REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

SETTLEMENT AGREEMENT

UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 1, 2017 – March 31, 2018

Respectfully Submitted By

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Independent Reviewer
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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's twelfth 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 twelfth review period from October 1, 2017, through March 31, 2018.

The Independent Reviewer reported previously, and repeatedly, that the Commonwealth's various regulations had impeded its ability to comply with provisions of the Agreement. At the end of the twelfth review period, the Commonwealth still had not approved revisions to its Department of Behavioral Health and Developmental Services (DBHDS) Licensing Rules and Regulations (Regulations), a process it began three years ago. However, it has since made significant progress, and has now completed all but the final step in its regulatory process to create emergency revisions. The revised draft emergency Regulations were approved by the State Board of Behavioral Health and Developmental Services on April 11, 2018, and were subsequently approved by Virginia's Office of the Attorney General, Department of Planning and Budget, and Office of the Secretary of Health and Human Resources. On May 9, 2018, the proposed emergency regulations were forwarded to the Governor's Office for review and approval. Once signed by the Governor, the emergency regulations will be in effect immediately. The draft emergency DBHDS Licensing Rules and Regulations will:

- Clarify that all providers must have quality improvement programs;
- Increase provider emphasis on risk management programs;
- Clarify and expand expectations of case managers' face-to-face visits and their direct assessments of the individuals' well-being; and
- Increase expectations regarding the content and review of Individual Service Plans.

Although the proposed emergency Regulations do not align fully with the Agreement, their approval and successful implementation is essential to move the Commonwealth substantially toward compliance. However, there is a critical missing element related to ensuring the adequacy of services.

The Agreement includes two external oversight provisions to safeguard the adequacy and appropriateness of services. The Commonwealth must ensure that the DBHDS "*licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services …* " (V.G.3), and case managers are required to "*assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual*" (V.F.2). The draft Regulations do not include that the Licensing process will assesses the adequacy of the individualized supports. The parties' agreement to strengthen service oversight provisions was an critical strategy to warrant good quality results. To be successful, though, both provisions must be fully functional, and the role of the DBHDS Office of Licensing (OL) is key to both. The Agreement specifically requires that the OL fulfill the responsibility to assess adequacy directly. The Commonwealth, however, has taken the position that the Licensing responsibilities to assess adequacy are better executed by a multi-component, multi-agency approach. As currently composed, however, this approach remains fragmented and uncoordinated.

The draft emergency Regulations do specify that case managers are responsible for assessing appropriateness. The OL is the current backbone of the Commonwealth's case management performance monitoring process. These Regulations, however, have not yet been approved and OL has not provided protocols, structured interviews, or evaluation checklists to guide implementation of

this emergency Regulation. When the emergency Regulations are approved, DBHDS will have substantial work before it is able to implement and fulfill these requirements.

In fairness, DBHDS recognizes that there are significant shortcomings in the Commonwealth's current approach and is working to improve processes for both provisions. In the twelfth review period, its OL sustained its increased focus on the case management service at the Community Services Board (CSB) level, but it has not assessed the adequacy of services directly. Its licensing processes for case management services have not been sufficient to ensure that CSBs fulfill their responsibilities, or, in some cases, significantly improve their performance. DBHDS assigned case management responsibilities in its Performance Contracts with the CSBs, which have been improved to align with the Agreement's case management requirements. However, DBHDS has not utilized its Performance Contract Exhibit D process to provide some CSBs with formal notices to resolve persistent case management problems. It should be noted that a number of CSBs are using some best practices in overseeing case management, and there are also several instances where the DBHDS performance improvement strategies currently being implemented are appropriate and timely.

DBHDS has begun a concerted and focused effort on local and systems improvements around case management. Most important, during the twelfth review period, the DBHDS Commissioner focused DBHDS attention on implementation of case management: he solicited from each CSB a self-assessment and a proposed plan for local improvements toward a case management transformation, both of which are due by July 2018. DBHDS plans to convene a workgroup to identify cross-state themes and to monitor the progress of these improvement efforts.

The Commonwealth's case management improvement, system coordination activities, and future plans are all positive and much-needed steps. To date, however, there is no plan for the Office of Licensing to fulfill these two provisions specified in the Agreement. In addition, the Commonwealth has not yet created an entity or mechanism to coordinate all its various case management monitoring and improvement activities. Fulfilling the two external oversight provisions of the Agreement is essential to ensuring that the services provided to the target population are adequate and appropriate.

