable supports", and there is an associated checklist of 48 competencies (revised to 27 in revision drafts) that a newly hired DSP must demonstrate via observation by their supervisor within 180 days of hire (the 180 deadline can be extended by DBHDS). Newly emphasized requirements throughout the instructions include denial of Medicaid reimbursement for DSPs who do not show proficiency on the competencies within 180 days, with no extensions. Formerly, the Division warned in supervisor training that DMAS could request paybacks (recoupment, retraction) for those services provided by DSPs and DSP supervisors who failed to pass the orientation test or

demonstrate competencies as required. This latter contingency was infrequently enforced reportedly due to workload issues at the DMAS Program Integrity Division.

The DMAS Quality Management Review (QMR) process audits samples of each agency's training records every two-three years on the assurance items in Table 1, among other performance measures. Findings from these reviews are then processed quarterly with DBHDS as way of ensuring the Commonwealth's assurances to CMS in its HCBS waivers. Obviously, Table 1 shows the agencies reviewed have the biggest challenge around assuring that the competencies are accomplished by DSPs. This makes some sense since C8 is validated by means of a written test of multiple choice and true/false questions, whose answers are available publicly; on the other hand, the competencies, C9, require direct supervisor observation and signoff. During the third quarter (1/1/19 to 3/31/19) FY19, the DMAS QMR determined that 78 of 137 (57%) of DSP records met the competency training requirements, and in the fourth quarter of FY19 (4/1/19 to 6/30/19) the DMAS QMR determined that only 46 of 105 (44%) of DSP records had met the competency requirements.

Table 1
FY 19 Performance Measures for Community Living Waiver
Sub-Assurances C8 and C9

Assurance	Q1	Q2	Q3	Q4
C8. Number and percent of provider agency staff meeting provider orientation training requirements.	36/37 97%	58/58 100%	121/155 78%	112/131 85%
C9. Number and percent of provider agency DSP staff meeting competency training requirements.	19/29 66%	44/56 79%	78/137 57%	46/105 44%

The DBHDS/DMAS assessment strategies surrounding supervisor evaluation of DSP and supervisor competencies are under revision. When implemented, the review will include a record of a) how the "training" was delivered (1:1, group, formal classroom), b) "observations" of skills being trained (e.g. demonstration, language used, relates individual needs and plan, etc.), c) "implemented skills" (supervisor's direct observations) and d) "proficiency confirmation" (supervisor verification that the employee is competent and requires minimal or low amounts of supervision). For all competencies the entire 27 items must be verified for proficiency by the supervisor within 180 days, which includes dating and initialing of a checklist by the supervisor. Supervisors must similarly have shown proficiency on the same 27 items. Again, DBHDS draft instructions indicate that:

> **From the date of that initial 180 day review, DMAS shall not reimburse for those services provided by DSPs or DSP supervisors who failed to pass the orientation test or demonstrate competencies as required.**

Additional "advanced" competencies are required for DSPs who work with individuals with autism, those with challenging behaviors, and those needing intensive health related supports. DBHDS policy requires that all these competencies will be reassessed annually for DSPs and supervisors, which the QMR evaluates in its reviews. Initial passing results in a DBHDS-issued certificate, while subsequent annual re-assessments are completed as written affirmations by DSPs and their supervisors.

DSP supervisor training topics are under further development and revision by DBHDS. These topics (work process, delegation, motivation, coaching, employee engagement, stress management, conflict management) appear appropriate and typical for front line managers.

Finally, as part of its annual inspection process the Office of Licensing also does review regulatory training requirements that include expectations that a) DSPs be oriented to the policy and procedures of agency, b) they receive orientation to the individuals receiving services, c) training policies are in place, and d) they have completed training in first aid and CPR . There were over 140 DD providers cited by OL for training shortcomings during FY19.

Recommendation:
Enforce the warnings of financial penalties for failure to train DSPs. The Commonwealth should reconsider the internal requirement that a DMAS Program Integrity audit is required for recoupment of reimbursement claims identified by the QMR process as problematic.

Suggestion for DBHDS Consideration:

While critical to achieving compliance with CMS and SA expectations, enforcement of financial penalties for staff who have not demonstrated competencies should be carefully transitioned into effect. Research has established that agencies that suffer high turnover lose most new employees during the critical initial employment period (typically the first 120 days). Precipitous application of financial penalties or paybacks could put some agencies into financial jeopardy where they lose resources they need to attract and retain employees.

APPENDIX I.

QUALITY AND RISK MANAGEMENT

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

Quality and Risk Management System

By

Rebecca Wright, MSW, LICSW

November 14, 2019

I. EXECUTIVE SUMMARY

The Settlement Agreement requires the Commonwealth to develop and implement a Quality and Risk Management System. Section V.B. states the overarching requirements: "*The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.*" In summary, this review focuses on the following requirements for that system (the full text for each is provided below in the relevant sections of this report):

- V.C.1. with regard to establishment of uniform risk triggers and thresholds and the provision of guidance and training to providers to proactively identify
- V.D.1. with regard to the Commonwealth's adherence to the CMS-approved waiver quality improvement plan;
- V.D.2. with regard to the collection and analysis of consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services;
- V.D.3. with regard to the collection and analysis of consistent, reliable data in key quality domain;
- V.D.4. with regard to the collection and analysis of data from specific available sources;
- V.D.5 with regard to the implementation of Regional Quality Councils; and,
- V.E. with regard to implementation and effectiveness of provider quality improvement strategies.

At the request of the Independent Reviewer, this is the seventh Report that assessed the Commonwealth's progress in meeting these terms of the Settlement Agreement. Maria Laurence previously reviewed and submitted reports that included findings and recommendations related to the Quality and Risk Management and Training systems. These reports were included with the Independent Reviewer's Reports to the Court, which were submitted on December 6, 2013, December 8, 2014, December 6, 2015, December 23, 2016, and December 13, 2017 and December 13, 2018. Using information from these reviews, and from other sources, the Independent Reviewer made previous determinations of compliance. This report includes references to previous reports, as they are relevant to recent findings.

For the 15th Report to the Court, due on December 15, 2019, the Independent Reviewer's monitoring priorities again included studying compliance with the provisions identified above, focusing on the progress the Commonwealth has made since the last study, and within the context of the Court's charges to the parties in April of 2019. At that time, the Court imposed upon the parties a requirement to provide it with an agreed list of all provisions of the Agreement with which the Commonwealth has complied and which provisions remained in dispute, including statements in measurable terms of what the Commonwealth would have to do to fully comply with the decree. Pursuant to this order, at the time of this report, the parties had not yet agreed to compliance measures, but continued to negotiate the language. For this study period, the Commonwealth had also not attested that it had complied with any of requirements related to the focus of this study. Based on these factors, the Independent Reviewer determined that this study would seek primarily to obtain updates on pertinent activities since the previous review without regard to assessments of compliance status as the Court has not yet finalized indicators of compliance. By the time the Independent Reviewer issues his final report for this review period, the parties may have reached some agreements with regard to indicators and these will be reviewed at the time of the next review.

The Independent Reviewer further determined that, unlike previous studies, this report would not address Section V.E.3. with regard to Quality Services Reviews. This decision was based on information DBHDS provided that indicated it was in the process of making fundamental changes to that quality function, including the issuance of a new Request for Proposals (RFP) to operationalize those changes.

Previous reports have found that the Commonwealth's approaches to its quality and risk management system had undergone frequent revisions from one review to the next. That remained true for this review as well. Since the previous review, this study found that the Commonwealth had engaged in substantial efforts of self-assessment related to its quality and risk management system and, as a result, had initiated and/or were planning many systems improvements to address identified needs. Much of the self-assessment described in this report was internal to DBHDS and included the development of a revised quality and risk management organizational structure, as described in the *DBHDS Quality Management Plan FY 2020*, as well as analytical reports on the topics of CSB quality improvement needs and data quality, reliability and validity.

