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 7, 2016 – September 30, 2016

Respectfully Submitted By

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Independent Reviewer
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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's ninth Report on the status of compliance with the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress and compliance during the review period from April 7, 2016 – September 30, 2016.

The Independent Reviewer reported previously that the Commonwealth's Home- and Community-Based Services (HCBS) waiver programs and its various regulations had impeded compliance with provisions of the Agreement. For more than three years, the Commonwealth's primary strategy to come into compliance has been the redesign of its HCBS waiver programs. The Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Medical Assistance Services (DMAS) organized an extensive and concerted multi-year effort to plan the redesign and to secure the approval of Virginia's General Assembly. The Commonwealth stated its goal for the redesign is *"to provide for a flexible array of community-based options with a rate structure that supports the cost of new and existing services and provides incentives to providers for offering expanded integrated options."* To accomplish this goal, the Commonwealth redesigned the HCBS waivers' *eligibility criteria, service definitions and expectations, payment rates, service limits, and cost caps.* In the Spring of 2016, Virginia's General Assembly approved the redesign as proposed by DBHDS and DMAS and approved most of the funds that the Governor requested for implementation. During this, the ninth review period, the Commonwealth achieved the next two essential steps. First, it secured the approval of the Center for Medicaid and Medicare Services (CMS) for the proposed redesign. Second, the Commonwealth began the extensive and complex process to implement the redesigned waivers.

The Commonwealth's effective implementation of the redesigned waivers requires extensive and statewide systemic changes, training and communication. Hundreds of service providers need to modify existing models of service and to develop new ones. Extensive training of case managers and service planning teams is needed to plan and to deliver services that meet the standards of the newly defined services. The most important challenge while implementing the change process is that services must continue to meet the daily needs and to protect the safety and well being of thousands of individuals with Intellectual and Developmental Disabilities (ID and DD).

As with implementing any complex and systemic change initiative, timely and effective communication with stakeholders who will be influenced by, and contribute to, the changes is critically important. This is especially so when changes require the understanding and participation of multiple state agencies, hundreds of service providers, forty Community Service Boards (CSBs), and thousands of individuals and families. With the new HCBS waivers, the Commonwealth began implementation of a new Waiver Management Information System (WaMS). Stakeholders raised questions and identified many concerns that implementation problems with WaMS could lead to negative unintended consequences for service providers and individuals. In following up on these issues, the Independent Reviewer found that DBHDS and DMAS were aware of the issues, which had been raised during their weekly open calls with stakeholders, and were planning or implementing needed changes.

The Commonwealth's redesigned waivers and improved payment rates will encourage systemic changes. The program development and transitions needed to impact a significant numbers of individuals, however, will take time. The Commonwealth will also be identifying and resolving the

obstacles and the inevitable unanticipated consequences when complex systems are substantially modified. The Independent Reviewer will determine the extent to which the Commonwealth's redesign has fulfilled the requirements of the Agreement during future review periods when sufficient implementation has occurred to document the impact of the redesign on individuals' lives.

The Commonwealth also recognizes that it must revise its regulations to achieve compliance with the Agreement. The Commonwealth prioritized gaining approval of its redesigned HCBS waivers, during which DMAS revised the waiver regulations. The Commonwealth has not, however, revised its other regulations (i.e., DBHDS licensing and human rights regulations) so they align with the requirements of the Agreement. Completing these revisions is an essential cornerstone to building an effective Quality and Risk Management System. The need for quality improvement and risk management systems is especially critical during periods of systems and programmatic change. Although the Commonwealth has made progress in planning the elements of the quality and risk management system, it has not yet implemented many of these provisions at the direct service provider level. Improving service effectiveness at the level of direct service transactions is the purpose of quality improvement processes. The Commonwealth's implementation of a quality and risk management system is needed now more that ever.

There continues to be support within DBHDS for developing a strong quality improvement and risk management system. Significant work has continued within DBHDS to design and to test elements of the quality management system required by the Agreement. There has been a change in leadership within the DBHDS Quality Division during this review period; new staff with needed expertise have been added; and the Interim Commissioner has undertaken a reorganization and refocus of the work of the DBHDS Quality Improvement Committee. The DBHDS Health Support Network has developed and implemented important statewide initiatives to build the capacity of providers to support individuals with intense medical needs. DBHDS is also moving forward with initiatives to develop more integrated residential and day activity options and to build additional behavioral and medical support capacity in central and southwest Virginia. These are all promising changes. Although these changes represent significant steps forward, they still must be considered as initial steps to achieve compliance.

The Commonwealth's staff recognize that to achieve a comprehensive quality improvement and risk management system, DBHDS needs to partner, and implement the elements of the system with the CSBs and its private providers. However, this has not yet occurred. There are three overarching themes to these challenges that the Commonwealth must address:

- Expand the scope of available data in order to allow comprehensive and meaningful quality improvement and risk management initiatives to occur;
- Ensure that systems and statewide curricula are in place and operational so that all staff demonstrate competence in the service elements of the individuals they support; and
- Ensure that qualified investigators at the provider and state levels complete competent investigations of the facts of serious incidents and negative outcomes, including the use of root cause analysis to determine effective corrective action plans.

To achieve these results, the Commonwealth must revise the DBHDS regulations. Once it revises its regulations, then a major and complex implementation process still will be required.

The Independent Reviewer also reported previously that the Commonwealth did not have sufficient provider capacity to achieve compliance. While the Commonwealth appears to have excess provider capacity to serve individuals with average needs in larger group homes and in segregated day support

centers, it has too few providers and qualified professionals with the expertise and experience to provide services to all individuals with intense needs or with Autism Spectrum Disorders. It also has too few providers of individualized services that occur in physically integrated settings that promote social and recreational engagement within their communities. The Commonwealth's initiatives to increase provider capacity are described in the Independent Reviewer's eighth Report to the Court.

During the ninth review period, the Independent Reviewer completed the fifth Individual Services Review (ISR) study of the transitions of individuals who have moved from the Training Centers to live in more integrated community-based settings. The ISR study again found that the Discharge and Transition process is well organized and well documented. The individuals had settled well into their new homes. The individuals with histories of intense behaviors, in general, had fewer and less intense behavioral episodes. The individuals with intense medical needs were found to have positive health care outcomes in almost all areas that the Independent Reviewer's nurse consultants have tracked since 2012. However, in two areas, needed services were not in place before individuals moved; day activities were not in place for five of the twenty-six individuals; and three individuals in the sample were uncertain where to receive dental care.

The Commonwealth has made substantial progress implementing the elements of a crisis services system for children and has continued to refine these services for adults. More children and adults with DD, other than ID, most of whom have Autism Spectrum Disorders, are now engaged with the Commonwealth's crisis services programs. Out-of-home crisis stabilization programs, a significant element of children's crisis services, however, are not yet available. These programs, which offer crisis prevention and crisis stabilization services, will help children avoid unnecessary hospitalizations. The Commonwealth has been provided new resources to develop an array of crisis stabilization program options, which it expects will be evident during the eleventh review period.

The Commonwealth has also made progress implementing the Agreement's employment support requirements. For the first period, it collected data from all of its Employment Services Organizations (ESOs) concerning employment services for individuals with ID/DD. These data include information regarding individuals with waiver-funded services and those receiving funding primarily through the Department of Aging and Rehabilitative Services (DARS). The Commonwealth successfully met several of its employment target milestones. Now that all ESO's are submitting data, the Commonwealth can begin to determine the extent of future changes.

The DBHDS Mortality Review Committee (MRC) has continued to meet and to review annually the deaths of hundreds of individuals. The work required to complete the required number of mortality reviews is an immense task and the MRC has not kept pace. The MRC has completed most reviews. The rate at which it completes reviews, however, has not occurred within the ninety-day requirement. As the number of required reviews has increased, the percentage of mortality reviews completed within the required ninety days has decreased from about one of every two during 2014 to about one in every four reviews during 2016. The MRC has not gathered or documented the unavailability of the records needed for a quality review, as required. The MRC has successfully addressed and began to receive death certificates and autopsy results during the second half of the ninth review period.

During this review period, the Commonwealth and the Department of Justice continued to negotiate outcome-timelines and expect to reach agreement on several areas of the Agreement. These areas in the Agreement lacked specificity, due dates and measurable outcomes. The Parties are currently negotiating outcome timelines for Quality and Risk Management, Individuals in Nursing Facilities and

Intermediate Care Facilities (ICFs), Individuals with Complex Medical and Behavioral Needs, and Integrated Housing Options.

During the ninth review period, the Commonwealth succeeded in gaining approval for its redesigned waiver programs. It has devoted extensive efforts in the first stage of implementation. The Commonwealth has made progress in several areas and achieved interim milestone targets in others. The areas of progress include:

- Implementing the elements of the crisis services system for children;
- Refining the operations of the crisis services for adults;
- Collecting data regarding and achieving milestones in employment support; and
- Planning and testing quality improvement initiatives.

These efforts, however, have not yet resulted in new determinations of compliance. Progress may have been achieved in other areas, as well. This is reported to have occurred with the provision of Independent Housing. However, the Independent Reviewer did not study the status of developments in these other areas during the ninth review period. The Independent Reviewer will prioritize studying these areas and determining updated compliance ratings during the tenth review period.

The Independent Reviewer's overview of compliance ratings provided in the Executive Summary of the eighth Report to the Court is still applicable. The Commonwealth's staff and stakeholders have engaged in concerted and collaborative efforts during the ninth period. They have planned and implemented initiatives and continued to make progress in several areas. Progress has begun to be evident in the provision of integrated day and residential programs for individuals in the community. This progress has yet not resulted in substantial changes to the Independent Reviewer's determinations of compliance.

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

During the next review period, the Independent Reviewer will prioritize monitoring the status of the Commonwealth's compliance with the requirements of the Agreement in the following areas: Case Management; Integrated Day Activities/Supported Employment; Licensing and Investigations; Independent Housing; Provider Training; Crisis Services for Children and Adults; Regional Support Teams; and an Individual Services Review study of individuals with complex medical needs in Regions I, IV and V.

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

II. SUMMARY OF COMPLIANCE

Settlement Agreement Reference	Provision	Rating	Comments
III	**Serving Individuals with Developmental Disabilities In the Most Integrated Setting**	**Compliance ratings for the fifth, sixth, seventh, eighth and ninth review periods are presented as:** (5th period) 6th period *7th period* 8th period **9th period**	**Comments include examples to explain the ratings and status. The Findings Section and attached consultant reports include additional explanatory information.** ***The Comments in italics below are from the prior period when the compliance rating was determined.***
III.C.1.a.i-v	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community …	Compliance *Compliance* Compliance **Compliance**	The Commonwealth created 645 waiver slots during FY 2012 -2017, the minimum number required for individuals to transition from Training Centers.
III.C.1.b.i-v	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities)… v. In State Fiscal Year 2016, 275 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs.	Non Compliance *Non Compliance* Non Compliance **Non Compliance**	The Commonwealth created 1800 waiver slots between FY 2012 and FY 2017, 250 more than the1550 required. This meets the quantitative requirements of this provision. A few children have begun to use the prioritized waiver slots to transition from living in large ICFs. Substantive change is expected by the Spring of 2017.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.1.c.i-v	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities)… v. In State Fiscal Year 2016, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs	Non Compliance *Non Compliance* **Non Compliance**	The Commonwealth created 740 waiver slots between FY 2012 and FY 2017 for individuals with DD, other than ID, 465 more than required. The Commonwealth expects that results from implementing its plan to transition children living in nursing facilities will be evident in the tenth period.
III.C.2.a-b	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2015, a minimum of 1000 individuals will be supported.	Non Compliance *Non Compliance* Non Compliance **Non Compliance**	The Commonwealth continues to meet the quantitative requirement. DBHDS will develop a plan by 6/30/17. Implementation will be evident 3/31/18.
III.C.5.a	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	Compliance *Compliance* Compliance	*25 (100%) of the individuals reviewed in the case management study during the 8th period had case managers and had current Individual Support Plans. DBHDS reported that 88-89% of individuals received case management services.*
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.i.	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	Non Compliance *Non Compliance* Non Compliance	*The substantive changes in the ISP process and the training of case managers resulted in progress. The case management study during the 8th period, however, found a high level of discrepancies in 2 (50%) of the 4 CSBs studied. DBHDS monitoring confirmed that 1 (25%) of the 4 CSBs had consistently performed below expected standards.*
III.C.5.b.ii	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	Non Compliance *Non Compliance* Non Compliance	*See comment immediately above.*

Settlement Agreement Reference	Provision	Rating	Comments
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* Non Compliance	*See comment regarding III.C.5.b.i.*
III.C.5.c	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	Compliance *Compliance* Compliance **Deferred**	The Individual Services Review case study found that case managers had offered choices of residential and day providers, but that none of the 26 individuals (0%) were offered a choice of case managers. This is a strong indication that the Commonwealth may not be in compliance with this provision. Twenty-six is too small a sample to make this determination, after previously determining compliance. The Independent Reviewer has deferred a compliance rating until the tenth review period's report.
III.C.5.d	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	Non Compliance *Non Compliance* **Non Compliance**	The DBHDS regulations and licensing monitoring protocols do not align with the Agreement's requirements.
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 all the Crisis Services provisions of the Agreement. It developed the required elements of a crisis system for adults with ID/DD, but had not fully developed crisis services for children. DBHDS expects its out of home crisis stabilization programs to begin in September 2017.

Settlement Agreement Reference	Provision	Rating	Comments
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 for adults with ID/DD. REACH hotlines are operated 24 hours per day, 7 days per week for adults with ID/DD.
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 **Compliance**	REACH continues to train CSB ES staff. DBHDS has developed a standardized curriculum. 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.	Compliance *Non Compliance* Non Compliance	*The Commonwealth's training program was previously found to be inadequate for team members to respond with effective assessments or good quality in-home supports in many cases. DBHDS has not provided information that demonstrates compliance.*
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.	(Compliance *Non Compliance* Non Compliance	*REACH programs did not provide effective prevention plans, treatment strategies, or in-home supports. Although DBHDS now requires crisis prevention plans to be completed for every individual referred, these are not being completed consistently.*
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 ID/DD comes into contact with law enforcement.	Compliance *Compliance* Compliance **Compliance**	During the review period, REACH continued to train law enforcement personnel in all five Regions. In total, 395 police were trained during the eighth review period and 599 were trained during the ninth period.
III.C.6.b.ii.D	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	Compliance *Compliance* **Compliance**	REACH Mobile crisis teams are available around the clock and respond at off-hours to adults with ID/DD.
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 **Compliance**	All Regions provided adults with ID/DD with more than an average of three days in-home support services during the second half of the review period.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.6.b.ii.G	By June 30, 2013, the Commonwealth shall have at least two mobile crisis teams in each Region that shall respond to on-site crises within two hours.	Non Compliance *Compliance* **Compliance**	The Commonwealth did not create new teams. It added staff to the existing REACH crisis teams, which achieved responses within the required time for 95.7% during the eighth and approximately 92.7% of calls during the ninth period.
III.C.6.b.ii.H	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond on site to crises as follows: in urban areas, within one hour, and in rural areas, within two hours, as measured by the average annual response time.	Non Compliance *Compliance* **Compliance**	The Commonwealth reported average response times for crisis calls from adults within the required response time in all Regions during the eight period and in four of five Regions during the ninth. The fifth Region exceeded the response time slightly for a six-month 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 with ID/DD.
III.C.6.b.iii.B.	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	Compliance *Compliance* Compliance **Compliance**	For adults with ID/DD admitted to the programs, crisis stabilization programs continue to be used as a last resort. For these individuals, teams attempted to resolve crises and avoid out-of home placements.
III.C.6.b.iii.D.	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	Non Compliance **Non Compliance**	All five Region's programs report stays that exceed 30 days, which are not allowed.
III.C.6.b.iii.E.	With the exception of the Pathways Program at SWVTC … crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	Substantial Compliance *Substantial 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.*

Settlement Agreement Reference	Provision	Rating	Comments
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.
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 **Compliance**	The Commonwealth has completed a review and has determined that it is not necessary to develop additional "crisis stabilization programs" for adults with ID/DD in each Region. It has also decided to add two programs statewide designed to accommodate individuals who require stays of longer than 30 days.
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 sub-provisions of integrated day, including supported employment, are in compliance.
III.C.7.b	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy… (3) employment services and goals must be developed and discussed at least annually through a person centered planning process and included in the ISP.	Non Compliance *Non Compliance* **Non Compliance**	The Individual Services Review study found that goals were not developed and discussed for 19 of 26 individuals (73%). And the typical day for 17 individuals (65%) did not include integrated activities.
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 *Non Compliance* Non Compliance	*The Commonwealth developed a plan for Supported Employment. Its written plan to increase integrated day activities is not comprehensive. It lacks plans to provide guidance re: building CE into the ISP process, training case managers, and an assessment of the extent additional provider capacity may be needed.*

Settlement Agreement Reference	Provision	Rating	Comments
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 on the Employment First policy and strategies. Trainings were provided to service providers, family members, CSB staff, advocates, provider staff and transition teachers and supervisors.*
III.C.7.b.i. B.1.	Establish, for individuals receiving services *through the HCBS waivers*, annual baseline information regarding:		The Commonwealth has significantly improved its method of collecting data. For the first time, data were reported by 100% of the employment service providers. It can now report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a, b, c, d, and e below.
III.C.7.b.i. B.1.a.	The number of individuals who are receiving supported employment.	Non Compliance *Non 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.	Non Compliance *Non 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;	Non Compliance *Non 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.
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 **Compliance**	The Commonwealth set targets to meaningfully increase the number of individuals receiving services through the waivers and on making substantial progress toward achieving the targets. The targets were surpassed for individuals receiving individual-SE and group-SE.

Settlement Agreement Reference	Provision	Rating	Comments
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) *Non Compliance* Compliance **Compliance**	The Commonwealth has improved data collection. Its goal that 85% of individuals will hold their jobs for at least twelve months has been exceeded. 89% individuals had worked at their job for one year.
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 *Non Compliance* **Compliance**	The RQCs met during both quarters of the ninth review period. They consulted with the DBHDS Employment staff, both members of the SELN. The RQCs reviewed quarterly the number of individuals employed and the number who remain in integrated employment for twelve months.
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 *Non Compliance* **Compliance**	The RQCs reviewed the employment targets and the State's progress for FY 2017. The RQCs discussed and endorsed the future FY 2016 – 2019 targets
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	Compliance *Non Compliance* **Non Compliance**	A review found that DMAS /Logisticare have implemented previous recommendations and DMAS added them to its RFP. The selected recipient of the transportation brokerage contract will implement changes to move toward compliance during the eleventh period.
III.C.8.b.	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.	Non Compliance *Non Compliance* Non Compliance **Non Compliance**	The Commonwealth will not revise its guidelines until after implementing its redesigned HCBS waivers.

Settlement Agreement Reference	Provision	Rating	Comments
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* Non Compliance **Non Compliance**	This is an overarching provision related to serving individuals in the most integrated setting. The need for more such settings will not be resolved until full implementation of the redesigned waivers.
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.	Non Compliance *Non Compliance* Non Compliance	*The Commonwealth facilitated an impressive additional 91 adults to live in homes of their own. This is 6% of the goal to provide 1,523 more adults their own home by 2021. To achieve compliance requires sustaining a higher rate of facilitating adults to move into their own homes.*
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.	Non Compliance *Non Compliance* Compliance **Compliance**	The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies.
III.D.3.a.	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ...	Compliance *Compliance* 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* Compliance **Compliance**	The Commonwealth estimated the number of individuals who would choose independent living options through FY 2015. It again revised its Housing Plan with new strategies and recommendations.

Settlement Agreement Reference	Provision	Rating	Comments
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 *Compliance* Compliance **Compliance**	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds have now been provided permanent rental assistance.
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	*Documents reviewed did not indicate that the family-to-family and peer programs were active and creating pairings for individuals served in sponsored homes or congregate settings.*
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).	Compliance *Non Compliance* Non Compliance	*Individuals were placed in settings of five or more, in nursing facilities or in ICFs without the review of the CRC or the Regional Support Teams.*
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. The ISR study found that less restrictive options were discussed and offered.
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 and are members of the Regional Support Team in each Region and are utilized for these functions.

Settlement Agreement Reference	Provision	Rating	Comments
III.E.2	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	Non Compliance *Non Compliance* Non Compliance	*PSTs did not submit some referrals as required. Individuals moved to settings of five or more, to nursing facilities or to ICFs, without the CRCs submitting referrals, or submitting with sufficient lead-time for the RSTs to fulfill their responsibilities or to utilize their authority.*
III.E.3.a-d	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	Compliance *Compliance* Compliance **Compliance**	DBHDS established the RSTs, which meet monthly. The CRCs refer cases to the RSTs regularly.
IV	**Discharge Planning and Transition**	**Compliance ratings for the fifth, sixth, seventh, eighth and ninth review periods are presented as:** (5th period) 6th period *7th period* 8th period **9th period**	**Note: The Independent Reviewer gathered information about individuals who transitioned from Training Centers and rated compliance during the fifth, seventh and ninth review periods.** ***The Comments in italics below are from the prior 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* **Compliance**	The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It implemented improvements in response to concerns the IR identified.
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* **Non Compliance**	The Commonwealth had just begun to implement the redesigned HCBS waivers to come into compliance. Most integrated residential and day options are not available for individuals with intense needs.

Settlement Agreement Reference	Provision	Rating	Comments
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* **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, well being, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	(Non Compliance) *Non Compliance* **Non Compliance**	Discharge plan goals did not include measurable outcomes that promote integrated day activities for most individuals. The Commonwealth had just begun to provide integrated day services and some progress was apparent.
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* **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* **Compliance**	The documentation of information provided was present in the discharge records □ for 26 (1000%) of the individuals studied during the ninth review period.
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	(Compliance) *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* **Compliance**	□ for 76 of 77 individuals (98.7%) studied during the fifth, seventh, and ninth review periods, the discharge records included these assessments.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	(Compliance) *Compliance* **Compliance**	The PSTs select and list specific providers that provide identified supports and services.
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	(Compliance) *Compliance* **Compliance**	The CIMs and Regional Support Teams document barriers on the data collection sheet.
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	(Compliance) *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* **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* **Non Compliance**	The Individual Services Review Study found that the discharge plans lacked recommendations for services in integrated day opportunities. DBHDS implemented improvements that led to more plans that included skill development goals.
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* **Compliance**	The Commonwealth's discharge plans indicate that individuals with complex 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* **Compliance**	The Individual Services Review studies during the fifth seventh, and ninth review periods found that □ 78 (100%) of individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	(Compliance) *Compliance* **Compliance**	Discharge records included evidence that the Commonwealth had offered a choice of providers.
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the … community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	(Non Compliance) *Non Compliance* **Compliance**	Reviews found that □ 22 of 26 individuals (84.5%) 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* **Compliance**	PST's and case managers assisted individuals and their Authorized Representative. For 100% of the 26 individuals studied, 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* **Compliance**	During the fifth, seventh, and ninth review periods, the reviews found that □ 70 of 78 individuals /Authorized Representatives (89.7%) 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* **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* **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.14	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	(Non Compliance) *Non 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* **Compliance**	The Independent Reviewer found that the residential staff for ▫ 100% of the 26 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* **Compliance**	During the fifth, seventh, and ninth period, the Independent Reviewer found that ▫ 75 of 78 individuals (96.2%) 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* **Compliance**	The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions. ▫ for 76 (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* **Compliance**	The Individual Services Review studies during the ninth review period found that ▫ for 25 of 26 individuals (96.2%), 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.	(Non Compliance) *Non Compliance* **Non Compliance**	The Individual Review study found that essential supports were not in place prior to discharge for 5 of 26 individuals (19.2%) in the ninth review period. Four individuals did not have a day program and one individual did have behavior supports in place *before* they moved.
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* **Compliance**	The discharge records reviewed in the ninth review period indicated that individuals who moved to settings of five or more did so based on their informed choice after receiving options.
IV.C.7	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	(Compliance) *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* **Compliance**	Community Integration Managers are working at each Training Center.
IV.D.2.a	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	(Compliance) *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.	(Non Compliance) *Non Compliance*	*The Commonwealth has created five Regional Support Teams. All RSTs are operating and receiving referrals. The Independent Reviewer found, during the seventh period, that □for 0 (0.0%) of 12 individuals referred to the RST, there was sufficient time to work with the PST and CIM to resolve identified barriers.*
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	(Compliance) *Compliance* **Compliance**	The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.
V.	**Quality and Risk Management**	**Rating** **Compliance ratings for the fifth, sixth, seventh, eighth and ninth review periods are presented as:** (5th period) 6th period *7th period* 8th period **9th period**	**Comments** ***The Comments in italics below are from the prior period when the compliance rating was determined.***
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	*Non Compliance* Non Compliance **Non Compliance**	This is an overarching provision of the Agreement. Compliance will not be achieved until the sub-provisions in the Quality section are determined to be in compliance.
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 has improved its draft list of risk triggers. It has not completed or implemented the lists. It has not changed regulations to allow collection of required data.

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.	(Non Compliance) *Non Compliance* Compliance	*DBHDS implemented a web-based incident reporting system. Providers now report 90% of incidents within one day of the event.*
V.C.3	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	(Non Compliance) *Non Compliance* Non Compliance	*The Commonwealth established a reporting and investigative process. The DBHDS Office of Human Rights (OHR) investigations do not align with the requirements of the Agreement.*
V.C.4	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	(Non Compliance) *Non Compliance* **Non Compliance**	The Commonwealth has developed and posted some completed training modules. Available trainings are incomplete, not adequate to ensure reliability, and not competency based.
V.C.5	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The …mortality review team … shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurses notes, and all incident reports, for the three months preceding the individual's death; … (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems … and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	(Non Compliance) *Non Compliance* **Non Compliance**	A Mortality Review Committee (MRC) completed reviews of unexpected and unexplained deaths. The MRC did not include a member independent of the State; most mortality reviews were not completed in 90 days; and a quality improvement assessment has not been completed to determine whether initiatives have addressed problems or to determine other actions to reduce mortality rates.

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*	*DBHDS cannot effectively use available mechanisms to sanction providers, beyond use of Corrective Action Plans. DBHDS reports that provisional licenses are being issued for repeat offenders.*
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 requiring effective quality improvement processes at the local and State levels. Compliance will not be achieved until effective processes to monitor participant health and safety are in place and the remaining quality improvement sub-provisions are in compliance.
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**	The Commonwealth has taken steps to improve gathering and use of available data, to develop reports and to share data among staff and divisions. Significant work remains to increase, organize, and to ensure data are complete and reliable.
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**	The Commonwealth plans to begin collecting data on 1/1/17 for one measure for each Domain. Analysis is expected to begin after 7/1/17, during the eleventh review period.

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 in non-compliance until reliable data are provided from all the sources listed and cited by reference in V.C. and in V.E-G.
V.D.5	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	(Non Compliance) *Non Compliance* **Non Compliance**	DBHDS shared and RQCs reviewed employment, OLS and OHR data. The RQCs, however, had limited and frequently unreliable data available for review.
V.D.5.a	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	(Non Compliance) 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 and had limited discussion. Data available were frequently not complete or reliable. The DBHDS Quality Improvement Committee directed the RQCs work.
V.D.6	At least annually, the Commonwealth shall report publically, through new or existing mechanisms, on the availability … and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	(Non Compliance) *Non Compliance* **Non Compliance**	The Commonwealth has previously begun to compile and to post Annual Report information on its website. The information is not yet complete and some is outdated.
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 not yet required providers to implement QI programs or root cause analysis

Settlement Agreement Reference	Provision	Rating	Comments
V.E.2	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	(Non Compliance) *Non Compliance* **Non Compliance**	The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS does not yet require reporting through the risk management and provider QI programs.
V.E.3	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	(Non Compliance) *Non Compliance* **Non Compliance**	The Commonwealth's contractor completed the first annual QSR process. There are problems with the validity of the contractor's tools and the process and therefore with the reliability of data collected and the accuracy of the results.
V.F.1	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	(Compliance) Compliance *Compliance* Compliance	*The case management study found that 24 (96%) of the 25 were in compliance with the required frequency of visits. DBHDS has identified data that frequency and type of case manager visit are inconsistent and, in some CSBs, consistently below target.*
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 *Non Compliance* Non Compliance	*The case management study found that 19 (83%) of 23 individuals reviewed were recommended for day support programs. They were not offered services in integrated settings appropriate to their needs. Of these 19, 3(15.8%) were not offered services consistent with the individuals' strengths and preferences.*

Settlement Agreement Reference	Provision	Rating	Comments
V.F.3.a-f	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	(Compliance) *Compliance* Compliance **Compliance**	The Individual Services Review study found that 25 (of the 26 (96%) were in compliance with the required frequency of visits. All received monthly face-to-face meetings as required.
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 *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, including case manager contacts.*
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) Compliance Compliance	*The Commonwealth developed the curriculum with training modules that include the principles of self-determination.*
V.G.1	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	(Compliance) *Compliance* Compliance	*DBHDS completed 434 unannounced licensing inspection visits between 4/1/15 and 9/30/15.*
V.G.2.a-f	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	(Compliance) *Compliance* Compliance	*DBHDS has maintained a licensing inspection process with more frequent inspections.*

Settlement Agreement Reference	Provision	Rating	Comments
V.G.3	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	(Non Compliance) *Non Compliance* Non Compliance **Non Compliance**	The DBHDS Licensing regulations and protocol do not align with the Agreement's specific requirements.
V.H.1	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self –determination awareness, and required elements of service training.	(Non Compliance) *Non Compliance* Non Compliance	*The Commonwealth has not created a plan to:* *develop the curriculum to train staff in the required elements of service for the individuals.*
V.H.2	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	(Non Compliance) *Non Compliance* Non Compliance	*Same as V.H.1 immediately above.*
V.I.1.a-b	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	(Non Compliance) *Non Compliance* **Non Compliance**	Same as Comments for V.E.3. Compliance will be achieved when results are based on valid and reliable data and are used to improve quality.
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* **Non Compliance**	Same as Comments for V.E.3 and for V.I.1. which is 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* **Non Compliance**	Same as Comments for V.E.3 and for V.I.1.
V.I.4	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	(Non Compliance) *Non Compliance* **Compliance**	The Commonwealth's contractor completed the first annual QSR process based on a statistically significant sample of individuals.

Settlement Agreement Reference	Provision	Rating	Comments
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 Intervenor's counsel.	(Compliance) Compliance *Compliance* Compliance **Compliance**	The DHBDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his Report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.
IX	**Implementation of the Agreement**	**Rating**	**Comment**
IX.C.	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented …	(Non Compliance) Non Compliance *Non Compliance* 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: mortality review, quality and risk management, and Quality Service Reviews.

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

III. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology:

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

- Reviewing data and documentation produced by the Commonwealth in response to requests by the Independent Reviewer, independent consultants, and the Department of Justice (DOJ);
- 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 and their families;
- Interviewing individuals and their care givers providers; and
- Visiting sites, including individuals' homes and other programs.

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

- Transition of Individuals from Training Centers to live in Regions I, II or III;
- Safety in the Community;
- Crisis Services for Children and Adults;
- Transportation;
- Supported Employment;
- Quality and Risk Management; and
- Mortality Review.

The Independent Reviewer retained eleven independent consultants to conduct the reviews and evaluations of these areas. To accommodate the Commonwealth's need to focus all of its staff resources during this period on implementation of the redesigned HCBS waivers, the Independent Reviewer postponed a planned study of Regional Support Teams and planned only brief reviews for four studies. The brief reviews of Transportation, Crisis Services, Supported Employment, and Mortality Review involved primarily a review of existing documents. For each study, the Independent Reviewer asked the Commonwealth to provide all records documenting that it has properly implemented the related requirements of the Agreement. Information that was not provided by the Commonwealth for the studies is not considered in the consultant's reports or in the Independent Reviewer's findings, conclusions, and determinations of compliance.

For the ninth time, the Independent Reviewer utilized his Individual Services Review study process and Monitoring Questionnaire to evaluate the status of services for a selected sample of individuals. By utilizing the same questions over several review periods, for different subgroups and in different geographic areas, the Independent Reviewer has identified findings that include positive outcomes and areas of concern. By reviewing these findings, the Independent Reviewer has identified and reported themes. For this Report, the Individual Services Review study was focused on the status of discharge planning and transition services for individuals who moved from Training Centers to live in community based settings in Virginia's Health Planning Regions I (central), II (northern) and III (southwestern). Twenty-six individuals were selected randomly from the list of individuals who moved from Training Centers between December 7, 2015 and June 22, 2016.

The other studies completed by the Independent Reviewer's consultants for this report examined the status of the Commonwealth's compliance with specific prioritized provisions that were targeted for review and evaluation. The Independent Reviewer shared the planned scope, methodology, site visits,

document review, and interviews with the Commonwealth and requested its suggested refinements. The Independent Reviewer also asked the Commonwealth to provide the measurable outcomes that it has established and the records that demonstrate achievement of these outcomes for each study.

The Independent Reviewer's consultants then reviewed the status of program development to ascertain whether the Commonwealth's initiatives had been implemented sufficiently for measurable results to be evident. The consultants conducted interviews with selected officials, staff at the State and local levels, workgroup members, providers, families of individuals served and other stakeholders. To determine the ratings of compliance, the Independent Reviewer considered information provided prior to October 30, 2016. This information included the findings and conclusions from the consultant's topical studies, the Individual Services Review study, and other sources. The Independent Reviewer's compliance ratings are best understood by reviewing the comments in the Summary of Compliance table, the Findings section of this report, and the consultant reports included in the Appendix.

During the tenth review period, the Independent Reviewer will study the status of the Commonwealth's progress toward achieving compliance with most provisions that were not studied during the ninth period. These provisions include Transitions from Nursing Facilities and Intermediate Care Facilities, Case Management, Regional Support Teams, Independent Housing, Licensing and Investigations, and Provider Training. Some of the provisions, which the Commonwealth believes that it will not achieve compliance with during the tenth period, will be studied during the eleventh or twelfth period. These include the Individual and Family Support Program and transitions of children from Intermediate Care Facilities. The Independent Reviewer will also complete qualitative reviews of Crisis Services and Integrated Day, including Supported Employment, during the tenth period. In general, the Independent Reviewer will not complete studies of the status of compliance for provisions, which the Commonwealth believes, will lack sufficient evidence of progress.

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

B. Compliance Findings

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

The Commonwealth had created a total of 2455 new waiver slots, 400 more than were required by the Agreement, prior to this reporting period. As this review period began, the General Assembly approved an additional 200 waiver slots to be awarded to individuals with DD, other than ID, prior to the end of Fiscal Year 2016. The General Assembly approved and funded these additional waiver slots to support implementation of the Commonwealth's redesign of its HCBS waiver programs.

Waiver Slot Allocation Summary Fiscal Years 2012 - 2017
Settlement Agreement - *required/actually created*

Fiscal Year	2012	2013	2014	2015	2016	2017	Total
Training Centers	60/60	160/160	160/160	90/90	85/85	90/90	645/645
Community Living Waiver (formerly Intellectual Disabilities)	275/275	225/300 (***25 slots prioritized)	225/575 (***25 slots prioritized)	250/25 (***25 slots prioritized)	275/325 (***25 slots prioritized)	300/300	1550/1800
Family and Individual Support Waiver (formerly Developmental Disabilities)	150/165	25/50 (***25 slots prioritized)	25/130 (***25 slots prioritized)	25/15 (***15 slots* prioritized)	25/240** (***25 slots prioritized)	25/140	275/740
Total	**485/500**	**410/510**	**410/865**	**365/130**	**385/650**	**415/530**	**2470/3185**

* From reserves
** Additional 200 for the top 200 people on the chronological Waiting List for the Family and Individual Support Waiver
*** For children living in nursing homes or large privately operated Intermediate Care Facilities

Under the Commonwealth's former HCBS waiver program, waiver slots were provided to individuals with DD, other than ID, chronologically, i.e., when an individual's name was added to the waitlist, rather than on the intensity of an individual's needs. As part of the redesigned HCBS waivers, the Commonwealth switched to a policy of awarding slots based on intensity, which was expected to be effective on July 1, 2016. The Commonwealth provided an extra 200 slots for the Family and Individual Support Waiver prior to the end of Fiscal Year 2016. These slots were provided for individuals with DD, other than ID, who had been on the waitlist for many years and who might have been deprived from receiving waiver slots under the new policy. The Commonwealth also created forty "transfer" slots that can be used to allow individuals to transfer between waivers. For example, individuals with DD, other than ID, who receive Family and Individual Supports waiver services could use one of these forty slots to transfer to the Community Living waiver to be able to receive waiver-funded congregate residential services.

The HCBS waiver slots that the Commonwealth created for Fiscal Year 2017 for both the Community Living and the Family and Individual Support Waivers have been approved by CMS and the Commonwealth has distributed the slots to the CSBs. As of December 2017, Waiver Slot Assignment Committees were in the process of determining the individuals to whom the slots would be assigned.

The Commonwealth has consistently met or exceeded the quantitative requirements to provide HCBS waiver slots that enable individuals with ID/DD to receive waiver-funded services in the community. The Commonwealth has created waiver slots for the residents of the state operated Intermediate Care Facilities (Training Centers), for individuals who have been on waiting lists, and for children and adults with ID/DD who are living in nursing facilities and privately operated large Intermediate Care Facilities.

Between October 13, 2011 and October 5, 2016, the Commonwealth facilitated the transition of 568 individuals from Training Centers to live in community-based homes. The combined census in the Training Centers has decreased from approximately 1080 to 339 residents. Now, the Commonwealth is developing a process to facilitate the transition of children from the large ICF/IIDs and reports that it has initiated its plan to transition children in nursing facilities to live and receive services in more integrated community-based settings. The Commonwealth has not yet achieved compliance with these qualitative aspects of the waiver slot requirements.

As reported previously, the Independent Reviewer's Individual Services Review studies have consistently found that waiver slots provide individuals and families with critical supports that significantly improve their quality of life. For these individuals, access to waiver-funded services is vital to their good health, personal growth, safety, and for the prevention of unnecessary institutionalization. That being said, the Commonwealth's former HCBS waiver programs were confusing and difficult to manage for families, especially for those who received in-home services. Although a waiver slot is intended to be a ticket to a wide array of services, families often have found that the services that they most wanted, such as in-home nursing and behavioral supports, were not available. At the same time, and for more than twenty years, the former waiver program definitions and rates created financial incentives for service providers to develop large congregate day and residential settings. These settings proliferated; they perpetuated the practice of grouping individuals with ID/DD together and separating them from their communities, rather than meeting their needs in the most appropriate integrated setting. The array of services currently available throughout the Commonwealth reflects the history of these incentives. Most individuals with Community-Living ID waiver-funded services live in larger group settings that separate them from non-disabled community members, other than staff. Being segregated does not allow for participation or interaction with non-disabled community members in typical activities.

The Commonwealth's newly approved redesigned waiver programs are intended to restructure the service system "to provide for a flexible array of community-based options with a rate structure that supports the cost of new and existing services and provides incentives to providers for offering expanded integrated options." The Commonwealth anticipates that these incentives will result in more integrated community-based program options. The Commonwealth also expects that improved access and availability of support services for individuals with intense behavioral or medical needs will result in decreased demand for crisis intervention and institutional levels of care. For Fiscal Year 2017, CMS left in place the "exceptional rate" process for individuals with intense medical and behavioral needs. The Commonwealth had intended, but did not, include a "customized rate" to ensure adequate funding for the services needed by these individuals. The Commonwealth is now planning to submit an amendment to CMS to include a customized rate, which, if approved, will become available as of July 1, 2017. During the ninth period, the Independent Reviewer's Individual Services Review study found indications that the Commonwealth's shift to more individualized and more integrated service arrangements may have begun. During the next and future reporting periods, the Independent Reviewer will monitor and report on the extent to which the Commonwealth achieves its goals and its compliance with provisions of the Settlement Agreement related to integration and to prevention of unnecessary institutionalization.

The Commonwealth is in compliance with Section III.C.1.a.i-v.
The Commonwealth is in non-compliance with the qualitative aspects of Section III.C.1.b.i.-v. and III.C.1.c.i.-v.