In addition, one external effort also stood out as a driving force to help move some long-contemplated initiatives forward. In December 2018, the Virginia Office of the State Inspector General (OSIG) issued a report critical of DBHDS incident management processes with regard to serious injuries. The *Department of Behavioral Health and Developmental Services: Review of Serious Injuries Reported by Licensed Providers of Developmental Services* made several recommendations for systems improvement, including deficiencies in the quality, consistency and reliability of reports with regard to serious injuries and limitations with regard to the QIC and RQCs' abilities to analyze serious injury data, identify patterns and trends or prioritize the highest risk injuries for performance improvement initiatives.

Overall, this reviewer's study found that DBHDS has made progress with regard to designing quality and risk management structures, such as re-defining its quality management framework, including principles, structures and data collection and analysis methodologies. The *DBHDS Quality Management Plan FY 2020* (dated September 13, 2019) was not yet complete, but once all components have been developed as envisioned, this plan should provide a mechanism which can be used to demonstrate how DBHDS will comply with the quality and risk management indicators described above. At the time of this review, DBHDS had also not yet finalized development and/or implementation of many of the other strategies that it intends will bring them into compliance. Some strategies, such as replacing the incident management system technology, were still in the early formative stages.

At present, however, and as described in detail below, the overall functionality of the framework continued to be severely hampered by the lack of valid and reliable data across much of the system. At the time of the previous Quality and Risk Management Systems study for the 13th review period, the Independent Reviewer urged DBHDS to create a comprehensive data quality improvement plan, with specific action steps and milestones, to expand and improve the quantity and quality of data to measure performance and to provide a structure for greater accountability of effort. DBHDS staff were keenly aware of the need to make improvements in this area, and were either engaged in improvement initiatives or planning efforts to make improvements. However, they still needed to develop a comprehensive and specific data quality improvement plan to tie all of those efforts together in a cohesive manner. The recently-developed *Data Quality Plan* and *CSB Quality Reviews* (April 26, 2019) will provide a good foundation for this effort.

II. STUDY METHODOLOGY

The study methodology included a review of documents and interviews with DBHDS and CSB staff, conducted in October and November 2019. A full list of documents and data reviewed may be found in Attachment A. A full list of individuals interviewed is included in Attachment B.

Prior to this study period the Court had ordered a hearing on April 23 and 24, 2019, for which one of the stated outcomes was to state in precise measurable terms what the Commonwealth must do to comply with each remaining provision of the decree. Further, the Court required the parties to provide it with an agreed-upon list of all provisions of the decree with which the Commonwealth has complied and of which provisions remained in dispute, including statements in measurable terms of what the Commonwealth would have to do to comply with the provisions of the Agreement. At the time of this report, the parties were still negotiating and had not yet informed the Court of their agreement on the compliance indicators for any of the provisions reviewed for this study. Therefore, in the absence of specific, measurable compliance indicators, the Independent Reviewer relied upon the set of questions and status update probes, and the indicators that he previously developed in making his determinations of compliance and that were used in the prior Quality and Risk Management Studies to guide this analysis. Future studies will be predicated on the final measures as approved by the Court.

The Court also indicated during the April 2019 hearing that the Commonwealth would need to produce the policies, procedures, instructions, protocols and/or tools it would use to operationalize and sustain the system improvements; further, that these documents would be used by the Independent Reviewer to formulate further compliance recommendations to the Court. In accordance with that Order, the Commonwealth submitted to the Court, on 11/6/19 its plan for developing a website (i.e., the "Library Website") to house these documents. Based on review of the submission, when completed, the Library Website will consist of the full text of the Settlement Agreement with hyperlinks to each provision of the Agreement and the relevant information and data for that particular Agreement provision. Development of the website was underway, and the Commonwealth indicated it expected it to be fully operational and accessible to the public by June 30, 2020. While this was also outside the scope of this current report due to the lack of final measures, future studies should evaluate whether the Library Website provides the minimum set of policies, procedures, instructions, protocols and/or tools needed to document ongoing compliance.

III. FINDINGS

Background

At the time of the 13th period review, the Quality and Risk Management Systems study summarized the status of the Commonwealth's development of an overall framework for quality and risk management processes, much of which was undergoing development. Since that time, DBHDS has continued to make some changes to its approaches and organizational structures and to develop a more robust and detailed description. The following provides an overview of the current status of the overall framework, as a backdrop to the rest of the findings of this study.

For this review period, DBHDS provided the most recent update to a document entitled *DBHDS Quality Management Plan FY2020,* with an effective date of 9/13/19. While the document indicated some pieces were still in development, Part 1: Quality Management Description and Part 2: Quality Improvement Committee, Council and Workgroups provided a clear overall conceptualization of the quality improvement structures and functions envisioned. In summary, the Quality Management Plan described the DBHDS quality management system as including the following components:

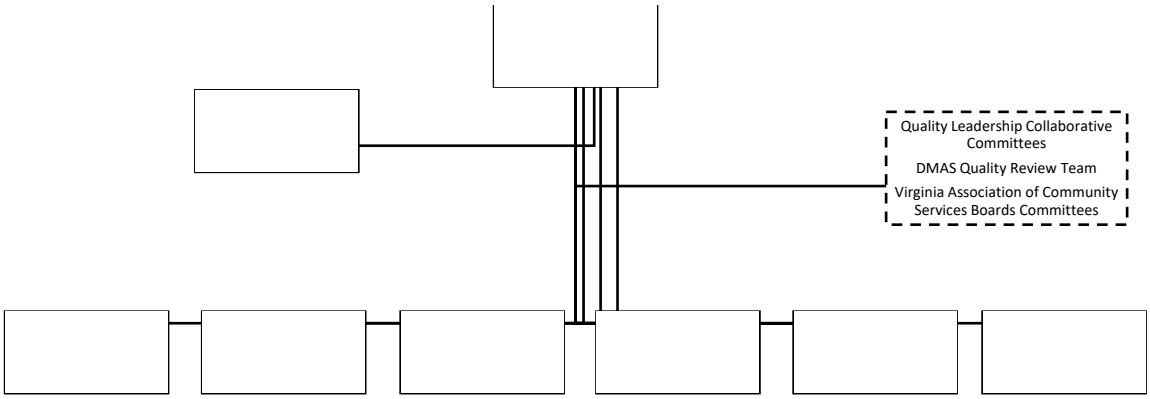
- The Division of Compliance, Legislative and Regulatory Affairs which oversees the regulatory, quality assurance and risk management processes and includes the Office of Human Rights and Office of Licensing;
- The Division of Developmental Services, which collaboratively implements the DD HCBS Waivers Quality Management Plans in conjunction with the Virginia Department of Medical Assistance Services (DMAS), administers the Office of Integrated Health and is responsible for tracking many settlement agreement compliance measures;
- The Division of the Chief Clinical Officer, including the Office of Clinical Quality Management, which oversees the quality improvement processes, and the Office of Data Quality and Visualization, which provides critical support across quality management functions.

The Quality Management Plan also described a hierarchy of interdisciplinary quality committees and workgroups, with specific charters and lines of authority. These included the following:

- The Quality Improvement Committee (QIC), which is the highest-level committee and provides oversight of the quality management program as a whole, including prioritization of needs and work areas. The QIC will also be charged to produce an annual report that addresses the availability and quality of supports and services, gaps in those areas and recommendations for improvement.
- The Risk Management Review Committee (RMRC), which monitors system-wide data to develop actions to prevent and ameliorate risks of harm. These actions may include setting performance goals and performance measures; establishing risk triggers and thresholds; identifying remedial, mitigation and improvement processes and actions; and, offering guidance and training for providers (e.g., root-cause analysis, corrective action planning, etc.)
- Regional Quality Councils (RQCs), as required by Section V.D.5. of the Settlement Agreement, which are expected to receive and analyze state and regional data to identify trends and make recommendations to the QIC for quality improvement initiatives.
- The Mortality Review Committee (MRC), whose purpose is to identify and implement system-wide improvement initiatives to reduce preventable deaths, through analyzing data to identify patterns at the individual service delivery and system levels.

- The Case Management Steering Committee, responsible for performance monitoring of case management, including review and analysis of relevant data sets to identify trends and progress toward meeting established Support Coordination/Case Management targets.
- Workgroups for each of the three Key Performance Areas, including Health and Wellness, Community Inclusion/Integrated Settings and Provider Capacity and Competency. Each workgroup recommends goals and performance measures within the respective domain.
- The DBHDS/DMAS Quality Review Team (QRT), which is charged with monitoring of data used to measure compliance with the waivers' performance measures. While this team is not a subcommittee to the QIC and does not report to it, its work is an integral component of the overall quality and risk management system.

The Quality Management Plan provided the following depiction of the organizational quality improvement committee structure:



Given that quality and risk management responsibilities are spread across several different divisions, and are therefore potentially more susceptible to fragmentation and siloed activities it was good to see that DBHDS staff had provided a framework for coordination and joint action, when needed, as well as clear lines of leadership and accountability.

Those components of the Quality Management Plan still under development included Part 3: Annual Report and Evaluation as well as the Appendices. The latter included the following: the results of licensing findings resulting from inspections and investigations; a data quality plan; the annual mortality review report; the Case Management Steering Committee report; the QSR annual report; and the National Core Indicators (NCI) annual report.

Once completed as envisioned, the Quality Management Plan should represent a mechanism which can be used to demonstrate how DBHDS will comply with the indicators included in this review. At present, however, and as described in detail below, the functionality of the framework is severely hampered by the lack of valid and reliable data across much of the system. In most instances, DBHDS staff were keenly aware of this need and were either engaged in, or planning improvement initiatives.

Sections V.C.1 and V.C.4.

V.C.1. The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risk of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.

V.C.4. The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.

Previous reviews of these provisions included the following probes to evaluate progress:

- Are the uniform risk triggers and thresholds that are planned or completed adequate to identify and to address risks of harm, not only actual harm?
- Do the risks include those that may not result in harm; for example, choking, bed sores, falls, peer assault, and the presence of staff who have not been trained and demonstrated competency to deliver the elements of each individual's services?
- Are the risks identified limited by existing regulations or by the data that are already being collected?
- What is the status of the Commonwealth's efforts to develop training and guidance to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions?

At the time of the 13th period review, the study summarized the status of the Commonwealth's development of an overall framework for risk management processes, and specifically with regard to the establishment uniform risk triggers and thresholds. That study found that DBHDS:

- Had not formalized an approach to the implementation of risk triggers and thresholds; and,
- Continued to assess options for a uniform approach to health risk assessment.

15th Review Period Findings

The findings below for this review period provide a summary of the status of continued efforts by DBHDS to expand and enhance risk management processes at the CSB and provider level.

Requirement for a Risk Management Program: As previously reported, the Commonwealth had issued emergency regulations to require licensed providers to develop and maintain a risk management program. The regulation at 2VAC35-105-520 states:

> *A. The provider shall designate a person responsible for the risk management function who has training and expertise in conducting investigations, root cause analysis, and data analysis.*
> *B. The provider shall implement a written plan to identify, monitor, reduce, and minimize risks associated with harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability.*
> *C. The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address (i) the environment of care; (ii) clinical assessment or reassessment processes; (iii) staff competence and adequacy of staffing; (iv) use of high risk procedures, including seclusion and restraint; and (v) a review of serious incidents. This process shall incorporate uniform risk triggers and thresholds as defined by the department.*

DBHDS had issued some additional guidance for providers in this area, in the form of a document entitled *Risk Management Program Best Practices*.

Risk Triggers and Thresholds: In interviews, DBHDS staff indicated that they were continuing to examine how to implement risk triggers and thresholds in a systematic way and had not yet settled on an approach. The Associate Commissioner for OLIS pointed to a previous iteration found on a DBHDS webpage for Facility Quality and Risk Management featuring a PowerPoint presentation entitled "Monitoring Risk Using Triggers and Thresholds, Part 1." It was dated September 8, 2015, and did not have a "Part 2" or any other updated material. According to presentation, DBHDS had at that time identified a number of risk triggers and thresholds, in three domains: Medical, Behavioral and Event-based. For example, the identified medical triggers included aspiration pneumonia, constipation/bowel obstruction, decubitus ulcers, seizures, sepsis, dehydration and urinary tract infections. Other webpages for the Office of Community Quality Management and the Office of Integrated Health (OIH) did not have any resources with regard to the topic of risk triggers and thresholds. Given the dated nature of this information and its location on the website, it would not be clear to most readers if this guidance continued to be in effect and/or was for the Training Centers only.

More importantly, it appeared that the presentation materials did not use the term "risk trigger" correctly. For example, for the purposes of risk management, aspiration pneumonia would be the adverse event, or topic, for which DBHDS would seek to develop a risk trigger. In turn, at an individual level, that risk trigger, such as choking or coughing while eating, would alert provider

staff to circumstances that might indicate a likelihood of an increase in aspiration pneumonias, before that increase either occurred or otherwise became apparent.

In general, though, as DBHDS staff continue to examine this issue, they should think of risk triggers and thresholds across a continuum, from the individual level to system-wide. In some respects, it is often easier to conceptualize the concept of risk triggers at individual level, as described above. For example, as part of a thorough risk assessment for an individual, an interdisciplinary team might recognize an individual has characteristics predisposing him or her to an adverse event (e.g., an individual with dysphagia will be more at risk for aspiration pneumonia) and perhaps some history of experiencing a precursor (i.e., choking while eating) to the adverse event. The team would then identify other known variables associated with the occurrence of an adverse event for individuals with this characteristic (e.g., increased coughing and/or fever.) While every cough or fever might not be caused by aspiration pneumonia, the team has enough information to recognize that there is some likelihood and take appropriate cautionary actions. At the individual level, the trigger serves to simply identify to the individual's care givers of a need to examine the situation.

Similarly, a system (i.e., a large provider with multiple settings, a CSB and/or DBHDS) may have information with regard to a group of individuals who have a diagnosis of dysphagia and choose to develop a trigger to alert the relevant system(s) when these individuals have an overall spike in antibiotic prescription. Again, while antibiotics might be prescribed for other reasons, it is also possible that individuals in the community might have been mis-diagnosed as having a bacterial pneumonia or other infection. In this case, the trigger, based on aggregate data of multiple events, can identify a systems' level need to examine the issue, and to potentially provide additional training, technical assistance, investigations, and occasionally system-wide targeted performance improvement initiatives.

While this is somewhat oversimplified, it provides a sense of what a risk trigger is and its purpose in risk management. The process of developing the trigger includes identifying a variable, or set of variables taken together, that may indicate the likelihood of adverse events occurring. It also involves setting a threshold that would cause the trigger to be activated. For example, for an individual with dysphagia and/or a history of choking, a single event of cough or fever might be enough to activate the trigger and seek medical advice. On a systemic level, setting the threshold is a more complex procedure. For a considerably more erudite discussion of the concepts of risk triggers and thresholds as a whole, DBHDS staff may want to explore some additional resources. One such resource is the *Risk Management in DD Series* from the University of Massachusetts Medical School, Center for Developmental Disabilities Evaluation and Research.