2. Discharge Planning and Transition from Training Centers

The Independent Reviewer has completed five Individual Services Review (ISR) studies of Discharge Planning and Transition from the Commonwealth's Training Centers. Each ISR study focused on the outcomes for individuals who had transitioned and the extent to which the Commonwealth had achieved compliance with the requirements of the Agreement. For each ISR study, the Independent Reviewer selected a cohort of individuals who had transitioned prior to each review period. The cohorts for the five studies included a total of 191 individuals who had moved to all five geographic regions of Virginia and from all five of the Commonwealth's Training Centers. The cohort for the first ISR study moved from Southside Virginia Training Center (SVTC) and Central Virginia Training Center (CVTC) between October 13, 2011 and June 30, 2012; the cohort for the ninth period ISR study moved from Southwestern Virginia Training Center (SWVTC), Northern Virginia Training Center (NVTC) or CVTC to live in Regions I (central), II (northern), or III (southwestern). From the cohorts in the five studies, 138 individuals were randomly selected for review. This selection provides a 90% confidence level that the findings from these studies can be generalized to the larger cohorts. (Appendix A includes detailed Demographic Information about the 138 individuals and additional information regarding the findings from the ninth ISR study). Overall, of every ten of the 138 randomly selected individuals who moved from the Training Centers, approximately:

- Six were males;
- Seven were age fifty-one or older;
- Four use wheelchairs for mobility;
- Seven use gestures as their highest form of communication;
- Nine moved into congregate residential programs; and
- Eight had a parent or sibling as his or her guardian or Authorized Representative

For the ninth review period, twenty-six individuals were randomly selected for the ISR study. These people were selected from the forty-eight individuals who transitioned from any Training Center to live in community-based homes in the three selected Regions during the six-month period (December 7, 2015, through June 22, 2016).

Although there were individual exceptions, the following themes and examples of both positive outcomes and areas of concern were found in the study of the transitions and services for these twenty-six individuals. These themes are very similar to those found in previous ISR studies. More positive outcomes were found than in the previous ISR studies (See Appendix A). These are noted below:

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

- Eighteen of the twenty-six individuals (69.2%) transitioned to settings of five or more individuals or to settings with residential programs clustered together. Four of the individuals are living temporarily in homes that are clustered next to a Training Center. For fourteen of the individuals, bedrooms and the common spaces of their homes included personal décor, while ten people live in homes with little personalization. The less personalized homes had environmental and program arrangements that are typical of institutions (e.g. large medication carts that are moved through the home to the individuals' rooms; standing orders for PRN medications for all residents rather than individualized parameters).

- A notable improvement: eight of the twenty-six individuals (30.8%) had typical days that included integrated activities. Others frequented integrated community settings, but were not yet engaging in activities with non-disabled community members. This finding involved a small sample of service providers (n=11) and individuals (n=26), and only individuals who transitioned from Training Centers. This study's findings, therefore, cannot be generalized to the service system. In a similar review in 2015, however, none of the twenty-four individuals studied had typical days that involved integrated activities.

- The discharge planning and transition processes were well organized and well documented. The selected residential providers were involved in the discharge planning process; and the residential provider staffs received training in the individuals' health and safety protocols. The Post-Move Monitor (PMM) visits occurred as expected and extra PMM follow-up visits occurred to confirm resolution if concerns were identified. Transition planning, provider training and post-move monitoring, however, did not guarantee that the Commonwealth had ensured that all the individuals' essential needs had been addressed before discharge. For four individuals, a day program was not in place at the time of discharge. Three individuals were receiving daily dental care at home, but did not yet have a community-based dentist identified.

- There were many positive healthcare process outcomes for virtually all the individuals studied. All individuals had a physical exam within a year and their Primary Care Physicians' and community medical specialists' recommendations were implemented within the prescribed time frames. As referenced above, however, it was uncertain where three individuals would receive dental services.

- The individuals made successful transitions and had settled well into their new home environments. This theme was also documented in previous ISR studies of individuals who had transitioned from Training Centers. After living in their new homes for less than a year and, in some cases, for only three months, the reviewers found several examples of individuals with histories of problematic behaviors who now were experiencing significantly fewer and less severe incidents.

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

Furthermore, it is positive that the ninth period ISR study found indications that the Commonwealth had made progress in an area where the Independent Reviewer has previously identified concern. Some of the individuals who transitioned to live in the community now have typical days that include integrated activities. However, other areas of concern remain. The Independent Reviewer has previously reported these concerns and made recommendations for improvement. Most identified areas of concern involve the continued predominance of larger congregate residential and day settings, the lack of day opportunities for individuals with intensive medical and behavioral needs, and the lack of community integration opportunities and habilitation. Two of the Commonwealth's previously reported initiatives to address these areas of concern are being implemented:

- The Commonwealth's redesign of its HCBS waiver programs for ID/DD has been approved and is now in the implementation stage;

- The Commonwealth is in the process of selecting from providers' responses to its Request for Proposals to build capacity to serve individuals with intense healthcare and behavioral support needs.

The Independent Reviewer has provided the Individual Services Review reports to the Commonwealth so that the Commonwealth and its providers will review the issues and areas of concern identified for each individual. The Independent Reviewer has asked the Commonwealth to share the reports with the individual's residential service provider and case manager and, by March 30, 2017, to provide updates on the actions taken and their results in regard to any issues identified.

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

3. Crisis Services

For the ninth review period, the Independent Reviewer retained an independent consultant to complete her ninth study of the Commonwealth's crisis services system. Due to the extraordinary demands of implementing the redesigned HCBS waivers and the related service development, the Independent Reviewer limited the foci and the methodology for this period's study. The study methodology was limited to primarily a review of documents and data. The foci of the study of Commonwealth's crisis services were limited to review of its:

- Activities that were in progress, but were not completed during the eighth period, and
- Progress implementing the crisis services for children, which had only been made available statewide during the previous year.

Because this study did not include a review of the quality of the crisis services, the Independent Reviewer did not gather sufficient facts to determine updated compliance ratings for all of the crisis services provisions of the Agreement. The updated compliance ratings of the crisis services provisions are in bold letters in the Compliance Table. A qualitative review of the performance of the Commonwealth's statewide crisis services for children and adults will be completed during the tenth review period. The Independent Reviewer has reported compliance ratings in this and previous Reports to the Court *based only on the statewide crisis services for adults*. The Independent Reviewer will not determine that the Commonwealth is in compliance with its full responsibility for the Crisis Services provisions until it complies with the Agreement's requirements for the provision of effective crisis services and crisis stabilization programs for children as well as for adults. The Independent Reviewer will begin to report compliance ratings based on the required services for both children and adults during future review periods as the Commonwealth's crisis services for children become fully operational.

Crisis Services for Adults

Individual's Major Diagnosis

The Independent Reviewer has expressed concern in past Reports that the Commonwealth's crisis services programs had not yet reached many individuals with DD, other that ID, who need these services. The Commonwealth has taken steps to inform these individuals and their families of the availability of crisis services. During the eighth review period an increased percentage of the adults referred for crisis services had this diagnosis (see Table 1 below). During the ninth review period, again an increased percentage of this segment of the target population was served. This increase is an indication that the Commonwealth's crisis services programs are engaging more of the individuals with this diagnosis.

Table 1
Percentage of individuals served with DD, other than ID– Adults

	FY16Q2	FY16Q3	FY16Q4	FY17Q1
	10%	13%	12%	16%

Response Times for Adults

The crisis services programs responded within the required time to 95.6% of the calls during the eighth review period and to 94.4% and 91% of crisis calls during the two halves of the ninth review period, an annual average of approximately 94.2%. There were nineteen late responses for adults statewide during the first half of the ninth period, seventeen of these late responses occurred in Region IV alone. The delayed response times occurred in the two regions designated as "urban" Regions where response times are required to occur within one hour versus two hours in the "rural" Regions. The delayed responses to individual crisis calls in the two urban Regions appear to indicate a systemic problem, and potentially additional systemic problems for the children's mobile response teams. The statewide annual average response times to calls for adults, however, occurred within the required time periods.

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

Training

All Regions continue to provide extensive training to law enforcement (Crisis Intervention Training) and to the CSB, ES, providers and the staff of other community partners.

The Commonwealth is in compliance with *Section III.C.6.b.i.B and III.C.6.b.ii.C.*

Mobile Crisis Assessments

During the first half of the ninth review period, at the time of crisis assessment of 312 individuals, 84 (27%) were hospitalized, and 193 individuals (62%) retained their home settings. During the second half of the review period, 422 individuals were assessed for a crisis. After using mobile crisis services, 148 of these individuals (35%) were hospitalized and 77 (52%) retained their home setting. There was a correlation when the number of individuals who required crisis assessments increased significantly, by 112 individuals (36%); the percentage of individuals who were hospitalized also increased significantly, from 84 (27%) to 148 (35%). Two quarters is too small a sample to determine that an increased workload for the crisis teams and the crisis stabilization programs caused the increase in the percentage of individuals who were hospitalized. The Commonwealth should study this to determine the service delivery factors associated with this correlation, as it could be an indication of insufficient crisis services capacity.

Table 2 **Disposition after crisis assessment – Adults**		
	FY16Q4	FY17Q1
# Assessed	312	422
% Hospitalized	84 (27%)	148 (35%)
% Retained their home	193 (62%)	77 (52%)
% Used crisis stabilization homes (CTHs)	22 (7%)	34 (8%)
% With another disposition	12 (4%)	21 (5%)

The independent consultant also found that a much lower percentage of individuals (7%) were hospitalized after receiving crisis prevention supports in the community than when REACH's initial assessment occurred during a crisis (35%). (See Tables 2 and 3) This indicates that the provision of in-home crisis prevention supports reduced the need for psychiatric hospitalization. That individuals were hospitalized in each situation underscores that some individuals in crisis required psychiatric hospitalization to stabilize. In the future, it will be important to have more detailed information regarding the reasons for admissions and the availability of community alternatives, especially as DBHDS enhances the array of crisis stabilization options.

Table 3 **Dispositions after using REACH mobile crisis services – Adults**		
	FY16Q4	FY17Q1
# Who used mobile crisis services	146	237
% Hospitalized	15 (10%)	17 (7%)
% Retained in their home	112 (77%)	190 (80%)
% Who transitioned to a new residence	13 (9%)	14 (6%)
% Used crisis stabilization homes (CTHs)	6 (4%)	14 (6%)

Crisis Stabilization Programs

During the first quarter of Fiscal Year 2017, DBHDS began tracking new information regarding the performance of its crisis stabilization programs, which DBHDS calls Crisis Therapeutic Homes (CTHs). The DBHDS report for this quarter includes a detailed analysis of the available capacity and the waiting lists for the CTHs. The percentage of days when the six beds in each of the five regional Crisis Stabilization Program were all occupied ranged from 17% (Region I) to 75% (Region III). There were nine individuals, however, who were on the waiting list. Six of these individuals live in Region V, which reported that its Crisis Therapeutic Home had beds available on 73% of the days in the quarter. During the eighth review period, case managers reported having stopped referring individuals to the Crisis Therapeutic Homes because of the waiting lists. A significant number of individuals with ID/DD continue to be admitted to psychiatric hospitals without being offered the Crisis Therapeutic Home as a last resort alternative to hospitalization. The data available did not include sufficient information concerning the reasons for admission. It is not possible, therefore, to complete an analysis of whether the Crisis Therapeutic Home setting would have been a viable alternative and, therefore, whether there is a sufficient out-of-home crisis stabilization capacity. However, the Commonwealth should determine the underlying cause for high vacancy rates in the Crisis Therapeutic Homes when there are members of the target population who likely need these services. The Commonwealth should also determine whether any individuals who REACH knows to be in crisis are admitted to psychiatric

hospitals without being offered an alternative placement in crisis stabilization programs prior to admission.

Region IV successfully moved its Crisis Therapeutic Home to a community-based setting during the ninth period. The Commonwealth plans to use the design of this home for two additional homes. These homes will serve as statewide resources for individuals whose crises have been stabilized but who have lost their home setting and need a place to stay for longer than thirty days. The Agreement limits stays in the Regional Crisis Therapeutic Homes to a maximum of thirty days.

During the ninth review, to help determine whether additional crisis stabilization programs are necessary, DBHDS reviewed the Crisis Therapeutic Home capacity for the seven-month period from December 1, 2015 through June 30, 2016. These crisis stabilization programs provide prevention support with planned stays and stabilization for individuals who are in crises. The average length of stay for the 46% of individuals who utilized these programs for planned prevention support was eight days; whereas, the average length of stay for the individuals who received crisis stabilization services was twenty-one days. All five Regions had individual stays in the crisis stabilization programs that exceeded the thirty-day limit established by the Agreement.

DBHDS has taken, or plans to take, steps to resolve the excessive lengths of stay. These include:

- Redesigned HCBS waivers that now allow the provision of an emergency reserve waiver slot for individuals who have lost access to their previous home and more timely access to waiver-funded community residential and support services;
- Redesigned HCBS waivers that allow residential services for individuals with DD;
- Plans to amend the redesigned HCBS waivers to include a customized rate* to fund enhanced services for individuals with complex behaviors, as of July 2017;
- Plans, beginning in Fall 2017, to develop two homes for individuals whose crises have been stabilized but who need a transition home for longer than thirty days

.

* The Commonwealth intended to include a customized rate for individuals with intense medical and behavioral needs in its original proposed amendment to redesign its HCBS wavier program.

The Commonwealth is in compliance for adult services with *Section III.C.6.b.iii.A., B.*, and *F.*
The Commonwealth is in non-compliance with *Section III.C.6.b.iii.D*

Involvement of law enforcement

During the first quarter of Fiscal Year 2017, DBHDS also began collecting data regarding the involvement of law enforcement in responding to crisis calls. During the quarter, law enforcement was involved in forty of the 289 responses (14%) to crisis calls. It is notable, however, that thirty-seven of the forty (92.5%) crisis responses that involved law enforcement occurred in Region IV; whereas, law enforcement was not involved in responding to any calls during the quarter in either Region II or V. To better understand this significant disparity, it would be very helpful for the Commonwealth to track whether law enforcement was initially notified and then contacted REACH, or whether REACH contacted law enforcement after receiving a crisis call. It is not possible to draw conclusions about the implications of this disparity without a qualitative review of individuals whose crises involved law enforcement personnel to determine the reasons; the officers' training in responding to the crises; and the outcomes of their involvement.

Psychiatric Hospitalizations

DBHDS completed a study of all admissions of adults with ID/DD to the DBHDS-operated Virginia Mental Health Hospitals during Fiscal Year 2015. A total of 269 individuals with DD were admitted to these psychiatric settings. It is notable that such a large percentage of the individuals who had their own home or lived in a community residential program were able to return to their home setting after being hospitalized. DBHDS utilized the Crisis Therapeutic Homes as step-down settings for thirty-three of 269 individuals (12.3%) who had been admitted to the DBHDS operated mental health hospitals. The Commonwealth should document the number of individuals in the target population who are admitted to state operated psychiatric hospitals during each quarter and should provide this information to the Independent Reviewer.

The DBHDS expected its REACH crisis services programs to be involved with all adults with ID/DD who were admitted to psychiatric hospitals in Fiscal Year 2015. The hospital documentation indicated that REACH was involved, however, with only seventy-six of the 272 individuals (28%). (Note: it was not possible to reconcile small differences, e.g. between 269 and 272 hospitalized individuals, when the numbers came from different data sources). Records indicated that REACH program involvement varied significantly, depending on the hospital, from 0% to 45% of the individuals with ID/DD. DBHDS reports that this disparity may reflect inconsistent documentation by the hospitals. It is a significant concern that more than 70% of the individuals admitted to these hospitals did not benefit from REACH expertise and resources, as these programs were designed to prevent unnecessary institutionalization and to provide short-term alternatives. This concern is underscored by documentation that not all CSB Emergency Staff or the DBHDS Mental Health Hospital staff contacted the Commonwealth's REACH programs when these staff were screening or admitting individuals with ID/DD.

DBHDS completed an analysis of the admissions of adults with ID/DD to psychiatric hospitals operated by the Commonwealth in Fiscal Year 2015. A two-person team of DBHDS clinicians determined that 64 of the 269 admissions (24%) could have been diverted from hospitalizations. The DBHDS analysis resulted in DBHDS making several recommendations (See Appendix B). DBHDS also created two internal work groups with responsibility to implement these recommendations. These work groups have started to meet monthly and plan to meet through Fiscal Year 2017. At the end of the ninth review period, DBHDS had not yet developed a work plan, the expected outcomes, or implementation timelines for the recommendations.

b. Crisis Services for Children

Referrals to the statewide children's crisis services programs increased from 205 to 363 (56.5%), from the eighth to the ninth period. The number of referrals was similar during the two Fiscal Year quarters of the ninth review period. During the first quarter, however, the percentage of referrals that occurred during an individual's crisis, rather than when the child wasn't in crisis, varied substantially among Regions. During the second quarter, however, the percentage of calls that involved crises versus non-crises was much more similar across the Regions since 53% of the referral calls occurred during a crisis.

By December 31, 2016, during the tenth review period, DBHDS expects that the five Regional Children's Crisis Services programs will be fully operational and will have met most performance expectations, including 95% on-time face to face responses to crisis calls. The number of referrals to the children's crisis programs increased by 56.5%% between the eighth and the ninth periods This increase is clear evidence of a period of significant program growth. During the two quarters of the

ninth period, however, the number of referrals was similar across regions. This indicates that the period of significant growth had largely stabilized.

Individual's major diagnosis of Children
The Children's REACH Programs continue to serve significantly more children with DD, other than ID, than children with an ID diagnosis. The percent of children with DD, other than ID, increased from 60% during the final quarter of Fiscal Year 2016 to 67% during the first quarter of Fiscal Year 2017. A high percentage of the children with DD were diagnosed with an Autism Spectrum Disorder.

Response times for Children
Response times for crisis calls for children occurred within the required timeframe in 93% and 86% of the calls in the two halves of the review period, an average of approximately 89.5%. The delayed response times for children, similar to those for adults, occurred in the two Regions designated as "urban" Regions. The delayed responses to individual crisis calls for children appear to include the same, and potentially additional, systemic problems for the children's mobile response teams. The statewide annual average response times to calls for children, however, occurred within the required time periods in four Regions. In Region II, however, there were a sufficient number of late responses to crisis calls for children. During a six-month period, the average response time to *all* calls was above the amount of time that the crisis teams are required to respond to *each* call for an individual in crisis.

Mobile Crisis Assessments of Children
During the ninth review period, a large majority of children retained their family home setting following the crisis assessment. In Regions III and IV, however, the rate at which children were admitted to psychiatric hospitals was much higher than in other Regions. Regions III and IV accounted for forty-six of the fifty-seven children (80.7%) who were hospitalized. In Regions I, II and V, a total of only eleven children were hospitalized. For every four children hospitalized in Regions III and IV, only one was hospitalized in the other three Regions. This four to one performance disparity appears to be evidence of a lack of sufficient or effective community-based resources for children with complex behavioral needs in these two Regions. This disparity should be a focus of the crisis study in future reporting periods. It is critical that DBHDS continues to develop better data regarding the reasons for admission to psychiatric hospitals that includes data on the lack of clinically appropriate community services.

Psychiatric Hospitalizations of Children
DBHDS reported that ninety-seven children were hospitalized in the Commonwealth's only state operated children's psychiatric hospital during the ninth review period. During the first quarter of Fiscal Year 2017, there were almost *fifty percent more* children admitted to this hospital than the children known to the DBHDS crisis service programs. DBHDS reported that thirteen of the children admitted to the state operated children's psychiatric hospital remained hospitalized at the end of the ninth review period. It must be noted that the out-of-home crisis prevention or stabilization settings required by the Agreement were not yet available for children with ID/DD. The lack of these community-based resources very likely contributed to more children being admitted to psychiatric hospitals and to longer duration of hospitalization than might be necessary.

A DBHDS work group analyzed the situations of all 139 children with ID/DD who were admitted to the state operated children's psychiatric hospital during Fiscal Year 2015. DBHDS reported that its clinicians' analyses determined that forty of these children (24%) could have been diverted, if crisis services program were available. However, for several reasons, the DBHDS clinicians' determination

that only forty children could have been diverted may be too few. For example, there was not an in-depth review of the issues that led to the admissions; the REACH Children's Programs were not fully functioning during FY15; community capacity is still not fully developed; and out-of-home crisis stabilization services are not yet readily available.

Crisis Stabilization Programs for Children

DBHDS received funding to expand crisis services for children and adults with ID/DD during Fiscal Year 2017. Based on its analysis of psychiatric admissions, DBHDS plans to implement a three-tiered approach. This includes:

- Development of crisis prevention out-of-home respite care;
- Therapeutic foster care; and
- Two crisis stabilization program (CTH) settings to support all five Regions.

These out-of-home supports will serve children from age three through seventeen. DBHDS shared its planned approach in the *Crisis Prevention and Stabilization Bed Capacity Children's Crisis Services Proposal* (October 19, 2016).

DBHDS is now in the process of writing an RFP (Request For Proposals) for development of crisis prevention out-of-home respite care, which will be required to coordinate with the REACH crisis services. DBHDS had previously reported that this RFP would be issued on May 1, 2016. The General Assembly has provided additional funding that will provide approximately 250 respite stays that average five days. DBHDS has not yet established a timeline for implementation of the new out-of-home respite supports.

DBHDS plans to develop therapeutic foster care to offer transitional residential settings with professional behavioral supports. The goal of therapeutic foster care is to support children through crises, stabilize them, and return them to the family homes.

DBHDS plan to develop two children's crisis stabilization programs (CTHs) with a total capacity of twelve beds statewide may not be adequate. DBHDS reported that there were forty children who could have been diverted from admission to the only state operated psychiatric hospital for children during Fiscal Year 2015. DBHDS is not able to estimate either the number of children statewide who were admitted to privately operated hospitals and psychiatric facilities or the number whose hospitalizations were extended due to the lack of available and appropriate step-down facilities. DBHDS plans to issue the RFP for the two children's crisis stabilization programs on December 1, 2016. DBHDS is optimistic that the homes will be operational within nine months, by September 1, 2017, near the end of the eleventh review period. The Commonwealth was responsible for implementing crisis stabilization programs for the target population in each Region by June 30, 2012 and to determine whether additional programs were necessary by June 30, 2013.

Summary: Crisis Services for Adults and Children

DBHDS continues to make progress implementing the crisis services requirements of the Agreement. There is evidence of continued outreach serving adults and greater coordination with the CSB Emergency Services programs. The adult crisis services programs are serving more individuals with DD, other than ID. The responses to almost all crisis referrals were face-to-face and the on-site response time was approximately 92.7% of the requisite timeframe during the period. The mobile crisis teams for adults in both urban Regions had an excess of late responses to individual crises; however both Regions had a higher percentage of on-time responses for adults than for children. DBHDS

should evaluate and address the obstacles to on-time responses in the two urban Regions, especially those for children.

REACH staff participated in more crisis assessments that are conducted at the psychiatric hospitals. The involvement of REACH staff ensures that these individuals are immediately linked with the community-based crisis services. These linkages will help ensure coordinated discharge planning and post-discharge services from community providers. The Crisis Therapeutic Homes are also being used as a step-down from the hospitals for some individuals in the population, which should positively impact length of stay for some individual's psychiatric hospitalizations.

The Children's REACH crisis services programs have experienced a significant increase in referrals. The referral sources indicate a working relationship with the CSB Emergency Services programs. The majority of children served have a diagnosis of DD, other than ID, and most of them have an Autism Spectrum Disorder. This demonstrates effective outreach to this subgroup of the Agreement's target population. Crisis assessments are conducted face-to-face. The assessments, linkage, training, and in-home support components of the children's crisis services programs are becoming better established. One stark area of non-compliance with the requirements of the Agreement is the lack of out-of-home crisis stabilization programs for children. It is promising that DBHDS has developed a proposal to address this requirement and is including three options to add to the array of community-based crisis supports for children.

The Independent Reviewer's compliance Ratings are, and have been, based only on the Commonwealth's crisis services for adults with ID/DD. The Independent Reviewer has consistently reported to the Court that the Commonwealth was in non-compliance with the overarching crisis services requirements; and that it would not come into compliance until crisis services requirements were met for children as well as for adults with ID/DD. The Commonwealth had planned and initiated its crisis services system for adults before the Agreement was approved. After the Court approval of the Agreement as a consent decree, the Commonwealth explored the options. It determined that children's crisis services and crisis stabilization services should operate separately from adult crisis service programs. Since that decision in 2012, the Commonwealth planned, requested and received funding, completed its procurement process to select service providers, and has developed the crisis services for children. The Commonwealth expects the children's mobile crisis services to achieve full operation and compliance in all five Regions during the next, the tenth, review period. The Commonwealth expects the mobile crisis services for children to achieve compliance with 95% on-time responses to crisis calls by December 31, 2016. The Independent Reviewer will include an evaluation of children's, in addition to adult's, crisis services in determining compliance ratings for the mobile crisis service provisions in the next Report to the Court. The Independent Reviewer will include the evaluation of children's out-of-home crisis stabilization services in the twelfth review period. The Commonwealth expects that these services will begin in September 2017 at the end of the eleventh review period.

4. Supported Employment

The Independent Reviewer retained a consultant to complete the ninth review of employment services. The purpose of the ninth period review, however, was limited. At the request of the Commonwealth, due to the extraordinary demands of implementing the redesigned HCBS waivers, the Independent Reviewer designed the ninth period reviews to reduce demands on the private providers, case mangers, and DBHDS staff involved with the provision of services and supports to individuals with waiver-funded services. The methodology for this study was limited to the review of available documents and interviews that were narrowly focused on the Commonwealth's implementation of priorities of employment. The study did not include a review of the qualitative aspects of service planning or delivery.

In the Agreement, the Commonwealth committed, to the extent that it offered services, that it would do so "in the most integrated setting appropriate to meet the needs of individuals with ID and DD." In order to fulfill this commitment, the Commonwealth agreed to:

- Establish a statewide Employment First policy;
- Develop a plan to increase integrated day opportunities, including supported employment;
- Establish targets for employment services to support individuals in integrated work settings where they are paid minimum or competitive wages;
- Establish Regional Quality Councils, which would review data regarding the extent to which the targets are being met, consult with employment providers and the SELN (aka EFAG) regarding the need to take additional measures to further enhance these services; and
- Develop and discuss employment goals at least annually through a person-centered planning process and to include them in ISPs.

The primary focus of the ninth period review of employment services was the Commonwealth's status and progress toward achieving its target milestones. The provisions of the Agreement apply to the services for individuals with ID/DD HCBS waiver slots. The Commonwealth has taken a broader approach; it has established targets for all individuals with ID/DD receiving supported employment services and separate targets for the subset of individuals with ID/DD with HCBS waiver slots. A much smaller percent of individuals with HCBS waivers, and those that are eligible for such waivers, receive supported employment services. The targets that the Commonwealth established reflect increased participation of individuals with ID and DD who receive HCBS waiver-funded services in both individual-supported employment and group-supported employment. Both occur in integrated settings. It is positive that the targets project an increase of 419% in the number of these individuals in the preferred individual-supported employment (I-SE) and a smaller increase of 55.9% in group-supported employment (G-SE) (see Table 4 below). During the five years, Fiscal Year 2016 – 2020, the Commonwealth will add at least 1,955 (+18.7%) new waiver slots in addition to the 10,470 waiver slots that existed as of Fiscal Year 2015. Achieving these employment targets will represent a significant shift away from Commonwealth's approach, since it joined the HCBS waiver program, of providing services by congregating individuals with ID/DD together in segregated settings.

Table 4 DBHDS Goal to Increase Employment in the HCBS Waivers			
Fiscal Year	**Individual-SE**	**Group-SE**	**Total**
2016	211	597	808
2017	301	631	932
2018	566	731	1297
2019	830	831	1661
2020	1095	931	2026
# increase	+884	+334	+1218
% increase	+419%	+55.9%	+151%

Employment Achievements

DBHDS continues to collect, analyze and report employment data semiannually. For its fourth semiannual employment services report, however, the DBHDS received, for the first time, data from 100% of the Commonwealth's employment service organizations (ESOs). This most recent and fourth report was for the period January 1, 2016, through June 30, 2016. The considerable and collaborative efforts of the DBHDS, Department of Aging and Rehabilitative Services (DARS), the Department of Medical Assistance Services (DMAS), and the employment service organizations contributed to the achievement of a 100% response rate from the ESOs. This represents an improvement from the December 31, 2015 semiannual employment report, which included data from 93% of the employment service organizations.

One consequence of the improved response rate, however, is that it is not possible to compare the number of individuals reported by 93%, to the numbers reported by 100% of the employment service providers. It is also not possible, therefore, to determine the extent to which changes had occurred during the six-month period between January 1, 2016 and June 30, 2016. The Commonwealth's June 30, 2016 semiannual report, however, provides the numbers of individuals actually working in supported employment sat the end of Fiscal Year 2016: 225 were receiving individual-SE and 665 were receiving group-SE. These achievements surpass the DBHDS targets of 211 and 597, respectively (see Table 4 above). It is very positive that DBHDS has established a goal that at the end of Fiscal Year 2017, 301 individuals in the HCBS waivers would be receiving individual-SE. This represents an increase of ninety more individuals (42.7%) that the goal of 211 at the end of Fiscal Year 2016.

It is also very positive that DBHDS set increasingly higher goals for individual-SE compared with group-SE. For individuals with HCBS waiver slots, the Commonwealth's total goal is for the number receiving SE to increase from 808 on June 30, 2016 to 2026 on June 30, 2020. Notably, the Commonwealth has set a goal to increase the number receiving individual-SE from 211 to 1,095, an increase of 419%; whereas, it set a goal to increase the number of individuals receiving group-SE from 597 to 931 at a significantly slower rate, an increase of 55.9%. By 2020, the Commonwealth has set a goal for the number of people receiving individual-SE that *exceeds* the number receiving group-SE.

The Commonwealth's data are inadequate regarding the extent to which case managers "discuss and develop employment goals annually." In addition to the data being self reported, the Commonwealth's data does not include information from the case managers for individuals with DD, other than ID. Data from each CSB were included in the most recent DBHDS semiannual report. Twelve of the CSBs were below DBHDS's expectations for discussing and developing employment-related goals. Five other CSBs reported that their case managers had not completed any ISPs during a six-month period.

DBHDS should establish improvement goals and improvement plans for the CSBs that perform below expectations for two successive quarters. The lack of information from the Commonwealth's DD case managers, an entire subgroup of the target population, is a significant problem. The Commonwealth must incorporate this information in future semiannual reports on employment.

Pre-vocational Services

Although the Commonwealth has eliminated pre-vocational services from its list and definitions of waiver-funded services, 565 individuals were reported being served in pre-vocational HCBS waiver services as of June 2016. Pre-vocational Services are provided in segregated sheltered workshop settings. It is promising that DBHDS is providing technical assistance to many of the providers of pre-vocational services. Doing so will help willing providers to convert to being able to offer community-based employment, community engagement activities, or a combination of both.

Hours Worked, Maintaining Employment, and Wages Earned,

In its June 2016 semiannual employment report, DBHDS provided more detailed point-in-time information on the number of hours worked than provided in its previous reports. Table 2 below provides a breakdown of the hours worked per week for individuals with ID/DD in SE, those who have waiver funded services or other funding sources. As of June 2016, DBHDS reported that of this larger cohort, 2089 of the 3,414 individuals (61.2%) worked fewer than twenty hours per week. Of those who work fewer than twenty hours per week, 834 individuals (39.9%) worked in group-SE and 1,255 (60.1%) worked in individual-SE arrangements. Table 5 below summarizes the number of hours individuals with ID/DD worked by in the two types of supported employment.

Table 5
Hours Worked by Individuals in I-SE and G-SE

Range of Hours	Individual-SE	Group-SE	Total
< 10	368	158	526
10-20	887	676	1563
21-30	474	293	767
31-39	247	36	283
40 or more	172	48	220
Unknown	26	29	55
Total	2174	1240	3414

DBHDS has established a goal that at least 85% of individuals who are employed will maintain their jobs for twelve months or more. The most recent semiannual employment report includes length of employment data for 3384 individuals, of whom 89% (3025) have been employed for at least one year.

DBHDS also reported on wages for 3,363 of 3,414 individuals (98.5%) in either individual-SE or group-SE. DBHDS did not report wages earned by fifty-one of the individuals (1.5%) in supported employment Of the 3,363 workers with wages reported, their employers paid them:

- 2,886 (85.8%) minimum wage or higher for their work
  918 (27.3%) minimum wage and 1,968 (58.5%) more than minimum wage
- 477 (14.2%) less than minimum wage.
  Note: 474 of these individuals (99.4%) are working in group-SE arrangements.

The June 2016 semiannual employment report also included information regarding 1,192 individuals (including all DARS- and waiver-funded individuals) who receive employment supports in segregated sheltered workshop settings. Of these individuals 724 (60.7%) receive less than minimum wage for their work.

Engagement of the Employment First Advisory Group (EFAG) and the Regional Quality Councils (RQCs)

The Agreement requires the Commonwealth to establish Regional Quality Councils. It requires the RQCs to review data regarding the extent to which the Commonwealth's supported employment programs are meeting its target milestones. The Agreement also requires the RQCs to consult with the Employment First Advisory Group (EFAG), formerly called the Supported Employment Leadership Network (SELN), regarding the need to take additional measures to further enhance these services and to work with providers and the EFAG in determining whether the Commonwealth should adjust it targets upward.

DBHDS convenes the EFAG to:

- Provide advice to the Department on employment service development;
- Recommend policy changes and training strategies;
- Participate in data collection and analysis; and
- Make recommendations to assist the Commonwealth in achieving its employment targets.

The Independent Reviewer's previous Reports to the Court have identified the operations of he EFAG as an area of concern, but improving. Based on a review of documents and interviews with EFAG members, there has been significant EFAG improvements. These include:

- Membership has stabilized since the changes were made in 2015;
- Membership reflects balance among stakeholder groups;
- Members attend much more consistently;
- Meetings operate more efficiently;
- Documents are distributed with sufficient time to review them prior to discussions; and
- Progress has occurred in data gathering and analysis.

The Regional Quality Councils (RQCs) are also required to review employment data quarterly, to discuss the targets and to offer recommendations annually. The minutes from the five RQCs quarterly meetings reflect discussions of employment concerns, review of the targets, and recommendations made. The employment related recommendations include:

- Addressing transportation;
- Connecting CSB staff with school transition planning meetings;
- Including career development as a support;
- Making employment transparent and publicly available;
- Learning and sharing best practices in securing employment;
- Educating families to change their expectations of their child's employability;
- Offering benefits counseling to families and individuals;
- Training case managers and ESO staff; and
- Offering employment provider fairs for case managers.

Two RQCs agreed to simply repeat recommendations made the previous year. This raises a significant concern with a lack of clarity regarding which DBHDS organizational entity has responsibility and

authority to approve, modify, or reject recommendations made by the RQCs and the process for, and timing of, informing the RQCs of these decisions.

The Agreement includes the expectation that the RQCs consult with providers and the EFAG. It is very encouraging that the RQC meetings now regularly include a review of employment data and a discussion of progress toward meeting the targets. There is no evidence, however, that the RQCs interface or consult with providers or that the Commonwealth shares the recommendations made by the RQCs with the EFAG. None of the EFAG members who were interviewed were aware of the RQCs involvement in the employment initiative; none had been briefed on either the RQCs recommendations or on what actions DBHDS took as a result of the RQC recommendations.

Summary: Regarding supported employment, DBHDS is making significant progress regarding data collection; defining and beginning to achieve the employment targets; and refilling the Employment Services Coordinator position. DBHDS has also supported the development of community engagement while it is implementing extensive changes to the existing HCBS waivers system. As DBHDS has developed the structure to improve employment opportunities, a lack of clarity has become apparent regarding which DBHDS entity has the responsibility and authority to make decisions, to develop action plans and to communicate the status of the RQC recommendations. DBHDS should clarify the lines of authority and responsibility regarding the recommendation made by the RQCs and should develop additional protocols to ensure that the RQCs consult with the Employment First Advisory Group.

5. Transportation Services

The Independent Reviewer's consultant completed his second evaluation of whether the Commonwealth provides effective transportation services for members of the target population who receive waiver-funded services. The Virginia Department of Medical Assistance (DMAS) administers the Non-Emergency Medical Transportation (NEMT) services through a brokerage system contracted to a multi-state private sector contractor, Logisticare. The effective functioning of the DMAS transportation brokerage is critical to achieving the goal of improving the lives of people with intellectual and developmental disabilities and to achieving compliance with the Agreement. The consultant's previous evaluation found that DMAS/Logisticare:

- Did not separate out individuals with ID/DD with waiver slots in its databases;
- Had not completed an analysis related to the delivery of transportation services for these members of the target population: and
- Was not able to undertake the required quality improvement processes without information about the transportation experiences of individuals with ID/DD waiver slots.

In December of 2015, the Independent Reviewer determined that the Commonwealth was in non-compliance with the transportation requirements of the Agreement. At that time, the Independent Reviewer requested that the Commonwealth develop a plan to address improvements needed "to ensure that its transportation services are of good quality, appropriate, available and accessible to the target population."

Since DMAS and Logisticare only implemented a number of changes this past summer, the impact of these changes cannot yet be evaluated. The consultant's study during this review period, therefore, represents a formative evaluation: a check-up to determine and to give feedback regarding whether and how the planned modifications are likely to achieve or to fall short of compliance. Based on the Commonwealth's expected

implementation schedule, the consultant projects that an evaluation will be possible after a full year of implementation. The Independent Reviewer will plan future independent evaluations to determine:

- The ability to separate out information regarding transportation services for individuals with ID/DD with waiver-funded services;
- The effectiveness of the planned transportation system changes for these individuals; and
- Whether DMAS has effectively completed a full annual cycle of its quality improvement program.

DMAS has instituted changes in current practice that it plans to institutionalize through its Request For Proposal (RFP) and contract award process. DMAS issued a new RFP for Non-Emergency Medical Transportation on November 1, 2016. The Commonwealth's resulting contract award for transportation broker services is projected to begin on July 1, 2017. A delay in the award of a new contract, however, could extend the period before an evaluation of these changes can be completed.

The new RFP includes requirements that address four of the eight recommendations that the consultant made in his previous evaluation report. The RFP includes requirements for the broker to:

- Address statistically valid customer satisfaction surveys from ID/DD Waiver users;
- Increase representation from the ID/DD Waiver community on advisory boards; and
- Implement "trip recovery" technology (i.e., software designed to redirect drivers in real time when another driver is unable to complete a ride).

The consultant's review also found that:

- DMAS/Logisticare extracted information from its databases and analyzed initial findings for the ID/DD Waiver population for July 2016. The consultant's previous report recommended this.
- DMAS analysis concluded that the ID/DD waiver-funded population uses proportionately more trips per individual than the larger group of users.
- LogistiCare advises users to communicate through its Rider Assist line.
- Logisticare reviews and reports responding to complaints that it determines are legitimate.
- LogistiCare determines that complaints are not legitimate if not made through its Rider Assist phone line. Complaints made directly to a driver of the subcontract transportation provider are considered not legitimate because LogistiCare cannot be assured of learning of, and has no way to track, the complaints. DMAS reports that complaints it receives directly are forwarded to Logisticare for investigation and resolution.
- A day program provider confirmed that LogistiCare had contacted them to "problem solve" regarding complaints of "late pickups" and it then took follow-up actions.
- LogistiCare reported following-up on all accidents/incidents, but does not complete follow-up reviews on all complaints due to the volume of calls into the Rider Assist line (more than 2,800 calls monthly. (See recommendations below).
- A day provider reported that there were numerous "late pickups" that were not reported.
- LogistiCare's follow-up does not always reflect double-loop learning about improvements. For example, it reviewed and confirmed the legitimate cause of one "late pickup," but it did not follow-up to determine whether there were any more occurrences of "late pickup" for this individual by that driver/contractor.
- DMAS reports that it receives copies of all complaints, approximately 2,800, on a monthly basis and that DMAS can evaluate individual complaints and the quality of LogistiCare's complaint resolution and can require that Logisticare reopen the complaint for further review.
- LogistiCare "case" managers become involved to help address problems and then report to LogistiCare on local attempts to resolve complaints.