Again, DBHDS should think of risk triggers and thresholds at all levels of the system. At the individual level, risk assessment processes should lead to the consideration of the need for risk triggers and ensure that if any are needed, they are fully integrated into the person-centered plan and daily supports. As the previous study also found, DBHDS continued to assess options for a uniform approach to health risk assessment. In Virginia, the managed care organizations (MCOs) were required to complete an annual Health Risk Assessment (HRA), and DBHDS Support Coordination training, (i.e., PC ISP Module 3, Identifying Risk) indicated the Support Coordinator

"can and should request a copy of this each year and use this as a resource to update the essential information, identify changes in status and determine if there are previously unidentified risks i.e. unidentified health or behavioral support needs." However, DBHDS staff reported that each MCO had its own proprietary tools and that these assessment results were not always readily accessible to the individual's case manager or residential provider. This finding was substantiated in a report entitled *CSB Quality Reviews* issued in April of 2019 by the DBHDS Office of Community Quality Improvement and Risk Management (CQIRM). This report documented that CSBs "consistently reported difficulty reaching the MCO care coordinators and few had received any information from the care coordinator on health risks identified in the HRA or the care coordinator's Individualized Care Plan." The inability of the case managers for individuals' with IDD to access health assessments completed by another entity that is working for the Commonwealth is a serious systemic flaw.

Also as related to this topic, DBHDS had continued to develop some educational resources to address some of the risk trigger topics as identified in the Part 1 presentation above. The OIH website currently offers provider education resources on a variety of health risk topics, including the following: immunizations; falls prevention; skin integrity; bowel obstruction; aspiration; seizures; gastroesophageal reflux disease (GERD); and, dehydration.

It was notable that the falls prevention training effort on the OIH website came about as a result of an RMRC quality improvement plan (QIP) on that topic, which, in turn, had been prompted by recommendations from the OSIG report on serious injuries occurring among individuals with I/DD. The OSIG report, described further below with regard to Section V.D., used DBHDS incident management data to identify that falls and urinary tract infections were among the most frequently reported adverse events; further, the report recommended that DBHDS should develop targeted performance improvement efforts related to these two issues as a starting point for its quality management efforts. While it was positive to see that DBHDS responded to this identified need, several concerns emerged from this review that staff may want to examine:

- It was not clear that DBHDS yet had the capacity to act with a needed degree of urgency (i.e., proactively) to address a systemic identified risk. The OSIG released its report in December 2018. RMRC minutes identified the need to develop a falls QIP initiative beginning in February 2019 and continued to report on the development of provider training each month. According to the draft RMRC minutes for August 2019, DBHDS intended to post the training sometime that month, in time to coincide with the national Falls Prevention Month. However, this represented a significant lag time to a known risk to individuals' health and safety of more than six months. In addition, based on the documentation submitted, DBHDS had not yet developed a QIP for UTIs.
- According to the *DBHDS Quality Management Plan FY 2020,* DBHDS uses the Plan-Do-Study-Act quality improvement model. This model relies heavily on data-based decision making, in which a clear measurement strategy for the proposed intervention is developed as an integral part of the planning stage, and data are rigorously collected during the implementation of the intervention. These data are then studied to determine whether the intervention had the desired impact. For this QIP, DBHDS did not specify any requirements for provider participation in and/or a means for measuring the efficacy of the

falls prevention intervention. RMRC minutes indicated the members discussed various strategies to encourage participation (e.g., sending letters to providers whose participants had sustained a fall in the preceding month.) It also did not appear that DBHDS staff planned to require providers with more frequent falls to provide this prevention training for their staff as a part of a corrective action plan or to demonstrate that their staff has demonstrated any improved competencies. The May 2019 RMRC minutes reflected a discussion of the possibilities of tracking staff training and/or using it for corrective action purposes, but later minutes only indicated that participation would be voluntary. The minutes did not provide a rationale for dropping these considerations. In the end, participation remained a voluntary process. For the purpose of measuring efficacy, the committee members also discussed requiring an 80% pass rate, but did not explain how, or if, these data would be collected and/or analyzed. Based on review of the online module "Fall Prevention Jeopardy Game," dated September 2019, however, it did not appear that DBHDS was collecting any provider-specific competency data. In general, any quality improvement plan should have a means by which to measure the extent to which the intervention was successfully implemented before it can attempt to correlate the intervention with the overall outcome (e.g., decrease in falls.) Once the OSIG report identified the apparent prevalence of falls within the I/DD population, DBHDS staff apparently did not drill down further into the available data to try to ascertain where root cause(s) might exist. This could have perhaps allowed them to better target the QIP interventions as well as determine what discrete data they would need to collect to determine the effectiveness of the interventions.

Root Cause Analysis: In April 2019, DBHDS provided training to DBHDS licensed providers entitled *Root Cause Analysis (RCA): The Basics*. This presentation included an overview of the regulatory requirements for CSBs and providers with regard to RCA, to wit:

- 12VAC35-105-20. Definitions: "Root cause analysis means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm."
- 12VAC35-105-160.E"A root cause analysis shall be conducted by the provider within 30 days of discovery for all Level II and Level III serious incidents"

The training also covered the purpose of a RCA, when to conduct a RCA, the three components of a RCA required by DBHDS licensing regulations (i.e., detailed description of what happened, analysis of why it happened, and identified solutions to mitigate its reoccurrence), approaches for finding root causes, and an exploration of how to make system changes based on a RCA.

The presentation also described how DBHDS licensing specialists would monitor providers going forward:

- "Provider has a clearly documented process for when and how RCA will be conducted;
- Staff have been trained on how to complete a RCA;
- There is a completed RCA for each Level II and Level III serious incident;
- RCA clearly contains all required components;
- Changes are made as a result of RCA, as appropriate such as revised protocols or policies;
- If changes are not made, reasons why are clearly documented;
- Changes are clearly communicated to all staff at all levels; and,
- Changes are monitored to ensure they are effective."
-

Case Management as an Integral Function of Risk Management: In addition to the aspects of the risk management system described above, this study found that the current conceptualization of the quality and risk management system, as presented in the *DBHDS Quality Management Plan FY2020* did not provide a specific emphasis on the role of the case manager. It was of particular concern that DBHDS staff reported the case managers did not have direct access to the CHRIS reports of critical incidents for the individuals they served; instead, CSBs could provide case managers with reports of incidents, based on protocols which might differ from one CSB to another, and only for reports generated by the CSB. Interviews with CSB staff for this review confirmed these observations.

This appeared to be a significant oversight and systemic flaw. Case managers are charged with ensuring individuals' health and safety and ensuring that remedial actions needed are identified and completed, and to identify previously unidentified risks. In addition, they are charged with ensuring that each person-centered plan identifies and addresses an individual's risks and updates that plan as needed to address emerging risks, as described above. Without access to both real-time and aggregate data, there is a very real likelihood that an individual's person-centered plan would not include a comprehensive risk assessment or risk mitigation plan.

The Independent Reviewer has previously raised this concern. In December 2016, the – Report to the Court included a study on *Safety and Protection from Harm Requirements of the Settlement Agreement*. At that time, the study documented that the Commonwealth's Quality Improvement Plan in existence at the time included a tiered approach that conceptualized the case manager as the "system's trip wire for quality assurance." The study further expressed concern that this conceptualization was flawed because case managers did not have the authority to obtain the reports of serious incidents that private providers submit to DBHDS through CHRIS. This made it unlikely that even a good case manager who was oriented to risk management and quality improvement would be able to gather a full risk profile and to be responsive to an individual's service planning needs. At that time, the study recommended that DBHDS seek to remove the obstacles to a case manager accessing CHRIS incident reports for individuals on his/her caseload.

It was not clear why the current version of the quality management plan no longer identified the case manager's pivotal role in risk management, or why DBHDS had not put forth a strategy to address the previous finding. This remained as a significant gap in the overall risk management system. It also directly undermines the Commonwealth's ability to achieve compliance with V.F.2. which requires that the IDD case managers "assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status",

DBHDS staff should strongly consider addressing this functionality as they continue to develop an RFP for a new incident management system, as discussed further below with regard to Section V.D.

Section V.D: Data to Assess and Improve Quality

Previous reports included the following probes to evaluate progress for the six subsections of Section V.D. (i.e., V.D.1 through V.D.6.):

- Obtain status of any modifications to the Centers for Medicare and Medicaid Services (CMS)-approved Quality Improvement (QI) plan and implementation efforts.
- What is the status of the Commonwealth's efforts to assess the reliability and validity of provider data that it plans or has collected and analyzed?
- Have any recommendations been developed and/or actions taken to ensure the completeness and reliability of data submitted?
- Have any reports been designed or completed in regard to improving the availability, accessibility, and quality of services offered to individuals receiving services under the Agreement.
- Obtain updates on the Commonwealth's efforts to identify the data to be collected and to collect valid and reliable data for the eight domains (i.e., as listed in Section V.D.3, a through h).
- Determine the status of the Commonwealth's work to verify the validity of the measures and reliability of the data (V.D.2, a through d) and the status of data analyses (i.e., Section V.D.4).
- Obtain updates on the status of CSBs' and providers' review of data (i.e., V.D.1.), as well as of the review processes of data at CSB's and by DBHDS/DMAS' review of CSBs' and providers' data review processes.
- Obtain updates on the status of the Regional Quality Councils (i.e., Section V.D.5a. and b) and the status of the Quality Councils assessments of relevant data, review of trends, and recommendations.
- Obtain updates on the status of the Quality Improvement Committee's review; any recommendations adopted, delayed or rejected; and any action taken and results achieved; and communication with the RQCs in response to their recommendations.
- Obtain updates on the Commonwealth website designed to report publicly on the availability, quality, and gaps in services, and recommendations made for improvement (i.e., Section V.6).

Section V.D.1

V.D.1: The Commonwealth's HCBS [Home and Community-Based Services] waivers shall operate in accordance with the Commonwealth's CMS [Centers for Medicare and Medicaid Services]-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers; identification, response and prevention of occurrences of abuse, neglect and exploitation; administrative oversight of all waiver functions including contracting; and financial accountability. Review of data shall occur at the local and state levels by the CBSs and DBHDS/DMAS, respectively.

The 13th review period study found that the draft quality management documents available at that time presented a high-level description of how DBHDS structured its quality management program, but with only brief mention of the CMS waiver assurances and how data from the waiver performance measures would be used to assess compliance. Therefore, the study report could not assess whether the Commonwealth's HCBS waiver were being operated in accordance with the approved waiver quality improvement plans.

15th Review Period Findings

For this review period, the consultant reviewed the Quality Improvement Strategy Appendix (Appendix H) to the waiver applications and the most recent waiver evidence report detailing the status of compliance with the waiver Assurances and sub-assurances. The study also reviewed the processes in place to ensure the review of data occurred at the local and state levels, by the CSBs and by DBHDS/DMAS respectively. The following provides a summary of findings.

To be granted authority to operate a home- and community-based services waiver, a state must provide detail about how it will show it meets the required Assurances:

- Waiver Administration and Operation: Administrative Authority of the Single State Medicaid Agency
- Evaluation/Reevaluation of Level of Care
- Participant Services - Qualified Providers
- Participant-Centered Planning and Service Delivery: Service Plan
- Participant Safeguards: Health and Welfare
- Financial Accountability

As the *CMS Instructions, Technical Guide and Review Criteria* (*Technical Guide*) instructs, a waiver application must also include components of a Quality Improvement Strategy (QIS) to ensure that those waiver assurances are met. To accomplish this, a state must define performance measures in each area. Appendix H of the application must then also define a specific quality improvement strategy that describes "(1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate."

The *DBHDS Quality Management Plan FY 2020* described a state-level collaborative and cross-agency Quality Review Team (QRT) responsible for the oversight of the quality improvement strategy as described in the waiver programs:

> "The Quality Review Team (QRT), a joint Department of Behavioral Health and Developmental Services (DBHDS) and Department of Medical Assistance Services (DMAS) committee, is responsible for oversight and improvement of the quality of services delivered under the Commonwealth's Developmental Disabilities (DD) waivers as described in the approved waivers' performance measures."
>
> "The QRT is responsible for reviewing performance data collected regarding the Centers for Medicare and Medicaid Services' (CMS) Home and Community-Based Services (HCBS) waiver assurances..."
>
> "The team identifies barriers to attainment and the steps needed to address them. The QRT re-examines data in the following quarter to determine if remediation was successful or if additional action is required. If remediation and/or improvement is not recommended for a performance measure that falls below 86%, the justification for that decision will be documented in the meeting minutes."

With regard to the review of data at the local level, the Commonwealth's documentation provided did not provide a clear picture of the role of the CSBs in the review of data with regard to the waiver performance measures and sub-assurances.

In order to evaluate the status of DBHDS' performance for this section, the consultant reviewed Appendix H for the Community Living Waiver. In that document, the Commonwealth described a process for quality improvement that appeared to be consistent with the description in the *DBHDS Quality Management Plan FY 2020* provided above:

- "Performance measure data is reviewed by the Quality Review Team (QRT), which meets quarterly, and the DBHDS Quality Improvement Committee (QIC), which meets monthly. The QRT reviews data related to the waiver assurances, while the QIC reviews the quality of community services provided to individuals with DD. Information flows freely between the QIC and the QRT and is used to determine priorities and oversee the

implementation of system changes. Representatives from DMAS and DBHDS participate on the QRT and QIC;" and,

- "Performance measure data related to each of the waiver assurances is reviewed. When performance is not meeting goals, the team reviews data from each unit noted above to monitor progress toward attainment of performance measures."

A brief review of Appendix H for the other two waivers (Family and Individual Support Waiver and the Building Independence Waiver) indicated they appeared to be largely consistent with the narrative for the Community Living Waiver.

The consultant also requested to review the waiver evidence reports. As the *Technical Guide* states, renewal of an existing waiver is contingent upon a CMS review of waiver data, or evidence, to determine if the state has met the assurances. Based on that review and findings, CMS will issue a report to the state summarizing its findings and conclusions concerning the operation of the waiver. If CMS identifies that a state has demonstrated it has not met performance measures for any of the assurances, it may require the state to propose remedial steps that are satisfactory to CMS to correct the problems.

The Family and Individual Support Waiver and the Building Independence Waiver had effective dates of July 1, 2018, so their renewals did not occur during this review period. However, the renewal for the Community Living Waiver was effective on July 1, 2019. In February 2018, the Region III office of CMS issued the most recent evidence report (*Draft Report for the Home and Community-Based Services Waiver Review Intellectual Disability (Community Living) Program*), in advance of the anticipated renewal request. After discussions and the opportunity for the Commonwealth to submit additional evidence, the final report (*Final Quality Review Report for the Virginia HCBS Intellectual Disability (ID) (CL) Waiver*) indicated that the Commonwealth did not demonstrate the assurance for Health and Welfare. For four performance measures across three sub-assurances, DBHDS did not collect and/or provide the required data.

As a part of this study, the consultant also requested QRT meeting minutes to assist in the evaluation of the thoroughness and efficacy of the state-level data review process, but DBHDS did not make those available in time to be included in this analysis. However, the lack of collected data for four performance measures across three sub-assurances, as described above, in and of itself called that thoroughness and efficacy into question.

Section V.D.2 through Section V.D.4.

V.D.2: The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement. The Commonwealth shall use data to:

a. *Identify trends, patterns, strengths, and problems at the individual, service-delivery, and systemic levels, including, but not limited to, quality of services, service gaps, accessibility of services, serving individuals with complex needs, and the discharge and transition planning process;*
b. *Develop preventative, corrective, and improvement measures to address identified problems;*
c. *Track the efficacy of preventative, corrective, and improvement measures; and,*
d. *Enhance outreach, education, and training.*

V.D.3: The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area:

a. *Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);*
b. *Physical, mental, and behavioral health and wellbeing (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status);*
c. *Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);*
d. *Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);*
e. *Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);*
f. *Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);*
g. *Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and.*
h. *Provider capacity (e.g., caseloads, training, staff turnover, provider competency*

V.D.4: The Commonwealth shall collect and analyze data from available sources,

including, the risk management system described in Section V.C. above, those sources described in Sections V.E-G and I below (e.g., providers, case managers, Quality Service Reviews, and licensing), Quality Management Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.