- LogistiCare "case" managers may not have the "tools" needed to resolve or to ensure sustained problem resolution.
- DMAS has instituted a revised mileage reimbursement form, which users can now submit for payment via fax, as the consultant previously recommended. This process does facilitate user payment. The reimbursement form, however, remains cumbersome and is not user friendly. To request reimbursement, the form requires the user to enter fifteen data items per trip. The user friendliness of this form is critical to giving users a personal alternative and choice to using Logisticare's sub-contract transportation drivers.
- Examples of problems were found that took so long to resolve that many users would likely have pursued any other available alternatives.

Summary:

- DMAS and LogistiCare appear committed to addressing needed quality improvements in transportation for users with ID/DD waiver-funded services. DMAS has implemented changes that reflect recommendations made previously by the independent consultant and has issued an RFP to institutionalize these new approaches.
- The DMAS finding regarding higher use per ID/DD Waiver users is a significant conclusion, which warrants additional analysis and/or action.
- DMAS should request that LogistiCare Quality Assurance or "case" managers sample survey users from the IDD Waiver who have complained to the Rider Assist line to see if their problem continues or is recurring within 30 days of the report
- It may take several continuous months of data analysis across seasons, school years, etc., to establish other actionable patterns or trends among users with ID/DD waiver-funded services.
- The effectiveness of DMAS actions to create an effective Quality Improvement Program for ID/DD Waiver participants will be able to be assessed after a complete annual cycle, which had not yet occurred.

The Commonwealth remains in non-compliance with *III.C.8.a.*

6. Quality and Risk Management

Annually, since 2012, the Independent Reviewer has retained the same independent consultant to assess the status of the Commonwealth's progress in its planning, development and implementation of the Quality and Risk Management requirements of the Agreement. When effectively implementing these provisions, the Commonwealth will "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."

The consultant's study focused the following areas of Quality and Risk Management:

- Risk triggers and thresholds;
- Providers;
- Data to assess and improve quality;
- Regional Quality Councils;
- Annual report to the public; and
- Quality Service Reviews.

The consultant reviewed relevant documents and interviewed staff from DBHDS, Community Service Boards (CSBs) and the private third-party contractor that is completing the Quality Service Reviews.

Within DBHDS, there was a significant leadership transition that slowed progress of its development of the Quality and Risk Management system. A new Assistant Commissioner of Quality Management and Development was hired two months after this ninth review period began. DBHDS recognized that a number of its quality initiatives had stagnated. The new Assistant Commissioner engaged in a transition that included a reassessment and redefinition of the structure and role of the Quality Management and Development Division in meeting the needs of the clinical and programmatic components of DBHDS.

Risk Triggers and Thresholds

Since an independent review in 2015, the Commonwealth made minor modifications and additions to its list of triggers and thresholds. For each trigger and threshold, DBHDS has identified the "domain," the "measures" and the "risk criteria." DBHDS has also identified the data that are currently available as well as the data and collection methods that are not yet available. The triggers and thresholds are designed to be useful to the direct service providers in order to improve responsiveness to health and safety concerns and to DBHDS in order to strengthen its monitoring and oversight.

The Independent Reviewer's previous Reports to the Court, and the consultant reports that are included in the Reports' appendices, have described concerns with the draft risk triggers and thresholds and have included recommendations for improvement. The concerns included that:

- Additional data are needed for the measures to be useful;
- Some terms need to be defined to ensure that reliable data are gathered;
- The triggers in the medical section should be better explained or defined; and
- The existing list of triggers does not meet the Agreement's definition of harm.

The draft risk triggers do not yet include deficits in the skills and knowledge of staff or any inadequate systems of care within provider agencies. The DBHDS Office of Licensing Services' investigations, however, have identified these shortcomings; and the Office of Licensing Services has cited providers for violating related regulations after events with negative health outcomes. The purpose of the triggers and thresholds is to alert providers prior to such events and the harm that results.

The DBHDS Risk Management Review Committee (RMRC) has gathered some data that were provided for other purposes (i.e., CHRIS reports). It has reviewed these data against the draft triggers. Since the previous independent review in 2015, the RMRC has started to review data and to take limited actions to contact and provide technical assistance to providers. Over a several month period, the RMRC tried different mechanisms to review and respond to individuals or providers that experienced events that met the current risk triggers or thresholds. In some cases, the RMRC's assistance resulted in improved outcomes for individuals. The RMRC has evaluated and determined the strengths and weaknesses of the monitoring and response approaches that it tested. The RMRC correctly concluded that, "For a truly effective risk management system, every provider must have the ability to monitor his own data and be required to take action when a trigger event occurs or a threshold is met." The Commonwealth, however, has not yet informed service providers that it will require them to implement the system and to submit the data to the Commonwealth. The RMRC envisions its role as providing oversight "to ensure that providers are taking action to reduce risks in response to triggers and thresholds." DBHDS has not yet identified the mechanisms and the methodologies to gather the data that are needed for an effective system of risk triggers and thresholds.

Not withstanding the quality of its work to date, the RMRC cannot reduce and manage risks without a working system of risk triggers and thresholds, and without effective incident investigations at the direct service level. The Commonwealth will not achieve compliance with the risk triggers and thresholds provision until it revises its regulations to align with the Agreement. After the revised regulations are approved, a very substantial statewide effort will still be necessary to effectively implement the required elements of the risk management system.

The Commonwealth remains in non-compliance with *Section V.C.1*.

Providers

In the risk management provisions, the Commonwealth committed to "offer guidance and training to providers on proactively identifying and addressing risks of harm …". A year ago, the Commonwealth reported that it had completed and posted on the DBHDS website one webinar on risk triggers and thresholds as evidence that it "offers" CSBs and providers risk management information, resources and tools. The Commonwealth has continued to develop training materials related to risk management and to make them available on its website. The Independent Reviewer has previously reported concerns with the posted training information. Two independent consultants recently verified the most fundamental and significant concern. Based on interviews with ten CSB and private provider staff, who were identified as managers of quality assurance efforts, the concepts of risk triggers and thresholds, and the mechanics of conducting root cause analysis, are not well known and have not been implemented. None of the ten staff were familiar with the terms "risk triggers" and "thresholds." One of the three CSB quality managers was not aware of the DBHDS requirements or the online investigation training at the "Human Rights for Service Providers" tab on the Department's website.

In order to accomplish substantial progress implementing the risk management provisions at the direct service level, the Commonwealth must take steps to offer and to require the participation of CSB and private provider staff in training and technical assistance on the:

- Development and implementation of the proactive identification of risks of harm;
- Concepts and practical implementation of root cause analysis; and
- Methods to be used to develop and monitor implementation of corrective actions.

The Commonwealth remains in non-compliance with *Sections V.C.4*

In the quality provisions of the Agreement, the Commonwealth committed to:

- Require all providers to develop and implement a quality improvement program, including root cause analyses;
- Develop measures that CSBs and providers report to DBHDS on a regular basis; and
- Monitor and evaluate service quality.

The Agreement includes provisions to require CSB and providers to report to DBHDS through risk management, critical incident or QI programs. The Agreement also requires the DBHDS Quality Improvement Committee (QIC) to:

- Monitor and review, with input from the Regional Quality Councils;
- Assess the adequacy of provider quality improvement strategies;
- Provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines are inadequate; and
- Assess the validity of each measure at least annually and then update measures accordingly.

The Independent Reviewer reported in December 2014 that the Commonwealth added Quality Improvement program requirements to its draft Performance Contract with CSBs, beginning in 2015.

The Commonwealth's oversight of community providers' Quality Improvement programs remains a work-in-progress. In 2015, the Commonwealth conducted a survey of the CSBs. It found, as expected, that CSBs have different levels of awareness and commitment to building quality improvement processes into their operations (see Appendix D for examples). During the ninth review period, DBHDS sent a survey to approximately 1,000 CSBs and community providers to ascertain a baseline regarding current quality improvement practices, At the end of this review period, responses had recently begun to be returned.

The Commonwealth remains in the development phase of its Quality Improvement system. It did not establish expectations for CSBs' and private providers' quality improvement programs by its target date of December 31, 2015 or as of October 2016. Also, the Commonwealth had not yet begun to implement a statewide process to assess the adequacy of its providers' quality improvement programs or to provide them formal training and technical assistance. The Commonwealth made some progress, but is still finalizing drafts of the data that it intends to collect. To address the requirements of the Agreement, however, submission of additional data, beyond what is described in the drafts, will be necessary. In some cases, the reliability of the available data requires improvement and the mechanisms and methodologies for collecting the data need to be developed. Once defined, the process to extract specific data that the Commonwealth needs will be difficult because CSBs and providers use many different electronic health records and/or paper records.

Although the Commonwealth has made progress, interviews with the CSB and private provider staff, who were identified as responsible for quality improvement, found that they had little or no knowledge of the quality improvement resources, information and training modules that DBHDS had developed and posted on its website, (i.e., risk triggers and thresholds and root cause analysis). An example of resources with which the CSB and provider staff were familiar is the medical/health risk Safety Alerts.

The Commonwealth's Quality Improvement Committee (QIC) continues to meet quarterly. DBHDS is currently revising its agenda and focus. The Interim Commissioner indicated that, in order to maximize the usefulness of the Committee, he has set the expectation that representatives will come to meetings with reports that include data analysis and actions/recommendations for his consideration. The QIC is currently working to answer questions regarding the responsibilities and authorities of each workgroup. These fundamental questions about organizational structure include:

- Which data will be collected and analyzed;
- Who should collect it;
- Who should analyze it; and
- Who should then develop the recommendations for subsequent actions.

DBHDS also needs to decide each workgroup's authority and responsibility to plan, to take actions, and to report. The need to answer these questions is apparent in the current lack of clarity. For example, if the primary role of the QIC will be to identify crosscutting themes or issues, will the QIC be responsible for planning and implementing any needed changes? Similarly, if the Mortality Review Committee is responsible to "analyze … problems at the individual service delivery level" and "to implement quality improvement initiatives," must another group approve these initiatives before implementation occurs?

Summary: The Commonwealth remains in the beginning stages of conveying to providers their responsibilities to maintain quality improvement processes and mechanisms and to share data with the Commonwealth. Forums for reviewing provider data, such as the Regional Quality Councils and the Commonwealth's QICs, also remain in the beginning stages. Some limited analysis of data has occurred, but only limited data are currently available to inform the Committees' decision-making; more in depth analyses will be needed over time. The Interim Commissioner's plan for revising the agenda and content of the QIC meetings should improve decision making, but DBHDS staff will likely require training and technical assistance to develop the reports that are envisioned by the Committee.

The Commonwealth remains in non-compliance with *Section V.E.1-3*.

Date to Assess and Improve Quality

Since the consultant's review in 2015, the Centers for Medicare and Medicaid Services, (CMS) approved the Commonwealth's amended Home and Community-Based Services (HCBS) Waiver program, including its *Quality Improvement Strategy*. This document provides the Commonwealth's description of its basic assurances of quality related to protections, services, and supports through its planned implementation of the redesigned Waiver program. The description includes many of the requirements of, and is not in contradiction with, the Agreement's requirements.

As reported in December 2015, the Commonwealth had taken significant steps forward in its ability to collect and use data to assess and improve quality, including the development of the DBHDS *OneSource* Data Warehouse. During the past year, the Commonwealth staff have continued to utilize available data to evaluate its progress in developing the eight domains that are required by the Agreement. It has not, however, added new sources of data.

As it described in its *OneSource Data Warehouse Data Quality Framework Overview* (February 24, 2016), the Commonwealth is establishing a system designed to continuously work toward high quality data. This document explains that, to be effective, data must be accurate, timely, relevant, standardized, accessible, unique, and complete. To accomplish this goal, Commonwealth staff are developing a number of processes (see Appendix D for details).

During the ninth review period, the Data Quality and Analytics Coordinator developed *Overview of DBHDS's Data Warehouse as a Resource for Eight Domains Measurement* (June 2016). This primer explains how a relational database works. It also provides practical applications for the eight Domains that are described in the Agreement. The DBHDS staff also produced *Defining the Eight Domains* (September 15, 2016). Although the definitions and measures for the eight domains are in various stages of development, they reflect a thoughtful approach to identifying what should be measured (i.e. valid measures), what is possible to measure reliably (i.e., reliable measures), what relevant fact tables currently exist within OneSource, and what additional data might be required. Some workgroups had more difficulty finalizing definitions and, consequently, some are further along than others in identifying fact tables that will generate the needed information. As the workgroups complete this process, the Commonwealth staff should continue to consider the independent consultant's previous recommendations regarding the scope and quality of data.

DBHDS reports that one measure will likely be included for each Domain when the initial "Eight Domain Report" is ready for implementation. DBHDS plans to collect data from January 1 through June 30, 2017, after which time the data would be analyzed. The Agreement required that reliable data would be collected and analyzed from each of Domains by June 30, 2014. Other DBHDS plans, techniques that account for changes, considerations for identifying problems early, and possibilities for deeper analysis are described in Appendix D.

The Commonwealth remains in non-compliance with *Section V.D.3 a-h and V.D.4.*

Regional Quality Councils

The DBHDS document *Guidelines for the Operation of Regional Quality Councils* (October 16, 2014) describes the function and structure of the Regional Quality Councils (RQC), as well as the RQC membership requirements and voting rules. These *Guidelines* state that the DBHDS Quality Improvement Council directs the work of the Regional Quality Councils.

During the ninth review period, the independent consultant found that the RQCs met quarterly and that, when members conducted analyses of the limited data, they engaged in more robust discussions than they had a year earlier. The RQC members asked good questions regarding the availability of further breakdown of the data, the reliability of the data, and the its context (see Appendix D for examples). The RQC members made recommendations regarding programmatic issues and their roles and responsibilities. More consequential discussions, analyses and recommendations will become possible as the RQCs are provided with more reliable and complete data.

DBHDS has achieved the memberships of the five Regional Quality Councils, as required by the Agreement. DBHDS recognizes that it will be challenged, however, to sustain membership and improve the performance of the RQCs in the future. The three-year terms of many current members will end simultaneously, three years after the Councils were formed. Some terms will likely need to be extended to ultimately reach staggered terms and less disruptive future transitions.

The Agreement defines the role of the Regional Quality Councils as "assessing relevant data, identifying trends, and recommending responsive actions." It is positive that the Division of Quality Management and Development's personnel regularly support the RQCs' activities and share with them the data that are currently available. For example, in recent RQC meetings, DBHDS shared employment, Office of Licensing, and Office of Human Rights data. Nonetheless, with only limited and frequently unreliable data available for review and because the risk triggers and thresholds system and the eight Domains have not been implemented at the direct service provider level, the RQCs cannot achieve compliance with the requirement to review relevant data and to recommend responsive actions.

The Commonwealth remains in non-compliance with *V.D.5*

Annual Report to the Public

The DBHDS website (i.e., http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/doj-settlement-agreement) includes a tab for an Annual Report. In December 2015, this site included reports with valuable information regarding demographics, the quality and quantity of supports, and recommendations for improvements. At that time, although the "Annual Report" site included reports, it was not yet complete. The recent review found that much of the information on the site is information from 2014 and 2015 and, therefore, is outdated. It will be important for DBHDS to ensure that the data provided in its Annual Report accurately reflect the current system, including the quality of services and the gaps in service.

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

Quality Service Reviews

The Commonwealth retained a third-party contractor to complete Quality Service Reviews (QSRs), as required by the Agreement. Overall, the purpose of the QSRs is "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." The QSR process is required to collect information through face-to-face interviews with a statistically significant sample of individuals receiving services and a sample of providers who serve the selected individuals. The planned QSRs involved:

- Conducting Person-Centered Reviews (PCRs) of a statistically significant sample of individuals receiving services and supports under the Settlement Agreement;
- Conducting Provider Quality Reviews (PQRs) of fifty direct service and support providers serving the individuals selected for the Person-Centered Reviews;
- Completing Quality Service Review Assessments, which involve reviews at the Community Services Board, regional, and statewide levels; and
- Submitting Quality Service Review Assessment reports, which include reports on the Person-Centered Reviews and Provider Quality Reviews for individuals in the sample, as well as assessment/analysis of the systemic data.

The Independent Reviewer previously reported that the Commonwealth's third-party contractor planned to complete 400 individual and family interviews as well as fifty provider reviews. The sample of individuals was selected to ensure regional representation, while taking into account certain demographics (e.g., service type), to ensure that large enough numbers of individuals are surveyed to allow for statistically valid conclusions.

Prior to the Commonwealth's implementation of its planned QSR process, the Independent Reviewer reviewed and expressed concerns about the draft audit tools that the third-party contractor planned to use. The Independent Reviewer's concerns (e.g., lack of standards, lack of definition of terms) were not addressed in the versions of the tools that were used. The Independent Reviewer has the following concerns with the QSR audit tools that were used:

- Lack of Definition of Standards/Terms: Only audit tools with well-defined standards can ensure inter-rater reliability and articulate clear expectations for providers. Although some of the tools include a column entitled "standards," these often consist of vague statements that do not set forth specific expectations (e.g., "The provider supports the person to progress towards desired outcomes," or "The provider has safety protocols and plans needed to help the person stay safe."). Broad statements such as these frequently result in varied interpretations by both auditors and providers.

- Lack of Definition of Methodology: Similarly, the QSR audit tools did not consistently identify the methodology that auditors would use to answer questions. For example, at times, the indicators included in the observation tools appear to require additional document review. For example, for the expectation that the "Person's health concerns are addressed," the audit tools for the record review do not identify the expected data source in order to answer the question (i.e., where in the provider records would one expect to find the necessary documentation).

- Lack of Criteria for Compliance: The third-party contractor provided reports that indicated whether or not providers had "met" or "not met" requirements, but the audit tools did not explain how these ratings were determined. The lack of criteria for determining compliance raises significant questions regarding the validity of the findings. The audit tools generally include numerous indicators. Most of the tools include columns with "suggested protocols" and "standards," but explanations are not provided regarding how a provider will be determined to "meet" the requirements. DBHDS staff, who also identified this as a concern, are working with the contractor to address this shortcoming in the audit tools. They have developed a draft spreadsheet, entitled *VA Tools – Driver Indicators* (September 21, 2016), as an attempt to connect the questions within the contractor's eight audit tools with DBHDS's eight Domains and overall standards. The contractor would pair the Driver Indicators with a Likert scale to assist reviewers to determine the extent to which the standard was met. Even with this approach, however, it was difficult to understand how success at meeting requirements would be measured in a valid and reliable manner.

- Auditor Assessments of Clinical Adequacy without Clinical Qualifications: The audit tools cover a wide variety of topics, including healthcare and behavioral supports. None of the QSR reviewers, however, are reported to have clinical qualifications. Judgments regarding the adequacy and appropriateness of behavior support plans, nursing care, clinical and medical supports, etc. would generally require an auditor with specific qualifications, such as a psychologist/Board Certified Behavior Analyst (BCBA), a nurse, and/or physical and nutritional management experts. The lack of qualifications of the staff auditors who made these assessments raises questions regarding the validity of the findings.

- Missing Components: The audit tools do not comprehensively address services and supports to meet individuals' needs, particularly regarding clinical services. For example, the lack of indicators to assess the quality of clinical assessments and the services provided raises questions regarding the validity of the findings.

Regarding inter-rater reliability, the process that the contractor described is not consistent with standard practice. Specifically, the contractor indicated that, after a new reviewer completes orientation training, he/she shadows a lead reviewer. Initially, a lead reviewer conducts a review with a new reviewer; the new reviewer does not ask any questions or look at additional documents. They both score the tools, and then discuss the results. The roles are then reversed; this process is repeated at least annually. This process does not provide an accurate determination of inter-rater reliability. The problems with this process include: 1) reviews, except for observations, should be completed independently, given that part of the reconciliation process should be to determine whether inconsistencies are due to reviewers looking at different documents or data sources; and 2) inter-rater reliability should be tested between reviewers, not just between a lead reviewer and a new reviewer.

The third party contractor issued its first Quality Services Review Assessment on September 7, 2016. This assessment clearly showed a substantial amount of work. In summarizing the results of the Person-Centered Reviews (PCRs), it stated:

> "While needs in general appear to have been met for individuals (93.3%), a Person Centered approach was not always employed (76.9%); individuals were often not receiving services in the most integrated setting appropriate to the person (84.3%) or participating in the community as desired (84.5%)."

Unfortunately, it is not clear whether these findings were accurate. The lack of confidence in the accuracy of these findings is due to the above-identified problems with the validity of the tools and the process, with the reliability of data collected, and with the lack of clinical qualifications of the reviewers. To have confidence in the accuracy of the QSR findings, additional work is needed to improve the QSR audit tools and to develop and implement an inter-rater reliability process that is consistent with applicable standards. An important missing piece is the lack of clinical reviews of the selected individuals' physical, therapeutic, and behavioral health supports and outcomes.

Summary of Quality and Risk Management: The independent consultant reported that there continues to be support within DBHDS for developing a strong quality improvement system. At this time, however, it is clear that significantly more work and much more progress is required to achieve compliance. A number of significant challenges remain. The Commonwealth's staff recognize that to achieve a comprehensive quality improvement system that is in compliance with the Agreement, DBHDS will need to partner with and implement the elements of the system with the CSBs and its private providers. This area requires considerable work. In addition, an overarching theme continues to be the need to expand the scope of available data in order to allow comprehensive and meaningful quality improvement and risk management initiatives to occur. Revisions to the DBHDS regulations are essential to ensure that the Commonwealth's requirements of service providers align with the provisions of the Settlement Agreement.

The Commonwealth remains in non-compliance with *Section V.I.1-4.*

7. Safety and Risk of Harm

The Independent Reviewer retained a two-person team of consultants, including a Registered Nurse, to assess the Commonwealth's status with provisions of the Agreement related to safety and risk of harm.

Several of the Quality and Risk Management provisions require implementation of strategies and themes that are directly related to safety concerns and the goal of protecting the individuals receiving services from harm. The strategies include risk management, quality improvement and the capacity to investigate negative outcomes. The themes include the root cause analysis of negative outcomes and risk triggers/risk thresholds. In the Agreement, the Commonwealth committed to implement these strategies and themes and to require service providers to do so.

The Independent Reviewer engaged the consultants to assess the status of the Commonwealth's progress toward full implementation of these strategies and themes throughout its system of services. The study methodology involved the review of relevant documents and interviews with administrators/managers regarding quality improvement by the private providers, CSBs, and DBHDS. The consultants also studied thirty-five of the Independent Reviewer's special Reports to the Court reviewing the serious injuries to and deaths of individuals who transitioned from Training Centers.

The Commonwealth's draft Quality Improvement (QI) Plan (including Appendix H of its HCBS Waiver program application to CMS) describes its commitment to system improvement. The most recent version of the QI Plan describes the Commonwealth's commitment to system improvement activities. These activities follow an analysis of aggregated discovery data, evaluation of system experience and actions to remediate negative outcomes.

The draft Plan describes a three-tiered approach to Quality Improvement: case management, Departmental, and third party. The Departmental tier includes the Quality Review Team (QRT), the Mortality Review Committee (MRC), and the Quality Improvement Committee (QIC) with five Regional Quality Councils (RQCs). The third tier is the contractor that completes Quality Service Reviews (QSR).

There are significant shortcomings in the implementation of the three-tier approach to Quality Improvement.

It is the experience and considered opinion of the Independent Reviewer that, on a daily basis, the direct service provider is the first layer or tier in an effective Quality Improvement system. Case managers may be considered the "eyes and ears" of those with an indirect role in QI, but should not be considered or depended upon as the trip wire for quality improvement on a daily basis. First, at the direct service level, there may be daily quality improvement opportunities; whereas, case managers typically visit individuals in their homes once every two months. A second reason that case managers should not be considered the first tier of a Quality Improvement system is that the Commonwealth currently prevents case managers from direct access to information that is important to reducing risks. Timely access to information about risks and negative outcomes is central to the required system of risk triggers that is intended to reduce harm. Yet, case managers do not have the authority to readily obtain CHRIS reports of serious incidents or injuries to individuals whose services they are assigned to monitor. They cannot review the findings from the investigations of these incidents to prepare for their quarterly reviews or annual service planning meetings. If the case manager becomes aware of the event or injury, then they may institute a process and "case management entities" may request a copy of the initial CHRIS report. The Independent Reviewer's previous studies have found that case managers are already stretched to fulfill requirements to "assemble," "assist" and "monitor," or "to complete observations or assessments to identify an unidentified or inadequately addressed risk, injury, need, or change in status." Also, case managers for individuals with complex behavioral and/or intense health care needs often lack the clinical expertise to assess healthcare risks or changes in behavioral status.

A second significant shortcoming in the Commonwealth's three-tier approach is the absence of a full description in the Quality Improvement Plan of the first line role of the provider of direct services in quality improvement. The Agreement requires every provider to develop and implement a quality improvement program and to report incidents; complete root cause analyses; verify implementation of corrective action plans and collect and provide data, etc. Some of this information is in the QI Plan

section entitled "Provider Record" and DBHDS staff do understand the central daily role that direct providers fulfill in assuring quality. As written, however, the QI Plan does not reflect the day-to-day reality that the trip-wire layer of Quality Improvement is within each direct service provider. It is the Independent Reviewer's experience and opinion that when the first tier of effective quality improvement exists at the transactional level, between individuals and support staff, then services to individuals improve. While DBHDS has worked internally to plan and develop QI systems, these efforts do not appear to have yet reached the providers who provide direct serves to individuals with ID/DD.

Another shortcoming of the Commonwealth's Quality Improvement process appears to be the absence of clear lines of accountability and parameters of responsibility. In the QI processes that were reviewed, DBHDS did not include "chartering" or "charging" strategies to the QI teams to ensure that their purposes, expected outcomes and timelines are clear and well understood. The Quality Improvement Plan does not adequately define the relationships between Committees, work groups and Councils. This lack of clarity contributes to these groups being uncertain about the outcomes and timelines expected for their work products. For example, the relationship between the Quality Review Team and the Quality Improvement Committee is not clear, since both appear authorized to implement improvement activities independently of each other. Clear directions regarding purpose and expected outcomes should also govern time-limited QI projects. Finally, the Quality Improvement Plan does not define the process for tracking the work products of its Committees, Teams and Councils. Tracking is necessary to ensure that quality improvement tasks are implemented and accomplished as planned and, if not, to ensure that the lack of implementation is recognized and appropriate corrective measures are considered and taken. The consultants did not find that DBHDS had dependable processes in place to ensure that Committee/Council recommendations were assessed, responded to and/or acted upon. The new Assistant Commissioner for Quality and Risk Management is aware that the draft Quality Improvement plan requires revisions which he intends to make during the tenth review period.

DBHDS is in non- compliance with *Section V.E.2*.

The Independent Reviewer recommends that the central role of the direct service provider be identified and fully described as the first tier of the Quality Improvement Plan. The Independent Reviewer also recommends that case managers for individuals with intense medical and behavioral needs have:

- Immediate access to all information related to the risks to individuals on their caseload;
- Qualifications that reflect the clinical expertise needed; and
- Case loads that reflect the additional work required to ensure that services are delivered as planned and with expected results.

Service Provider focus on Safety

The independent consultant team's assessment of service provider focus on safety was based on personal interviews with the staff who were designated as the responsible administrators or as the quality management managers of three Community Service Boards and seven private providers. All of these agencies provide day, residential or case management services in one or more Regions. These ten agencies provide services in three of Virginia's five health planning regions: Region I (central), Region III (southwest) and Region V (Virginia peninsula). The Agreement requires the Commonwealth to establish "uniform risk triggers and thresholds" to enable providers, with the oversight of DBHDS, to "adequately address risks of harm."

As previously reported, the Commonwealth has been working to develop the required "risk triggers and thresholds" for more than three years. It has developed and completed initial training modules including those on root cause analysis. The training modules have been posted on the DBHDS website. In December 2015, these processes had not yet been implemented. The consultants' review sought to determine whether the providers had in place quality improvement plans and programs, rather than to complete a qualitative assessment of these programs. The consultants' review also explored whether providers were familiar with the concepts of "risk triggers and thresholds" and with "root cause analysis."

The consultants found that there was significant variability in the quality assurance processes at the service provider level. All three CSBs (100%) had Quality Management Plans, but only two of the seven private providers (28.8%) had formalized QI plans or processes in place. Regarding root cause analysis, only two of the CSBs (66.7%) and two of the private providers (28.8%) were familiar with the concepts. The review found a pattern of larger agencies with formalized processes in place, while smaller agencies had not yet incorporated a commitment to system improvement into their processes. The review did not find directives from the Commonwealth to the providers regarding the development and implementation of these required approaches. It appears, therefore, that the extent of provider development of QI processes was not in response to the Commonwealth's efforts to implement these provisions of the Agreement. Under the DBHDS draft proposed Office of Licensing Services (OLS) regulations, all providers would have to establish and implement formalized "quality improvement programs that include root cause analysis, as required by the Agreement." The Commonwealth's efforts through the ninth review period, however, appear insufficient to influence CSB and private provider understanding and performance.

Finally, the fundamental building block of an effective risk management and quality improvement system is a competent investigation of the facts of serious incidents. The consultants' review found that provider understanding of the investigation process pursuant to online investigation training was also variable. For example, one CSB Quality Management manager was not familiar with the DBHDS requirements or the online investigation training at the "Human Rights for Service Providers" tab on the DBHDS website.

The Commonwealth's development of a system of services fully committed to quality improvement and protection from harm is incomplete and has only partially been implemented. The Commonwealth's efforts to date have not significantly influenced the development or implementation of Quality Improvement programs, of root cause analysis, or of risk triggers and thresholds.

Licensing Specialist Focus on Safety

One member of the consultant team interviewed six Licensing Specialists to assess their awareness of the concerns for safety and for protecting individuals from harm. The Licensing Specialists reported the following:

- All of those interviewed stated that they "know their providers" and monitor more closely those with histories of performance problems. None, however, reported using an objective, data driven review to analyze incident and event data over time, places and individuals. Two Licensing Specialists (33.3%) indicated that the Data Warehouse can be utilized to obtain information about a provider, but also reported that they have found that it is not user-friendly and that they have not yet received training regarding its use.

- All of those interviewed were aware that DBHDS had some sort of safety/risk management committee, but none were aware of its duties. Two Licensing Specialists (33.3%) reported knowing that there is a Quality Improvement Plan; none, however, were aware of what was in the Plan.

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- All of those interviewed create Corrective Action Plans within fifteen days after a health or safety issue/regulatory violation is identified. All of the Licensing Specialists interviewed complete follow-up reviews within forty-five days to determine whether the Corrective Action Plan (CAP) has been met, as required by the OLS.

- All of those interviewed were aware of DBHDS Safety Alerts and took steps to share the information. All of those interviewed expressed concerns that, although Alerts are sent to each organization, the contents of the Alert might not get to the direct support staff.

- All of those interviewed were aware that they "can" pursue a provisional license for a provider if it does not fulfill the requirements of a CAP or of a second CAP related to the same regulatory violation. All of the interviewed Licensing Specialists, however, acknowledged that "obtaining" a provisional license is extremely difficult, is very labor intensive and is very slow to occur. None of those interviewed had initiated sanctions that involve the pursuit of either a provisional license or license revocation.

- Five of the six Licensing Specialists interviewed (83.3%) do not use the entire root cause analysis process. Three of those interviewed (50%) reported using part of the process when developing CAPs.

- All of those interviewed were uninformed about and unfamiliar with risk triggers and risk thresholds.

- None of the Licensing Specialist interviewed recalled receiving feedback about their investigations, but all would like and benefit from feedback.

- Four of the Licensing Specialists interviewed (66.6%) commented that providers would benefit from investigation training.

The Licensing Specialists believe that they contribute to making needed service changes/improvements by maintaining good rapport with their assigned providers and by adjusting the frequency of their visits, as needed. They also believe that OLS has little actual power and cannot effectively sanction the few providers, who repeatedly fail to fulfill requirements, because the available sanctions are too difficult to utilize. Licensing Specialists would like more training to increase their skills and consistency. They identified training needs for themselves in the use of the Data Warehouse, for providers on writing Corrective Action Plans, and for both providers and OLS staff on investigations.

The Commonwealth has recently funded additional staff positions, which will allow OLS to implement the role of Regional Supervisors.

Serious Incident Analysis

The Agreement requires that the Commonwealth notify the Independent Reviewer of the death of or serious injury that requires on-going medical care to any former resident of a Training Center who moved to a community setting under the Agreement. For the review of Safety, the consultant team studied the thirty-five most recent special Reports completed by the Independent Reviewer of the reviews of the serious injuries and deaths that involved one of the 568 former residents. The Independent Reviewer's Individual Services Review studies found that the former residents of Training Centers are, overall, significantly older and more disabled than the general population of individuals with intellectual disabilities. Seven of every ten of the randomly selected former residents were age fifty-one or older; four use wheelchairs, and seven use gestures as their highest form of communication.

The age profile and level of disability of the individuals who has moved from Training Centers is relevant for several reasons. Age is the most significant factor in mortality rates. Research has also established that adults with intellectual disabilities have poorer physical health, receive poorer quality health care, have elevated mortality rates, and shorter life expectancies than people without intellectual disability.

Recommendations from the Independent Reviewer's Special Reports are recapped at the end of Appendix D. The recommendations included two or more times in these special Reports, listed most to least, were that DBHDS should:

- Establish minimum investigation standards for OLS for use in the review of deaths and serious incidents;
- Develop a script for case managers and/or providers to use to encourage next of kin to agree to autopsies to determine the causes of unexpected deaths;
- Conduct root cause analysis of selected events when there are negative outcomes for individuals;
- Develop collateral agreements to share/release/disclose investigative findings with relevant sister agencies (Adult and Child Protective Services, Public Health, etc.);
- Maintain a statewide registry of Stage 2 or higher decubitus ulcers for those individuals living in settings other than their own or family home; and
- Cite providers who report serious incidents later than the required "within 24 hour notice."

Of the thirty-five Special Reports of reviews of serious injuries or deaths of the individuals who moved from the Training Centers, twenty-four of the Reports were of deaths. Nine of the deaths occurred within one year of discharge. It could not be established whether these deaths were a result of: 1) the individual being high-risk, regardless of where he/she lived; 2) inadequate transition planning (discharge and post move); or 3) substandard care and treatment from their provider or from their community-based physician, Emergency Rooms or hospitals where they received medical care. It is likely that one or more of these factors were present for different individuals at different times. The Independent Reviewer recommends that the Mortality Review Committee gather more complete information and make these assessments. The Mortality Review Committee should use their findings to determine problems at the individual service level and systemic patterns and trends. The consultants found that causes of death among this group of individuals are similar to those identified in other states. (See Appendix D, Table 2 for data regarding the thirty-five incidents.)

Health and Wellness Initiatives

A key to developing systems of care committed to protecting individuals from harm and to ensuring their well being is a proactive effort to ensure good health through competent nursing and medical care. DBHDS has developed and implemented the Health Services Network (HSN) to help Community Service Boards (CSBs) and private service providers to build such systems and to meet the healthcare needs of individuals who require intense medical supports. Four full-time equivalent nurses, RN Care Consultants (RNCC), lead the Network. During 2016, the HSN has been involved in a wide range of proactive initiatives and actions in reaction to the identification of possible concerns. The HSN initiatives have included:

- Providing on-site technical assistance to service providers and major pharmacies;
- Providing one-day trainings on supporting individuals with complex health care needs;
- Providing consultation to agencies on the access to and coordination of local health services;
- Participating in investigations at the request of CSBs;
- Completing post-move monitor visits and on-site trainings;
- Developing an Oral Health program for direct support professionals (DSPs);
- Creating and distributing oral health brochures;
- Establishing a Fixed Rate Dental Program in two of the five Regions;
- Partnering to provide education seminars to dentists and oral hygienists;
- Consulting to case managers, upon request;
- Developing a Daily Health Checklist and a new orientation manual for DSPs;
- Coordinating monthly Community Nursing Meetings in all five Regions;
- Developing regional Skin Care Workshops; and
- Providing mobile rehabilitation utilizing two newly purchased and equipped vans.

The Health Support Network is in the process of defining outcomes that it will track to determine whether, and to the extent that, the HSN positively impacts improvement in health care. For the period of serious injuries and deaths that were reviewed by the Independent Reviewer and then included in this study, the DBHDS Health Support Network's efforts had not reached the providers or impacted the services provided. Although it is not possible to document the specific connection with the work of the HSN, the Individual Services Review study found improved health care outcomes and fewer areas of concern for individuals who transitioned from Training Centers during 2016, the period when the HSN was implementing these initiatives.

The DBHDS Health Services Network has made significant initial efforts to support, and to build the capacity of, community providers to serve individuals with challenging and/or intense healthcare needs. This is particularly so in the Dental and Oral Health care arena, where HSN is piloting best practice models of efficient care. This is especially important as the Individual Services Review study has found previously, and again during the ninth review period, that dental services and dental care are areas of important concern.

Individual, incident, and mortality reviews have found that Emergency Rooms and hospitals involve difficult transaction points for providers and for case managers. Emergency Rooms need to understand the current health status and medical histories of individuals with ID/DD, who typically cannot provide this information without assistance. Frequently, local hospitals do not have the relationships with local providers and case managers that are critical to ensure comprehensive and timely discharge planning.

The DBHDS Health Services Network is challenged to sustain support to provider agencies in all Regions and on all health care fronts. These efforts are worthy of significantly more resource investment, especially during a period when service providers are not yet implementing many of the quality improvement requirements of the Agreement. It is positive that DBHDS reports having received a little more than $1.2 million added to its base budget in Fiscal Year 2017 for expansion of the DD Health Services Network. At the time of this Report, DBHDS was in the process of hiring more RN Care Consultants.

8. Mortality Review

The Independent Reviewer prioritized completing a full review of the DBHDS mortality review process during the ninth period. The scope of the planned study was reduced, however, due to the intense workload of the DBHDS Quality and Risk Management staff. Their workload, beyond on-going projects, is due to implementation of the redesigned HCBS Waiver programs and to requests for documents and interviews for two other Independent Reviewer studies. This evaluation, therefore, was limited to a review of available documents. These documents included the 2013 and the 2014 Annual Mortality Report (both labeled "draft"), the minutes of Mortality Review Committee meetings (February 2015 – June 2016), and the Mortality Review Committee tracking databases. The review of available documents provides an initial determination of the quality, scope, and completeness of the mortality review process. The documents lacked information needed for a thorough document review study. The MRC has still not published a final Annual Report for either calendar year 2013, 2014 or for Fiscal Year 2015. It was unclear whether MRC annual reports were finalized, and if so, whether these reports were made available to the public. The Independent Reviewer will request the Commonwealth to provide more complete information during the tenth review period. In addition, questions that cannot be answered with the document-only review will be addressed in the full review that will be planned for the tenth review period.

The DBHDS Mortality Review Committee (MRC) was established in 2013 under the direction of its Medical Director. At that time, the membership of the MRC possessed appropriate experience, knowledge and skills, and met the membership requirements of the Agreement.

The DBHDS Annual Mortality Report 2014 (draft) outlined the process that the MRC developed for mortality reviews. The intent of the DBHDS mortality review process includes a review of deaths "of all individuals with intellectual disabilities or developmental disabilities for whom a licensed provider has direct or oversight responsibility." Providers of community-based licensed settings are required to report deaths to the Office of Licensing within 24 hours. Training Centers are expected to report deaths within twelve hours. The DBHDS Medical Director reviews available information about both expected and unexpected deaths to determine the need for a mortality review. The DBHDS process includes collecting additional information and convening its Mortality Review Committee to review this information within 90 days of the death. The MRC would then determine whether the death should be categorized as "expected" or "unexpected" and whether additional steps should be taken. These additional steps could include: 1) requesting additional information; 2) communicating identified issues to the provider; 3) issuing a *Safety and Quality Alert* to providers regarding an identified risk; 4) establishing a subcommittee to study or take action regarding an identified risk; 5) making recommendations to the Quality Improvement Committee to reduce the risk of death; or 6) taking other actions, not further specified.

The draft 2014 Annual Mortality Report indicates that the Mortality Review Committee would then give these outcomes (findings, recommendations, etc.) to a DBHDS quality management committee and to the Commissioner for review and action.

DBHDS created a uniform death review and reporting system for individuals who live in Training Centers and in community residential programs. Medical professional participation was an integral part of this process. One of the goals of the MRC was to develop a database and to analyze the data to determine any risk trends. Once trends were identified, strategies were to be developed to reduce the risks identified. Training needs were also to be identified. The end result was for the MRC to provide an annual public report concerning mortality review data for individuals with ID/DD.