Inasmuch as Section V.D.2., V.D.3. and Section V.D.4. each focus on various aspects of the collection and analysis of reliable and valid data, this study provides the joint examination below.

At the time of the 13th period review, the study found DBHDS:

- Had developed a Quality Management Framework that described roles and responsibilities for the RMRC and the QIC in this area;
- Had made limited and intermittent progress toward the development of clear and valid measures for the Key Performance Areas, or KPA, (i.e., Provider Capacity/Competency, Person-Centered Services, Health and Well-being and Integrated Settings/Community Inclusion);
- Had developed, and presented to the QIC, a template for further defining the KPA measures, but the draft measures still needed significant work with regard to prioritization; validity and reliability of data, including defining the data sources; baseline measures; and goals and targets;
- Had updated an Incident Management Report with actual systems data that had potential for allowing DBHDS staff to drill down into the data for further analysis (e.g. by Region, by CSB, by provider locations, by individual, by type of incident, etc.) and that staff were testing the report, with some additional modifications pending;
- Had not yet begun to use the Incident Management Report to identify individuals at risk or providers that require attention; triaging the data so that highest priority issues are addressed first; or following up on identified issues; and,
- Had not yet developed a structured plan, including specific goals, objectives, tasks and timelines, to guide the efforts necessary to identify, define, collect, analyze, report, and effectively use relevant data to evaluate and improve services.

15th Review Period Findings

These three sections of the Settlement Agreement require the Commonwealth to collect and analyze data on a number of topics and from a variety of available sources. As described in the Background section above, DBHDS had continued to make modifications to its Quality Management Framework, including additional definition of the roles and responsibilities of the QIC and RMRC in the development, implementation and oversight of processes to collect and analyze valid and reliable data.

Within that context, this review examined the progress DBHDS had made toward the development of specific measures and data collection methodologies and sources. In addition, the review documented significant issues with regard to the challenges DBHDS continued to face with regard to the collection of reliable and data and the ongoing or pending efforts to resolve them. The findings below are organized into three areas:

1. The development of the specific performance indicators the Commonwealth will use to measure the broad requirements laid out in the Settlement Agreement, including data needed to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services as described in Section V.D.2., as well as the eight domains specified in Section V.D.3. (i.e., safety and freedom from harm; physical, mental, and behavioral health and wellbeing; avoiding crises; stability; choice and self-determination; community inclusion; access to services; and, provider capacity*);*
2. An overview of metrics the Commonwealth currently collects data for across a variety of platforms; and,
3. The status of the processes the Commonwealth uses to collect and analyze reliable data with regard to the performance indicators, including an update on the information sources and the related information technology systems architecture

1. Performance Measures

As described in the Background section above, DBHDS had promulgated the *DBHDS Quality Management Plan FY 2020*. That document defined three broad categories aimed at addressing the availability, accessibility, and quality of services: Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity. The plan also chartered three KPA workgroups, one for each domain, and charged them with the proposal and development of measures, which would be reviewed and approved by the QIC.

At the time of the 13th review period, the study documented some progress toward measure development for the eight domains set out in Section V.D.3. a.-h, but found this was a work-in-progress, with much of the activity taking place toward the end of the review period. Based on the minutes submitted for this review period, which were only provided for July and August of 2019, this pattern of activity had continued. At the time of this review, DBHDS indicated it had completed three draft output measures for Health, Safety and Well-being, one output measure for Provider Competency and Capacity and none yet completed for Community Inclusion and Integration. It is anticipated that the pace of measure development will increase as the parties reach agreement on compliance indicators.

Also at the time of the previous review, DBHDS staff had drafted a template to memorialize the details of proposed performance measures, including outcomes, target objectives, performance measures, data sources, responsible departments, and frequency of reporting. The previous study recommended expanding upon this template to include other components, such as a baseline or benchmark measure, a goal, a timeline, definitions and a detailed methodology for collecting reliable data. For this review, e . It was also positive to see that, in an effort to integrate and

streamline measurement efforts and methodologies, the PMI template cross-referenced the eight domains described in Section V.D.3., the Settlement Agreement section and the respective CMS assurance. A KPA Action Summary, dated August 27, 2019, indicated the workgroups were still working to improve the PMI template and had made several recommendations for further review.

2. Additional Metrics and Data Collection Efforts

In addition to the KPA effort described above, DBHDS currently collects data on a variety of metrics from various sources, as described in Section V.D.4. The following summarizes some of the major efforts.

- DBHDS collects data with regard to critical incidents, including abuse, neglect and exploitation, through the Computerized Human Rights Information System (CHRIS).
- DBHDS collects licensing data with regard to service providers, including the service(s), location and program details, as well as data on inspections and investigations.
- Through its performance contracts with the CSBs, DBHDS requires these entities to collect and report a wide range of case management data, which DBHDS organizes by CSB in Case Management Data Quality Reports. Examples included:
    - Percentage of individuals receiving DD Waiver services who meet the criteria for receiving enhanced case management (ECM) services who: a. Receive at least one face-to-face case management service monthly with no more than 40 days between visits, and b. Receive at least one face-to-face case management service visit every other month in the individual's place of residence;
    - Percentage of adults (age 18 or older) receiving developmental case management services from the CSB whose case managers discussed integrated, community-based employment with them during their annual case management individual supports plan (ISP) meetings, and the percentage of adults whose ISPs contained employment outcomes, including outcomes that address barriers to employment;
    - Data about individuals whose case managers discussed community engagement or community coaching opportunities with them during their most recent annual ISP meeting, and whose ISP contained community engagement or community coaching goals.
    - As of October 4, 2019, DBHDS required that all ISPs must be entered into the Waiver Management System (WaMS), which will further enable the aggregation and analysis of data with regard to the aforementioned metrics and other ISP-related metrics. In addition, DBHDS will collect data to measure CSB compliance with this requirement.
    - In addition to ensuring the ISPs are entered into WaMS, in February 2019, DBHDS also notified the CSBs that going forward there would be a focus on the metrics with regard to Case Managers making timely RST referrals on everyone seeking less integrated residential authorizations and (3) Increased Number of Individuals receiving supports for Employment on Waiver.

- The Commonwealth participates in the National Core Indicators to collect a wide range of data with regard to quality of life, community integration and individual satisfaction.
- DBHDS has currently paused the collection of data from Quality Services Reviews (QSRs), as it seeks to revamp that process, but it will be resumed following the conclusion of the current RFP process and selection of a new vendor.

3. Processes for Data Collection and Analysis

This study found that, while DBHDS collected considerable data from various sources, significant issues with the reliability and validity of the data still existed throughout the system. These issues hampered the ability of DBHDS staff to complete meaningful analyses of the various data the collected and/or implement needed improvements. It was positive, though, that DBHDS staff had identified many of these concerns and were either engaged in or planning initiatives to rectify them. The following paragraphs provide a description of some of the concerns and the steps that DBHDS has taken or are planned. As context, the following provides a brief summary of five major data collection and management systems DBHDS currently employs for the purposes of quality and risk management:

- Computerized Human Rights Information System (CHRIS), which includes dual reporting systems, one for serious incidents and deaths and one for allegations of human rights violations (i.e., abuse, neglect and exploitation);
- Office of Licensing Data System (OLIS) contains data on licensure inspections and investigations.
- Community Consumer Submission 3 (CCS 3) gathers data from CSBs on individual characteristics, service data and case management indicators;
- Waiver Management System (WaMS), which is used for service authorization and to manage CSB waiver slot allocations; and,
- OneSource Data Warehouse, a reporting service used to create and customize various reports.

Since the previous report of the 13th review period, DBHDS had engaged in a period of self-assessment with regard to several of these major systems. In 2019, the Office of Data Quality and Visualization completed an examination of data quality concerns for various data sources that DBHDS uses for purposes of quality and risk management. The draft *Data Quality Plan* identified data validity and reliability issues with regard to the CHRIS serious incident and death reporting system, the CHRIS human rights reporting system, the OLIS and, in addition, Regional Support Team data and the PAIRS system for facility injuries and deaths. In each case, the report examined the current state to identify the specific concerns and described improvements needed as well as any existing or planned initiatives toward resolving those concerns.

For example, the draft report described limitations with regard to the CHRIS architecture and processes that needed to be addressed before DBHDS could extract and analyze meaningful data to identify patterns and trends or monitor the impact of corrective actions and quality improvement strategies. These included, but were not limited to, the following:

- The lack of clear definitions for reportable incidents, resulting in inconsistent reporting practices and, therefore, unreliable data.
- System design concerns that prevented DBHDS staff from using the data to identify systemic needs for preventative, remedial or improvement interventions. For example, a confusing and incomplete protocol of check-boxes with regard to type of incident had resulted in the majority of incidents being coded as "other." In addition, the report noted that the majority of the information about how and why incidents occurred was recorded in free-text boxes, which did not make aggregation for analysis feasible. Other design concerns included:

    - A provider address drop-down menu could include thousands of locations, including closed locations, and these options are not listed in alphabetical or numeric order. As a result, addresses were often incorrect;
    - When an injury occurs as the result of abuse, the CHRIS architecture requires providers to enter a report twice, once in the licensing database and once in the OHR side of the system. This increases the likelihood of error and conflicting information. In addition, the reporter must enter the number of the abuse report on the injury incident report; otherwise, the system cannot link the two; and,
    - Individuals served do not have a unique identifier in the system, making it difficult to match records within CHRIS and externally for identifying potential individual trends.

These findings were largely consistent with, and affirmed by, an external examination related to DBHDS' critical incident management system. In December 2018, the Office of the State Inspector General (OSIG) issued the *Department of Behavioral Health and Developmental Services: Review of Serious Injuries Reported by Licensed Providers of Developmental Services*, for which one of the objectives was to "review the efficiency and effectiveness of DBHDS' QIC and RQCs relevant to serious injuries reported by providers serving individuals with developmental disabilities to identify actual and potential risk points and make recommendations to improve the process and individuals' overall safety and freedom from harm. This report highlighted many of the same concerns as found in the draft *Data Quality Plan* and made recommendations for improvements. The OSIG report found the following:

- The quality, consistency and reliability of reports used by DBHDS relevant to serious injuries were insufficient;
- DBHDS offered no definitions to providers relevant to serious injuries or guidance to support consistent and reliable reporting; and,
- The lack of clearly defined terms and guidelines limited the QIC and RQCs' abilities to analyze serious injury data, identify patterns and trends or prioritize the highest risk injuries for performance improvement initiatives.

In the current Independent Reviewer's Report to the Court, another study (i.e., *Licensing and Human Rights Requirements of the Settlement Agreement*) describes how DBHDS had been actively addressing some of those issues even prior to the the OSIG report recommendations for improvement. Documentation provided for this report indicated that, on September 1, 2018, DBHDS promulgated emergency amendments to its licensing regulations to categorize incidents by severity and reporting requirements and specify incident definitions. DBHDS has also implemented updates to the CHRIS system, including refining system protocols that led to inaccuracies in the data, and published related final guidance on December 28, 2018.

However, DBHDS staff have recognized for some time that these changes would not address all of the concerns presented with this legacy system and were currently developing an RFP to obtain a long-planned new system for critical incident management. At the time of this report, DBHDS staff reported they were still developing the specifications and did not have a draft ready to share. In addition to addressing the issues described immediately above and the case management functionality mentioned earlier, DBHDS should seek to integrate the capability to address the Compliance Oversight Model Practices found in the Joint Report *Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight* issued in September 2018 by the U.S. Office of the Inspector General, the Department of Health and Human Services, the Administration on Community Living and the Office of Civil Rights.

Data reliability issues also existed within CCS3, another system DBHDS uses to collect data with regard to quality and availability of services, service gaps and accessibility of services. DBHDS performance contracts require the CSBs to provide monthly CCS 3 extracts that report these service data and case management data to DBHDS. On April 26, 2019, the DBHDS Office of Community Quality Improvement and Risk Management (CQIRM) issued a report entitled *CSB Quality Reviews*, which detailed a quality improvement initiative that took place over the course of the last two quarters of FY 2018. This initiative was in response to ongoing concerns with regard to the r data and undertaken at the behest of the QIC. The report described the purposes of the on-site visits as:

- "Provide consultation and technical assistance on case management process and data reporting to ensure CSBs are using valid data as part of a comprehensive quality management process to improve case management outcomes;
- Assist CSBs to complete a root cause analysis that identifies gaps, issues, and underlying causes for why the CSB is not meeting case management processes and data reporting targets; and,
- Assist in resolving the identified case management and data process gaps and issues and determine needed action steps to make system process and outcome changes to ensure that case management processes are implemented and data is reported as required."

Among other findings with regard to the utility of the measures as described above, the report indicated the following related to the ability to collect, manage and report valid and reliable data:

- The CCS 3 was developed to collect data related to services for federal grant purposes and was unlikely to support future data reporting demands. DBHDS may need to determine how these limitations may influence data quality and validity;
- Most CSBs did not have the technical expertise or capability to develop or generate specific reports related to the case management data metrics and those that did could not replicate DBHDS aggregate reporting numbers and were unable to reconcile the reports to improve data quality; and,
- DBHDS generated reports did not allow for timely correction of issues identified due to the lag time between data submission and report generation. CCS 3 allows the CSBs up to 30 days to analyze, correct, and submit data after the close of the reporting month. DBHDS generally has an additional 30 days to generate reports from the data submitted. This limited capability to identify and correct errors in data reporting in a timely manner challenges the ability of both the CSB and DBHDS in effectively monitoring performance measurements.

The report further detailed extensive technical assistance CQIRM staff provided to the CSBs and the development of a specific QIP for each CSB, based on their unique results. The CSBs, in turn, made regular reports to CQIRM as to their progress, which was tracked by the assigned DBHDS staff. As the report noted, while this project had a discovery component, it was largely an ongoing technical assistance to assist CSBs to identify and resolve issues with quality data. This appeared to have been a well-planned and well-organized effort. In interviews with a small sample of CSB staff, they reported this had been a very helpful and valuable process.

In summary, DBHDS continued to collect data in many areas relevant to the Settlement Agreement requirements, and had made some incremental progress with regard to development of related measures. However, the efforts of DBHDS staff to conduct any meaningful analysis continued to be severely hampered by the lack of valid and reliable data across much of the system. DBHDS staff were keenly aware of the need to make improvements in this area, and were either engaged in improvement initiatives or planning efforts to make improvements. However, they still needed to develop a comprehensive and specific data quality improvement plan to tie all of those efforts together in a cohesive manner. At the time of the previous Quality and Risk Management Systems study for the 13th review period, the Independent Reviewer had urged DBHDS to create a comprehensive data quality improvement plan, with specific action steps and milestones, to expand and improve the quantity and quality of data to measure performance and to provide a structure for greater accountability of effort. The recently-developed *Data Quality Plan* and *CSB Quality Reviews* (April 26, 2019) provided a good foundation for moving forward on this recommendation.

Section V.D.5

The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.

a. The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders; and,

b. Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.

At the time of the 13th period review, the study found that RQCs were operational and consistently held meetings each quarter in each of the five Regions. While meeting minutes reflected some specific discussion on data reports for certain topics, (e.g., employment and housing report), they were inconsistent with regard to identifying specific feedback and recommendations from the regional participants.

15th Review Period Findings

The *DBHDS Quality Management Plan FY 2020* described the roles and responsibilities of the RQCs, prescribed the membership and issued a charter. Per the charter "RQCs are to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and evaluate data to identify and respond to trends to ensure continuous quality improvement. RQCs review and assess state and regional data related to quality indicators (performance measure indicators) for developmental disability services...Each RQC reviews and evaluates the data, trends and monitoring efforts."