In 2015 and in 2016, the Mortality Review Committee categorized some cases as "pending" after its initial review (see Table 6 below). In 2015, of the forty-eight cases that were initially categorized as "pending," seventeen mortality reviews had no further information collected and were not closed at the end of the calendar year. In contrast, as of June 30, 2016, the MRC had closed all but one case. Of the fifty pending cases in 2015 and 2016, only thirty-two (64%) had been closed. The MRC records the original date of the mortality review in the MRC Tracker database. It was not possible, however, to "track" which pending cases were followed through to closure. It is not possible, therefore, to determine that the Commonwealth had met the Agreement's requirements to "prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations." Most of the mortality reviews were not completed "within ninety days of a death."

Table 6
# of Deaths Reviewed – Outcomes - Actions

Year	# Deaths reviewed	Outcome – pending	Outcome blank	Pending resolved	Action steps / alerts, etc.
2015	307	48	15	31	75
2016, through June	134	2	8	1	14

Limited available information was the most common reason that the MRC decided "pending" status. This reflects the MRC's continued challenges to obtain adequate information from which to complete its mortality reviews. Various MRC minutes indicated that some efforts to obtain additional information have occurred. For example, as of June 10, 2016, the MRC succeeded in gaining access to autopsy results and to death certificates. The Independent Reviewer understands that DBHDS requested, but other state agencies denied, access to additional information related to the deaths of members of the Settlement Agreement's target population. The available MRC documents did not indicate whether DBHDS has taken additional actions to secure the information needed to complete the mortality review.

The Agreement requires the MRC members to "possess appropriate experience, knowledge, and skills", as determined by the Commonwealth; and for "at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State." The MRC is required by the Agreement to "conduct monthly mortality reviews for unexplained or unexpected deaths" and to do so "within ninety days."
Tables 7 through 12 below provide information regarding the MRC's determinations of "expected" and "unexpected" deaths (Table 7); the months when the MRC did not meet (Table 8); the member attendance at MRC meetings (Table 9); the members' areas of expertise (Table 10); and the percent of mortality reviews completed within ninety days (Table 11)

Table 7 # of Expected and Unexpected Deaths			
Year	**Total**	**Expected deaths**	**Unexpected deaths**
2013*	179	56	123 (68.7%)
2014	226	75	151 (67.8%)
2015	290	92	198 (68.3%)
2016 (through June)	164	53	111 (67.7%)

- From 2014 Annual MRC Report DRAFT

Table 8 MRC Meetings		
Year	**# Meetings**	**Months without a meeting**
2015	12	Jan, Aug, Sept,
2016 (through June)	7	Apr, May

Table 9 MRC Member Attendance		
Year	**Attendance range at meetings**	**Average attendance**
2015	5-10	7.4
2016 (through June)	6-12	7.4

Table 10 MRC Member Expertise								
Year	**MD**	**Clinical Nurse**	**Psych/ behav/ mental health**	**Data analyst**	**QA/QI/ risk mgmt**	**Education**	**Other**	**No info**
2015	2	2	2	2	2	1	1	6
2016 (through June)	1	2	1	2	1	1	1	7

Table 11 MRC Mortality Reviews Completed within Ninety Days			
Year	**Within 90 days**	**Exceeds 90 days**	**% compliance**
2014	123	103	54.4%
2015	71	216	24.7%
2016 (through June)	37	127	22.6%

The Mortality Review Committee minutes (see Table 9 above) indicate that the MRC met an average of twelve or more times per year, but that these meetings did not occur monthly. There were no MRC meetings during two consecutive months in 2015 (August-September) and again in 2016 (April-May). The months when the MRC did not meet added to the number of reviews which were not completed by ninety days and, thus, became overdue. In 2015 and 2016, a significantly smaller percentage of mortality reviews was completed within ninety days of the reported deaths than in 2014.

The Agreement also requires that *"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 nurses 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*

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

The MRC Mortality Tracker database indicated significant gaps (see Table 12 below) in important information that is needed to complete mortality reviews that will meet expected standards of quality. The columns in the database were blank for virtually all 679 reviews in 2014 through June 2016 for: the medical records, doctor's notes, nurses notes, Individual Program Plans, physical examination records, death certificates and interviews. There was no apparent documentation that these records and interviews were not available or that the MRC specifically requested them. It is possible that the Mortality Tracker database did not reflect information that DBHDS had available and was used as part of its mortality reviews. DBHDS had custody of the majority of these documents for deaths at its Training Centers. Similarly, its providers had some of these records, which could have been obtained through reviews by Licensing Specialists. The MRC Tracker database indicated that these documents were not reviewed for most of the death reviews. For the maltreatment data in the Tracker, an additional indicator beyond the current "No" entry is needed. The correct interpretation of the entry "No" was not clear. Two very different interpretations were possible: "No" could mean that no data were collected or that data were collected but indicated no maltreatment.

Table 12
MRC Mortality Data Tracker
Annual Summary of Records Reviewed and Interviews Completed

Year	# Cases	Med. Rec.	Drs' notes	Nurses' notes	IRs	ISP/ IPP	Mal tx data	Phys. Exam. record	Death certif.	autopsy	Inter-view
2014	226	0	0	0	0	0	0	0	4	1	0
2015	289	1	1	1	289	3	40	0	2	1	0
2016*	164	1	1	2	164	2	39	1	15	5	3

* through June

During the ninth review period, the membership of the Mortality Review Committee (MRC) did not comply with the requirements of the Settlement Agreement. The MRC did not have a member who has clinical experience in mortality reviews and is independent of the Commonwealth.

For 2016, it appears that the MRC changed its protocol regarding closing cases. During the first six months of 2016, the MRC rarely categorized a case as "pending." Instead, the MRC closed virtually all cases at the time of the initial review meeting. Many cases, however, appeared to have been closed despite a similar lack of the basic information needed to complete a mortality review that occurred in 2015. The available documents indicate that, during the first half of 2016, the Mortality Review Committee frequently made final mortality review decisions based on limited information and with no further follow up. When the MRC closes cases without adequate information, its deliberations cannot include informed findings and recommendations. With a significant percentage of cases closed without

adequate information and deliberation, the MRC cannot effectively identify problems at the individual service level or the systemic trends and patterns.

The Commonwealth's Mortality Tracker and the MRC meeting minutes do not include sufficient records to document that the requirements of the Agreement are being properly implemented. Also, the available records do not indicate the efforts that the MRC took to gather the documents that are important for mortality reviews that meet expected quality standards. The MRC has not completed a significant percentage of mortality reviews within the ninety days required and has not completed mortality reviews of all reported deaths. It was not clear in the documents available for review whether these shortcomings represent gaps in the mortality review or gaps in documentation.

The Commonwealth is in non-compliance with *Section V.C.5 and with IX.C.*

IV. CONCLUSION

During the ninth review period, the Commonwealth successfully gained CMS approval for its proposed redesign of its HCBS waiver program. For three years, the redesign has been the Commonwealth's primary strategy to come into compliance with many provisions of the Agreement. The Commonwealth structured the redesigned waiver program to reform the service system "to provide for a flexible array of community-based options with a rate structure that supports the cost of new and existing services and provides incentives to providers for offering expanded integrated options." The Independent Reviewer has consistently reported that a redesign of the HCBS waiver programs was an essential step toward achieving compliance. During the ninth review period the Commonwealth, CSBs, and private providers began the extensive and phased implementation of the recently approved redesigned waiver programs. The planned changes to, and the availability of, new service options are also just beginning, and will take a year of more to become available for many individuals with ID/DD and their families. The Independent Reviewer will determine compliance based on whether the new service options meet the requirements of the Agreement for the members of the target population.

The Commonwealth has long been aware that it must also make substantial changes to its regulations to effectively comply with the Agreement. The Independent Reviewer has consistently reported that the Commonwealth's existing regulations require revisions to make progress toward compliance. Although, DMAS revised its HCBS waiver regulations as part of the HDBS waiver redesign, the Commonwealth has not yet revised its other regulations, such as the DBHDS licensing regulations and its human rights regulations.

The Commonwealth has continued to plan, to develop, and to implement new and reformed systems to move toward compliance with the provisions of the Agreement. Its efforts have newly achieved compliance with several provisions during the ninth period. It also sustained compliance with the provisions that it had achieved during previous review periods. The Commonwealth also began a range of provider development and capacity-building initiatives during the ninth period. These initiatives are needed to create new and additional service options, especially for individuals with intense medical and behavioral needs and for those with Autism Spectrum Disorders. The Independent Reviewer has reported previously his considered opinion that these planned efforts may not be sufficient to meet the needs of the individuals who require more intense services.

DBHDS staff have continued to plan to put into effect the risk management and quality improvement provisions of the Agreement. The Commonwealth has not yet, however, implemented these provisions at the direct service level or informed service providers of the its expectations and the requirements of the Agreement. The direct service level is where these approaches are intended to reduce risks and to improve the quality of services for individuals with ID/DD. The Commonwealth's strategy to move toward compliance with these provisions involves revising its regulations, which currently prevent it from acting in accordance with specific requirements of the Agreement.

The parties continue to negotiate outcome-timelines for several topic areas of the Agreement that lacked due dates and measurable outcomes. These topic areas include children with ID/DD live in large nursing facilities and Intermediate Care Facilities, Quality and Risk Management, integrated housing, and supports for individuals in need of intense behavioral and medical services and supports. By reaching agreement the parties will add needed definition to the measurable outcomes that will help the Commonwealth to accomplish the Agreement's goals of community integration, self-determination, and quality services.

Summary: The Commonwealth's leaders are pleased to have begun implementation of its redesigned HCBS waiver programs throughout the ninth review period. It looks forward to continuing its phased implementation plan during the tenth and eleventh review periods. They continue to express strong commitment to the implementation of the initiatives to develop new service options and to develop the capacity needed to achieve compliance. Although the Commonwealth has needed to revise some of its regulations since the beginning of the Agreement, there is increased urgency to do so.

The Commonwealth must revised its regulations to move toward achieving compliance with the quality and risk management provisions of the Agreement. Functioning quality improvement and risk management systems are especially needed during periods of systemic change. The Commonwealth is now in the beginning stages of implementing its redesigned waivers which it expects will create such systemic changes. These changes may have some unintended consequences for service providers and for the individuals and families served. Only with a fully developed quality improvement and risk management system will the Commonwealth be able to identify and to address complications that are inevitable with such a complex undertaking. An effective quality and risk management system is also necessary for the Commonwealth to comply with the requirements of the Agreement and to fulfill its promises to all Virginians, especially to those with intellectual and developmental disabilities 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 April 15, 2017. The Commonwealth should also consider the recommendations and suggestions included in the consultants' reports included in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the tenth review period (April 1, 2017 –September 30, 2017).

Case Management

1. The Commonwealth should establish guidelines for case managers to:

- Ensure that individuals are offered full employment opportunities, including the type of jobs and the number of hours they wish to work;
- Ensure meaningful discussions occur at least annually with individuals about employment; and
- Develop possible employment and/or employment readiness goals to help individuals who have not previously been involved with employment to explore possible interests and the options.

2. The Commonwealth should establish guidelines for the caseload sizes and credentials (i.e., specialized training, mentoring, etc.) for case managers for individuals with complex behavioral and/or intensive healthcare needs. These guidelines should ensure that these case managers have sufficient time to prioritize the monitoring function and the expertise to assess the status of identified and unidentified risks and to determine whether the individual's support plan is being implemented appropriately.

3. The Commonwealth should remove the obstacles to a case manager pulling from the CHRIS incident and other databases any reports regarding the risks and negative outcomes for individuals on their caseload.

Crisis Services

4. The Commonwealth should:

- Document the number of individuals in the target population who are admitted to state operated psychiatric hospitals during each quarter;
- Establish clear criteria for determining when the diversions of admission to psychiatric hospitals are appropriate;
- Provide more detailed information about the causes of admissions and the reasons for longer stays;
- Determine the underlying cause for high vacancy rates in the Crisis Therapeutic Homes when there are members of the target population who likely need these services.
- Determine whether any individuals who REACH knows to be in crisis are admitted to psychiatric hospitals without an offer of an alternative placement in crisis stabilization programs;
- Make public its retrospective reviews of psychiatric hospitalizations available; and
- Report on the status of implementation of the recommendations made as a result of the two retrospective reviews of psychiatric hospitalizations during 2015.

Office of Licensing Services

5. DBHDS should establish protocols to ensure that Licensing Specialists automatically address in their investigations the safety of other individuals living with an individual whose negative outcome is being reviewed. In their investigation reports, Licensing Specialists should state the affirmative, if accurate, that no "risks to others in the home/program were found."'

Mortality Review and Investigation of Serious Incidents

6. The Commonwealth should make a concerted effort to ensure that it effectively completes in a timely manner the basic step of obtaining adequate information for a quality mortality review. The Commonwealth should make additional efforts to ensure provision of documents in its custody or control to allow completion of the mortality reviews.

7. DBHDS should establish minimum standards for OLS's investigation processes and reports. The MRC should clarify whether Licensing Specialists are part of the mortality review. If so, the MRC should establish guidelines to ensure that Licensing Specialists review doctors' and nurses' records and to complete interviews needed for the mortality review. Licensing Specialists should have access to and utilize the medical expertise required to for a qualified assessments of records and interviews.

8. The Mortality Review Committee Tracker database should include sufficient information to document that the Agreement's requirements are being properly implemented. The database should:

- Provide a date when each review is closed;
- Identify either that the required documents were available and reviewed or were not available;
- Include data regarding to whom and when requests were made for required documents;
- Include whether recommendations were made to improve services;
- Track whether recommended actions steps were taken.

9. Although not required by the Agreement, a more well rounded Mortality Review Committee membership would likely assist in obtaining more complete and more timely information. It would also provide additional insights into identifying problems and developing recommendations. These additional representatives would provide more perspectives when deliberating and interpreting the findings. They might also assist in developing processes to obtain additional information. More complete information will result in improved analysis and recommendations to reduce avoidable deaths and mortality rates. DBHDS should consider adding members who represent Adult Protective Services, the Medical Examiner's/ Coroner's Office, one or more individual/family advocacy associations, legal counsel from DBHDS, a member of the Virginia Department of Health who oversees nursing homes, DMAS (Department of Medical Assistance Services), etc.

Quality and Risk Management

10. DBHDS should establish a regional count and monitor the status of individuals with ID/DD who experience decubitus ulcers at Stage two to four.

11. The DBHDS Health Support Network should develop and market "best practices" tools for Emergency Room visits and for local hospital discharge planning for case managers and providers.

12. The Commonwealth should:

- Continue to identify and/or develop relevant sources of data for the eight Domains;
- Establish a definition for each measure developed for each Domain;
- Identify the data source and specify the data collection methodology;
- Determine baselines to allow changes to be determined.

13. The Commonwealth should ensure that the QSR process includes valid tools and processes. The QSR process should include:

- Definitions of standards and of the methodology that auditors use to answer questions;
- Written criteria for determining compliance;
- Audit tools that comprehensively address services and supports to meet individuals' needs, particularly regarding clinical services;
- Auditors with clinical qualifications to complete the required clinical assessments of adequacy; and
- Use an inter-rater reliability process that is consistent with standard practices.

I. APPENDICES

A. INDIVIDUAL SERVICES REVIEWS

B. CRISIS SERVICES

C. SUPPORTED EMPLOYMENT

D. TRANSPORTATION

E. QUALITY AND RISK MANAGEMENT

F. SAFETY AND RISK OF HARM

G. LIST OF ACRONYMS

APPENDIX A.

INDIVIDUAL SERVICES REVIEWS
April 7, 2016 - September 30, 2016

Completed by:
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Elizabeth Jones, Team Leader
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Demographic Information

Sex	n	%
Male	15	57.7%
Female	11	42.3%

Age ranges	n	%
Under 21	0	0.0%
21 to 30	0	0.0%
31 to 40	4	15.4%
41 to 50	5	19.2%
51 to 60	11	42.3%
61 to 70	2	7.7%
71 and over	4	15.4%

Levels of Mobility	n	%
Ambulatory without support	11	42.3%
Ambulatory with support	1	3.85%
Total Assistance with walking	1	3.85%
Uses wheelchair	13	50.0%

Relationship with Authorized Representative	n	%
Parent or Sibling	18	69.2%
Other Relative	5	19.2%
Other e.g. friend	2	7.7%
Public Guardian	1	3.8%

Type of Residence	n	%
ICF-ID	3	11.5%
Group home	21	80.8%
Sponsored home	1	3.8%
Own home	1	3.8%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	2	7.7%
Limited spoken language, needs some staff support	7	26.9%
Communication device	2	7.7%
Gestures	10	38.5%
Vocalizations, Facial Expressions	5	19.2%

Demographic Information

Individuals who transitioned from Virginia's Training Centers

Five Individual Services Review Studies of 193 Individuals who moved between 7/1/2012 and 6/22/2016

NOTE: The Individual Services Review Studies randomly selected 138 former residents of the Training Centers who transitioned to live in community-based homes. They were selected from a cohort of 191 individuals who had moved from Training Centers between October 2011 and June 2016. These individuals live in all five of Virginia's Health Planning Regions. The random selection of 138 individuals gives 90% confidence that the findings from these study can be generalized to the larger cohort.

Individual Services Review Studies	**1st period** 3/6/12 – 10/6/12	**3rd period** 4/7/13 - 10/6/13	**5th period** 4/7/14 - 10/6/14	**7th period** 4/7/15 - 10/6/15	**9th period** 4/7/16 - 9/30/16	**Totals 1st, 3rd, 5th, 7th and 9th periods**
# of Individuals studied **(# in the cohort)**	32 (cohort=58)	28 cohort=42)	28 cohort=42)	24 (cohort=42)	26 (cohort=48)	**138 individuals** **(cohort = 232)**
Gender	21 (65.6%) males	16 (57.1%) males	13 (46.4%) males	16 (66.7%) males	15 (57.7%)	**81 (58.7%) males**
Age Ranges	20 (62.5%) age fifty-one or older	21 (75%) age fifty-one or older	22 (78.5%) age fifty-one or older	17 (70.9%) age fifty-one or older	17 (65.4%) age fifty-one or older	**97 (70.3%) age fifty-one or older**
Levels of **Mobility**	12 (37.5%) use wheelchairs	13 (46.4%) use wheelchairs	11 (39.3%) use wheelchairs	9 (37.5%) use wheelchairs	13 (50.0%) use wheelchairs	**58 (42.0%) use wheelchairs**
Highest Level of **Communication**	25 (78.1%) use gestures	19 (67.8%) use gestures	18 (64.3%) use gestures	17 (70.8%) use gestures	15 (57.7%) use gestures	**94 (68.1%) use gestures**
Type of Residence	Information Not collected	24 (85.7%) live in congregate residential programs	26 (92.9%) live in congregate residential programs	21 (87.5%) live in congregate residential programs	24 (92.3%) live in congregate residential programs	**95 (89.6%) live in congregate residential programs**
Relationship w/ Authorized Representative	Information Not collected	21 (75%) AR is his or her parent or sibling	24 (85.7%) AR is his or her parent or sibling	22 (91.6%) AR is his or her parent or sibling	18 (79.2%) AR is his or her parent or sibling	**85 (80.2%) AR is his or her parent or sibling**

Discharge Planning

Discharge Planning – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Did the individual and, if applicable, his/her Authorized Representative participate in discharge planning?	26	96.2%	3.8%	0.0%
Was the discharge plan updated within 30 days prior to the individual's transition?	26	96.2%	3.8%	0.0%
Did person-centered planning occur?	26	100.0%	0.0%	0.0%
Were essential supports described in the discharge plan?	26	100.0%	0.0%	0.0%
Did the discharge plan include an assessment of the supports and services needed to live in most integrated settings, regardless of whether such services were currently available?	26	100.0%	0.0%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	26	100.0%	0.0%	0.0%
Does the discharge plan (including the Discharge Plan Memo) list the key contacts in the community, including the licensing specialist, Human Rights Officer, Community Resource Consultant and CSB supports coordinator?	26	100.0%	0.0%	0.0%
Did the Post-Move Monitor, Licensing Specialist, and Human Rights Officer conduct post-move monitoring visits as required?	26	100.0%	0.0%	0.0%
Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists?	26	100.0%	0.0%	0.0%
Was it documented that the individual and, as applicable, his/her Authorized Representative, were provided with opportunities to speak with individuals currently living in the community and their families?	26	84.6%	15.4%	0.0%
Was it documented that the individual, and, if applicable, his/her Authorized Representative, were provided with information regarding community options?	26	100.0%	0.0%	0.0%

Discharge Planning Items – areas of improvement TRENDS – 2013 – 2014 – 2015 – 2016			
3rd review period 2013	***5th review period 2014***	***7th review period 2015***	***9th review period 2016***
Was it documented that the individual and, as applicable, his/her Authorized Representative, were provided with opportunities to speak with individuals currently living in the community and their families?			
14.3% (4 of 28)	64.3% (17 of 28)	50% (12 of 24)	84.6% (22 of 26)

Discharge Planning Items – areas of concern				
Item	***n***	***Y***	***N***	***CND***
If a move to a residence serving five or more individuals was recommended, did the Personal Support Team (PST) and, when necessary, the Regional Support Team (RST) identify barriers to placement in a more integrated setting?	14	42.9%	57.1%	0.0%
If barriers to move to a more integrated setting were identified above, were steps undertaken to resolve such barriers?	6	50.0%	50.0%	0.0%
Were all essential supports in place before the individual moved?	26	80.8%	19.2%	0.0%

Discharge Planning Items – areas of concern TRENDS – 2013 – 2014 – 2015 – 2016			
3rd review period 2013	***5th review period 2014***	***7th review period 2015***	***9th review period 2016***
Were all essential supports in place before the individual moved?			
78.6%% (22 of 28)	71.4%% (20 of 28)	87.5% (21 of 24)	76.9% (20 of 26)

Healthcare

COMPARISON Healthcare – positive outcomes improvement – 2013-2014-2015			
3rd review period 2013	***5th review period 2014***	***7th review period 2015***	***9th review period 2016***
Does the provider monitor weight fluctuations, if applicable per the physician's orders?			
83.3% (20 of 24)	92.9% (26 of 28)	100% (24 of 24)	100% (26 of 26)
If weight fluctuations occurred, were necessary changes made, as appropriate?			
77.8% (14 of 18)	88.0% (22 of 25)	68.8% (11 of 16)	100.0% (14 of 14)
Is there documentation of the intended effects and side effects of the medication?			
66.7% (8 of 12)	75.0% (9 of 12)	66.7% (6 of 9)	85.7% (12 of 14)

Healthcare Items - positive outcomes				
Item	***n***	***Y***	***N***	***CND***
Were appointments with medical practitioners for essential supports scheduled for and, did they occur within 30 days of discharge?	25	100.0%	0.0%	0.0%
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	26	100.0%	0.0%	0.0%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	25	100.0%	0.0%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	26	88.5%	11.5%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	21	100.0%	0.0%	0.0%
If ordered by a physician, was there a current psychological assessment?	7	100.0%	0.0%	0.0%
If ordered by a physician, was there a current speech and language assessment?	6	83.3%	16.7%	0.0%
Is lab work completed as ordered by the physician?	24	95.8%	0.0%	4.2%
If applicable per the physician's orders, Does the provider monitor fluid intake?	17	100.0%	0.0%	0.0%
Does the provider monitor food intake?	14	100.0%	0.0%	0.0%
Does the provider monitor bowel movements	19	100.0%	0.0%	0.0%
Does the provider monitor weight fluctuations?	23	100.0%	0.0%	0.0%
Does the provider monitor seizures?	9	100.0%	0.0%	0.0%
Does the provider monitor positioning protocols?	7	100.0%	0.0%	0.0%
Does the provider monitor tube feedings?	6	100.0%	0.0%	0.0%
If applicable, is the dining plan followed?	16	87.5%	6.3%	6.3%
If applicable, is the positioning plan followed?	11	100.0%	0.0%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	26	88.5%	11.5%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	22	77.3%	22.7%	0.0%
Is there any evidence of administering excessive or unnecessary medication(s) (including psychotropic medication?	26	3.8%	84.6%	11.5%
If applicable, is there documentation that caregivers/clinicians Did a review of bowel movements? Made necessary changes, as appropriate?	24 14	100.0% 100.0%	0.0% 0.0%	0.0% 0.0%
After a review of tube feeding, Made necessary changes were made, as appropriate?	6 4	100.0% 75.0%	0.0% 25.0%	0.0% 0.0%

Healthcare Items – areas of concern				
Item	***n***	***Y***	***N***	***CND***
Are there needed assessments that were not recommended?	26	34.6%	65.4%	0.0%

Healthcare Items –Psychotropic Medications - areas of concern				
Item	***n***	***Y***	***N***	***CND***
Is the individual receiving supports identified in his/her individual support plan?				
Mental Health (psychiatry)	13	76.9%	23.1%	0.0%
If the individual receives psychotropic medication: is there documentation of the intended effects and side effects of the medication?	13	84.6%	15.4%	0.0%
is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	13	84.6%	15.4%	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)?	13	7.7%	92.3%	0.0%

Individual Support Plan

Individual Support Plan Items – positive outcomes				
Item	***n***	***Y***	***N***	***CND***
Is the individual's support plan current?	26	100.0%	0.0%	0.0%
Is there evidence of person-centered (i.e. individualized) planning?	26	100.0%	0.0%	0.0%
Are essential supports listed?	26	92.3%	7.7%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	26	100.0%	0.0%	0.0%
Medical	26	96.2%	3.8%	0.0%
Recreation	26	96.2%	3.8%	0.0%
Mental Health (behavioral supports)	14	92.9%	7.1%	0.0%
Transportation	26	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?	25	96.0%	4.0%	0.0%
For individuals who require adaptive equipment, is staff knowledgeable and able to assist the individual to use the equipment?	18	100.0%	0.0%	0.0%
Is staff assisting the individual to use the equipment as prescribed?	18	100.0%	0.0%	0.0%

Individual Support Plan Items – areas of concern				
Item	***n***	***Y***	***N***	***CND***
Has the individual's support plan been modified as necessary in response to a major event for the person, if one has occurred?	7	57.1%	42.9%	0.0%
Does the individual's support plan have specific outcomes and support activities that lead to skill development or other meaningful outcomes?	26	46.2%	53.8%	0.0%
Does the individual's support plan address barriers that may limit the achievement of the individual's desired outcomes?	26	100.0%	0.0%	0.0%
If applicable, were employment goals and supports developed and discussed?	25	24.0%	76.0%	0.0%
Does typical day include regular integrated activities?	24	29.2%	70.8%	0.0%

Case Management

Case Management – positive trend, sustained				
There is evidence of case management review, e.g. meeting with the individual face-to-face at least every 30 days, with at least one such visit every two months being in the individual's place of residence.				
1st review period 2012	***3rd review period 2013***	***5th review period 2014***	***7th review period 2015***	***9th review period 2016***
46.9% (15 of 32)	88.9% (24 of 27)	96.4% (27 of 28)	95.8% (23 0f 24)	96.2% (25 0f 26)

Integration items – areas of concern				
Item	*n*	*Y*	*N*	*CND*
Do you live in a home in a home licensed for four or fewer individuals with disabilities and without other such homes clustered on the same setting?	26	30.8%	69.2%*	0.0%
Were employment goals and supports developed and discussed?	25	24.0%	76.0%	0.0%
If no, were integrated day opportunities offered?	20	25.0%	68.2%	0.0%
Does typical day include regular integrated activities?	26	30.8%	69.2%	0.0%

** Four of these eighteen individuals live temporarily in homes with other programs on adjacent property.*

COMPARISON – Most Integrated Setting				
The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.				
1st review- 2012	***3rd review- 2013***	***5th review- 2014***	***7th review- 2015***	***9th review- 2016***
46.9% (15 of 32)	53.6% (15 of 28)	57.1% (16 of 28)	41.7% (10 of 24)	30.8% (8 of 26)

***** Four of the eighteen individuals who do not live in "most integrated settings" are living temporarily in homes with multiple other programs on adjacent property. The provider reports that it is in the process of locating homes for four or fewer individuals. After these moves occur, then 12 (46.2%) of the 26 individuals will live in most integrated settings.

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?	25	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?	25	96.0%	4.0%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's talents/contributions and what's important to and important for the individual?	25	96.0%	4.0%	0.0%
Is there evidence the staff has been trained on the desired outcome and support activities of the individual's support plan?	26	100.0%	0.0%	0.0%

Residential Environment Items – positive outcomes				
Item	***n***	***Y***	***N***	***CND***
Is the individual's residence clean?	26	92.3%	7.7%	0.0%
Are food and supplies adequate?	25	96.0%	4.0%	0.0%
Does the individual appear well kempt?	26	100.0%	0.0%	0.0%
Are services and supports available within a reasonable distance from your home?	26	100.0%	0.0%	0.0%
Is the residence free of needed repairs?	26	100.0%	0.0%	0.0%
Do you have your own bedroom?	26	88.5%	11.5%	0.0%
Do you have privacy in your home if you want it?	26	88.5%	11.5%	0.0%
b. Has there been a Licensing Visit that checked that smoke detectors were working, that fire extinguishers had been inspected, and that other safety requirements had been met?	24	100.0%	0.0%	0.0%

Residential Environment Items – areas of concern				
Item	***n***	***Y***	***N***	***CND***
Is there evidence of personal décor in the individual's room and other personal space?	26	61.5%	38.5%	0.0%

APPENDIX B.

CRISIS SERVICES

By: Kathryn du Pree MPS

Crisis Services –Status Briefing on the Implementation of the Virginia Commonwealth's Settlement Agreement Requirements

November 2016

Introduction

This is the ninth review of crisis services as developed by the Commonwealth in response to the Settlement Agreement. Previous reviews have included a review of:

- All relevant documents detailing the Commonwealth's implementation of crisis services for children, adolescents and adults with ID and DD
- Data supporting implementation
- Proposals and RFPs
- Qualitative reviews of crisis plans for individuals in HCBS waivers
- Focus groups and interviews with key DBHDS and REACH staff and other stakeholders

DBHDS, CSBs, case managers, and providers are in the midst of implementing HCBS waiver reform and related service development. Therefore, the Independent Reviewer, Donald Fletcher and DBHDS agreed that this period's study of crisis services would be limited primarily to the review of the activities that were in progress but not completed by DBHDS at the time of the eighth review. DBHDS undertook an analysis of psychiatric admissions for all age groups that occurred between July 2014 and June 2015. The department planned to use these data to help determine general improvements to both the adult and the children's' crisis programs. DBHDS also analyzed whether these data indicated a need for additional crisis stabilization programs, which DBHDS calls Crisis Therapeutic Homes (CTH), for adults and how to meet the Agreement's requirement to provide out-of-home crisis stabilization for children. The Independent Reviewer was also interested in the Commonwealth's progress implementing the crisis services for children, which had only been made available in all five regions during the previous year. I reviewed the following documents:

1. REACH Data Summary Reports for Adult Services: 4th Quarter FY16 and 1st Quarter FY17
2. REACH Data Summary Reports for Children's Services: 4th Quarter FY16 and 1st Quarter FY17
3. Adult REACH Annual Report: FY 2016
4. REACH Annual Report: Children's Program FY 2016
5. Retrospective Study of Children with Developmental Disabilities Admitted to the Commonwealth Center for Children and Adolescents (CCCA) FY2015
6. Retrospective Study of Adult Civil Admissions with Developmental Disabilities to DBHDS Virginia Mental Health Hospitals
7. Crisis Therapeutic Home Capacity Review-Review Period 12/1/15-6/30/16
8. DBHDS Crisis Prevention and Stabilization Bed Capacity Children's Crisis Services Proposal

I also interviewed Heather Norton, Director of Community Support Services. I greatly appreciate Ms. Norton's time. She oversees the Commonwealth's crisis services programs, but also is currently coordinating much of the department's responsibilities to successfully accomplish waiver reform. I appreciate the department's efforts to provide the reports timely so that this status review could be completed by early November.

Current Status of REACH Services for Adults

Although not the primary focus of this study, I reviewed the quarterly reports for the fourth quarter of FY16 and the first quarter of 2017 to determine if all crisis services requirements were still being met. I also reviewed data regarding individuals with ID and DD who experienced psychiatric hospitalizations.

Referrals and Referral Sources- In FY16Q4 referrals to the REACH adult program totaled 289. There were an increased number of referrals from CSB Emergency Services (ES), except in Region V. The Region V crisis services program did not receive any referrals from CSB ES staff, but received 83% of its referrals from CSB Case Managers. The Commonwealth's crisis services in its other four regions received between 23% and 42% of referrals from ES staff. This is evidence of a stronger relationship and collaboration between the CSB ES and REACH crisis services in these four regions.

There were a similar number of referrals in FY17Q1 when 281 individuals were referred. The sources of the referrals varied somewhat from the previous reporting period. The CSB ES programs were still the primary referral source in three regions: Regions III, IV and V. Case Managers were the primary referral source in Region I, whereas families made the most referrals of any group in Region II.

Individual's Major Diagnosis-Thirty-six adults who were referred to REACH crisis programs in FY16Q4 had a developmental disability, other than an intellectual disability. The number of referrals of individuals with DD only increased from thirty-six to forty- six in FY17Q1. Individuals with DD, other than ID, represented 12% of the referrals in FY16Q4 and 16% of the referrals in FY17Q1.

Referral Response Time- In FY16Q4 three of the regions responded onsite to all of the crisis referrals received by the REACH programs. Seven (77.8%) of nine crisis referrals were not responded to face-to-face occurred in Region V. Two (22.2%) occurred in Region III. In FY16Q4 the average response time is well below the required time of one hour in the urban regions and two hours in the rural regions. However, seventeen of the 300 crisis calls were not responded to within the required time period, resulting in 94.4% of the calls responded to within required timeframes. During FY17Q1 all crisis calls were responded to onsite. The regions' response time within the expected timeframes decreased from FY16Q4, resulting in 91% of the calls responded to within the time parameters. Region IV experienced the greatest delays in arriving onsite to respond to crises. Eighteen (17.1%) of its 105 calls were not responded to within the one-hour requirement. Of the late responses, eleven (64.7%) of the untimely responses occurred within 90 minutes.

Mobile Crisis Assessments and resulting dispositions -During FY16Q4 the number of crisis assessments occurring in the hospitals increased from previous reporting periods. Hospitals were the primary location for response by REACH staff in all regions except Region V. The second most common location for crisis assessments was family homes. A similar number of individuals used the crisis stabilization programs (CTHs) (162) as used mobile crisis support (154). Some used both. More individuals used the CTH for crisis stabilization in Regions I, IV and V versus a greater use of the CTH program for prevention in Regions II and III. There is growing utilization of the CTH programs for step-down support after individuals with ID and DD have experienced psychiatric hospitalization, particularly in Regions IV and V. DBHDS did not provide any data regarding the waiting lists for access to the crisis stabilization (CTH) programs. All regions continue to provide extensive training to law enforcement (CIT) and to CSB, ES, provider and community partner staff.

Crisis assessments continued to primarily take place in hospitals (231) or in the individual's residence or day program (150) in FY17Q4. It is noteworthy that 89 of the onsite assessments were conducted at homes operated by residential providers. This indicates a growing recognition and value of REACH services by the provider community.

The DBHDS Quarterly Reports contain information on psychiatric hospitalizations including the number of admissions that occur at the time of initial crisis assessment and after individuals receive mobile crisis support. A separate report addendum provides the disposition for all individuals who are known to REACH. The latter report includes both new referrals and active cases so the number of individuals known is greater than in the former two reports, which included only individuals who had a mobile crisis assessment during the quarter.

The DBHDS report on the disposition of individuals who are referred for a crisis assessment during the FY16Q4 includes information on the disposition at the time of assessment and the disposition at the completion of mobile crisis services. At the time of assessment of the 312 individuals, 27% were hospitalized, 62% retained their home setting; and 7% used the crisis stabilization homes (CTHs).

During FY17Q1, 422 individuals were assessed for a crisis. After using these services, 35% of the individuals were hospitalized, 52% retained their home settings, either with or without mobile crisis supports; and (8%) used a CTH. This represents an increase in the percentage of individuals who were hospitalized and a reduction in the percentage of individuals who retained their home settings as compared to the previous quarter. From the documents available for review, it could not be determined what caused this increase in hospitalizations or whether some of the increase was an indication of inadequate community-based behavioral, crisis services, or crisis stabilization program capacity. DBHDS should analyze these data

For future quarterly reporting, DBHDS should establish indicators to determine whether the extent that the recent trend continues of a higher percent of individuals in crisis being hospitalized. Indicators should also be established regarding when hospitalizations might have been avoided with adequate community based resources and available beds in short-term crisis stabilization alternatives.

The summaries of the dispositions are included below in *Table 1- Disposition after crisis assessment-Adults*.

Table 1 **Disposition after crisis assessment – Adults**		
	FY16Q4	FY17Q1
# Assessed	312	422
% Hospitalized	27%	35%
% Retained their home	62%	52%
% Used crisis stabilization homes (CTHs)	7%	8%
% With another disposition	4%	5%

During FY16Q4 146 individuals used mobile crisis supports. After using REACH mobile crisis services, 77% of the individuals served retained their home setting and 9% transitioned to a new residence. In addition 4% used the CTHs. Another 10% were hospitalized. In future reports it would be useful to know the final disposition for the individuals who use the CTH programs.

In FY17Q1, after receiving mobile crisis support, only seventeen adults were hospitalized and 190 retained their home setting. During this quarter, fourteen individuals transitioned to a new residence after receiving mobile crisis supports and another fourteen used the CTH program. The percentage of individuals needing psychiatric hospitalization after the crisis supports is significantly lower than the number at the time of assessment: 7% compared to 35% at the time of initial crisis assessment. This is an indication of the success of these in-home crisis supports, while recognizing that some individuals at the time of crises may have required psychiatric hospitalization to stabilize. It will be important going forward to have more detailed information regarding the reasons for admission and the availability of community alternatives, especially as DBHDS enhances the array of crisis stabilization options as reported further in this status brief.

The summaries of the dispositions are included below in *Table 2- Dispositions after using REACH mobile crisis services – Adults*.

Table 2 **Dispositions after using REACH mobile crisis services – Adults**		
	FY16Q4	FY17Q1
# Who used mobile crisis services	146	237
% Hospitalized	10%	7%
% Retained in their home	77%	80%
% Who transitioned to a new residence	9%	6%
% Used crisis stabilization homes (CTHs)	4%	6%

Psychiatric Hospitalizations- The report contains an addendum with supplemental information about individuals who are psychiatrically hospitalized. This number is higher than the numbers reported in the previous paragraphs because the data includes individuals already served by REACH in addition to the new referrals.

During FY16Q4, the REACH programs were aware of 145 individuals who experienced a psychiatric admission. Of these individuals:

- 64% returned to their home
- 7% transitioned to a new residence
- 17% used the CTH as a step down service
- 10% remained hospitalized at the time of the report
- 2% had other outcomes

During FY17Q1 the REACH programs were aware of 163 adults who were admitted to psychiatric hospitals. Of these individuals:

- 58% returned to their homes
- 12% transitioned to a new residence
- 7% used the CTH as a step down service
- 13% remained hospitalized at the time of the reports
- 10% had other or unknown outcomes

CTH Capacity-The FY17Q1 report includes a detailed analysis of the capacity of the CTHs and the presence of any waiting lists, which has been developed for the first time. It is very helpful that DBHDS has begun to track this information and summarizing it. There were ninety-two days in the reporting period. Regions' beds in CTH programs were all full as a percentage of the ninety-two days as follows: Region I-17%; Region II-62%; Region III- 75%; Region IV- 46%; and Region V- 27%. Yet there were nine individuals on the waiting list during the quarter, with six of them on Region V's list even though Region V was only at capacity for twenty-five of ninety-two days. DBHDS is conducting a more detailed review of what led to the waiting list for Region V. Individuals on the waiting list primarily used mobile supports as an alternative to a CTH. One individual's discharge from a mental health hospital was delayed as a result of the waiting list for the CTH program.

During the ninth reporting period there were individuals on the waiting lists for the CTHs. During the eighth period case managers who attended focus groups reported having stopped making referrals because of being told beds were generally filled previous times they made a referral. Individuals with ID/DD continue to be admitted to psychiatric hospitals, apparently without always being offered the CTH as an alternative. While some hospitalizations may be clinically necessary, the data does not allow me to draw a conclusion as to whether the CTH setting may be an appropriate alternative because there is insufficient information about the reasons for admission. DBHDS should continue to hone its reports on psychiatric hospitalizations to inform the Expert and Independent Reviewers of the specific reasons for these admissions and how alternatives are considered prior to admission. The DBHDS plan to develop two additional CTH settings (described later in this report) for longer length of stays may help to reduce hospitalizations. However, the underlying cause for high vacancy rates in the CTHs should be determined in future studies.

Training by the REACH staff of community stakeholders continued in FY17Q1. This report includes new data about the involvement of law enforcement with crisis calls. Law enforcement personnel were involved in 40 of the 289 crises calls. Of these 40 calls statewide, 37 (92.5%) occurred in Region IV. There was no involvement of law enforcement with any crisis calls in either Region II or Region V. DBHDS plans to continue to report this data, which responds to a recommendation made during the eighth crisis services review. It is difficult to draw any conclusions about this data without a qualitative review of some percentage of individuals whose crises involved law enforcement personnel to determine the reasons; the officers' training in responding to the crisis; and the outcome of their involvement.

Current Status of REACH Services for Children

The Children's REACH Reports for FY16Q4 and FY17Q1 include information that demonstrates how well the programs are meeting the REACH standards. For this briefing I will highlight and summarize those program elements that are most critical to the success of the program and that are necessary to make progress toward achieving the provisions the Settlement Agreement. There will be a much more in-depth analysis during the tenth review of crisis services.

Referrals- Referrals increased from a total of 108 in the two quarters of the previous reporting period to a total of 363 during the two quarters of this reporting period (179 in FY16Q4 and 184 in FY17Q1). In FY16Q4, there was more difference across the regions in terms of crisis versus non-crisis referrals. There was a greater number of crisis referral in Regions I and IV, whereas the other three regions had more non-crisis calls. Regions II and III each had fewer than five crisis calls. In FY17Q1 there was more commonality across the regions and 53% of the calls were of a crisis nature.

Referral Sources- The primary source of referrals in FY16Q4 and FY17Q1 was the CSB ES. An exception was Region IV, which received the most referrals from families in both quarters. Families were the second largest referral source in each of the other four regions in FY17Q1.

Referral Response Time-The same expectations for timely response to children's crises are set for the urban and rural regions that have been longstanding for the adult REACH programs. Referrals are received mostly during the day but some during evenings and weekends in all regions. There were 122 crisis calls responded to during FY16Q4, all of which were face-to-face. The average response times in FY16Q4 were all within the expected times and ranged from thirty-eight minutes in Region I to sixty minutes in Region II. There were nine that were responded to late, resulting in 93% of the crisis calls responded to timely.

All crisis calls in FY17Q1 were also responded to face-to-face, but the timeliness of the responses dropped from 93% to 86%. Regions I and III responded to all calls within two hours, as required, and Region V responded late to only one crisis. The two urban regions had difficulty meeting the requirement to respond to calls within one hour. Region II responded on time to twelve (60%) of twenty crisis calls and Region IV responded on time to thirty-one (79%) of thirty-nine crisis calls. It will be important to see if this pattern in the urban regions improves for children in the next reporting period. Both of these regions have responded on a timely basis at a much higher rate for adults. If the pattern for children does not significantly improve, the DBHDS should analyze

the facts related to the late responses to determine the reasons and to recommend solutions to systemic problems experienced by the REACH programs in these two regions. Region II's untimely response rate dropped its average response time below the expectation of responding to the call within sixty minutes, a standard that is met by both urban regions for adult mobile crisis responses.

Individuals' Major Diagnosis- The Children's REACH Programs continue to serve more individuals with DD only, than those with DD who also have an ID diagnosis. The children referred in FY16Q4 included 106(60%) with DD only, which increased to 122 (67%) in FY17Q1. Children who also have an ID diagnosis continue to represent a small percent (14-18%) of the referrals in the two quarters. These data are vastly different than for the adult crisis services programs, which struggled initially to connect with the DD population. DBHDS credits this to linkages with schools and other children's providers and the ability of these entities to inform families of this crisis resource. The comparatively small % of adults with DD, other than ID, who are served in the adult crisis services programs is evidence that the crisis programs for adults continue to have difficulty reaching the adults who need and would benefit from this service.

Mobile Crisis Assessments- Mobile crisis assessments were primarily provided in family homes, hospitals, or the CSB ES site. Hospitals were the assessment site for 39% of the referrals for children in both quarters. This demonstrates good knowledge of the REACH children's program by CSB emergency services. The vast majority of children in FY16Q4 retained their family setting at the time of the crisis assessment with the exception of Regions III and IV. These two regions accounted for twenty-six (86.7%) of the thirty children who were hospitalized. This represented 28% of all children assessed for a crisis were admitted to a hospital or psychiatric hospital. Seventy-three children retained their settings and three transitioned to alternative settings. Three additional children retained their setting with mobile crisis support and one received residential treatment facility.

During FY17Q1 a similar number of children were hospitalized at the time of crisis assessment. Twenty-seven (22%) children were hospitalized at the time of assessment, while a total of ninety-five (78%) retained their setting, most without needing mobile crisis support. The same pattern of the greatest number and percentage of children hospitalized exists in Regions III and IV. Eight children in Region III and twelve children in Region IV were hospitalized during this quarter. This accounts for 74% of the hospitalizations for this age group. This appears to be evidence of a lack of effective community-based alternatives for children with I/DD in these two regions. This should be a focus of the crisis study in the tenth reporting period. It is critical that DBHDS continues to develop better data regarding the reasons for admission to psychiatric hospitals that includes data on the lack of clinically appropriate community services.

The summaries of the dispositions are included below in *Table 3-Disposition after crisis assessment-Children.*

Table 3 **Disposition after crisis assessment – Adults**		
	FY16Q4	FY17Q1
# Assessed	110	105
% Hospitalized	27%	22%
% Retained their home	69%	78%
% With an alternative setting	3%	0%

Sixty-two children used mobile crisis supports in FY16Q4. The supports helped 58 (94%) maintain their family home. Four children were hospitalized. Overall 176 children received mobile crisis support during FY17Q1. Mobile crisis supports helped 160 (91%) retain their setting of whom four continued to rely on these supports. An alternative residence was needed and offered to three children. Thirteen (7%) of the children were admitted to a psychiatric hospital.

The summaries of the dispositions are included below in *Table 4-Disposition after using REACH mobile crisis services-Children*

Table 4 **Disposition after using REACH mobile crisis services – Children**		
	FY16Q4	FY17Q1
# Using Crisis Mobile Supports	62	176
% Hospitalized	4 %	7%
% Retained in their home	58 %	91%
% Who transitioned to a new residence	0%	2%

Psychiatric Hospitalizations-DBHDS reports supplemental information on children in psychiatric hospitals who are known to the REACH programs. Forty-one children were admitted to the only state operated psychiatric children's hospital, CCCA in FY16Q4. REACH reported on the disposition of thirty-nine of them. Twenty-eight children returned to their original community setting and five were transitioned to an alternative community residential setting. Two others returned to their original community and also received community crisis support; one moved to a residential treatment setting; and three (8%) were still hospitalized at the time of the report.

DBHDS reported that fifty-nine children were hospitalized in the state operated facility during FY17Q1. This is a higher number than the forty hospitalizations that DBHDS reported in the body of its FY17Q1 report of hospitalizations made at the time of the crisis assessment or after receiving mobile crisis services. The higher number includes children who were hospitalized without the knowledge or involvement of REACH staff but who were reported to REACH by the children's psychiatric hospital after admission. REACH reported on the dispositions of fifty-eight

of them. Thirty-nine (67%) of these children returned to their original home setting including one who lived with another family member. Six (10%) transitioned to an alternative residential setting. However, thirteen (22%) remained hospitalized. It must be noted that there are no out-of-home crisis prevention or stabilization settings available yet for children with I/DD. The lack of this support in all likelihood contributes to the number of children who are admitted to psychiatric hospitals and to longer duration hospitalizations than necessary.

The summaries of the dispositions are included below in *Table 5- Disposition in Psychiatric Addendum – Children.*

Table 5 **Dispositions in Psychiatric Addendum – Children**		
	FY16Q4	FY17Q1
# Hospitalized during the quarter and reported	39	58
% Returned to their home	77 %	67%
% Moved to an alternative residence	13 %	10%
% Who were still hospitalized	8%	22%

Retrospective Studies of Adult Civil Admissions with Developmental Disabilities and Children with Developmental Disabilities Admissions to Psychiatric Hospitals

DBHDS completed two retrospective studies in September 2016 to review the admissions to psychiatric hospitals of individuals with ID/D that occurred between July 1, 2014 and June 30, 2015. The purpose was to analyze the data to determine the reasons for admissions; the need for community based crisis support; and particularly to assist DBHDS to decide the need for additional CTH settings for adults. DBHDS also wanted to determine how to best provide out-of-home crisis stabilization services for children. DBHDS approached each review similarly. DBHDS reviewed:

- Demographic data;
- Admission and discharge dates;
- Length of stay;
- Admission and discharge diagnoses;
- Reasons for admission;
- Residence prior to and after hospitalization;
- Opportunities to divert psychiatric admission; and
- The involvement of REACH crisis services.

DBHDS made a number of recommendations as a result of its analysis. DBHDS also established an internal review committee to develop and to implement new strategies from the recommendations. This committee is meeting monthly.

Psychiatric Admissions of Children with Developmental Disabilities

A total of 139 individuals with I/DD were admitted to the Commonwealth Center for Children and Adolescents (CCCA) in FY15. Thirty-one of these individuals experienced multiple admissions, which totaled seventy-three. These thirty-one (22.3%) individuals account for 40% of the total admissions of individuals with I/DD. Twenty children were admitted twice; eight had three admissions; two had four admissions; and one child experienced five admissions. The age range of these children is wide. While most (sixty children) are 15-17 years old, thirty-one are age ten or younger and forty-seven are between 11 and14 years old. Most individuals came from their family home (111, 80%) and of them eighty-three (75%) were able to return home. While only sixteen were admitted from group residences, forty-one were discharged to group residences. This indicates many of the twenty-eight children who did not return home transitioned to community residential programs, which may have increased the length of stay because of the time required to develop new residential supports. Six of the children moved to placements out of state. DBHDS will track these placement and attempt to return individuals when they are stabilized. One of the children was re-hospitalized after returning from a placement in another state and was not fully stabilized before the transition occurred.

The length of stay (LOS) in psychiatric hospitals ranged from less than twenty-four hours to 156 days, with a median of thirteen days and an average of twenty-three days. While DBHDS could not specifically break out any differences in the LOS by age group, Ms. Norton confirmed that the length of stays were typically shorter for the younger children. She confirmed that the majority of individuals who stayed more than thirty days were adolescents. DBHDS reports that the diagnoses of the children admitted included ID only (43), ID and DD (36) and DD (53). Eight of the children were determined to have neither an ID nor a DD diagnosis. Of the seventy-nine without an ID diagnosis, seventy had Autism and another nine were diagnosed with Asperger's Syndrome. This may have implications for the development of appropriate community behavioral supports and the enhancement of the skill set of REACH support staff.

The DBHDS review also considered the mental health diagnosis of the children. Thirty-one of them did not have any co-occurring mental health diagnosis but rather had challenging behaviors. As a result, these children may not have had a long stay

The reasons given for admission were an acute mental health crisis or chronic mental health disorders and related behaviors, yet 6.5% did not have a mental health diagnosis as noted earlier. The review was to determine if any admissions could have been diverted. The DBHDS spoke with CCCA staff to ascertain their clinical judgment regarding the possibilities for diversion. The DBHDS clinicians decided forty individuals (24%) of the admissions could have been diverted if there were functioning crisis services program available in their communities, including REACH. This may be an under representation for several reasons. There was not an in-depth review of the issues that led to the admissions; the REACH Children's Programs were not fully functioning during FY15; community capacity is still not fully developed; out-of-home crisis stabilization services are not yet readily available.

Based on its review, DBHDS made the following recommendations:

- Determine the family support needs that exist and are unmet;
- Determine how best to ensure appropriate community placement including training and support to allow the return of the child to their family home;
- Target training and resource development to reduce readmissions;
- Determine if community access to mental health care for individuals with mild or moderate ID or autism can result in better outcomes;
- Assess how to include behavioral support and psychiatric treatment into routine clinical protocol for children with and without DD;
- Promote knowledge and use of clinical tools to facilitate better diagnosis and treatment; determine variance in admission across regions; train discharge planners to orient them to the availability of community resources;
- Document REACH involvement in the hospital record; and
- Develop out of home crisis stabilization and prevention settings.

Planning Out-of-Home Crisis Stabilization Services for Children

DBHDS shared the DBHDS Crisis Prevention and Stabilization Bed Capacity Children's Crisis Services Proposal (10-19-16). DBHDS received funding for FY17 and FY18 to expand crisis services for children and adults. Based on its analysis of the psychiatric admissions DBHDS has proposed a three-tiered approach. This includes the: development of crisis prevention out of home respite care; therapeutic foster care; and two crisis stabilization program (CTH) settings to be shared by all five regions. These out-of-home supports will serve children who range in age from 3 to 17.

DBHDS has $500,000 to develop respite to assist families to prevent a crisis, to address a crisis and to prevent its re-occurrence. An RFP is being developed. REACH programs will not necessarily directly provide the respite but DBHDS expects the crisis respite programs to be linked to REACH. The funding will provide approximately 250 respite stays of five days on average. There isn't a timeline yet for the implementation of crisis respite for children.

DBHDS plans to develop therapeutic foster care to offer transitional residential settings with professional behavioral supports. The goal of therapeutic foster care is to support children through crises, stabilize them, and return them to the family home. The service will link with REACH. REACH staff will insure the foster and natural families remain in communication during the child's stay in foster care. The Commonwealth has not designated funding for this crisis support yet so no timeline has been set for this development nor has the capacity of this alternative been determined.

The CTHs will have no age restriction but will focus on the needs of adolescents. Two CTHs will be developed, each with capacity to serve six children at one time. One will serve children in Regions I and II and one will serve children in Regions III, IV and V. The DBHDS does not believe the data support the need for one CTH in each region. The DBHDS assumption that two programs with a total capacity of twelve beds may not be adequate given that at least forty admissions to CCCA could have been diverted during FY 2015. Further study would be needed once the two

homes open to determine utilization, capacity and waiting lists, if any. In part this may be dependent on the adequacy of the other aspects of out-of-home support and the success of these supports maintaining children in their homes or other appropriate community settings.

DBHDS plans to issue the RFP for the Children's crisis stabilization programs (CTHs) December 1, 2016. DBHDS is optimistic that the homes will be available within nine months, by September 1, 2017.

Psychiatric Admissions of Adults with Developmental Disabilities

The DBHDS study included review of all admissions of adults with I/DD to the DBHDS operated Virginia Mental Health Hospitals. A total of 269 individuals with DD were admitted to these psychiatric settings in FY15. Forty-two of these individuals experienced multiple admissions, which totaled 102 admissions, which is 38% of the total number of admissions. The data do not indicate the number of multiple admissions the adults experienced. One third of the individuals came from their own or family's home (89) and of them eighty-five were able to return home. Fifty-two individuals were admitted from group homes and returned to their residence. It is notable that such a large percentage of the individuals who had their own home or lived in a community residence were able to return to it. Thirteen adults were admitted to the psychiatric hospitals from a REACH CTH. The CTHs were also used as step-down settings for thirty-three (12.3%) of 269 individuals who had been admitted to the DBHDS mental health hospitals. It would be interesting to have data as to whether the availability of the REACH CTH resulted in shorter lengths of stay.

The lengths of stay (LOS) ranged from 1 to 120 days, including 102 individuals who stayed for more than thirty days. Of these 64% of these stayed hospitalized for between 61 and 120 days. Overall 115 individuals, 46% of the total number of admitted, were discharged within fourteen days of admission.

DBHDS reported the diagnoses of the adults admitted included ID (167), ID and DD (44) and DD (25). Twenty-two individuals had no ID or DD diagnosis at the time of discharge, although they had a diagnosis of ID or DD at the time of admission. DBHDS assesses that these original diagnoses may have been driven by a sense that a developmental disability may result in greater access to community supports upon discharge. Of the individuals with DD, fifty-two had Autism and another five were diagnosed with Asperger's Syndrome. The prevalence of these diagnoses among the hospitalized adults is consistent with the diagnoses of the children with DD who experienced psychiatric hospital admissions. Similarly, this may have implications for the development of appropriate community behavioral supports and the enhanced skill set of REACH support staff. It is notable that the prevalence of the DD diagnoses was similar for adults and children, the community-based REACH programs for adults serve a small percent of individuals with a DD, other than ID, diagnosis, while the children's crisis programs serve a very percentage with these diagnoses.

The reasons given for admission were the same as for children as for adults: an acute mental health crisis or chronic mental health disorders and related behaviors. There was no detailed analysis of each person's community living situation or family dynamics, or whether the lack of available community-based supports may have contributed to the need for these admissions. The

DBHDS review was to determine whether any admissions could have been diverted. The DBHDS spoke with the hospital staff to ascertain their clinical judgment regarding the possibilities for diversion. The DBHDS staff decided sixty-four **(24%)** of the admissions could have been diverted if there were functioning crisis services in the community, including REACH. This may be an under representation since there was not an in-depth review of the issues that led to the admissions and the determinations are based on the clinical opinion and judgment of hospital based clinicians who may not be fully aware of the possible range of community supports and their impact on maintaining individuals in their communities. The percentage of individuals hospital staff thought could have been diverted varied from 13% to 47%. These differences may be related to the clinical needs of the individuals, the capacity of the community crisis system or the philosophy of hospital staff about hospitalization and diversion. Analyzing the reasons for these discrepancies might inform and assist DBHDS to develop different or revised strategies to assist hospitals to think through the assessment of appropriate diversions.

- REACH was expected to be involved with all adults with DD who were admitted to psychiatric hospitals in FY15. The hospital documentation indicated that REACH was only involved, however, with only seventy-six (28%) of the 272 individuals. REACH involvement with individuals ranged from 0% to 45% depending on the hospital. DBHDS reports that this may be an inaccurate representation of REACH involvement since it may reflect inconsistent documentation by the hospitals. DBHDS's analysis did not include a crosscheck with the REACH programs. However, there was documentation that not all CSB Emergency Staff or MH Hospital staff contacted REACH when individuals with ID/DD were being screened or admitted. There is also information that some REACH programs may have limited involvement for a variety of reasons. These include:
- The level of aggression presented by the individual
- Elopement risks
- History of non-compliance with medications
- Intensity of the medication monitoring that would be required after discharge from the hospital setting.

It is very concerning that more than 70% of individuals admitted to these hospitals did not benefit from REACH expertise and resources, as these programs were required to prevent unnecessary institutionalization and to provide short-term alternatives.

The DBHDS report does a thorough job of breaking down diagnoses and data regarding the placements of individuals before admission and after admission by the sub-populations of no ID or DD; mild ID; or unspecified or borderline ID. This includes 181 of the 269 individuals, of whom 125 have a diagnosis of mild ID. These individuals may not always be eligible for waiver services. Forty of these 125 individuals have a substance abuse/use/dependence disorder. Only one other individual was noted as having a substance related disorder at the time of discharge. There are no recommendations related to this population although DBHDS acknowledges that treatment for individuals with ID or DD remains challenging.

DBHDS made several recommendations, including to:

- determine what drives re-admissions to determine needed community supports;
- analyze the spike in admissions for the 51-60 age group;
- compare age of admission with the non-DD admissions to determine if there are identified family support needs;
- develop supports that allow all individuals to return home when home remains an appropriate setting;
- reduce the length of admissions;
- create better access for individuals with mild or moderate ID, or autism spectrum disorder;
- improve the accuracy of diagnoses by community practitioners and increase their use of diagnostic tools and effective clinical treatment;
- train MH hospital staff to address challenging behaviors associated with DD;
- determine reasons for the difference in admission patterns across MH hospitals;
- train MH discharge planners and social work staff to be better informed about community services and eligibility criteria for various program services;
- improve documentation of REAH involvement; and
- determine the types of supports the individuals identified for potential diversion need.

DBHDS has created two internal work groups that are responsible for implementing these recommendations. The members include professionals from the:

- Division of Development Services including facilities and community operations
- Division of Mental Health and Forensic Services including facility and community operations
- Division of Quality Management and Development including Data Warehouse and Risk Management, and
- Representatives of the REACH adult and children's programs

The group has started to meet monthly and plans to meet through FY17. DBHDS has not shared a specific work plan or the expected timeframes for implementation.

Expanding the Out-Of –Home Crisis Stabilization Settings for Adults

DBHDS undertook a review of CTH capacity for the time period: 12/1/15-6/30/16 to help determine if additional CTH settings are needed. The CTHs had 340 admissions during the seven-month period. The CTH provides crisis stabilization and also prevention support. One hundred fifty-eight (158) of the admissions were for prevention. This represents 46% of all admissions to the CTHs, which is consistent with other reporting periods. The average length of stay for these visits was eight days. One of these individuals remains.

The crisis stabilizations admissions totaled 182 with an average length of stay of twenty-one days. All regions had individual stays that exceeded the thirty days expected. The reasons for the longer stays varied but all have been discharged. The DBHDS report notes that there were not any days in the reporting period when all CTH beds were filled across the state. However, the

report does not specify the days that any particular CTH had all of its beds filled. The report does not refer to a waiting list although the REACH quarterly reports now include this data as of the FY17Q1 report.

DBHDS reports that the implementation of the waiver redesign should reduce some of these longer stays. There is a new emergency reserve HCBS waiver slot process that can result in more timely access of community supports; individuals with DD will have access to a broader range of supports including 24 hour residential support; and the redesigned waivers will include a customized rate to fund enhanced services effective February 2017. DBHDS is communicating with REACH weekly to provide updates on housing development for individuals. The REACH quarterly reports effective October 2016 include detailed bed capacity data that allow for more in-depth analysis. Additionally DBHDS proposes to develop two adult programs to function as step-downs from psychiatric hospitalization and enhanced support to what is now available through REACH. These two settings will support individuals who need more than a 30-day stay to stabilize or to transition to a new residential setting. DBHDS anticipates that individuals will utilize the programs for up to six months while comprehensive clinical assessments are done, providers are comprehensively trained and new residential settings are designed as needed. The DBHDS has the funding for this new initiative and will issue an RFP for housing development within thirty days. DBHDS anticipates that these two homes will be available within nine months of the award of the RFP. For these new settings, DBHDS will use the architectural design of the new community-based CTH in Region IV that opened in September 2016.

Summary and Recommendations

Summary- DBHDS continues to make progress implementing the crisis services recommendations of the Settlement Agreement. There is evidence of continued outreach and success serving adults and greater coordination with the CSB ES units. The adult programs are serving more individuals with DD, other than ID. The responses to all crisis referrals were face-to-face and the on-site response time was above 90% in both quarters. REACH staffs are participating in more crisis assessments conducted at the psychiatric hospitals, which insures that the person is immediately linked with REACH for coordinated discharge planning including linkages with community providers. The CTH program is also being used effectively as a step-down from the hospitals for some individuals in the population, which should positively impact length of stay for some individual's psychiatric admission. Individuals are most commonly able to return to their previous residential setting.

It is positive that DBHDS is able to report on the involvement of law enforcement in crisis responses and has initiated a more detailed report on the capacity of the CTH program, which includes waiting list information.

The Children's REACH program is experiencing an increase in referrals. The referral sources evidence a positive relationship with the CSB ES units. The majority of individuals served have a diagnosis of DD only, or a combined diagnosis of ID and DD demonstrating effective outreach to this population. Crisis assessments are conducted face-to-face but it is concerning that the response time dropped to 86% of the referrals responded to within the one and two hour timeframes with significant difficulty meeting the expectation in the two urban regions. The

assessments, linkage, training and in-home support components of the program are becoming better established. One stark area of non-compliance with the requirements of the Settlement Agreement is the lack of out-of-home crisis stabilization for children. It is promising that DBHDS has developed a proposal to address this requirement and is including three options to add to the array of community-based crisis supports for children.

Recommendations- DBHDS should lead the development of the plans to develop crisis stabilization options for children, and add the two CTH settings for adults that will afford longer planned stays when clinically appropriate. DBHDS should insure effective coordination with REACH if other providers are selected to operate these new out-of-home options and describe how REACH will be involved in intake, discharge planning and oversight.

DBHDS has identified the work groups that are responsible for implementing the crisis services recommendations that emerged from its reviews of psychiatric admissions. DBHDS should also describe the resources available to implement the recommendations, the reporting required of the assigned individual or group, and the expected timeframes for implementation.

All of the recommendations made as a result of the two retrospective reports on psychiatric admissions should be implemented and the status should be reported periodically to the Expert and Independent Reviewers. The DBHDS focus on psychiatric admissions, and current monitoring of these admissions to ensure REACH involvement from the onset, is very encouraging. It will be useful in determining the outcomes of this greater attention to admissions to have more detailed information about the causes of admissions; the reasons for lengthy admissions; and a clear sense of the criteria to determine when diversions are indicated.

Submitted by:

Kathryn du Pree
Expert Reviewer
November 15, 2016

APPENDIX C

SUPPORTED EMPLOYMENT

By: Kathryn du Pree MPS

Employment Services –Status Briefing on the Implementation of the Commonwealth's Settlement Agreement Requirements

November 2016

Introduction
This is the ninth review of employment services as developed by the Commonwealth in response to the Settlement Agreement.

In its Settlement Agreement with the U.S. Department of Justice, the Commonwealth of Virginia, committed to the extent that it offered services, that it would do so "in the most integrated setting appropriate to meet the needs of individuals with ID and DD". In part to fulfill this commitment, the Commonwealth:

- Established a statewide Employment First policy,
- Developed a plan to increase integrated day opportunities, including employment,
- Established "targets for employment services to support individuals in integrated work settings where they are paid minimum or competitive wages, and
- Committed to develop and discuss employment goals at least annually through a person-centered planning process and included in ISPs.

The targets established by the Commonwealth reflect these commitments. They include increased participation of individuals with ID and DD in individual supported employment, which occurs in integrated settings. The targets project increasing the number of individuals in the preferred Individual Supported Employment (ISE) by 282% while only projecting the increase in Group Supported Employment (GSE) by 45.0% (see Table 2 below). Achieving these targets will represent a significant shift away from Virginia's approach, since it joined the HCBS waiver program, of providing services by congregating individuals with ID/DD together in groups and in segregated settings.

Previous reviews of the Commonwealth's plans for employment and integrated day activity development and the current status of implementation have included a review of documents, interviews and focus groups. The documents reviewed included plans; work group meeting minutes; proposals; RFPs; data; and employment plans for individuals with HCBS waiver funded services. The interviews and focus groups were with key DBHDS staff, CSB staff and members of the Supported Employment Leadership Network (SELN), which has been renamed the Employment First Advisory Group (EFAG).

During the ninth review period DBHDS, CSBs and providers are in the midst of waiver reform and related service development. The Independent Reviewer, Donald Fletcher, and DBHDS agreed that this review would be limited to the implementation of priorities of employment. This review is based primarily on a review of the following documents:

- DBHDS Semi-Annual Employment Report dated 10/1/2016(June 2016 data);
- Regional Quality Council and EFAG meeting minutes; and
- The DBHDS Community Engagement Plan Update.

I also interviewed five members of the EFAG to discuss their involvement in reviewing the employment targets and interviewed Heather Norton, Director of Community Support Services. I greatly appreciate Ms. Norton's time, as she is currently coordinating much of the department's responsibilities to successfully accomplish waiver reform.

Employment Achievements

DBHDS continues to collect and analyze employment data semi-annually. The most recent report is the fourth semi-annual collection of relevant employment data from the Department of Aging and Rehabilitative Services (DARS), the Department of Medical Assistance Services (DMAS), and employment service organizations (ESO) that provide HCBS waiver funded employment services to individuals with ID and DD. Notably DBHDS received data from 100% of the ESOs. During the previous reporting period DBHDS had achieved a 93% response rate. This is a note worthy achievement and reflects the collaboration of DBHDS, DARS, and the EFAG data subcommittee coupled with responsiveness of the provider community. It is also important to note that with three additional providers reporting, the numbers of individuals reported being served in December 2015 couldn't be compared to June 2016 to determine the extent of changes between subgroups during this six-month period.

The following summarizes the employment status of individuals with ID or DD who participate in DARS or DBHDS waiver funded employment services June 2106. This includes data from 100% of ESO providers. A total of 4,606 individuals participated in individual supported employment (ISE), group supported employment (GSE) and sheltered employment, as follows:

- 2174 individuals were in ISE,
- 1240 were in GSE, and
- 1192 were in sheltered workshops.

The data reported as of June 2016 includes 388 more individuals participating in employment and sheltered work programs than the incomplete number reported by 93% of the ESO providers in December 2015 when 4218 were reported. Of the additional 388 individuals reported:

- +49 (12.6%) were in Individual Supported Employment
- +329 (84.8%) were participating in Group Supported Employment, and
- +10 (2.58%) were in sheltered workshops.

DBHDS has identified 15,429 individuals with I/DD in the Commonwealth who are either participating in a HCBS waiver or are on the waiting list for HCBS services. Of this number 3414 are now in either ISE or GSE including HCBS, DARS and other employment programs. Overall 22% of the total number of individuals with ID or DD identified by DBHDS is in ISE or GSE compared to 20% in December 2015.

The majority of individuals (73%) in ISE are in a DARS funded program. Of the 2174 in ISE, 1587 are in Extended Employment Services (EES), Long-Term Employment Support Services (LTESS) or another DARS program; whereas only 225 (10.3%) of the individuals in ISE are in HCBS waiver-funded programs. More individuals are noted as being in ISE (362) in the "other" than receive ISE through a waiver program. Of the individuals in GSE only 84 (6.8%) are funded by DARS. The "other" category accounts for 491 of the individuals participating in GSE. Given the high number of individuals in the "Other" category DBHDS should report more specifically about its funding sources.

DBHDS has identified 15,429 individuals as being the total number of individuals with I/DD on the waivers or on the waiver waiting list. This number is used to calculate the target of 25% of these individuals being employed by June 2019. DBHDS reports as of June 2016 that overall 18% (2471) of the total ID population and 57% (925) of the DD population is employed in either ISE or GSE.

It is notable that of the 925 individuals with DD, other than ID who are employed, 85% (788) participate in ISE, whereas only 44%(1103) of the 2471 individuals with ID in a work setting participate in ISE.

Although pre-vocational services will no longer be a waiver service, 565 individuals were reported being served in prevocational HCBS waiver services as of June 2016. Prevocational Services are provided in segregated sheltered workshop settings. Ms. Norton explained that comparing the numbers of individuals who were reported in each employment subgroup as of June 2016 to the numbers reported in December 2015 could lead to incorrect conclusions. For example, a comparison shows that ten more individuals are in sheltered work as of June 2016. This is not necessarily an increase in the number of actual individuals in sheltered work but rather an outcome of better reporting. One of the providers that reported for the first time, however, reported serving 100 individuals in sheltered work. Rather than an increase of ten individuals, there may have been a decrease of 90 individuals, because these 100 individuals had not previously been counted.

The Commonwealth's continued reliance on this service type in segregated settings as recently as June 2106 is troubling in light of the removal of this service from the revised HCBS waiver service array. It is promising that DBHDS is providing technical assistance to many of the providers of pre-vocational services. Doing so will help willing providers to convert to be able to offer community-based employment programs, community engagement programs, or a combination of community-based employment and inclusive activities.

As of June 2016 DBHDS reported that 1563 (45.8%) of the 3414 of the individuals in supported employment work between 10 and 20 hours per week. This includes 676 in GSE and 887 in ISE. Table 1 summarizes the amount of hours worked for everyone known to work in ISE or GSE.

Table 1 Hours Worked by Individuals in ISE and GSE			
Range of Hours	**ISE**	**GSE**	**Total**
< 10	368	158	526
10-20	887	676	1563
21-30	474	293	767
31-39	247	36	283
40 or more	172	48	220
Unknown	26	29	55

DBHDS provides more detailed information on the number of hours worked in this semi-annual employment report than in prior reporting periods. The December 2015 Semi-Annual Employment Report noted that individuals in employment worked an average of 21 hours per week. The data in the draft June 2016 Semi-Annual Employment Report indicates that 61.2% of individuals in ISE and GSE for whom hours are reported, work 20 or fewer hours.

DBHDS has a goal that at least 85% of individuals who are employed will maintain their jobs for 12 months or more. The most recent semi-annual report includes length of employment data for 3384 individuals of whom 89% (3025) have been employed for at least one year.

DBHDS reports on wages for the population. These data include 3414 individuals in either ISE or GSE of whom wages are unknown for 51 of them. Wages are known for 3363 of the individuals. Of these workers, 477 (14.2%) make less than minimum wage; 918 (27.3%) receive minimum wage; and 1968 (59%) earn more than minimum wage. All but three of the individuals who earn less than minimum wage are in GSE. There is a significant reduction in this number from the previous report when 41% of individuals in GSE were paid less than the minimum. Included in this report, however, is that 1,192 individuals (DARS- and waiver-funded) remain being served in segregated sheltered workshop settings. Of these individuals 724 (60.7%) are paid less than minimum wage for their work.

Targets

DBHDS has established numerical targets for the number of individuals who will be employed through 2019. These targets project steady increases in the number of individuals who will be receiving both ISE and GSE. The Commonwealth has committed to an overall goal of assisting 25% of its citizens with intellectual or developmental disabilities to work. They determine the goal based on a calculation of the total number of individuals with ID or DD, ages 18-64, on the HCBS waivers or on the waiver wait lists, as of June 30, 2016. This totals 15,429 individuals. DBHDS reports achieving the goal will result in 3,857 individuals being employed by June 30, 2019. This is the target number established in the Semi-Annual Draft Report on Employment dated 10/1/2016. This goal is strictly represented by the total number that the Commonwealth projects will be employed. There is no breakdown by program area or by funding source with the exception of the increased employment projected for the HCBS waiver programs, which is depicted in Table 2 below. I have noted in previous reports that it would be useful to establish sub-targets including for

school graduates, individuals transitioning from sheltered work, and individuals transitioning from the training schools.

As of the draft June 2016 Semi-Annual Employment Report, with 100% of ESOs and DARS reporting, 3,414 individuals were employed in ISE or GSE in DARS and HCBS waiver-funded programs. In December 2015, with 93% ESOs reporting, there were 3,036 individuals reported in DARS or HCBS waiver employment programs. This is an additional 378 individuals, however, we cannot be certain that all of this 12% increase occurred in the six-month period. It does appear that achieving the goal of 3,857 individuals in ISE or GSE in three years is very attainable. The Commonwealth would need to increase employment by approximately 145 individuals in each of the next three years.

DBHDS has also set targets for increasing the number of individuals participating in HCBS waiver ISE and GSE services. The department has clarified these goals in the most recent semi-annual employment report. These targets summarized in Table 2.

Table 2 DBHDS Goal to Increase Employment in the *HCBS Waivers*			
Fiscal Year	**ISE**	**GSE**	**Total**
2016	211	597	808
2017	301	631	932
2018	566	731	1297
2019	830	831	1661
2020	1095	931	2026
# increase	884	334	1218
% increase	+419%	55.9%	151.0%

The actual numbers of individuals in ISE and GSE at the end of FY16 (6/30/16) are: 225 in ISE and 665 in GSE. These achievements surpass the DBHDS expectation of 211 in ISE and 597 in GSE. The DBHDS expects to increase the number of individuals in ISE by an additional 91 in FY17, which is very positive. The growth in ISE for HCBS waiver participants between December 2015 and June 2016, however, was only 14 or fewer. The Individual Employment Report (H2023) through June 2016 the fourth quarter of FY 2016 documents that ISE enrollment for waiver participants increased by only thirty-eight individuals in FY15 and thirty-seven (or fewer) individuals in FY16. This particular report has always posed some issues with potential redundancy (i.e. counting the same individual more than once), but still can be used as a reasonable measure of past performance. DBHDS will need focused efforts with its providers and other stakeholders to achieve its interim goal. It is very positive that DBHDS sets increasingly higher goals for ISE so that the number of people in ISE will ***exceed*** the number in GSE by 2020.

There appears to be a lack of correlation between the overall employment targets and the targets established for individuals who receive HCBS waiver employment services. By 2019 DBHDS expects 3,857 individuals with ID and DD to be employed in either ISE or GSE including all DARS and DBHDS employment opportunities, which as noted before is an increase of 443 individuals. In the same time period, DBHDS projects in its targets for the waiver programs that 853 more individuals will participate in either ISE or GSE reaching a

total of 1661 by the end of FY19. Adding 853 individuals to waiver employment programs totals 410 more individuals than the Commonwealth projects in the overall employment target goal. The data in the report appears to indicate that fewer individuals with ID or DD will have employment opportunities through the DARS funded programs: EES and LTESS. However, Ms. Norton explained that the targets are established separately. The targets set for the increases in the waiver employment participation reflects initial commitments made to the Court and to the Independent Reviewer. The overall employment target will continue to reflect the Commonwealth's goal that 25% of all individuals with ID and DD (as known identified through waiver enrollments and waiver waiting lists). These target numbers may remain unaligned.

It is unclear how the number of school graduates in each of the next three years are factored into these targets and whether these targets account for the need for the 1192 individuals who are currently receiving services in segregated sheltered workshops. Of these individuals 565, who are currently in sheltered workshops programs funded by the HCBS waiver, will be transitioned to ISE or GSE as appropriate to meet their needs and preferences.

DBHDS has established two related goals to meet the employment targets. These goals place responsibility on each CSB to ensure that Case Managers discuss employment needs, preferences and options with 100% of the individuals receiving case management, and develop individual employment related and/or readiness goals for 35% of these individuals. DBHDS included the data reported by the CSBs for the latter part of FY16 (1/1/16-6/30/16). In this time period the CSBs reported that 5,425 adults had an annual ISP meeting. Case managers reportedly discussed employment with 4,445 individuals (82%) and developed an employment related goal for 1,711 individuals (31.5%). Even though self-reported by Case Managers, the discussion of employment increased by 4% and the development of employment goals decreased by 3% from the previous reporting period. Both levels of achievement remain below the expectations set by DBHDS. DBHDS clarified that these expectations have also been set for DD case managers who report to DBHDS separately and through Survey Monkey and that these results are not yet included. The CSB reports as of January 2017 will include the planning activities to promote employment of both the ID and the DD case managers.

Data for each CSB was included in the most recent DBHDS report. Twelve of the CSBs were below the expectation of discussing employment with 85% of individuals and fifteen of the CSBs were below 25% achievement for setting an employment related goal. Five CSBs, however, reported that no ISPs were completed during the six-month period. DBHDS needs to set improvement goals and monitoring protocols for each CSB and establish improvement plans for the CSBs that perform below expectations for two successive quarters.

Engagement of the Employment First Advisory Group and the Regional Quality Councils

DBHDS convenes the EFAG to:

- Provide advise the department on employment service development;
- Recommend policy changes and training strategies;
- Participate in data collection and analysis; and
- Make recommendations to assist the Commonwealth to achieve its employment targets.

I routinely interview 5-7 members of the EFAG and was able to interview five of the same members for this ninth period review. The focus of the conversations during this review period was to determine if the EFAG has a continuing role in reviewing the targets, in making recommendations to further the efforts, and in determining the members' satisfaction with the data and the department's progress in achieving the targets. I also reviewed the minutes of the EFAG meetings that occurred during the review period, April – September 2016. All of the EFAG members interviewed report increased satisfaction with the functioning of the Advisory Group. The membership has stabilized since the changes were made in the summer of 2015. The EFAG members attend much more consistently and there is a balanced representation across stakeholder groups, although recruitment is continuing for another family member. Meetings are reported to run efficiently and members receive documents and proposals with sufficient time to review them prior to the meeting in which they are presented and discussed. Members report great progress in the areas of data gathering and analysis. They also report starting to see measurable increases in employment among the target populations. There is some concern that the recent rate clarification for GSEs billing units may have negative impact on the initiative to reach the employment targets.