Progress and continuing concerns noted with regard to the operations of the RQCs included the following:

- At the time of this study, RQCs continued to meet regionally on a quarterly basis and minutes continued to be consistent with the findings from the previous review;

- The previously-referenced OSIG report from December 2018 documented a finding that RQC members had not received any training in quality management or performance improvement and recommended that they receive training in quality management QM principles and performance improvement. On August 22, 2019, through the auspices of a Virginia Commonwealth University (VCU) Partnership for People with Disabilities "Living Well" grant, DBHDS convened a joint training session for all five RQCs. Among other topics, presentations included a review of the DBHDS quality management structure, understanding the big picture of the role of quality councils, roles and responsibilities of a Quality Council: and using data to improve system performance. CSB staff interviewed with familiarity of the training reported it was both valuable and much-needed;

- The OSIG report also found that data presentations provided to the RQCs did not facilitate the members' ability to track, trend or identify serious-injury patterns in their specific regions, make comparisons of serious injuries by quarter or develop targeted performance improvement plans to benefit those served in their regions. For this review, RQC minutes also appeared to indicate that the members did not yet have a clear picture of the data they would receive, but had made some specific requests to receive data that were both regionalized and relatively current. Minutes further stated that DBHDS staff observed that there may be limitations on the ability to provide data for trending on a regional level due to constraints with the data collection processes. DBHDS staff working on the incident management RFP should be sure to consider those constraints and how to address them. Also, as described above, DBHDS has not been able to consistently provide current, and therefore actionable, data to the CSBs. This remained a systemic need DBHDS staff needed to address; and,

- Overall, based on interviews with DBHDS staff and some stakeholders, a general consensus seemed to emerge that the RQCs lacked a clear value-added purpose in their current format. DBHDS leadership indicated they planned to continue discussions with stakeholders about the role of the RQCs and how to move forward. It was notable, though, that DBHDS staff reported it had been difficult to sustain RQC membership and attributed this in part to a lack of clarity about purpose and expectation, even with the recently issued charters. It was therefore interesting that CSB staff interviewed reported finding the meetings valuable and informative. As much as anything, it is possible that the perceived lack of functionality of the RQCs has as much to do with the lack of needed tools to undertake their assigned tasks (i.e., current and regionalized data, training and expertise, etc.). These factors should be considered as the discussions about the future of the RQCs move forward.

Section V.D.6

> *At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvements.*

At the time of the 13th period review, the study found that DBHDS had not yet developed the functionality for the required public reporting, due in part to issues with its website operations.

15th Review Period Finding

For this review period, DBHDS staff did not provide any documentation to demonstrate it had provided pubic reporting on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvements. As described in the Background section above, however, going forward the QIC will be tasked with developing an annual report.

Section V.E.1 and V.E.2

V.E.1: The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of this Agreement.

V.E.2: Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3. above. The measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from Regional Quality Councils, described in Section V.D.5 above. The DBHDS quality improvement committee will assess the validity of each measure at least annually and update measures accordingly.

Previous reports included the following probes to evaluate progress for these two Sections:

- Has DBHDS established a baseline regarding existing QI practices?
- As of August 1, 2019, had DBHDS established expectations for providers' and CSBs' quality improvement systems?
- Has DBHDS required providers and CSBs to report on key indicators that address both positive and negative outcomes for health and safety and community integration?
- Has the Commonwealth reviewed and determined the reliability of data submitted by providers through their risk management of quality improvement programs?
- Has the DBHDS Quality Improvement Committee begun to review and address these measures?
- Have providers and CSBs begun implementing root cause analysis, as appropriate? If so, has action been taken to address identified causes, has the Commonwealth determined whether these actions resulted in desired outcomes, and if not, have remediation plans been modified?

At the time of the 13th period review, the study found that DBHDS:

- Had revised regulations to required providers to develop and implement quality improvement programs (12VAC35-105-620. Monitoring and Evaluating Service Quality) and to conduct, at least annually, systemic risk assessment reviews that incorporated uniform risk triggers and thresholds (12VAC35-105-520. Risk Management); and,

- Had not developed clear criteria and expectations for the requirements for a provider risk management system to serve as guidance and to allow DBHDS to consistently monitor providers' and CSBs' implementation and adherence to the requirements.

15th Review Period Findings

As previously reported, the Commonwealth had issued emergency regulations to require licensed providers to develop and maintain quality improvement programs. The regulation at 12 VAC 35-105-620 states the following:

> *The provider shall develop and implement a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. The program shall: (i) include a quality improvement plan that is reviewed and updated at least annually; (ii) establish measurable goals and objectives; (iii) include and report on statewide performance measures, if applicable, as required by DBHDS; (iv) utilize standard quality improvement tools, including root cause analysis; (v) implement a process to regularly evaluate progress toward meeting established goals and objectives; and (vi) incorporate any corrective action plans pursuant to 12VAC35-105-170. Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when indicated.*

This regulation was effective September 1, 2018 through February 29, 2020, or until the permanent regulation takes effect.

In November 2018, DBHDS also issued a guidance document (*Office of Licensing Guidance for a Quality Improvement Program*) to providers regarding these requirements. This guidance indicated that DBHDS did not require a specific template for the quality improvement plan, but provided some additional detail with regard to the six subsections of the regulation (i.e., quality improvement plan reviewed and updated at least annually; measurable goals and objectives; include and report on statewide performance measures; utilize standard quality improvement tools; regularly evaluate progress; and (vi) incorporate any corrective action plans.)

DBHDS did not provide records to document the OL protocol for monitoring whether, and the extent to which, CSBs and providers have implemented the Commonwealth's quality improvement program requirements. Once implemented, the initial results of the Office of Licensing monitoring process will provide information needed to determine what additional actions are necessary for the Commonwealth to ensure that CSBs and providers are fulfilling these requirements. DBHDS communicating its expectations regarding the six subsections was a good and important start. DBHDS will need an organized methodology and protocol to monitor and gather information of effective implementation to provide records that demonstrate that the Agreements QIP requirements have been properly implemented. As has occurred with other new Settlement Agreement requirements, some CSBs and providers will likely need considerably more guidance, technical assistance, and potentially enforcement to ensure that these requirements are effectively implemented.

With regard to Section V.E.2., while the Commonwealth collected various data, as described above under Sections V.D.2. through V.D.4., there remained considerable work to be done in the area of measure development. The *DBHDS Quality Management Plan FY 2020* provided a clear

process and hierarchy for the development, review and approval of these measures, but that process had not yet generated a set of approved valid measures.

IV. CONCLUSIONS AND RECOMMENDATIONS

DBHDS is fully aware that it is not yet gathering valid and reliable data, which is essential to the effective functioning of its Quality and Risk Management system and to achieving compliance with the requirements of the Agreement. Accordingly, DBHDS should continue to focus on building the capacity and infrastructure to collect valid and reliable data. The following recommendations would assist in this foundational effort.

- As previously recommended, DBHDS should develop a structured plan, including specific goals, objectives, tasks and timelines, to guide the efforts necessary to identify, define, collect, analyze, report, and effectively use relevant, valid and reliable data to evaluate and improve services.

- DBHDS staff working on the incident management RFP should be sure to consider these plan requirements and how to address them.

- As DBHDS continues to develop an RFP for a new critical incident management system, they should ensure that case managers receive notification of all reports of serious incidents and injuries experienced by individuals on their caseloads for whom they are responsible for assessing previously identified and unidentified risks, injuries, or other changes in status.

- DBHDS should seek to integrate the capability to address the Compliance Oversight Model Practices found in the Joint Report *Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight* issued in September 2018 by the U.S. Office of the Inspector General, the Department of Health and Human Services, the Administration on Community Living and the Office of Civil Rights.

APPENDIX J.

LIST OF ACRONYMS

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

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