The Regional Quality Councils are also required to review employment data on a quarterly basis, and to discuss the targets and to offer recommendations annually. The meeting minutes from the five RQCs during July/August and September/October provide evidence that discussions about employment occurred at all meetings and a review of the targets at one of the meetings for each of the five Councils. The need to clarify the targets for the waiver ISE and GSE programs and the Commonwealth's progress or need for greater improvement (waiver ISE programs) was shared with each RQC. Recommendations were made by all of the Councils. These included:

- Addressing transportation;
- Connecting CSB staff with school transition planning meetings;
- Including career development as a support;
- Making employment transparent and publicly available;
- Learning and sharing best practices in securing employment;
- Educating families to change their expectations of their child's employability; offering benefits counseling to families and individuals;
- Training case managers and ESO staff; and
- Offering employment provider fairs for case managers.

One RQC expressed concern that documentation requirements may be too burdensome for providers. Two RQC's expressed that they would simply repeat recommendations made the previous year. This approach raises a significant concern with a lack of clarity regarding the entity that approves, modifies, or rejects recommendations made by the RQCs and the process by which the RQCs are informed of these decisions.

The Settlement Agreement includes the expectation that there is linkage between the RQC's and the SELN (now the EFAG), and that the RQC consult with providers as well as the SELN. It is very encouraging that the RQC meetings now regularly include a review of employment data and a discussion of progress toward meeting the targets. However, I see no evidence that the RQC's interface or consult with providers, or that the recommendations the various Councils make are shared with the EFAG. None of the EFAG members who I interviewed had any awareness of the RQCs involvement in the employment initiative. None had been briefed on the Council's recommendations or what occurred as a result of the RCQ recommendations regarding employment. Heather Norton is a member of the EFAG as is the Employment Services Coordinator (vacant during this review period). While these two staff can provide the link between the Advisory Group and the five RQCs, this has not resulted in a formal review by the EFAG of the RQC recommendations or feedback to the EFAG regarding the disposition of the RQC recommendations.

Heather Norton reports that she shares the recommendations of the RQCs with the EFAG. Because they are often repeated or common recommendations they may have not engendered another review by the EFAG. DBHDS will more clearly identify the RQC recommendations as a specific agenda item for the EFAG and communicate the activities to address the recommendations back to the RQCs in the future.

Employment Services Coordinator
This position became vacant during the eighth reporting period and remained vacant through the ninth reporting period. It has been recently filled and the individual began performing the functions in late October. While the Coordinator was not functioning during this reporting period having her on staff now is very encouraging as DBHDS moves forward with implementation of employment initiatives under the revised HCBS waivers.

Community Engagement
Employment was the focus of this limited review. I was provided with, and reviewed, the minutes of the Community Engagement Advisory Group (CEAG) and an update to the Community Engagement Plan: FY 2016-2018. The following has been accomplished during this reporting period:

- Training has been completed for day support staff, families and individuals, and residential providers. Training has been given to 1571 providers, 830 case managers, and 671 families and individuals
- A website to gather photos for the photo voice project is underway to visually show examples of community engagement
- DBHDS holds weekly calls with provider and family groups to discuss new services and to address concerns with implementation

- The CEAG is developing the section of the provider manual to describe community engagement and coaching, and to provide fact sheets for case managers and providers
- Training was provided to DBHDS service authorization staff
- RFPs to convert from segregated center based to community inclusion were awarded in June 2016. DBHDS meets regularly with the selected providers and is developing data collection tools
- Community day service providers are adding community engagement and coaching to the service array

Conclusions
DBHDS is making significant progress regarding data collection; defining and beginning to achieve the employment targets; refilling the Employment Services Coordinator position; and supporting the development of community engagement while it is implementing dramatic changes to the existing HCBS waivers system.

Recommendations
To achieve full implementation of the employment service goals it needs to:

- Propose how CSBs and DBHDS will determine if individuals have full employment, i.e. are able to secure both the type of jobs and the number of hours they wish to work
- Insure that the CSBs are having meaningful conversations with individuals about employment and developing and setting employment goals for individuals who are both interested in and in need of employment supports
- Create an opportunity for the RQCs and the EFAG to share their analyses and recommendations, and document the DBHDS plans to implement those recommendations it embraces

Compliance with the Settlement Agreement

The Commonwealth is in compliance with the following employment requirements::
III.C.7.b.i.A
III.C.7.b.i.B.1.a-e
III.C.7.b.i.B.2.b
III.C.7.d

Based on this review I recommend that the DBHDS also be found in compliance with:
III.7.i.B.2.a- The Commonwealth has set meaningful targets for employment and is working toward achieving these targets, and
III.C.7.c- RQCs have reviewed employment data quarterly

APPENDIX D

TRANSPORTATION SERVICES

by: Ric Zaharia, Ph.D.

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

Transportation
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

Consortium on Innovative Practices

November 5, 2016

Introduction

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a review of the 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. The effective functioning of the DMAS transportation brokerage is critical to the goal of improving the lives of people with intellectual and developmental disabilities in Virginia. This group of users requires over 200,000 trips each month to fulfill their personal goals.

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". Since DMAS and Logisticare implemented a number of changes this past summer, this report represents a check-up on the implementation of modifications to the transportation system. An evaluation of the effectiveness of these changes, and of the DMAS quality improvement program, should be possible after a full year of implementation, i.e. 6/30/17. DMAS's issuance of a new Request for Proposals (RFP) and an award of a new contract could extend the period before an evaluation of these changes can be completed.

This report is organized with an introductory statement of the requirements of the Agreement, a description of the methodology, a report on the findings from this evaluation, and recommendations to achieve full compliance. Suggestions are offered where an area might be improved. The compliance table below recaps the compliance assessments made in this review.

Compliance Table

Settlement Agreement	Settlement Agreement Language	Compliance	Page
Section 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	4

Transportation operations

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.

Goal:
To determine if the Commonwealth has made progress towards implementing a quality improvement program in Transportation services as identified in this consultant's previous study and in the Independent Reviewer's Report to the Court of December 6, 2015.

Methodology:
- Interviewed DMAS officials regarding transportation, quality improvement planning, and safety;
- Interviewed LogistiCare officials regarding transportation, quality improvement planning, and safety;
- Reviewed quality improvement/action plans since December 2015;
- Reviewed the records maintained to demonstrate implementation of the changes to transportation services and related quality improvement program provisions of the Agreement (See Attachment A and B).

Findings:
DMAS compiled in its action planning document (*Response to Recommendations,* 8/9/16) the changes it would institute in current practice and would institutionalize in an RFP that DMAS plans to issue later this year. DMAS has implemented or clarified four of the eight recommendations/suggestions made in this consultant'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;
- Analysis of the LogistiCare databases using the IDD Waiver as a sub-group for assessment of 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 capacity gaps in transportation.

DMAS plans to include specialized requirements in its new RFP[1] and contract. These requirements include: addressing statistically valid customer satisfaction surveys from IDD Waiver users, representation from the IDD Waiver community on advisory boards, and 'trip recovery' technology (i.e., software designed to redirect drivers in real time when another driver is unable to make a ride.

The mileage reimbursement form for users can now be faxed for payment, which does facilitates user payment. The reimbursement form, however, remains cumbersome and not user friendly. For example, the form requires the user to enter 15 data items per

[1] The NEMT RFP was issued 11/1/16.
[2] http://www.ct.gov/dds/lib/dds/health/reports/mortality_report_fy_14.pdf

reimbursement request. This form is critical to giving users a personal alternative and choice to using commercial drivers, but they will not use a form that is burdensome.

DMAS/LogistiCare extracted findings for the IDD Waiver population for this past July 2016. LogistiCare reports that it did not find a variance in complaints, usage patterns, etc., between the IDD Waiver users and the larger group of Medicaid transportation users. However, DMAS has pointed out in its analysis (*Response to Recommendations*) that the IDD Waiver population uses proportionately more trips per individual than the larger group of users. It may take several continuous months of data analysis across seasons, school years, etc., to establish other actionable patterns or trends among users from the IDD Waiver.

This latter finding, higher use per IDD Waiver user, is a significant conclusion which warrants additional analysis and/or action. For example, if Joe from the IDD Waiver uses 2 one-way trips each day to his day program for 180 days a year, he gets 360 rides annually; if Jane from the general Medicaid population uses 2 one-way trips a month to a doctor's appointment, she gets 24 rides a year. Joe has 15 times more opportunities to experience a ride problem.

During a ten-agency tour of IDD providers for another study, this consultant interviewed a day provider who logged problems with the LogistiCare rides that its program participants experienced. Six complaints were recorded by this Region 1 provider on behalf of users between 8/22 and 9/1/16. These six complaints were discussed with LogistiCare at the time of our corporate interview. LogistiCare determined that one complaint was not legitimate (the transportation provider did not answer when contacted directly by the day provider – Logisticare advises users to communicate through the Rider Assist line rather than the driver directly, so as to ensure accountability). LogistiCare determined that the other five no show complaints were determined to be valid and appeared to be "breakdowns in communications" ascribed to the contract drivers.

In subsequent follow-up with the day provider agency, this consultant learned that the local LogistiCare representative made contact with the day provider and the transportation contractor to problem solve. LogistiCare had replaced one contractor. However, between 9/12/16 and10/3/16 two complaints about 'no show' trips' had reoccurred for two of these same five individuals. The day provider also reported that there were also numerous unreported (i.e. no complaint filed) 'late pickups' (beyond 15 minutes of the appointment time) among the five individuals.

LogistiCare's Quality Assurance section currently completes follow-up reviews for accident/incidents but does not complete follow-up reviews for all complaints. Furthermore, LogistiCare's follow-up does not always reflect double-loop learning about improvements. For example, LogistiCare's complaint # 50324212: Quality Assurance followed up to verify that the provider was 45 minutes late due to a flat tire, but there was no follow-up to see if there were anymore occurrences of late pickup for this individual by that driver/contractor. This also suggests DMAS's Quality Improvement program does not periodically examine LogistiCare's rider complaint database in order to validate or look over LogistiCare's work. DMAS does evaluate individual complaints and the quality of complaint resolution by LogistiCare when complaints escalate or travel different paths.

A review of LogistiCare's "case" management reports on local attempts to resolve difficult issues suggest that LogistiCare "case" managers might need additional tools and support to hasten the resolution of problem situations. For example, the problems of Member #....25018 in the spring of 2016 with his driver/s are illustrative:

April - 6 provider late complaints
May - 6 provider late complaints
June – 8 provider late complaints
July – 2 provider late complaints
– 1 no show complaint
Total: 23 complaints from this individual

Notwithstanding the LogistiCare "case" manager's involvement from late May on, the fact that it took six more weeks to resolve a situation that had gone on already for six weeks, speaks perhaps to a lack of tools available to the "case" manager to resolve situations in a timely manner. Many riders would likely have switched to any other available alternative after twelve weeks of poor transportation services and filing more than twenty complaints.

Conclusions:
DMAS and LogistiCare appear committed to addressing needed quality improvements in services to users from the IDD Waiver. The effectiveness of their actions to create an effective Quality Improvement Program for the transportation services for individuals with IDD waiver funded services cannot yet be assessed. It will likely be mid-2017 but a good evaluation will want to review a complete QI cycle before the impacts of their actions can be assessed. Until DMAS demonstrates a functioning and effective quality improvement program for transportation services for individuals with IDD waiver funded services then III.C.8.a will continue to be assessed as non-compliant.

Recommendations toward achieving full compliance:
DMAS should request that LogistiCare Quality Assurance or "case" managers sample survey users from the IDD Waiver who have complained to the Rider Assist line to see if their problem continues or is recurring within 30 days of the report.

DMAS should formalize and include in its quality improvement program the gathering of more direct information from users. DMAS should request that the contractor/s conduct focus groups with users and facilities from the IDD Waiver, in order to further identify problems and the root causes for their complaints.

DMAS should determine whether its "improvement" to allow mileage reimbursement forms to be faxed has achieved the desired result. It appears that a more user friendly mileage reimbursement form would be more effective at encouraging this valuable alternative to using a transportation contractor.

DMAS should request that LogistiCare evaluate the tools available to its "case" managers to sanction poor or non-performing contract providers; for example, fines, new appointment freezes, performance letters, etc.

Suggestions for DMAS Consideration:
Given the higher frequency utilization of Logisticare rides per users in the IDD Waiver, DMAS may want to consider special credentialing/training of contractors who respond to high proportions of IDD waiver user requests; for example, specialized orientation to the needs of individuals with IDD, strategies for accepting rides for regularized pickup, etc.

Attachment A

DMAS Documents Reviewed

1. Field Monitoring
2. New Provider Packets
3. Provider Meeting – Safety topic
4. Gas Reimbursement Form updates
5. Attendant Approval Forms and Attendant Log
6. Accident/Incident Reports
7. Contract Requirements for Providers, Drivers, Vehicles, Volunteer Drivers, and Attendants
8. New Technology
9. Commonwealth Coordinated Care (CCC) Plus (name changed from MLTSS)
10. OPS Meeting Agendas
11. Complaints
12. Contract Performance Reductions
13. New Survey – Monthly Survey Description and Survey Questions
14. New Reports
    - ID/D Trips Scheduled by Region, By Level of Service (LOS)
    - ED/D Trips Canceled by Level of Service (LOS)
    - ID/D Trips Completed by Level of Service (LOS)
    - ID/D Unduplicated Riders by Level of Service (LOS)
    - ID/D Total Trips by Day of Week
    - ID/D Completed Trips by Destination
    - ID/D Member Issue or Member No Show Complaint Report
    - ID/D Late & Missed Trips
    - ID/D Cancelled Trip Reasons
    - ID/D Unfulfilled Trips
    - ID/D Denied Trips
    - ID/D Provider Late (PL) & Transportation Provider No Show (TPNS) Complaints
    - ID/D No Vehicle Available (NVA)
    - ID/D Alternative Transportation (public transportation, gas reimbursement and volunteer driver)
    - ID/D Public Transit Monthly Analysis (listed by transit agency)
    - ID/D Complaints separated from the rest of complaints
15. New DMAS RFP – ID/D additions to RFP, additional Safety requirements/changes; to go live July 1, 2017
16. Network Capacity Analysis Tool-Logisticare

Attachment B
Logisticare Document List

Monthly Reports
Vehicle Inspection Report
DMAS Report Monthly
DMAS Customer Satisfaction Survey
Healthcare Manager Outreach Activities
Provider No Show Trip Cancellation Report
Trip Cancellation Detail Report
DMAS Discharge Report
Key Staffing Report
Attendant Tracking Spreadsheet
Accident/Incident Report
Complaint Report

- ID/D Trips Scheduled By Region and Level of Service
- ID/D Complaint Report
- ID/D Provider No Show Trip Cancellation Report
- ID/D Trip Cancellation Detail Report

Accident/Incidents
Date Range: July 2015 – June 2016

Outreach and Education
Outreach Activity Report January 2016
Webinar Invitations
Webinar Power Point Presentations
Presentation: Arranging Non-Emergency Medical Transportation
Presentation: Facility Services Web Portal – Monthly Attendance
2016 Advisory Board Members
Presentation: May 2016 Advisory Board Meeting
May 2016 Advisory Agenda and Minutes
Region 1 Agenda and Minutes
Region 2 Agenda and Minutes
Region 3 Agenda and Minutes
Region 4 Agenda and Minutes
Region 5 Agenda and Minutes
Region 6 Agenda and Minutes
Region 7 Agenda and Minutes

Operational Information and Reports
Complaint & A/I Workflow
Complaints
Vehicle Inspection Policy & Procedure
June 2016 Vehicle Inspection
Transportation Attendant

Transportation Provider Release Process
New Provider Utilization Plan
Provider Mentor Program
2nd Quarter Q365 Presentation
Quarterly Provider Presentation
Monthly Ops Meeting Agenda
Technology Presentation
Quality Manager Job Description
Mileage Reimbursement Policy & Procedure
Provider Performance Review

DMAS Monthly Case Management Reports
July 2015 – June 2016

Network Development Processes
Credentialing Process for Drivers
PASS Training
EMT/EVOC Requirements
Driver Exclusion Process (Search Engines)
Non-Compliant Process (NC Process)
NEMT Driver Infraction Process
Driver Denial Process
Operating Authority Verification Process
Certificate of Insurance Tutorial
Corporate Credentialing Training Manual

APPENDIX E

QUALITY AND RISK MANAGEMENT

By: Maria Laurence

Report on Quality and Risk Management

United States v. Commonwealth of Virginia

Submitted by: Maria Laurence,
Independent Consultant
November 17, 2016

INTRODUCTION

The Settlement Agreement requires the Commonwealth to develop and implement a Quality and Risk Management System that will "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.)

At the request of the Independent Reviewer, this is the fourth Report that assessed the Commonwealth's progress in meeting these terms of the Settlement Agreement. This Consultant has previously reviewed and submitted reports that included findings and recommendations related to the Quality and Risk Management systems. These reports were included with the Independent Reviewer's Reports to the Court, which were submitted on December 6, 2013, December 8, 2014, and December 6, 2015. 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 relevant to recent findings. This consultant's most recent previous report is referred to as the "last Report".

This Report is focused on four discrete areas of Quality and Risk Management:

1) Risk triggers and thresholds;
2) Data to assess and improve quality;
3) Providers; and
4) Quality Service Reviews.

At the outset, it is important to note that since the last review, the Department of Behavioral Health and Developmental Services (DBHDS) experienced changes in leadership that impact its quality management program. The new Interim Commissioner of DBHDS envisions the quality management program as playing an important role across the agency beyond the requirements of the Settlement Agreement. In addition, in May 2016, a new Assistant Commissioner of Quality Management and Development (QM&D) was appointed. Appropriately, the Assistant Commissioner is working with the Quality Management and Development Team to redefine their identify and role with the clinical and programmatic components of the Department. He is working closely with other offices within the Department to determine their needs from a quality management perspective and to identify the quality management activities in which these offices already engage.

The assistance given throughout the review period by the Assistant Commissioner of Quality Management and Development is greatly appreciated. In addition, a number of other Commonwealth staff, staff from the DelMarva Foundation, as well as staff from three Community Services Boards (CSBs), participated in interviews and provided documentation. Their candid assessments of the progress made, as well as the challenges ahead, were very helpful, and are an indication of their commitment to future progress. The organizational assistance provided by the Senior DD Administrative and Policy Analyst also was of significant help.

METHODOLOGY

The fact-finding for this Report was conducted through a combination of interviews and document review. Between June and October 2016, interviews were held with staff from the DBHDS, DelMarva Foundation, and CSBs. (Appendix A includes a list of the individuals interviewed and the documents reviewed.) It is important to note that many of the Commonwealth's Quality and Risk Management System initiatives are in the process of development and implementation. As a result, a number of draft documents formed the basis for this Report.

FINDINGS AND RECOMMENDATIONS

For each of the four areas reviewed, the language from the Settlement Agreement is provided and is then followed by a summary of the status of the Commonwealth's efforts and highlights of the accomplishments to date. Recommendations are offered for consideration, as appropriate.

> *V.C.1. The Commonwealth shall require that all Training Centers, CSBs [Community Services Boards], 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.*

One purpose of this Review was to determine whether the Commonwealth has established and implemented risk triggers and thresholds that enable it to adequately identify and address harms and risk of harms. A second goal was to determine the status of the development of related training for providers.

Since the last Report, the Commonwealth made some minor revisions to its list of triggers and thresholds, but overall, the list included the same general categories. As discussed in further detail below, CSBs and private providers are largely unaware of the concept of risk triggers and thresholds. As described in the last Report, some triggers and thresholds the Commonwealth developed were event-based (i.e., events that have already occurred), and some provided ways to identify the potential for risk. For example, the list included annual risk assessment triggers, medical triggers, and behavioral triggers, which set the stage to <u>proactively</u> address individuals' risks. The event-based triggers and thresholds retroactively identify occurrences. They are designed to allow review from a provider, as well as an individual, perspective.

As described in the last Report, for event-based triggers and thresholds, the most recent draft identifies:

- The domains (e.g., restraint, aggression, hospitalization, etc.);
- The measures (e.g., restraint use, restraint use with injury, aspiration pneumonia with medical attention, etc.); and
- The risk criteria (e.g., number of individuals injured as a result of restraint).

For all categories, this document also identifies for which triggers and thresholds:

- Data currently are available;
- Data are available, but a system to capture data/reports is needed;
- Are new and not yet implemented: and
- Data collection method is not yet developed.

In terms of development of risk triggers and thresholds, as during the last review, the medical and behavioral ones remain in draft form. The medical risk triggers include a domain (e.g., aspiration pneumonia, bowel obstruction), measures (e.g., frequently chokes or coughs when eating, feeding tube, history of aspiration pneumonia), and a risk plan section. This risk section asks for an indication of whether or not the Individual Support Plan (ISP) includes a risk reduction plan if any criterion is checked. It is positive that DBHDS plans is to incorporate risk assessment and related service planning into each individual's ISP. It appears, however, that there is a conflict between the summary of risk triggers and thresholds and the draft training module. In the summary any "measure" is considered a trigger; whereas, the draft training modules considers the domains (e.g., aspiration pneumonia) as the triggers. This is discussed in further detail below (i.e., pages 8 and 9 of Part 2).

The behavioral risk triggers follow a slightly different format with domains (e.g., criminal justice involvement, psychiatric hospitalization), a measure (i.e., number of times individual has engaged in risk criteria over a set period of time), and risk criteria (e.g., aggressive to others, property destruction). From this summary, it appears that a trigger occurs any time an individual meets the criteria in the "measure," which reflect the risk criteria. However, the draft training modules appear to indicate that the domains (e.g., criminal justice involvement, psychiatric hospitalization) are the triggers (i.e., pages 8 and 9 of Part 2).

For both of these sections, it will be important to make clear that the "measures" are the triggers that should evoke proactive action to prevent the poor outcomes described in the "domains." Certainly, though, if an individual does experience a condition described in the domains, the individual's interdisciplinary team and the provider(s) need to act to prevent recurrence.

With regard to the current status of implementation, some triggers and thresholds are considered final, and the Commonwealth has begun to collect and review the limited available data. Others are in various stages of implementation. More specifically:

- The Risk Management Review Committee (RMRC) has begun to receive monthly data related to twenty-four event-based individual triggers and thresholds (i.e., risk criteria), and 11 provider-level thresholds. The status of the RMRC's review of this data is discussed below.
- The Mortality Review Committee was involved in the initial development of the medical triggers. As the last Report indicated, the Commonwealth's plan is to include them in the ISP format to move interdisciplinary teams towards thinking about individuals' risks and service planning to address identified risks. Based on the documentation provided for this review, the Division of Intellectual Disability/Developmental Disability (ID/DD) is in the process of including them in the ISP format and developing training for providers. The Division of Quality Management and Development is developing plans for monitoring provider implementation. According to the Assistant Commissioner, his team was working with the Integrated Health Services team to identify potential data sources, and to develop tools that non-clinical staff, such as many of the case managers could use, which was good to hear.
- According to the summary of risk triggers and thresholds, "Behavioral Risk Triggers and Thresholds are drafted by the Division of ID/DD but are not yet finalized."
- Of ten selected administrators/quality assurance managers of private providers and CSB, none were familiar with the terms "risk triggers and thresholds. The DBHDS "risk triggers and thresholds" initiative within DBHDS appears not yet to have reached the providers who will ultimately utilize the triggers and thresholds.

The Commonwealth staff have taken some reasonable actions to collect data that providers submit for other purposes. However, the need for revised regulations to facilitate the data collection necessary to effectively implement the risk triggers and thresholds continues to be an obstacle to the Commonwealth's full implementation of these provisions of the Settlement Agreement. Based on conversations with Commonwealth staff, efforts are underway to try to modify relevant regulations.

Since the last Report, Commonwealth staff made minor changes to the list of triggers and thresholds. DBHDS has not yet implemented some of the recommendations made in this Consultant's previous reports, has not begun to involve service providers in the implementation of this program, and has not yet revised the Licensing regulations that it identifies as primary obstacle to implementing the risk triggers and thresholds requirements that it agreed to in the Settlement. As a result, many of the Consultant's previous concerns continue to exist. Therefore, the following recommendations are offered, most of which have been offered in previous reports:

- Definitions for some terms (e.g., frequent diarrhea, difficulty swallowing, etc.) or criteria (e.g., for peer-to-peer aggression – victim or aggressor or both, adverse medication event, etc.) should be added to assist in data reliability.
- For the medical section, triggers and thresholds should be better defined or explained.

- The Settlement Agreement provides a fairly inclusive definition of harm (i.e., "Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes"). There are important risks that fall within this definition that are not yet included in the triggers and thresholds that DBHDS has developed. Over time, the Commonwealth added some important triggers or thresholds, and should continue to identify others. Now that some data collection has begun, and as other triggers and thresholds are finalized, it will be important to regularly review the list (e.g., semi-annually), as part of an ongoing quality improvement cycle, to determine whether others should be added.
- The Mortality Review Committee identified eight conditions that uniquely contribute to the deaths of individuals with ID/DD (i.e., urinary track infection, constipation/bowel obstruction, aspiration pneumonia, decubitus ulcers, sepsis, seizures, falls, and dehydration). As Commonwealth staff recognize, the early indicators of these conditions should be included in the ISPs and on lists of triggers and thresholds for individuals with ID/DD. Highly sensitive "triggers" should be included for individuals who are older (i.e. over age 45) and who are considered medically complex based on their Support Intensity Scale (SIS) assessments.
- The Commonwealth should consider triggers or thresholds that identify deficits in staff skills or knowledge, or in residential provider support systems. Often, these are the factors that put individuals most at risk. (One example would be neglect findings that illustrate repeated failures on staff's part to meet individuals' needs.)
- As the medical risk triggers are further developed and implemented, it will be important for the current question on the list of risk triggers and thresholds regarding whether a risk reduction plan exists to also ask whether it includes the basic elements of a quality plan (i.e., provide a clinically relevant and achievable goal by which to measure an individual's progress or lack thereof, include actions steps sufficient to minimize to the extent possible the individual's risk, and provide mechanisms to monitor the implementation of the plan), and whether staff are competent in this element of an individual's services.
- Although weight is included as an indicator of potential skin issues, consideration should be given to triggers and thresholds related to changes in status, such as excessive weight loss and/or gain, and/or incorporating such indicators into other relevant triggers and thresholds.
- As noted in previous Reports, it will be important to identify mechanisms to gather data from providers not licensed by DBHDS to provide ID/DD services or DBHDS-operated Training Centers, including nursing homes, private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and private homes.

At the time of the last Report, the role of the RMRC largely had been to review and provide recommendations about the draft lists of triggers and thresholds. Since that time, the RMRC started to review data, and take some limited action to contact and provide technical assistance to providers. Over a several month period of time, the RMRC tried different mechanisms for reviewing and responding to individuals or providers who met risk triggers or thresholds. In some cases, the Committee's efforts resulted in improved outcomes for individuals. For example, an individual met the criterion for falls, and after the Commonwealth contacted the provider, the individual saw a doctor, was diagnosed and treated for diabetes, and no additional falls were reported. However, the RMRC determined

that quarterly review of each individual that had met criteria often meant that the interventions might be coming too late in the process. In addition, even with the use of a subcommittee, the volume of initial provider contact and then follow-up made the system less responsive than it should be.

In approximately July 2016, the RMRC recognized the need to develop a process that placed more responsibility at the CSB and private provider level. At the time of the onsite review in early October 2016, such a process was still under development. The RMRC is meeting at least monthly, and they are working with relevant offices, including the data warehouse to develop reports, and licensing, human rights, and integrated health services to define each role. In a document provided to the Consultant, the Commonwealth summarized the goal as follows: "For a truly effective risk management system, every provider must have the ability to monitor his own data and be required to take action when a trigger event occurs or a threshold is met. Any new system must require both the prompt CO [Commonwealth Office] identification of risk and the equally prompt identification of the event and a response by the provider. The role of the CO RMRC would then be to ensure that providers are taking action to reduce risks in response to triggers and thresholds."

The RMRC created a draft workflow that included a daily run of reports showing individuals and providers that meet criteria for triggers and thresholds, and routing of the report to internal offices that need the information (e.g., licensing, case management, integrated health services). As needed, action would be requested/taken, with reporting to the RMRC, and eventually the QIC. This remains a work in progress.

As discussed in further detail below, based on the Consultant's and other members of the Independent Reviewer team's interviews with CSBs and private providers, they were largely unfamiliar with the concept of risk triggers and thresholds. Therefore, the next phase of the implementation of the existing triggers and thresholds will be substantial.

As the Commonwealth recognizes itself, it is unrealistic to have the Commonwealth Office responsible for identifying when individuals or providers have met triggers or thresholds in real time, and then notifying CSBs and providers. However, many steps are needed to educate providers about risk triggers and thresholds, and then ensure that the providers have the internal capacity to track and respond when triggers and thresholds are met. This will be a particular challenge given that not all providers use the same record keeping procedures, including some electronic health records and some paper records. Based on conversations with CSBs and providers, these systems do not always provide easy access to needed data, and CSBs do not currently receive the same reports that are available to the RMRC. Work was underway, though, to develop a report format. The Commonwealth Office needs to also define its role in the oversight process.

In summary, the Commonwealth continues to have limited data with which to track risk triggers and thresholds. A significant challenge continues to be the ability of the Commonwealth to collect data from providers on a complete list of risk triggers and thresholds. This has been the primary obstacle to implementing risk triggers and thresholds for more than three years. DBHDS is aware that its Licensing regulations do not align with the requirements of the Settlement Agreement. Until the Commonwealth revises

its regulation, it does not appear to be able to make substantial progress toward meeting this requirement of the Agreement. DBHDS reports that it has continued efforts to revise the ISP format to include goals/objectives and/or risk assessments, and to collect data through the ISP development and implementation process. Since the last review, the RMRC trialed mechanisms for responding to available data, but found them too cumbersome, and potentially unreliable. DBHDS efforts are underway to devise a system that would give CSBs and private providers regular access to risk trigger and threshold data, and to provide the same information to Commonwealth Office staff who need it. This would allow more timely responses to risk triggers and thresholds. However, this plan remains in the development stage. Providers and CSBs have not begun implementation. Timely responses are essential, because without the implementation of adequate triggers and thresholds, the potential for harm will likely not be caught early enough to prevent actual harm. The Commonwealth should continue to identify and/or develop relevant sources of data to allow expansion of the list of relevant risk triggers and thresholds, and to develop a viable process for requiring CSB and private provider to respond, and then to monitor the results.

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.

The actions taken to complete this Report were designed to obtain a status update on the Commonwealth's efforts to develop training and guidance to providers on proactively identifying and addressing risk of harm, conducting root cause analysis, and developing and monitoring corrective actions.

Since the last review, the Commonwealth continues to develop training materials related to risk management and to make them available on its web site. However, based on this Consultant's interviews with CSB staff, and interviews other members of the Independent Reviewer's team held with CSB and private provider staff, the concepts of risk triggers and thresholds, as well as mechanics of conducting root cause analysis are not well known and have not yet been implemented at either the CSB or the provider level.

At the time of the last review, Commonwealth staff had posted one webinar on risk triggers and thresholds on the DBHDS website. It also offers CSBs and private providers a number of risk management tools on its website (e.g., Organizational Risk Assessment Tool, Risk Reduction Plan, Status Report, Root Cause Analysis Directions, Root Cause Worksheet, Mortality Review Worksheet, Self-Assessment). Based on staff interview, the decision was made to revise the Part 1 – Triggers and Thresholds training that is currently posted on the website. To replace it, Commonwealth staff are developing three draft PowerPoint presentations entitled:

- Part 1 – Triggers and Thresholds: The Basics;
- Part 2 – The DBHDS Triggers and Thresholds; and
- Part 3 – Establishing Provider-Specific Triggers and Thresholds.

Overall, the draft training provides some good information about this approach to risk management. However, Part 2 appeared largely incomplete, and although Part 1 included a question and answer quiz at the end, none of the modules included competency demonstration components. It was unclear, therefore, how the Commonwealth would evaluate the effectiveness of the training.

In addition, DBHDS needs to review the training information to ensure that it is consistent throughout the presentations and with other documents. For example, the following should be clarified: 1) on page 3 of Part 2, a slide states: "The DBHDS Triggers and Thresholds are measures that are designed to…" (emphasis added), but on page 5, the slide states: "Triggers and Thresholds are not measures…"; and 2) as noted above, the training appeared to define medical and behavioral risk triggers differently from the definition in the summary of risk triggers and thresholds.

This Consultant met with representatives from three CSBs who had responsibility for quality assurance/improvement activities. As part of the Independent Reviewer's Safety study, another independent consultant interviewed an additional three CSBs and seven private providers. None of these CSBs or private providers were familiar with the terms "risk triggers and thresholds," and none had begun implementing them. Moreover, for the most part, it did not appear that the staff responsible for quality management at these CSBs and private providers were aware of and/or using the resources the Commonwealth had developed to date.

As noted in the previous two Reports, the training and technical assistance materials DBHDS provided for root cause analysis impart excellent information, including a realistic example that illustrates the root cause process in an easy-to-understand format. Based on the Consultant's as well as other members of the Independent Expert's interviews with CSBs and private providers, approximately half of them reported some familiarity with the term root cause analysis, but again, knowledge of and use of the tools the Commonwealth developed was minimal.

As noted in previous Reports, Commonwealth staff recognize that publishing these resources on the DBHDS website is a first step. DBHDS understands that additional training and technical assistance is needed, and, if they are not used, the DBHDS resources will not strengthen providers' efforts to reduce risks or reduce harm for the members of the target population. At this juncture, it is important that the Commonwealth take steps to offer and to require the participation of CSB and private provider staff in training and technical assistance on the development and implementation of the proactive identification of risks of harm, to conduct of root cause analysis, and to develop and monitor implementation of corrective actions.

Included in its next steps, DBHDS should:

- Finalize the definitions of the risk triggers and thresholds;
- Finalize the training and adding competency demonstrations to the modules;
- Provide training to all CSBs and private community providers; and

- Require that CSBs and other providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, as the Settlement Agreement requires.

As has been discussed in previous Reports, the optional nature of the current training options related to risk management remains a challenge. This is an area that the Commonwealth needs to address. It appears that CSBs and providers are not using, and in many cases are not even aware of, the quality resources and tools that DBHDS has "offered" by posting them on its website. For both the Risk Triggers and Thresholds training and the Root Cause Analysis training, the Commonwealth should offer classroom training, as well as online training, including the equivalent of experiential-based learning, such as role-plays and discussion.

V.D.1-6 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…

1. *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.*
2. *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 well being (e.g., access to medial 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)…*

3. *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.*
4. *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.*
    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.*
5. *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.*

The fact-finding for this Report was designed to:

a) Obtain a status of the Commonwealth's efforts to develop a Centers for Medicare and Medicaid Services (CMS)-approved QI plan to determine if it aligns with the Settlement Agreement, including how it applies to the waiver redesign transition plan (what are the indicators of success or failures).
b) 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).
c) Determine the status of 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).
d) Obtain updates on the status of CSBs and providers' review of data (i.e., V.D.1.), as well as DBHDS/DMAS' review of CSBs and providers' data review processes.
e) Obtain updates on the status of the Regional Quality Councils (i.e., Section V.D.5a. and b) and the status of assessments of relevant data, review of trends, and recommendations.
f) 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).

Since the last review, the Centers for Medicare and Medicaid (CMS) approved the Commonwealth's amended Home- and Community-Based (HCB) Waiver, now known as the Community Living (CL), the Family and Individual Support (FIS), and the Building Independence (BI) Waivers. The Commonwealth provided a copy of Appendix H: Quality Improvement Strategy. This document provides a description of the basic assurances the Commonwealth provides to CMS with regard to ensuring the quality provision of protections, services, and supports through the implementation of the Waiver. The document describes levels of quality improvement activities, including:

a) Case management, including the case managers' role in monitoring individuals' services, providing data to DBHDS, and the case management supervisor's role in reviewing records and identifying any issues;
b) The Quality Review Team, which consists of Department of Medical Assistance Services (DMAS) and DBHDS representatives, that meets quarterly to review performance measures, and the document listed sources of data it reviews (e.g., CHRIS data, Office of Licensing Services data, DMAS audit data);
c) The DBHDS Quality Improvement Committee (QIC) and Regional Quality Councils (RQCs);
d) Quality Services Reviews (QSRs) that an independent contractor implements, along with National Core Indicator surveys;
e) Mortality Review Committee, the role of which is described as: "to learn from a person's death, to discover if the same or similar situation may affect others in the future, and to improve the overall quality of care at individual and systemic levels"; and
f) Establishment of a Provider Record, which will include Quality Service indicators (i.e., related to meeting policy and regulation requirements), and Expertise indicators (i.e., related to staff competency in supporting individuals with DD from basic to more advanced levels).

This description included many of the requirements of the Settlement Agreement with regard to quality improvement, so was consistent with and not in contradiction to the Settlement Agreement.

The Commonwealth also provided a copy of the DBHDS Draft Quality Management Plan, updated 5/19/16. The Assistant Commissioner for Quality Assurance and Development indicated that this was in the development stage, which was an accurate assessment. It provided a general outline of the Department's plan for quality management, but just as the system is developing, the plan also needs to develop to accurately reflect the expectations for what the system ultimately will include, while also recognizing the current status of the system. For example, the performance indicator and risk management trigger and threshold sections of the plan appeared to describe the goals for these programs, but they were written in a tense that gave the impression this was the current state of practice. There are different options for communicating the ultimate expectations for the system, as well as the current status and plan for future expansion. For example, a policy could set forth the ultimate expectations, and an annual plan could provide a status update and set the expectations for next steps in the way of actions steps, persons responsible, and timeframes for completion.

As noted in the last Report, the Commonwealth's took significant steps forward in its ability to collect and use data to assess and improve quality. These steps included the development of the OneSource Data Warehouse and the development of some standard reports that allow DBHDS users to pull data from the warehouse in a usable format. The 2015 Report includes a list of sources of data in the warehouse. Based on conversations with staff and review of the document Overview of DBHDS' Data Warehouse as a Resource for Eight Domains Measurement, dated June 2016, significant changes in these sources had not occurred.

Since the last review, Commonwealth staff continue to take steps to utilize data to evaluate its progress across the eight domains:

- As described in OneSource Data Warehouse Data Quality Framework Overview, dated February 24, 2016, the Commonwealth is establishing a system designed to continuously work towards high quality data. As this document explained, in order for data to be effective, it should be accurate, timely, relevant, standardized, accessible, unique, and complete. To accomplish this goal, Commonwealth staff are engaged in a number of processes/procedures. These include:
    - A Data Governance Committee, which is a two-tiered group: a Steering Committee that the Interim Chief Deputy chairs and Technical Work Groups that are comprised of subject matter experts and technical team representatives;
    - Software development, which includes testing after development and before production;
    - Use of a national standard for data maturity and capability. The Director of the Business Analytics Center of Excellence explained that this set of standards allows scoring of processes across six domains to determine the system's maturity level. Using this as a decision-making tool, decisions will

have to be made along the way regarding what level of maturity is necessary while remaining cost-effective;
    - Implementation of a data quality defect management process to define: who can sound the alarm when there is a defect in the data, the team who would evaluate the concerns, the Data Governance Committee's prioritization of which defects need to be fixed and in what order, and then resolution and closure of the issues; and
    - Statistical process controls, which are used to measure code performance and any associated variation.
- In June 2016, the Data Quality and Analytics Coordinator developed a document entitled: "Overview of DBHDS's Data Warehouse as a Resource for Eight Domains Measurement." It explains how the various dimension tables within OneSource can be related to develop fact tables. So in other words, individual demographic data is held in one dimensional table, while information about individuals' deaths is contained in another dimension table, and information about providers is held in a third dimension table. A death record fact table can then be created and maintained within OneSource that pulls together information from the demographic, death, and provider dimension tables as well as a few others to provide a fuller picture about individuals' deaths. The document then provides examples across the eight domains of the dimension tables that could be pulled together in various configurations to create fact tables. This document provides a good primer on how a relational database works with practical applications for the eight domains.
- For Domains 1 – Safety, 2 – Health and Well-Being, 3 – Avoiding Crises, and 5 – Choice and Self-determination, the Data Quality and Analytics Coordinator, in conjunction with subject-matter experts, has begun to develop documents entitled "Defining the 8 Domains," dated 9/15/16. These documents are in various stages of development, but show a thoughtful approach to what should be measured (i.e., valid measures), what is possible to measure reliably (i.e., reliable measures), what relevant fact tables currently exist within OneSource, and what additional data might be required. A first step in each of these documents is to identify the relevant definitions. Doing so was easier in some cases than in others. For example, for safety, regulations provide a number of definitions, such as for abuse, neglect, and various types of restraint. It was more challenging, however, in cases, such as for the term "crisis," which a DBHDS regulation defined differently than the ID Community Services Manual. "Choice" also provides measurement challenges, particularly for individuals with intellectual and developmental disabilities for whom questions arise about informed choice and restricted choice. As a result, some workgroups are further along than others in terms of identifying fact tables that will generate needed information. Overall, though, this appears to be a reasonable approach to ultimately identify valid and reliable measures for the eight domains. Previous Reports by this Consultant have included recommendations related to the scope and quality of data. Commonwealth staff are encouraged to continue to consider those recommendations as they complete this process.
- According to the DOJ Settlement Advisor, by 12/31/16, DBHDS plans to have an initial Eight Domain Report ready for implementation with likely one measure in each Domain. Data collection will occur between 1/1/17 and 6/30/17.

- During this Consultant's onsite review in early October 2016, the Director of the Business Analytics Center of Excellence discussed a couple measures that are being considered and some of the analytical calculations they plan to use. These included reported injuries and founded neglect. As the group discussed, it is important to keep calculations simple so that the results are user-friendly to the groups that need to use and understand the information (e.g., QIC, RQCs, programmatic and clinical staff, etc.). As the Director of the Business Analytics Center of Excellence noted, it also is important to use techniques that account for changes, such as increasing numbers of individuals supported in the community. That being said, within the context of public administration, in order for DBHDS to be proactive, it is often important to conduct analyses that are sensitive enough to identify problems early. Doing so will allow the various regulatory, clinical, and programmatic components of DBHDS to act in a thoughtful and informed manner, but with sufficient expediency. Depending on the initial findings and the subject area, many possibilities exist for deeper analysis. In the spirit of continuous quality improvement, it will be important for DBHDS to continuously evaluate when further analysis is necessary. Some possibilities include:
    - Looking more closely at outliers;
    - Drilling down into the outcomes for individuals with specific risk profiles (e.g., as opposed to looking at the incidence of aspiration pneumonia for the entire DOJ population many of whom are not at heightened risk, consider the incidence for those individuals identified as at medium or high risk for it to provide a better indication of whether or not plans of care are effective);
    - Place the numbers into the context of evidence-based practice and current standards (e.g., for issues that are known to be largely preventable set higher expectations); and
    - Conduct more in-depth qualitative analysis and utilize this information in the overall decision-making process (e.g., mortality reviews, serious injury reviews).
- This Consultant's last Report provided a list of some of the data reports available for users to run and to customize. DBHDS data analytics staff are continuing to work with other DBHDS staff to generate reports that are in usable formats. One example is for the RMRC for whom data analytics staff continue to modify the report format to make it easier to identify individuals and/or providers who meet triggers and thresholds.

In summary, Commonwealth staff completed and submitted a QI Plan for inclusion in the revised Waiver application, and CMS approved it. The assurances include a number of the quality improvement requirements in the Settlement Agreement. The DBHDS Quality Improvement Plan still requires work. The data warehouse is a valuable resource, and Commonwealth staff continue to take necessary steps to ensure the data is of high quality. Since this consultant's review in 2015, the Commonwealth made limited progress in expanding the identification of data to assess and to improve quality, which is necessary to ensure the data are complete. DBHDS anticipates, however, that by 12/31/16, approximately one measure for each of the eight Domains will be ready for initial implementation. As discussed in further detail below, the Commonwealth was not yet

sharing information related to the need to address the eight Domains with CSBs and private providers. Previous recommendations by this consultant related to these efforts remain relevant. These include:

- The Commonwealth should continue to identify and/or develop relevant sources of data.
- For each of the measures identified for the Settlement Agreement domains, DBHDS should develop definitions and methodologies, in addition to identifying the data source. DBHDS should also determine baselines, identify benchmarks, and set targets or goals.

A DBHDS document entitled "Guidelines for the Operation of Regional Quality Councils," dated October 16, 2014, sets forth the function and structure of the Regional Quality Councils, as well as membership requirements and voting rules. It indicates that the DBHDS Quality Improvement Council directs the work of the Regional Quality Councils.

DBHDS staff continue to work to ensure broad membership on the Regional Quality Councils. Based on discussions with the Case Management Coordinator, who has been assisting with the RQCs due to a staffing vacancy, one of the current challenges is that many of the members' three-year terms will end close together. This seems to be due to the fact that many of the members started at the same time as the RQCs were getting up and running. Given that the RQCs deal with content that can be difficult to initially grasp, it likely would be prudent for DBHDS to extend some of the terms so that the intent of the operational guidelines of staggering the terms is met.

Although the Agreement defines the role of the Regional Quality Councils as "assessing relevant data, identifying trends, and recommending responsive actions," the RQC only had limited data available for its review. On a positive note, the documents reviewed continue to confirm that members of the Division of Quality Management and Development regularly support the Councils' activities and that the Commonwealth shares the data that are currently available. For example, in recent Council meetings, DBHDS shared employment, Office of Licensing, and Office of Human Rights data.

Based on previous reviews and the review of minutes of RQC meetings for the last two quarters, more robust discussions are documented in recent meeting minutes. RQC members ask good questions. They often request further breakdown of the data presented and raise questions related to data reliability (e.g., definitions of what CSBs and private providers need to report through CHRIS, definitions of adverse medication events, employment data that is not fully inclusive), and they ask for more context to the data (e.g., numbers of providers offering certain types of supports, total number of providers and total number of licensing reviews, severity of disability). The RQC members also make programmatic recommendations, as well as recommendations related to their roles and responsibilities.

In summary, the Regional Quality Councils are using some of the data currently available, are conducting limited analyses of such data, and are beginning to use such analyses to determine what, if any, actions should be taken. These are activities that should increase

over time, particularly as more reliable data becomes available, and more in-depth analyses of the data are made available.

As noted in the last Report, a page on the DBHDS website (i.e., http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/doj-settlement-agreement) includes a tab for an annual report. Last year, the Commonwealth indicated that this site was not yet complete, but that it included reports targeted to a variety of audiences. These reports offered information regarding demographics, the quality and quantity of supports, and recommendations for improvements. As indicated in the last Report, the site includes valuable information and is a good start to meeting the requirement of the Settlement Agreement. Based on a recent review of the site, much of the information was from 2014/2015, and should be updated. It will be important to ensure that the data provided to the public accurately reflect the current system, as well as unmet needs. For example, the information does not identify information about barriers to "most integrated housing" from the Regional Support Teams; gaps in the transportation service availability, quality or safety for individuals with ID on HCBS waivers; or the adequacy and any gaps in crisis services for adults or children.

In summary, at the time of this review, the Commonwealth maintains a format on its website to provide the "annual report" information described in the Settlement Agreement. The website, however, is not yet complete. It will require further review and updating in the future.

V.E.1-3

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.*
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 the 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.*
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.*

Goals for this Review included to determine whether or not:

a) DBHDS has established a baseline regarding existing QI practices;
b) DBHDS has established expectations, as of December 2015, for providers' and CSBs' quality improvement systems (i.e., Section V.E.1);
c) DBHDS requires providers and CSBs to report on key indicators that address both positive and negative outcomes for health and safety and community integration per Section V.E.2; and
d) DBHDS Quality Improvement Committee has begun to review and to address these measures.

As noted in the last Report, the Settlement Agreement established the requirement for providers to monitor and to evaluate service quality; it references the DBHDS Licensing Regulations at 12 VAC 35-105-620. Specifically, the regulations require: "The provider shall implement written policies and procedures to monitor and evaluate service quality and effectiveness on a systematic and ongoing basis. 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 assurance system. The provider shall implement improvements, when indicated."

Beginning with Fiscal Years 2015 and 2016, the Commonwealth added Quality Improvement program requirements to the draft Performance Contract with CSBs. Details regarding these requirements were included in this Consultant's report in 2014.

The Commonwealth's oversight of community providers' Quality Improvement programs remains a work in progress. As stated in the 2015 Report, the Commonwealth conducted a survey of all 40 CSBs. As expected, CSBs were found to have different levels of sophistication regarding their quality improvement processes. DBHDS's next step was to survey a sample of the 900 community providers to ascertain a baseline with regard to quality improvement practices. In September 2016, the Commonwealth sent out a survey to CSBs as well as private providers (i.e., upwards of 1000 recipients) asking foundational questions about their quality assurance/improvement programs. At the time of this Consultant's onsite review in early October, responses had just begun to come back.

The Commonwealth did not establish expectations for CSBs' and private providers' quality improvement programs by its target date of 12/31/15, and had not completed them as of October 2016. The Agreement's provision requiring formal training and technical assistance to CSBs and private providers had also not yet begun.

As noted in the sections above, the Commonwealth has made some progress, but is still in the process of finalizing drafts of the data that it intends to collect. The Commonwealth has identified some of the data CSBs and providers will need to collect. In order to address the requirements of the Settlement Agreement, however, additional data will likely be required. In some cases, the reliability of the data requires improvement. In other cases, mechanisms and methodologies for collecting the data need to be developed.

For example, CSBs and private providers of residential services likely collect considerable information about individuals' health. However, based on conversations with Commonwealth Office staff as well as CSB staff, unless events rise to the level that requires that a CHRIS report is submitted, the Commonwealth has not yet defined the data that providers will be required to report. Once defined, actually extracting specific data will be challenging because many CSBs and providers use different electronic health records (EHRs) and/or paper records.

Based on the Consultant's meetings with three CSBs in different regions of the Commonwealth as well as the interviews by another independent consultant with three additional CSBs and seven private providers, the Commonwealth's initial survey results rang true. The following are some of the impressions from this initial, albeit limited, introduction to these quality improvement staff, all of whom were very helpful and gracious in sharing information about the work they do:

- The various CSBs and private providers each allotted different levels of resources to the quality assurance/improvement functions, even when taking into consideration the size and scope of the services they provide. The level of resources ranged from no or part-time staffing to 16 staff. This disparity clearly impacts the ability of the agencies to develop fully working quality improvement programs, as the Agreement requires.
- The activities in which the CSB and private provider QI staff were involved varied from making sure basic functions were completed timely and completely, to more advanced quality improvement activities. The basic functions included submitting CHRIS reports and following-up to ensure corrective action was taken, completing investigations, conducting environmental safety checks, and addressing licensing report citations and human rights complaints. The more advanced quality improvement activities included completing internal audits, providing technical assistance to programmatic areas to make improvements and/or to reduce risk, developing reports on data with varying levels of sophistication, conducting satisfaction surveys, and developing and implementing outcome and performance measures, including goals for improvement.
- Some of the CSBs had Quality Councils or leadership meetings at which quality improvement information was presented and discussed. In these cases, staff provided examples of improvements made as a result of the analysis of information, and the resulting recommendations for changes.
- In discussing the Commonwealth's requests for data, CSB staff cited CHRIS reports as the main data request. Case Management extract data also was identified as data they regularly submitted. They also indicated that new contract requirements further defined data regarding employment and community engagement that they are required to submit. As noted above, none of them were familiar with or had knowledge of risk triggers and thresholds. A couple of CSBs indicated that recently the behavioral health managed care company, Magellan, also requested data. CSB and providers expressed concerns about the current data collection:

  - Some data requests were duplicative. An example was that a provider might need to report the same incident through CHRIS, to the Office of Human Rights, and to Magellan.
  - Similarly, for mortality reviews, multiple requests are made for the same information. These CSB staff recommended that it would be helpful for the Commonwealth to collect all of the information at once, and maintain it in a central location, so that all entities within the Commonwealth could easily access it.
- A common theme for CSBs and providers was that current record-keeping practices (i.e., various EHRs, combinations of paper and electronic systems) presented challenges in terms of easy extraction of specific data points.
- Staff from one of the CSBs mentioned that the Virginia Association of Community Services Board's data workgroup engages with DBHDS staff to address some of the data validity, reliability, and collection issues.
- In terms of requirements the Commonwealth has articulated with regard to quality improvement, some of the CSBs referenced the contract requirements.
- The CSBs and providers staff involved with quality improvement had no or limited knowledge of the resources, information, or training that the Commonwealth has offered regarding quality improvement. Some examples of offerings that were familiar involved the medical/health risk Safety Alerts and training on investigations.

The Commonwealth's Quality Improvement Committee continues to meet quarterly. Its agenda and focus is currently being revised. The Interim Commissioner indicated that to maximize the usefulness of the Committee, he has set the expectation that representatives will come to meetings with reports that include data analysis, and actions/recommendations for consideration. At a minimum, these representatives include staff from the Office of Licensing Services, the Office of Human Rights, the Mortality Review Committee, Case Management, and Risk Management. In addition, the Agreement requirements and timelines are included in the Committee's discussion. Fundamental questions the QIC is currently answering revolve around which data will be collected and analyzed, who should collect it, who should analyze it, and who should develop recommendations for actions. The Interim Commissioner indicated that the eight domains of the Settlement Agreement should be woven throughout. In addition to reviewing data reports and discussing recommended action, the Interim Commissioner's intent is that a key role of the QI Committee will be to identify cross-cutting themes or issues. As of early October 2016, these revisions were still being developed. The Interim Commissioner estimated that it would be Spring 2017 before the QI Committee would begin to function as it should.

In summary, the Commonwealth remains in the beginning stages of conveying to providers their responsibilities for maintaining necessary quality improvement processes and mechanisms for sharing data with the Commonwealth. Forums for reviewing provider data, such as the Regional Quality Councils and the Commonwealth's Quality Improvement Committee, also remain in the beginning stages. Some limited analysis of data is occurring, but only limited data are available to inform the Committees' decision-making; more in-

depth analyses will be needed over time. The Interim Commissioner's plan for revising the agenda and content of the QIC should improve the usefulness of the Committee, but Divisions likely will require training and technical assistance to develop the reports envisioned.

V.I.1-4

1. *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. QSRs shall collect information through:*
    a. *Face-to Face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and*
    b. *Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.*
2. *QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on the individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.*
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.*
4. *The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.*

A goal of this Review was to determine the adequacy of the revised QSR process, the extent to which it aligns with the Agreement (e.g., to evaluate the "quality of services" and to complete assessments, including via face-to-face interviews with individuals, professional staff, and others involved in the individual's life, and assessments of treatment records, incident/injury data, etc.), and the status of its implementation. This review includes determining the adequacy of the Commonwealth's process for selecting a statistically significant sample.

As noted in this Consultant's last Report, on May 18, 2015, the Commonwealth's contract with the Delmarva Foundation went into effect to conduct the QSR reviews. As also described in that Report, according to its contract, DelMarva uses a multi-tiered approach to conduct the Quality Service Reviews, including:

- Conducting Person-Centered Reviews (PCRs) of a statistically significant sample of individuals receiving services and supports under the Settlement Agreement;
- Conducting Provider Quality Reviews (PQRs) of 50 direct service and support providers serving the individuals selected for the Person Centered-Reviews;
- Completing Quality Service Review Assessments, involving reviews at the Community Services Board, regional, and statewide levels; and
- Submission of Quality Service Review Assessment reports, including reports on the Person-Centered Reviews and Provider Quality Reviews for individuals in the sample, as well as assessment/analysis of the systemic data.

As part of the onsite review, this Consultant met with members of the contractor's staff. They clearly are a dedicated group with a strong person-centered philosophy. It was helpful to hear about their process and procedures directly from them.

In terms of staffing, a Project Director is responsible for coordination with DBHDS and for overall oversight of the project, and a Project Manager is located in Virginia. In addition to a Team Lead who also conducts reviews, Delmarva employs five other reviewers for the QSR project, 17 subcontractors from Virginia Commonwealth University complete individual and family interviews, and a Data Analyst provides support to the team. As discussed below, none of the reviewers have clinical backgrounds.

At the time of the previous review, implementation of the QSR process had just begun. The contract required Delmarva to complete 400 individual and family interviews, and 50 provider reviews. The sample was selected using a regional approach, while taking into account certain demographics (e.g., service type), to attempt to ensure that large enough numbers of individuals are surveyed to allow statistically valid conclusions to be drawn. As noted in the last report, one concern regarding the sample was the small number of providers included in the reviews (i.e., 50 out of 900). The sampling methodology for the current review period used a similar approach, resulting in the same number of individual and provider reviews. However, DBHDS made the decision to select 50 day support providers for review. Reportedly, this was due to the fact that the small number of providers made it difficult to draw conclusions, and with the new Waiver and further emphasis on day supports, this area seemed a good one on which to focus.

In an email dated 8/5/15, the Independent Reviewer summarized some initial comments that he had provided verbally on the draft protocols/audit tools Delmarva planned to use. Many of the concerns expressed in this email (e.g., lack of standards, lack of definition of terms) were not addressed in the versions of the tools provided for the last review or this review. Overall comments on the tools include:

- **Lack of Definition of Standards/Terms –** As the Independent Reviewer noted, it is important for standards to be well defined in audit tools in order to ensure inter-rater reliability, as well as to clearly articulate expectations for providers. Although some of the tools include a column entitled "standards," these often consist of vague statements that do not set forth specific expectations (e.g., "The provider supports the person to progress towards desired outcomes," or "The provider has safety protocols and plans needed to help the person stay safe"). Broad statements such as these frequently result in varied interpretations by both auditors and providers. If specific licensing regulations or policies drive the expectations, then they should be cited. If not, then, clear standards should be set forth.

- **Lack of Definition of Methodology –** Similarly, the audit tools do not consistently identify the methodology that auditors would use to answer questions. For example, at times, indicators on observation tools appear to require additional document review (e.g., "Person's health concerns are addressed" or "Provider provides person with education/resources and tools to prepare for potential safety concerns."). Record review audit tools do not identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation).

- **Lack of Criteria for Compliance –** The contractor provides reports that indicate whether or not providers have "met" or "not met" requirements. The audit tools, however, do not explain how this is determined. This calls into question the validity of the findings. These tools generally have numerous indicators. Most of the tools include columns with "suggested protocols" and "standards," but no explanation is provided regarding how a provider will "meet" the requirements. Based on interviews with DBHDS staff, they also identified this shortcoming as an issue. The Case Management Coordinator is working with the contractor to develop a spreadsheet entitled: draft "VA Tools – Driver Indicators," dated 9/21/16. This was an attempt to connect the various questions within Delmarva's eight different audit tools with DBHDS'S eight Domains and its overall standards. These Driver Indicators would be paired with a Likert scale to assist reviewers to determine the extent to which the standard was met. Even with this, it was difficult to see how success at meeting requirements would be measured in a valid and reliable manner.

- **Scope of Review without Definition of Auditor Qualifications –** The audit tools cover a wide variety of topics, including, for example, healthcare and behavioral supports. However, based on an interview with contractor staff, none of the reviewers had clinical qualifications. Judgments of the adequacy and appropriateness of behavior support plans, nursing care, clinical and medical supports, etc. would generally require an auditor with specific qualifications, such as a psychologist/Board Certified Behavioral Analyst (BCBA), a nurse, and/or physical

and nutritional management experts. The lack of staff auditors who are qualified to make these assessments staff calls into question the validity of the findings.

- **Missing Components –** Particularly with regard to clinical services, the audit tools do not comprehensively address services and supports to meet individuals' needs. For example, indicators to assess the quality of clinical assessments, as well as service provision, are not evident. This calls into question the validity of the findings.

In terms of inter-rater reliability, the process the contractor described is not consistent with standard practice. Specifically, the contractor indicated that after a new reviewer completes orientation training, he/she shadows a lead reviewer. Initially, a lead reviewer conducts a review with a new reviewer, and the new reviewer does not ask any questions or look at additional documents. They both score the tools, and then discuss the results. The roles are then reversed, and this process is repeated at least annually. This does not provide a true-read of inter-rater reliability. Problems include: 1) reviews, except for observations, should be completed independently, given that part of the reconciliation process should be to determine whether inconsistencies are due to reviewers looking at different documents or data sources; and 2) inter-rater should be tested between reviewers, not just between a lead reviewer and a reviewer.

On September 7, 2016, the contractor, Delmarva, issued its first Quality Services Review Assessment. It clearly showed an intense amount of work. In summarizing the results of the PCRs, it stated: "While needs in general appear to have been met for individuals (93.3%), a Person Centered approach was not always employed (76.9%), individuals were often not receiving services in the most integrated setting appropriate to the person (84.3%) or participating in the community as desired (84.5%)." Unfortunately, due to the problems identified above with regard to validity of the tools and process and reliability of data collected, and the lack of clinical qualifications of reviewers, it remained unclear whether these findings were accurate. The small provider sample size means that these findings, even if accurate, cannot be generalized to the larger group.

In summary, since the last review, the Commonwealth's contractor selected a sample of individuals and providers and conducted QSR reviews. However, additional work is needed to improve the audit tools that the contractor used, and to develop and implement an inter-rater reliability process consistent with applicable standards. An important missing piece is clinical review of individuals' physical, therapeutic, and behavioral health supports and outcomes.

CONCLUDING COMMENTS

In conclusion, leadership changes have occurred that slowed the rate of progress of the development of the Commonwealth's Quality and Risk Management system. At the time of this review, the new Assistant Commissioner of Quality Management and Development had only held his position for a few months. The DBHDS staff recognized that a number of initiatives have stagnated, but plans appear to be taking shape to make needed changes.

Since the last review, work continued with regard to a number of components of the system. These include data to assess and improve quality across the eight domains, the definitions of risk triggers and thresholds, continued work with the RQCs, and implementation and completion of the first annual QSRs. There continues to be support within DBHDS for developing a strong quality improvement system. As noted in previous Reports, the system is being built from the ground up and developing the infrastructure for a solid quality improvement system is labor intensive.

At this time, however, it is clear that significantly more work is required, and much more progress is required for compliance to be achieved. A number of significant challenges remain. As Commonwealth staff recognize, in order for a comprehensive quality improvement system to exist that is in compliance with the Settlement Agreement, DBHDS will need to partner closely with CSBs and private providers. This is an area that requires considerable work. In addition, an overarching theme continues to be the need to expand the scope of available data in order to allow comprehensive and meaningful quality improvement and risk management initiatives to occur. Revisions to the DBHDS regulations are essential to ensure that the Commonwealth's requirements of service providers align with the provisions of the Settlement Agreement.

APPENDIX A – Interviews and Documents Reviewed

Interviews:

- Jack Barber, MD, Interim Commissioner
- Dev Nair, DBHDS, Assistant Commissioner, QM&D
- Peggy Balak, DOJ Settlement Advisor
- Jodi Kuhn, Data Quality and Analytics Coordinator
- Allen Watts, Director of the Business Analytics Center of Excellence
- Marion Greenfield, DBHDS, Director of Clinical Quality, and Risk Management
- Challis Smith, Case Manager Coordinator
- Jennifer Jones, QI Supervisor, District 19 CSB
- Cheryl Turner, Quality Assurance Branch Manager, and Lisa Snider, Compliance Supervisor, Loudon County CSB
- Kelly Rinehimer, Quality Improvement Specialist, Prince William County CSB
- Anna Quinton, Lead Reviewer; LaDonna Walker, Program Manager; Theresa Skidmore, Manager; and Charmaine Pillay, Director, DelMarva Foundation

Documents Reviewed:

- Draft PowerPoint presentations on Risk Management: Monitoring Risk Using Triggers and Thresholds:
  - Part 1 – Triggers and Thresholds: The Basics
  - Part 2 – The DBHDS Triggers and Thresholds
  - Part 3 – Establishing Provider-Specific Triggers and Thresholds
- Thresholds and Triggers Summary, dated 9/16/16
- RMRC Reporting Protocol, dated 12/10/15
- RMRC Overview, dated 8/23/16
- RMRC Minutes Shell
- RMRC Minutes, dated 5/12/16, 7/14/16, and 8/11/16
- RMRC Action Tracking, dated May 2016, and June 2016
- RMRC template for follow-up letter
- Sample follow-up letter from the RMRC
- Triggers and Thresholds Report Shell
- RMC Workflow, dated March 2016, and July 2016
- ISP Review: Quarterly Review of Medical Risks
- Draft Division of Developmental Services Annual Risk Assessment, dated 1/8/16
- Draft Person-Centered Review, dated 1/8/16
- Daily Health and Wellness Review, dated 5/9/16
- Community Consumer Submission (CCS) 3 Extract Specifications Version 7.3.2, dated March 2016
- CCS Extract Specifications manual, dated 7/16/16
- OneSource Data Warehouse Data Quality Framework Overview, dated 2/24/16
- Overview of DBHDS' Data Warehouse as a Resource for Eight Domains Measurement, dated June 2016

- Defining the 8 Domains for Domain #1 – Safety, Domain #2 – Health and Well-Being, Domain #3 – Avoiding Crises, and Domain #5 – Choice and Self-determination, dated 9/15/16
- Appendix H: Quality Improvement Strategy
- Quality Management Plan, revised 5/19/16
- QIC Minutes, dated 7/16/15, 10/15/15, 1/21/16, and 4/21/16
- RQC meeting minutes for fourth quarter Fiscal Year (FY) 2016, and first quarter FY 2017
- Guidelines for the Operation of Regional Quality Councils, dated 10/16/14
- Organizational Chart for the Division of Developmental Services, dated 9/15/16
- Draft Case Management Performance Checks for Community Service Boards
- Day Support Waiver Quality Review Measures: 7/1/15 to 6/30/16
- Virginia PCR PQR Sample Selection 2016-2017
- Quality Service Review Operational Manual, dated 9/15/15
- PCR ISP QA Checklist – Year 2
- PCR Family Member Guardian Interview – Year 2
- PCR Support Coordinator Interview Tool – Year 2
- PCR Support Coordinator Record Review Tool – Year 2
- PCR-PQR Individual Interview Tool – Year 2
- PCR-PQR Observation Review Checklist – Year 2
- PCR-PQR Provider Interview – Year 2
- PCR-PQR Provider Record Review Guide – Year 2
- PQR Administrative Review Polices and Procedures – Year 2
- PQR Administrative Review Qualifications and Training – Year 2
- VA Tools – Driver Indicators, dated 9/21/16
- Quality Services Review Assessment: Year 1 Annual Report for June 2015 through June 2016, dated 9/7/16
- Inter-rater Reliability Procedures, undated
- PCR Draft Status Grid, dated 9/21/16

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APPENDIX F

SAFETY AND RISK FROM HARM

by: Ric Zaharia, Ph.D.

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

Safety and Protection from Harm
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.
&
Julene Hollenbach, BSN, RN, NE-BC

November 5, 2016

Introduction

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement (SA) requested a review of the Safety requirements of the Agreement.

Several provisions of the Settlement Agreement require implementation of strategies and themes related to Safety concerns and the goal of protecting individuals receiving services from harm. These strategies include risk management, quality improvement, and the capacity to investigate negative outcomes. These themes include the root cause analysis of negative outcomes and risk triggers/risk thresholds. The strategies are structured under the global CMS (Center for Medicaid and Medicare Services) concepts of Discovery and Remediation (*DBHDS Quality Improvement System Context*, undated). This focus study is to generally assess the status of the movement of the system of services toward full implementation of these themes and strategies.

We approached this assessment, by:

- reviewing DBHDS Quality Improvement Plans,
- interviewing ten selected CSB and private service provider administrators/quality managers to determine their focus on safety processes,
- interviewing six Licensing Specialists to evaluate their emphasis on safety, and
- reviewing the thirty-five most recent reports of reviews of serious injuries and deaths made by the Independent Reviewer to the Court.

Because health and wellness are important outcome indicators, this study also includes a review of strategies that DBHDS has used to transition the centralized healthcare of individuals placed from Training Centers (TC) to the decentralized care of local communities. DBHDS has initiated the Health Services Network (HSN) to implement this effort and to strengthen the capacity of agencies serving individuals who need intensive healthcare supports. The work of the Health Support Network is also focused on building the capacity of CSBs and private service providers to meets the healthcare needs of individuals who need intense medical supports

We have attempted not to overdraw conclusions or overreach on recommendations. Where we have affirmatively stated a point or made a recommendation, it is because it is supported or validated from this, previous or collateral studies.

This report is organized with an itemization of the requirements of the Agreement, a description of the methodology, a report on the findings from this evaluation, and recommendations to achieve full compliance; suggestions are offered where an area might be improved. The compliance table on the next page recaps the compliance assessments made in this review. The compliance ratings have not changed from prior assessments review for the seven provisions reviewed.

Compliance Table

Settlement Agreement Section	Settlement Agreement Language	Compliance as of 9/15/2016	Page
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	10
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 the waiver are met….and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care…assurance of qualified providers; identification, response and prevention of occurrences of abuse, neglect and exploitation. Review of data shall occur at the local and state levels by the CSBs and DBHDS/DMAS, respectively.*	Non-Compliance	10
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….a. Safety and freedom from harm (e.g. neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations;*	Non-Compliance	10
V.E.1	*The Commonwealth shall require all providers …to develop and implement a quality improvement ("QI") program, including root cause analysis, 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.*	Non-Compliance	10
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 programs. 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.5 above. The DBHDS quality improvement committee will assess the validity of each measure at least annually and update measures accordingly.*	Non-Compliance	7
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 copies to the Parties. The Parties shall seek a protective order permitting these reports to be shared with Intervenors' counsel and upon entry of such order, shall promptly send copies of the reports to Intervenors' counsel.*	Compliance	17
Section IX.C	Requires that the Commonwealth maintain *"…sufficient records to document that the requirements of the Agreement are being properly implemented…"*	Non-Compliance	n.a.

Safety

Settlement Agreement
Section V.C.1, V.D.1, V.D.3, V.E.1, V.E.2, VI.D.

Goal:
To determine if the Commonwealth has made progress ensuring the safety of individuals with intellectual or developmental disabilities (ID/DD) receiving services in the community.

Methodology:
- Reviewed CMS-approved waiver quality improvement plan and DBHDS quality management plans under the redesigned waiver, including selected performance measures,
- Interviewed selected administrators/quality assurance managers at ten agencies: three Community Service Boards (CSB) and seven private providers from three Regions regarding risk management and agency quality improvement plans,
- Reviewed Office of Licensing Services (OLS) and Office of Human Rights (OHR) data collected for neglect, abuse, injuries, peer to peer assaults, infectious diseases, seclusion, restraint, deaths, corrective action effectiveness, licensing violations, etc.,
- Conducted an analysis of thirty-five Reports by the Independent Reviewer to the Court on his review of serious injuries and deaths of individuals, who have moved from the Training Centers since 4/6/15,
- Reviewed proposed draft (9/16) revisions to OLS Regulations,
- Reviewed a report by OLS of physical plant, fire drill, evacuation planning, and cleanliness citations with Corrective Action Plans (CAP) by ID/DD providers during State FY 2016,
- Interviewed six Licensing staff regarding safety,
- Reviewed HSN Concept Paper (October 2014) and updates,
- Interviewed DBHDS Director of Office of Integrated Health, Assistant Commissioner of Quality Management and Director of Office of Licensing Services.

Quality Improvement Planning

Findings:
The Commonwealth's Quality Improvement (QI) Plan (including the approved Appendix H for the Waiver Redesign and the May 2016 DBHDS Quality Management (QM) Plan) is an expanded document from previous versions we have reviewed. The QI Plan describes the Commonwealth's commitment to system improvement activities following an analysis of aggregated discovery data and after evaluating system experience and actions to remediate negative outcomes. This Plan also illustrates an understanding of the CMS expectations of Discovery-Remediation-Improvement as the global governing process for QI.

The Plan describes a tiered approach to QI. The tiers are case management, Departmental, and third party reviews. The Departmental tier includes:

- Quality Review Team (QRT),
- Quality Improvement Committee (QIC) with five Regional Quality Councils (RQCs), and
- Mortality Review Committee (MRC).

The third tier is a third party (Del Marva) - Quality Service Review (QSR)

The Commonwealth's tiered approach to quality improvement has several shortcomings in implementation. The first revolves around conceptualizing the case manager as the system's trip wire for quality assurance. There are three reasons that this is a shortcoming. First, case managers do not have the authority to obtain the reports of serious incidents that private providers submit to DBHDS through the Computerized Human Rights Information System (CHRIS). A good case manager who is oriented to risk management and quality improvement will want to do an annual review of CHRIS incident reports in order to prepare for an individual's annual service planning meeting; this is not currently permitted. Second, case manager workloads are such that keeping up with behaviorally or medically complex conditions in annual, quarterly and monthly documentation requirements, authorizing services, visiting monthly face to face, etc. are difficult given current caseloads. Previous studies by the Independent Reviewer have found that case managers/support coordinators performance does not consistently fulfill current Agreement requirements to assemble the ISP team, to assist individuals to access needed services, and to monitor the ISP to make timely referrals. And third, the Independent Reviewer's reviews of serious injuries and deaths have found that for complex conditions case managers often lack the clinical expertise, or access to accessible clinical resources, to assess healthcare risks or changes in status.

A second shortcoming in the Commonwealth's tier approach is the missing recognition in the description of the QI Plan of the first line role of the direct provider of services in quality improvement. The Settlement Agreement requires that the providers of services fulfill a central role in assuring continuous quality improvement. These provisions require that every provider develop and implement a QI program – and then to:

- report incidents,
- complete root cause analysis,
- verify implementation of corrective action plans, and
- collect and provide data, etc.

This central role is not fully described in the Department's QI/QM plan, aside from a discussion of the planned Provider Record, a provider-reporting framework. Day to day reality is that the very first layer of QI is within each service provider. The first tier of a systems approach to quality assurance is at the transactional level between individual and support staff. To the extent each service provider "gets it and does it", then services to individuals will improve. If the service providers are considered secondary to the service system's quality assurance effort, then all other QI efforts will be noise and reflective of a system destined to repeat the same mistakes over and over again. This is reflected in the lack of emphasis in eighteen QIC/RQC meetings from the past year on redressing gaps in direct support staff training (only six mentions) and in twenty-five OLS safety/abuse-

neglect citation CAPs from the past year (only thirteen actions focused on direct support staff training).

A third shortcoming in the Commonwealth's QI Plan is the likely reality that the quality and risk management workgroups: the RQCs, QRT, MRC and QIC, all draw members from the same resource pool of people. This may limit the creativity, divergent thinking and effectiveness in the quality management process.

Another shortcoming of the QI process appears to be the absence of clear lines of accountability and parameters of responsibility. In the QI documents provided for this review DBHDS did not include 'chartering' or 'charging' strategies to the QI teams to ensure that their purposes, expected outcomes, and timelines are clear and well understood. For example, although it may be clear to some involved in implementation, it is not clear where MRC recommendations go to be assessed. The responsibility and accountability between the QIC's and RQC's is also not defined (Can the QIC reject a proposed quality improvement suggested at the regional level? Can the RQC implement an improvement within its Region without the approval of the QIC?). The relationship between the QRT and the QIC is not clear, since both appear authorized to implement improvement activities independent of each other. Time limited QI projects should also be governed by clear directions as to purpose and expected outcomes.

Finally, tracking for all Committees, Teams and Councils is critical to ensure tasks are implemented and accomplished as planned. For example, in a 1/21/16 QIC minutes the Committee decided to put Safety Alerts on letterhead with dates, presumably to enhance their usefulness and presentation. Upgrading, updating and professionalizing their appearance are definitely warranted to ensure continued credibility and utilization. As of this review, however, this Committee's decision had not been tracked or completed.

The CSB and private provider officials interviewed for this study were familiar with, and quoted, these Safety Alerts guidance tools. Other reviews of serious incidents, however, have found that the Alert guidance was not always followed and some individuals have experienced negative outcomes that could have been avoided. However, we recognize that when the Alert guidance has been followed and serious incidents are averted, that does not get reported.

Conclusions:
The DBHDS Quality Management Plan is a good first step towards overall direction in the system towards quality improvement. It creates a complex, multi-pronged central QI oversight structure for the service system. As described, it t overlooks the importance of provider quality improvement responsibilities that are required by the Agreement (which expectations are more fully addressed in the 9/16 version of a revision to OLS Regulations), it. Furthermore, the Plan addresses safety and protection from harm concerns and emphasizes prevention and system improvements.

DBHDS is not yet in compliance with SA Section V.E.2, relative to regular reporting from providers through risk management and quality improvement programs.

Recommendations toward achieving full compliance:
Reduce case manager caseload sizes and/or credential case managers (i.e. specialized training, mentoring, etc.) for individuals with complex behavioral and/or intensive healthcare needs, in order to ensure the monitoring function can be prioritized.

Remove the obstacles to a case manager pulling CHRIS incident reports from the database. There are no violations of privacy rules if a case manager is authorized to do so only for individuals on his/her caseload.

Include a fuller discussion in the next revision of the DBHDS Quality Management Plan of the role and indicators of successful provider quality improvement planning. It should also clarify the lines and processes of accountability across various sections, teams, councils and committees focused on quality improvement activities.

The QIC needs to document its annual review of the validity of the measurable indicators that are selected for monitoring, including those in the Data Dashboard.

Finalize the proposed revision to OLS regulations.

Suggestions for DBHDS Consideration:
Additional personnel resources may need to be drawn up the chain from the service delivery system and from outside resources, such as universities, medical associations, school systems, etc., for the QIC, QRT and MRC. These resources should be deployed to not just expand capacity but to influence diversity of perspective, expertise, etc.

DBHDS should upgrade the appearance and usefulness of DBHDS Safety Alerts, since these are important tools. It should also clarify both: the staff person or team that "owns" each Safety Alert and the "owner's" responsibility for updating, marketing, etc.

Agency Focus on Safety

Findings:
Table 1 on the next page illustrates our findings from a review of ten agencies -three CSBs and seven private providers. These agencies were drawn from entities in Virginia's Health Planning Regions 1, 3 and 5, although three of the private providers operated statewide. A check mark in Table 1 indicates the presence of an item, but not a qualitative assessment of the item. This assessment is based on personal interviews with the staff that are designated as the responsible administrators or as QM managers of the agencies. Because of the significant variability in the interviews about quality assurance processes, it is a reasonable assumption that the quality of the actual processes, plans, training, etc., also varies.

Table 1
Agency Adoption of Protection from Harm Practices and Strategies

	CSB 1	CSB 2	CSB 3	Res. Prov. 1	Res. Prov. 2	Res. Prov. 3	Day Prov. 1	Day Prov. 2	DD Agency 1	DD Agency 2
In Place:										
Safety-Risk Mgt Plan - Process?	√	√	√	√	√	√	√	√	√	√
QM Plan-Process?	√	√	√	-	-	√	√	-	-	-
Trained Investigators?	√	√	-	-	-	√	√	-	-	-
Discovery Process?	√	√	√	√	√	√	√	√	√	√
Remediation Process?	√	√	√	√	√	√	√	√	√	√
Familiar with:										
Root Cause Analysis?	√	√	-	-	√	√	-	√	-	-
Risk Triggers-Thresholds?	-	-	-	-	-	-	-	-	-	-

All CSB and private provider agencies reported having some version of a safety or risk management plan, committee and/or strategy. This was an expected finding, as the current OLS regulations require the designation of a person responsible for risk management. DBHDS's draft OLS regulations appropriately raise expectations around risk assessment, incident review, etc.

Similarly, those interviewed for these ten agencies each had a basic understanding of the need for continuous discovery efforts that are combined with remediation strategies to ensure corrective activity. All ten agencies, even the smallest in size, have a fundamental understanding that this basic discovery to remediation paradigm is essential to achieve improvements.

Only two (28.8%) of the seven private providers have in place formalized QI plans or programs, as required by the Agreement (V.E.1). The extent of the QI program development varied with the size of the agency in terms of number of individuals served. This review found a pattern that larger agencies have formalized processes in place, while smaller agencies have not incorporated a commitment to system improvement into their processes. As no Commonwealth QI directives to these agencies were found in this review, it appears that the extent of the development of QI processes was not in response to the Commonwealth efforts to implement the provisions of the Agreement. Under the DBHDS

draft proposed OLS regulation, all providers would have to establish and implement formalized “quality improvement programs”, as required by the Agreement. Based on this review only one provider (a national provider) was able to describe a complete and competent QI program, which should ensure an effective and continuously learning management system within a residential environment.

This review found that agency understanding of the process of “root cause analysis” (problem solving that tries to identify the underlying causes of a problem) is variable. One CSB quality management team was unfamiliar with, and obviously not implementing, root cause analysis. Under draft proposed OLS regulation revisions, all providers would have to establish and implement formalized quality improvement programs that include root cause analysis. However, the variability is disappointing. The concepts of root cause analysis are fairly simple and the Department has invested in this topic (see the Clinical Quality and Risk Management tab on the DBHDS website). The Commonwealth’s current efforts, however, appear insufficient at influencing CSB and private provider understanding and performance.

This review found a similar situation with the “risk triggers and thresholds” required by the Agreement. The officials from the ten agencies were not familiar with the terms, and clearly have not begun to implement, “risk triggers and thresholds”, which DBHDS defines as ‘risks identified before anyone is injured’. This lack of familiarity was surprising given that this was a four-year old requirement of the Settlement Agreement, and that DBHDS has been working on these concepts for a few years (see the Clinical Quality and Risk Management tab on the DBHDS website). These DBHDS efforts appear insufficient at influencing CSB and private provider performance. Under draft proposed revisions to the OLS regulations, all service providers would be required to collect and review risk trigger and threshold data.

Finally, the fundamental building block of an effective risk management and quality improvement system is a competent investigation of the facts of serious incidents. "Agency understanding of the investigation process pursuant to the online 'Training for DBHDS Licensed Providers' was variable among providers. For example, one CSB QM Manager was not familiar with the DBHDS online investigation training at the "Human Rights for Service Providers" tab on the Departmental website."

Conclusions:
The development of a system of services fully committed to quality improvement and protection from harm is incomplete and has only partially been implemented. The Commonwealth’s efforts to date do not seem to have significantly influenced the development or implementation of Quality Improvement programs, of root cause analysis, or of utilizing risk triggers and thresholds.

The finalization of the proposed revision to OLS regulations is a key to DBHDS ability to enforce the goal of all programs focused on quality improvement and protection from harm.

DBHDS is not yet in compliance with SA Section V.C.1, relative to risk triggers and risk thresholds.

DBHDS is not yet in compliance with SA Section V.D.1, relative to effective processes to monitor participant safety.

DBHDS is not yet in compliance with SA Section V.D.3, relative to the collection of reliable data.

DBHDS is not in compliance with SA Section V.E.1, relative to root cause analysis and quality improvement planning by providers.

Recommendations toward achieving full compliance:
Finalize and implement revisions to OLS regulations that align with the requirements of the Settlement Agreement.

Enhance educational efforts focused on provider use of quality improvement strategies, including root cause analysis, risk triggers and thresholds, and investigator training, until revised regulations are promulgated.

Suggestions for DBHDS Consideration:
Consider sponsoring/cosponsoring an annual conference on quality improvement to motivate and educate the provider community. Such a conference could highlight elements of an effective quality improvement program that other service providers have successfully implemented in Virginia.

Identify providers with model QI programs and market them to the broader provider community.

Licensing Specialist Focus on Safety

Findings:
In order to assess the awareness of Licensing Specialists of the concerns of safety and of protecting individuals from harm, six Specialists were interviewed face to face or by telephone. More than a dozen questions in this area and about their work were posed to them. Selected questions and a summary of their responses are provided below.

Is there a safety/risk management committee?
All six Licensing Specialists reported knowing that DBHDS has some type of Risk Committee but all six were unclear of the Committee's duties. They generally thought it had a statewide function, reviewed trends and dealt with safety issues, including issuing Safety Alerts,

How do you analyze incident and event data over time, places and individuals?
None of the Licensing Specialists reported using an objective, data driven review. All Licensing Specialists indicated that they "knew their providers"; therefore, they watched more closely those providers who had histories of problems. Three of six Licensing Specialists reported using the Computerized Human Rights Information System (CHRIS) to identify repeated incidents that involve an individual. Two reported utilizing Corrective

Action Plans to identify repeated concerns. Two indicated that the Data Warehouse can be utilized to obtain information about a provider, but also reported that they have found that it is not user-friendly and that they have not yet received training regarding its use.

Do you have some examples where your analysis resulted in findings about safety improvements needed in the larger service delivery region?

- A group home was struck with lightning during the night resulting in the home catching on fire. Everyone was successfully evacuated but the incident reinforced the importance of doing fire drills, including evacuation, at all times of the day to ensure a safe evacuation. The Licensing Specialist reminded all providers in the region of the rationale, importance and requirement for emergency evacuation drills at all times of the day, which is included in OLS regulations by cross reference to the applicable Virginia Statewide Fire Prevention code; the Specialist then included it in her routine reviews.
- A provider was removing a control medication from the bubble pack and sending it to the day program daily. After the Licensing Specialist identified the problem and ensured that it was corrected by the provider, the Licensing Specialist reported confirming that all providers in the region were sending control medications in the bubble pack in a locked container each day to the work area.

Do you use a hierarchy of interventions, corrective actions, and sanctions?

- To ensure that problems are corrected, all Licensing Specialists reported sharing verbally with the provider the concerns that they identified. Two of the six also reported doing so in writing.
- If the concern is a health or safety issue/regulatory violation, all six Licensing Specialists reported creating a Corrective Action Plan within 15 days. Three of six stated that a better definition is needed to determine what constitutes a health or safety issue.
- Following the issuance of a CAP, all six Licensing Specialists reported that they do follow-up reviews in 45 days to determine if the CAP has been met, as required by OLS.
- If the provider does not fulfill the requirements of a CAP, all six Licensing Specialists reported that they discuss the shortcomings with the provider and then develop another CAP.
- If the provider does not fulfill the requirements of the second CAP, then the Licensing Specialists reported that they can pursue a provisional license for that provider. A provisional license can only be renewed for six months. If the provider is not compliant after the issuance of a provisional license, then the revocation of the provider's license can occur.
- All six Licensing Specialists stated that obtaining a provisional license is extremely difficult, is very labor intensive, and is very slow to occur. The Licensing Specialists report that because of these systemic hurdles to the effective use of the provisional license sanction, they avoid the process and, instead, continue to monitor. Although pursuing a provisional license and the revocation of a provider's license are available options, none of the Licensing Specialists report having initiated either of these sanctions.

Do you have any examples of safety matters where you applied what you learned to the larger system?
Four of six Licensing Specialists were not able to report any such examples. The two examples were:

- Same as question above regarding the group home struck by lightning
- A vehicle with individuals had an accident. The staff was injured and could not answer any questions about the individuals. A procedure was established and implemented region-wide that required individual Information Sheets, including a picture, be taken on all trips.

How do you connect the dots? What do you do when you find the same issue in two or more different places?
One Licensing Specialist reported not having experienced this issue. Two of the other five reported that they will now be able to obtain direction from the recently established OLS Regional Manager supervisory positions. Two of five might convene a group to discuss the issue, determine a resolution, and then share with all providers. Three described reviewing these issues with the Community Resource Specialist who meets with the providers every other month to discuss and resolve issues.

Do you stop everything periodically and assess your operations with your strategic plan, regulatory requirements, hoped for outcomes and make plans to improve? Is there a strategic plan?
Two of six do not know whether a strategic plan exists. Four indicated that they are aware that a plan exists, but have not read or been taught about its contents.

What have you done to use DBHDS risk triggers and thresholds?
All Licensing Specialists identified, incorrectly, that the DBHDS Safety Alerts are the risk triggers. Licensing Specialists were uninformed about and unfamiliar with risk triggers and risk thresholds. This may suggest that no Licensing Specialist is participating on the QI team focused on defining risk triggers and thresholds. This lack of availability also suggests, along with the findings from our agency interviews, that DBHDS's work developing risk triggers and thresholds may have not yet involved providers.

When a DBHDS Safety Alert is developed, four of six of the Licensing Specialist reported that they send them to their assigned providers; two of the six notify the providers that the Alert is available online. For follow-up, four of six reported reviewing the provider's books to ensure that the Alerts are included. Two of six request that the providers have staff read and sign off on each Alert. All six Licensing Specialists reported concerns that, although Alerts are sent to each organization, they might not get to the direct care staff.

How do you use the process called "root cause analysis"?
Five of six do not use the entire root cause analysis process, which surprised us because it is an approach to investigations that investigators would find helpful and it is also a Settlement Agreement requirement that the Commonwealth offer guidance and training on the use of root cause analysis to proactively identify and address the risk of harm. Three of six reported that they use a portion of this process when developing CAPs.

Does your agency have a QI/QM Plan?
Four of six speculated that the QI/QM Plan is probably in the DBHDS Strategic Plan. Two of the six stated there is a plan; however, six of six did not know what was in the Plan.

How do you know when to do a desk review with a closure note versus a full onsite investigation?
Five of six do a desk review for an expected death (i.e. one that results from an individual's previously diagnosed terminal condition) of a person not living in a group home. All six Licensing Specialists reported that they do a full investigation for all unexpected deaths and expected deaths for persons living in a group home. The Independent Reviewer's reviews of deaths of individuals who moved from Training Centers, however, have found that an investigation was not always completed. For serious incidents, all six Licensing Specialists indicated that they use their own judgment. Factors that trigger an investigation include whether the cause is unknown, the incident could affect others in the home or there is a regulatory citation.

What are you expected to provide the MRC regarding a death?
All six Licensing Specialists reported that they use the MRC checklist that identifies the documents to be submitted. Three of six indicated that they do not send the documents to MRC until all are complete. Two of six stated that it is possible for MRC to review a death without all documents having been submitted. The Settlement Agreement, however, requires that the MRC must review these documents or it must document that these records that are not available. Five of six have never been asked by MRC for additional information.

What kind of feedback do you get on your investigation reports?
All six Licensing Specialists did not recall having received feedback, but they all would like, and benefit from, feedback.

Are provider investigations done? Do you use them?
Four of six Licensing Specialists stated that providers must complete investigations on allegations of abuse or neglect. Two of six stated that providers are expected to do investigations on serious incidents and death, but do not always complete them or they write a short summary on the CHRIS reporting form and do not submit the full investigative report (which is acceptable practice per Departmental Instruction 201 (RTS)03). Four of six reported using the provider investigation, if available. Licensing Specialists commented that providers would benefit from investigation training.

Conclusions:
Overall, the Licensing Specialists do not see themselves impacting the service delivery system, except possibly in their own region. This seems to result in their not analyzing data for trends or patterns. They believe that, in fact, OLS has little actual power and cannot effectively sanction providers because the available sanctions are so difficult to utilize. They agreed that, as a result, a very few providers do not implement the agreed upon Corrective Action Plans in a timely or effective manner. The Licensing Specialists believe that they contribute to making needed service changes/improvements by maintaining good rapport with their assigned providers and by adjusting the frequency of their visits as needed.

Licensing Specialists would like more training to increase their skills and consistency. They identified training needs for themselves in the use of the Data Warehouse, for providers on writing Corrective Action Plans, and for both providers and OLS on investigations. The Licensing Specialists lacked knowledge of DBHDS's Risk Management Plans, Strategic Plans and Quality Improvement/Quality Management Plans. As a group, they were also unsure how those plans impacted them and the importance of their role in the service system.

Recommendations toward achieving full compliance:
DBHDS should retrain Licensing Specialists in root cause analysis, risk triggers and thresholds, and the Department's approach to quality improvement. The goal of this retraining should be to ensure that Licensing Specialists better understand their roles and how their work fits into DBHDS's overall approach to improve the quality and effectiveness of services delivered by the providers they are assigned to monitor.

DBHDS should assess its Data Warehouse to determine if it can be made more user friendly and if it is feasible to provide additional user training.

DBHDS should clarify in the OLS Office Protocol a) when a full investigation into a death should occur; for example, an expected death may warrant an onsite investigation, if the determination of 'expected' is not clear cut and obvious (e.g. when an individual dies after life supports are removed by hospital physicians ten days after choking on food and losing consciousness, and later being determined to be brain dead, should be treated as an unexpected death) and b) when others in a home or homes should be assessed by the Licensing Specialist for same or similar risks flowing from a serious incident (e.g., serious medication errors for one individual should automatically trigger a review of others in a home who receive medication).

DBHDS should retrain Licensing Specialists on a hierarchy of practical interventions that promote expedient remediation of issues including when to initiate a provisional license or a license revocation.

DBHDS should clarify for the MRC (and OLS) which documents can be overlooked in its review (e.g. individual's daily schedule) and which cannot be overlooked and for which the case may not be closed (e.g. all incident reports during the previous three months and the death certificate).

Suggestions for DBHDS Consideration:
Clarify in the OLS Office Protocol that Licensing Specialists should request and consider the provider investigation in their investigation findings or to document for OHR that the provider did not complete the required investigation.

Retrain providers and Licensing Specialists on an investigation protocol that defines expectations regarding when and how to complete a thorough investigation process and investigation report.

Serious Incident Analysis

Findings:
The Settlement Agreement requires the Independent Reviewer to review the death or serious injury to any former resident of a Training Center (VI.D.). The Independent Reviewer's thirty-five most recent such special Reports to the Court were reviewed for this study. These injuries and deaths occurred during the nineteen-month period between May 2014 and December 2015. Table II on the next page summarizes the findings from this review.

These Special Reports to the Court also included recommendations offered for the consideration of the Commonwealth. Recommendations from all thirty-five Special Reports are recapped in Attachment C. Recommendations, which were made two or more times from this group of thirty-five, included (most to least frequently):

DBHDS should establish investigation minimum standards for OLS for use in the review of deaths and serious incidents.

DBHDS should develop a script for case managers and/or providers to use to encourage next of kin to agree to autopsies to determine the cause of unexpected deaths.

DBHDS should conduct root cause analysis of selected events when there are negative outcomes for individuals.

DBHDS should develop collateral agreements to share/release/disclose investigative findings with relevant sister agencies (Adult and Child Protective Services, Public Health, etc.).

DBHDS should maintain a statewide registry of Stage 2 or higher decubitus ulcers for those living in settings other than their own or family home.

DBHDS should cite providers who report serious incidents later than the required "within 24 hour notice".

Table II
Data from thirty-five serious incidents

Number:	35 - 11 serious injuries and 24 deaths
Ages:	Average = 55, Range = 29 to 82
Time Period:	Deaths - 11.14.14 to 6.3.15
TC's:	SVTC – 17, NVTC – 8, CVTC – 5, SWTC – 4, SEVTC - 1
Discharge to Death Days:	Average = 443 days, Median = 545 days, Range = 80 days to 1084 days, 9 of 24 occurred within one year
Expected Deaths: Unexpected Deaths:	3 21
Causes of Death:	7 cardiac arrest/heart failure, heart attack 6 sepsis 3 cancer 3 aspiration/asphyxiation 2 respiratory failure 1 stroke 2 undetermined
CHRIS report type:	24 - deaths, 4 - fractures, 3 - decubitus ulcers, 2 – behavioral, 1 – burn, 1 - emergency room visit
Chris report filed timely (within 24 hours):	22 - yes 13 - no
OLS Investigation:	28 - yes 7 - no
Corrective Action Plan:	10 - yes 24 - no 1 - unknown
OHR Involved	4
Quality of Investigation	1 - done well 17 - adequate but omissions 10 - inadequate
MRC timely: (within 90 days of death)	14 - yes 7 – no 3 – unknown

Conclusions:
The findings from the thirty-five reviews with some degree of confidence can be generalized to the overall target population who died or experienced injuries that resulting in on-going medical care to the other nearly 600 individuals who have also transitioned from a Training Center under the Settlement Agreement. Deaths and serious injuries for individuals who entered the Home and Community Based Waiver programs directly from their family home placement or who moved from a Training Center before May 2014 or after December 2015 may have had different experiences.

The causes of death among this group of individuals who moved from a TC under the Agreement (i.e. since 10/2011) are similar to those identified in other states. For example,

the Connecticut Department of Developmental Services last Annual Report on Mortality[2] for a larger, statewide population also reported the leading causes of death as Heart Disease, Respiratory Disease, Cancer, Aspiration/Pneumonia and Sepsis.

Among the twenty-four deaths, nine occurred within one year of discharge, but it could not be established whether these were a result of a) being high risk individuals regardless of where they lived, b) inadequate transition planning (discharge and post move) or c) substandard care and treatment from their provider or from their community-based physician, Emergency Rooms and hospitals where they received medical care. It is likely that one or more of these factors were present for different individuals at different times. The Mortality Review Committee should be making these assessments and use their findings to determine problems at the individual service level and systemic patterns and trends. The MRC completed its work timely (i.e. within 90 days) for 58% (14) of these 24 deaths.

Individuals formerly living at Southside Virginia Training Center (SVTC) account for almost half (17) of this group of injuries and deaths. This was expected because most of the individuals, who moved from Training Centers, transitioned from SVTC during the first years of the Agreement. Fractures and decubitus ulcers accounted for more than half of serious injuries that were reviewed. Twenty-two of the thirty-five (63%) incidents were reported timely, as required, which confirms other studies of improvements in timeliness; twenty-eight incidents (80%) were investigated by OLS in one fashion or another. However, only rarely did the Licensing Specialists report that they had assessed the safety of other individuals living with the individual who was the subject of the investigation.

Eighteen of the twenty-eight (64%) investigations were assessed by us as minimally adequate, since most investigations contained significant omissions.

DBHDS is in compliance with SA Section VI.D.

Recommendations toward achieving full compliance:
DBHDS should increase the level of case management oversight or competency for individuals over age 55 or who have intense or complex medical needs.

DBHDS Licensing Specialists should automatically address in their investigations the safety of other individuals living with individual being reviewed by stating the affirmative, if accurate, that no 'risks to others in the home/program were apparent'.

DBHDS should establish investigation minimum standards for OLS for use in reporting their review of deaths and serious incidents.

[2] http://www.ct.gov/dds/lib/dds/health/reports/mortality_report_fy_14.pdf

Health and Wellness Initiatives

Findings

A key to developing systems of care committed to protecting individuals from harm and to ensuring their well being is a proactive effort to ensure good health through competent nursing and medical care. DBHDS has focused its efforts through the development of a Health Services Network. This network is led by a group of four full time equivalents RN Care Consultants (RNCC) who are community and integration focused. Its activities since January have included:

- Onsite technical assistance/consultation to over a dozen providers (81 locations), including information on specific health conditions, writing health protocols, use of lifts, tracking input/output, fall risk planning, bowel movement tracking, medications, writing justifications for durable medical equipment and other supports, ventilator and g-tube care, utilizing nursing services for fractures, decubitus ulcers, diabetes, hospitalizations, and other chronic conditions;
- Onsite technical assistance/consultation to major pharmacies providing services to providers in Regions II, IV, V;
- Formal one-day workshops and trainings on supporting individuals with complex health needs (145 participants to date); consultation to agencies in the access of and coordination of local health services (nutritionists, diabetic management, dental care, health clinics);
- Guidance and support to agencies in lieu of regulatory citations; participation in investigations as requested by CSBs in matters involving health issues;
- Post-move monitoring visits, including individual specific onsite training for those supporting individuals recently placed;
- Development of an Oral Health program for direct support staff (97 participants to date); creation and distribution of oral health brochures;
- Establishment of a Fixed Rate Dental Program in two of Virginia's five regions (which so far has involved referrals for 382 people); partnered with Oral Health Coalition to provide education seminars to dentists, oral hygienists, etc.; established a Sedation Dental Program at Northern Virginia Training Center (NVTC); 112 referrals have been processed to date; initiated a pilot in remote dentistry in Western Virginia;
- Consultation and guidance to case managers upon request;
- Participation in the development of competencies for staff serving individuals with more intense medical needs;
- Participation in the development of a Daily Health Checklist, geared to direct support staff to ensure they report health status changes immediately;
- Participation in the revision of a new Orientation manual for direct support staff;
- Coordination of monthly Community Nursing Meetings in all five Regions; support for the creation of self-directing local leadership teams;
- Development of region-based Skin Care Workshops using subject matter experts;
- Purchase of two vans to provide mobile services for Mobile Rehabilitation; Engineering program (engineer, occupational therapist and RN); consultation services to 61 individuals and repairs/adjustments to 93 pieces of equipment.

The Health Support Network is in the process of defining the measurable outcomes that it will track to determine whether, and the extent that, the HSN has positively impacted improvements in health care. The HSN expects to complete the development of the outcomes during 2017. It expects to be able to begin reporting measurable progress on achieving desirable outcomes by the end of 2017.

Conclusions:
The DBHDS Health Services Network has made significant efforts into support, and capacity building, of community providers who have individuals with challenging healthcare needs. This is particularly so in the Dental and Oral Health care arena, where emerging best practice models of efficient care are being piloted.

The DBHDS Health Support Network's efforts had not yet reached the providers or impacted the services provided for the period of serious injuries and deaths that were reviewed by the Independent Reviewer. This is not to conclude that there is no positive effects but rather that its impacts to date have not been observed in the Independent Reviewers' multiple assessments of system performance.

We have noted through individual and incident reviews that a transaction point of major difficulty for providers and case managers is working with local hospitals on well done discharge planning.

The DBHDS Health Services Network is challenged to sustain support to provider agencies in all regions on all fronts. These efforts are worthy of significantly more resource investment.

Recommendations toward achieving full compliance:
Because the HSN is action oriented and has limited resources, there needs to be an expanded capacity to demonstrate significant quantitative and qualitative progress. For example, the continuation of planned regional Skin Care Workshops may benefit from a count of decubitus ulcer reports before the training event in a region and after the event in that region in the following months. Impact data will support the long-term sustainability of the Network. Beginning to measure the HSN's impacts should not be delayed into 2017.

Develop and market 'best practices' tools for local hospital discharge planning for case managers and private providers.

Suggestions for DBHDS Consideration:
DBHDS should clarify in bulletins, brochures, emails, websites, etc., to families, individuals, and case managers the purposes and limitation of each pilot as it is launched.

Attachment A
Recommendations from Reports #34-#68

Report #	Move Date	Incident or Death Date	Recommendations
34	May 19, 2014	May 19, 2014	1. The Commonwealth should ensure that all public agencies coordinate their oversight of individuals with ID/DD in the target population. This coordination should include sharing the results of all investigations of serious injuries to or allegations of mistreatment of individuals receiving services under the Agreement. The Commonwealth should promptly receive copies of APS investigations that conclude that an individual whose services are being overseen by DBHDS is at risk of harm should be shared promptly with DBHDS. The Commonwealth cannot comply with the Agreement's provision ensuring that services include avoidance of harm when information about risks is not shared with those responsible for managing risks.
35	Jan 22, 2014	May 23, 2014	1. The discharge planning discussions of the barriers to successful community placement should include what might go wrong when planning the transition of medically complex individuals. Post-move monitoring and case management oversight processes should include enhanced monitoring of the individual's risk factors in relationship to areas of identified concerns. 2. XX was randomly selected for review by the Independent Reviewer's nurse consultant. On 8/18/14, he was observed at the Hiram Davis Medical Center. The HDMC Medical Director and PW's nurse were interviewed at length. The report from Individual Review site visit was submitted to the Commonwealth on 11/15/14. It recommended, and the Independent Reviewer repeats the recommendation here, that the Commonwealth conduct a root cause analysis to determine the issues that contributed to the failure of XX's community placement and steps that can be taken to avoid such harms in the future. 3. The OLS should document when residential providers do not comply with its SIR reporting requirements and take corrective actions that ensure the provider will fulfill reporting requirements consistently in the future.
36	May 19, 2014	Sep 1, 2014	1. The DBHDS should complete a root cause investigation of the events surrounding XX's discharge and his psychiatric hospitalizations. Its findings and conclusions should address the reasons why essential vocational and behavior supports were not in place prior to his discharge from XXTC. The investigation recommendations should outline the actions needed to ensure that Personal Support Teams do not repeat these gaps in transition and discharge planning and implementation with others. The investigation should also determine whether XX's first residential provider was negligent in failing to provide psychotropic medication prescribed for him; whether the behavior supports provided met professional standards; and whether the direct support staff implementing these services were trained and competent to implement the elements of XX's service plans.

			2. The DBHDS should establish standards to ensure that OLS investigations are completed when provider staff call the police rather than REACH crisis services as instructed in the individual's service plan. 3. DBHDS should work with its sister agencies to ensure that police officers are trained in respectful, effective, and least intrusive means of responding to individuals with a disability in a behavioral crisis.
37	Mar 3, 2012	(Sep 25, 2014)	1. DBHDS should set minimum standards for OLS investigations into a death. These standards should include a review Case Manager notes and the gathering of the basic information required for its mortality review process.
38	Feb 8, 2012	(Sep 24, 2014)	1. Following an unexpected death OLS Specialists should routinely do spot checks for similar issues at other provider sites.
39	Jan 6, 2014	(Sep 20,2014)	1. All OLS investigations of deaths should have a minimum standard of reviewing case manager notes. 2. DBHDS should consider issuing a safety alert to all providers and case managers that the ADA recommends antibiotic treatment for those with "heart conditions".
40	May 15, 2014	Sep 30, 2014	1. DBHDS should establish standards that require an investigation when there is a pattern of injuries leading up to a more serious injury.
41	May 28, 2014	Nov 12, 2014	None
42	Dec 30, 2013	Jan20, 2015	1. The Commonwealth should establish standards that require OLS investigators to broaden their reviews of incidents that surface multiple regulatory violations that involve health and safety. The expanded review should include the provider's history of regulatory violations and its effectiveness implementing corrective action plans. The purpose of the expanded review should be to ensure the well being of other individuals served by the provider. 2. DBHDS should consider development of an autopsy protocol that uses the OLS investigator to trigger a formal system request for autopsy in medical examiner cases where the circumstances of an unexpected death warrant additional discovery.
43	Feb 18, 2014	(Nov 14, 2014)	1. The Commonwealth should establish standards for OLS investigation processes and reports of unexpected deaths. Interviews should occur soon (such as, within 72 hours) after an incident so that facts are still fresh with interviewees. 2. OLS should establish standards for Licensing Specialists to cite providers for late submission of CHRIS reports. DBHDS should track providers' compliance with DBHDS's 24-hour web-based reporting requirement. Providers who exhibit a pattern of late submission of CHRIS reports should be held accountable for timely submission with escalating consequences. 3. Peanut butter is a high-risk food for choking even for those with normal diets. DBHDS should consider a general cautionary alert to the dangers of choking on peanut butter. The American Academy of Pediatrics has issued cautions (http://www.med.umich.edu/yourchild/topics/choking.htm) about the use of peanut butter up to age 7.
44	Feb 29, 2012	(Jan 16, 2015)	1. The Commonwealth should ensure that OLS investigators have access to, and utilize the support of, medical professionals to

			assist in interpreting medical histories and recent health events when investigating deaths and other negative health outcomes of individuals with complex medical conditions and treatment regimes. 2. The Commonwealth should establish minimum standards for OLS investigations of unexpected deaths. These standards should include a review of case manager notes, the relevant sections of the ISP, and the health care monitoring records for the months preceding an unexpected or unanticipated death. These standards should also include a review of previously cited deficiencies and the extent to which CAPs had been effectively implemented during the preceding year. OLS investigations should determine if there are repeat deficiencies found. If so, then the investigation should be expanded to determine whether other individuals served by the residential provider are exposed to similar deficiencies. Consequences for a provider's repeated failure to comply with regulations should increase over time. 3. The Mortality Review Committee should establish a standard practice of developing and making recommendations based on its deliberations and findings in individual service delivery situations and at systemic levels. An established minimum standard should include communicating to hospitals or medical practitioners its concerns. DBHDS should inform the hospital where XX died of the MRC's reviews of three bowel obstruction cases that involved an apparent lack of response.
45	Nov 14, 2011	May 28, 2014	1. DBHDS should establish clear expectations of residential providers and of case managers to ensure timely reassessment when an individual's experiences a potentially negative change in health status. The case manager should ensure that the individual support plan is amended when the reassessment indicates that revisions in the plan are needed to address and meet an individual's changed needs. The amendment should include an implementation schedule for the changes needed to address the individual's needs 2. DBHDS should review its directives regarding mandated policies and consider whether additional steps need to be taken to ensure that all community-based provider agencies actually develop such policies and train and monitor staff in their expected performance.
46	Jul 24, 2013	Feb 2, 2015	1. An autopsy request script for use by case managers and providers describing the positive benefits of an autopsy should be developed in order to enhance the chances that next of kin will consent to the procedure. Autopsy results would have been particularly helpful in clarifying XX's complex conditions, the actual causes of death, and potentially quality improvements in provider practices. 2. DBHDS should thoroughly audit the residential provider's medication practices to ensure that systems are in place to ensure that doctors' orders are implemented in a timely manner that doctor's prescriptions match the medications provided by the pharmacist, and that complete medication administration records are maintained.
47	Nov 24, 2014	Feb 9, 2015	1. DBHDS should clarify that it requires providers to report all Stage 2-4 decubitus ulcers through the CHRIS system.

			2. DBHDS should ensure that Licensing Specialists understand that decubitus ulcers are preventable, that their presence is always an indication of inadequate physical care, and that corrective actions should always be required when decubitus ulcers occur. 3. The post move monitoring protocols should be revised to ensure that needed health and safety protocols exist and are effectively and consistently implemented. 4. DBHDS should consider creating a statewide decubitus ulcer registry, so that these preventable injuries can be monitored and eliminated. 5. DBHDS should consider modifying its Pressure Ulcer Alert to add a cautionary note regarding federal non-payment for Stage 3-4 pressure ulcers. 6. OLS should consider coordinating/sharing investigation findings with ICF/IID surveyors.
48	Nov 25, 2013	Feb 2, 2015	None
49	May 5, 2014	(Feb 5, 2015)	1. OLS should coordinate/share with the Department of Health survey team findings on ICF/IID homes. 2. An autopsy request script for use by case managers and providers describing the potential positive benefits of an autopsy should be developed in order to enhance the chances that next of kin will consent to the procedure. An autopsy would have been particularly helpful in clarifying XX's complex conditions and in confirming the cause of death. It may have also provided information about whether health protocols had been properly implemented.
50	Apr 10, 2013	Feb 7, 2015 (Feb 11, 2015)	1. An autopsy request script for use by case managers and providers describing the positive benefits of an autopsy should be developed in order to enhance the chances that next of kin will consent to the procedure. An autopsy would have been particularly helpful in clarifying XX's complex conditions and in establishing a cause of death. It may have also provided information about whether health protocols had been properly implemented. 2. DBHDS should take systemic action that ensures that all residential service providers and case managers understand the importance to nutritional planning, especially for individuals with weight management issues. For non-ambulatory individuals who are unable to stand on a typical scale, mechanical approaches to provide frequent body weights should be readily available.
51	Sep 9, 2013	Mar 6, 2015	1. This provider should be required to obtain the services of an external health care professional(s) to audit its group home health care records and operating procedures. The provider should be required to make needed changes that ensure that operating systems related to health and safety protocols are implemented consistently and effectively. Staff training should be reviewed to ensure that each staff demonstrates competent implementation of all health and safety service elements of the individuals served. 2. Although subsequent CAPs have been issued to the CSB case management services and the CSB group home, these providers should receive intense oversight (frequent onsite visits) until all issues have been resolved.

52	Oct 20,2014	Jan 25, 2015	1. DBHDS should develop a protocol for OLS investigations when the person is living in their own or a family home. This protocol should reflect the balance between family privacy and the potential for abuse and neglect.
53	Aug 21,2013	May 9, 2015	1. ISPs should clearly define the supports individuals need, including, but not limited to, nursing supports, physical and nutritional management supports, and support coordinators' responsibilities. Objectives for these supports should be stated in measurable terms so that a determination can be made regarding whether the objectives were or were not achieved. 2. DBHDS should develop minimum standards for the investigation review process and for investigation reports. For OLS investigations of deaths, minimum standards should include review of the individual's ISP; case management/support coordination notes; the provider's documentation of healthcare monitoring, as ordered/applicable; the death certificate; and relevant hospital records. 3. DBHDS should ensure that Licensing Specialists initiate and complete investigations in a timely manner and that OLS is aware of and takes necessary actions when Licensing Specialists fail to do so. 4. The Mortality Review Committee should document when OLS fails to complete investigations of unexpected and unexplained deaths within ninety days. The MRC should also make recommendations for needed corrective actions by OLS, CSBs, and the GH provider. 5. DBHDS should review and determine whether this Group Home provider is properly implementing and documenting health care monitoring protocols, as ordered by the medical practitioners of the individuals it serves.
54	Aug 15, 2013	Jul 14, 2015	1. For injuries of unknown origin, OLS Specialists should document, at a minimum, review of the provider's investigation and the individual's ISP, including whether services related to the individual's known high risk factors were being provided. 2. ISPs should define the supports individuals need, including staffing supports. 3. The Commonwealth should develop and implement standards for provider investigators and investigations. 4. The Commonwealth should take steps to ensure that DBHDS receives information from DSS regarding findings from its investigations of neglect and abuse allegations.
55	May 29, 2013	Oct 9, 2015	1. Licensing investigations should routinely review and comment on the well-being of other individuals in the setting when a provider is cited with substantive violations that are related to the operations of the group home. 2. The Commonwealth should establish that Licensing investigators of an unexpected death should include the review of the individual's case manager notes for at least the 6-month period preceding the death.
56 160715	Sep 18, 2013	Jul 31, 2015	1. Licensing should cite providers for providing inadequate physica care when individuals are known to be at risk for skin breakdow and when providers do not implement adequate protocols to ensure needed physical care. When a repositioning plan has been recommended and not implemented, the Licensing Specialist

			should also cite case managers for inadequate monitoring to ensu that an individual's known risks are addressed. 2. Licensing should always cite providers who submit CHRIS report later than required for significant injuries such as a decubitus ulc 3. DBHDS should implement a plan to ensure that Licensing staff an case managers are familiar with and use the DBHDS Safety Alerts The DBHDS Safety Alert recommendations to protect the health a safety of the individuals with known risks should be included in t individual's support plan. The individual's case manager should monitor to ensure the effective implementation of Safety Alert recommendations and the Licensing Specialists should include these in their recommendations to providers.
57	May 19, 2014	(Jun 7, 2015)	1. An autopsy request script for use by case managers and providers describing the positive benefits of an autopsy should be developed. Having a script will enhance the chances that next of kin will consent to the procedure. An autopsy would have been particularly helpful in clarifying FG's complex conditions and cause of death.
58	Dec 1, 2014	(Jul 11, 2015)	1. OLS should track unexpected deaths centrally and should monitor for timely and complete Licensing Specialist investigation reports, Corrective Action Plans, if applicable, and follow-up visits that verify any needed corrective actions have been effectively implemented. 2. The Licensing Office Protocol should require a written findings report for unexpected deaths even when no violations are noted. In addition, the required components of an Investigation Findings Report (documents reviewed, individuals interviewed, findings, recommendations, etc.) should be specified in the Office Protocol. 3. DBHDS Health Safety Alert #15 should be modified to include, "a normal blood pressure range should be established for each individual with hypertension, so that staff know when they should contact a physician or EMS". Licensing staff and case managers should be familiar with Safety Alerts, in order to include them in their monitoring of services provided and recommendations to providers. 4. When an individual, who has transitioned from a Training Center, experiences a subsequent change in placement within a year, the post-move monitoring process should activate a 'checkup' process to ensure transition planning documents and processes are made available to the new provider. 5. An autopsy request script for use by case managers and providers that describes the positive benefits of an autopsy should be developed to enhance the chances that next of kin will consent to the procedure. An autopsy would have been particularly helpful in clarifying XX's complex conditions and the cause of death.
59	Nov 19, 2014	(Sep 3, 2015)	1. DBHDS should establish a Request for Review process that is pre-arranged with the appropriate licensing jurisdiction for skilled nursing facilities.
60	Oct 28, 2014	(Jul 27, 2015)	1. The OLS should revise its Office Protocol to require a written findings report for unexpected deaths. The MRC should also require written findings reported for unexpected deaths. 2. OLS should establish standards that require an assessment of the well being of co-residents of a GH when there is a CAP that

			involves a violation of a regulation that indicates that inadequate care was provided by the group home.
61	Jun 17, 2014	(Oct 11, 2015)	1. The Mortality Review Committee and OLS should establish processes to request a review of an incident by the Commonwealth's appropriate licensing bodies of hospitals, nursing homes or other outside health care facilities. The processes should also include a mechanism for communicating concerns to health care facilities or medical practitioners and for collaborating to problem solve issues. These processes are needed to reduce mortality rates and to enhance the quality services for people with ID/DD. 2. The OLS minimum standards for investigations should include a review of medical records including physician case notes and nursing notes from hospitalizations and/or nursing home stays for the months preceding an unexpected death.
62	Oct 23, 2013	(Dec 3, 2015)	1. Licensing should establish a sampling audit protocol for supervisors of Licensing Specialists investigation reports as a quality control measure to ensure that the investigation process and reports meet standards.
63	Jun 23, 2015	(Sep 12, 2015)	1. OLS should establish a process that tracks the status of its investigations. This process should identify for OLS supervisors when an investigation has not been initiated, has not been completed, or has not been submitted, as expected. It should also identify when a needed Corrective Action Plan (CAP) has not been developed or has not been implemented, as expected. The implementation of a tracking system should result in OLS learning when it should initiate follow-up action to ensure that the performance of its Licensing Specialists' adheres to OLS expectations and standards.
64	Mar 10, 2015	Dec 29, 2015	1. DBHDS should maintain a statewide registry of all individuals with ID/DD who are receiving out of home care and who experience at least Stage II decubitus ulcers and track their progress. If XX's first wound occurred on a statewide registry with no prior history, Licensing staff might have been prompted to evaluate whether services were meeting his needs early on and, possibly, prevented worsening of the ulcer and further complications.
65	May 15, 2013	Dec 25, 2015	1. Post-move and case management monitoring should include a review of the person's safety risks and whether safety protocols are understood and consistently implemented. If monitors find disagreements and inconsistent use of health and safety protocols, then the issue should be documented, the individual's service planning team should be convened to address it, and the resolution should be documented. 2. The OLS should establish standards for investigations that include a review of the person's risk factors and safety protocols to determine if preventative measures were being implemented as expected.
66	Mar 26, 2015	(Dec 23, 2015)	1. Licensing should establish a sampling audit protocol for supervisors of Licensing Specialists' investigation reports, in order to ensure that the process and reports meet expectations.
67	Mar 11, 2015	(Dec 13, 2015)	1. OLS should establish processes that require OLS investigators to broaden their investigations to include: • whether case

			managers were monitoring, as required, for whether the ISP was being properly implemented for known health risks, especially those that are known to contribute to avoidable deaths, and • other individuals in the home who may be affected when OLS discover regulatory violations that involve health and safety.
68	Jan 13, 2013	(Dec 27, 2015)	1. The MRC should ensure the review of the records of an individual's health status and the care provided for the weeks prior to an individual's unexpected death. The MRC should establish a procedure that requires obtaining this information to identify and to help answer health care questions that arise during the mortality review process. 2. The DBHDS should revise the OLS Investigation protocol to require a full investigation findings report in the case of an unexpected death.

APPENDIX G.

LIST OF ACRONYMS

APS	Adult Protective Services
AR	Authorized Representative
AT	Assistive Technology
BSP	Behavior Support Professional
CAP	Corrective Action Plan
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CIT	Crisis Intervention Training
CM	Case Manager
CMS	Center for Medicaid Services
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTH	Crisis Therapeutic Home
CVTC	Central Virginia Training Center
DARS	Department of Rehabilitation and Aging Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disabilities
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice, United States
DS	Day Support Services
DSP	Direct Support Professional
DSS	Department of Social Services
ECM	Enhanced Case Management
EDCD	Elderly or Disabled with Consumer Directed Services
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
ICF	Intermediate Care Facility
ID	Intellectual Disabilities

IFDDS	Individual and Family Developmental Disabilities Supports ("DD" waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
LIHTC	Low Income Housing Tax Credit
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
ODS	Office of Developmental Services
OHR	Office of Human Rights
OLS	Office of Licensure Services
PASSR	Preadmission Screening and Resident Review
PCP	Primary Care Physician
POC	Plan of Care
PMM	Post-Move Monitoring
PST	Personal Support Team
QI	Quality Improvement
QIC	Quality Improvement Committee
QSR	Quality Service Review
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
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
WDAC	Waiver Design Advisory Group