During the twelfth review period, the Commonwealth continued to implement its redesigned Home and Community Based Services (HCBS) waivers, which has resulted in even more individuals now living in integrated residential settings and engaging in their communities. These improvements continue the trend that began in the tenth review period. Specifically, in residential settings, 257 more individuals are now living in smaller homes for four or fewer people with disabilities. In community engagement, 314 more individuals are participating in two integrated day services, Community Engagement and Community Coaching, both of which were created by the redesigned waivers.

For services to children with intense medical and behavioral needs, as previously reported, the Commonwealth adopted a two-part strategy to offer and provide integrated community-based, rather than institutional, services. These two approaches involve diverting children referred for admission to nursing facilities and the largest Intermediate Care Facilities (ICFs) to receiving needed supports in their families' homes or other community-based settings. The second involves facilitating discharge planning and transitions of children who already live in institutions to community settings. As of the end of the twelfth review period, the Commonwealth has designed and effectively implemented instrumental steps that have reduced the number of children with intellectual and developmental disabilities (ID/DD) living in nursing homes.

DBHDS established in its Office of Integrated Health (OIH) a structure and processes to screen children with ID/DD prior to admission to a nursing home, and to facilitate discharge and transition planning for children admitted. To screen children, the Commonwealth revised its practices to better align with the Federally required Preadmission Screening and Resident Review (PASRR) process. OIH now manages the PASRR process for the individuals requiring a Level II process for screening individuals who have indicators of a developmental disability. This screening process involves identifying the obstacles to children being supported in their family homes, determining the available alternatives, and addressing and resolving the obstacles; thus, allowing the children and families to access alternative community-based services.

For children referred for admission to the two largest private ICFs, the DBHDS had developed plans, but had not yet created a single point-of-entry process, and had not diverted any children who were referred for admission, as of March 31, 2018. Since then, however, the Commonwealth successfully amended its protocols to create a single point-of-entry process for ICFs. These changes required the approval of the Center for Medicaid and Medicare Services (CMS) of a State Plan Amendment, which became effective on May 1, 2018, and will be further addressed through regulation . OIH staff expect that this process, like the one implemented for nursing homes, will have a positive impact and that many children will be diverted from admission to receive community-based services.

For children who have been living in, or are newly admitted to, institutions other than Training Centers, OIH began several initiatives to facilitate the transitions from two nursing facilities and two large ICFs. Since March 2015, only twenty-three children have been admitted to nursing facilities, all for targeted short-term purposes (i.e. medical rehabilitation, respite care, or hospice), and fourteen have already been discharged. For children who were admitted prior to the realigned PASRR process, the Commonwealth facilitated the discharge of ten of these children from one of the nursing facilities during 2017. Whereas, unfortunately, at the other nursing facility, the discharge and transition process has not worked well. None of the children living at this second nursing facility were discharged during 2017. For children living in the largest ICFs, DBHDS successfully transitioned nine older children during 2017. However, none of the children under age ten who live in these ICFs were discharged. These children were not in the age group that was prioritized for transition to community-based settings.

As a result of the initiatives described above, the Commonwealth has effectively diverted children from unnecessary placement in the two nursing homes, and admitted children only for targeted short-term purposes. It has also successfully facilitated the transition of older children from the two ICFs. As of March 2018, DBHDS reports that 171 children with ID/DD were residing at these two nursing and two ICF facilities, twenty-five fewer than the 196 that it reported in 2015.

The Independent Reviewer has previously reported to the Court that families of individuals with ID/DD who live at home were not able to hire or retain nurses or direct support professionals to provide critically needed supports. This problem still continues, and is unlikely to be resolved until higher rates of pay are addressed for the qualified staff needed to competently care for individuals in rural areas or with intense needs. Although the Commonwealth's state budget for Fiscal Year 2019 is not yet approved, the Independent Reviewer has been apprised that it will not likely include funding to increase pay rates for these positions. The Commonwealth has reported that it is currently studying this issue and will decide by the Fall whether to propose pay rate increases for Fiscal Year 2020.

The Agreement's crisis services requirements are not being implemented properly. Rather than providing in-home initial assessments to individuals in crisis before removing them from their homes, CSB Emergency Services (ES) staff are still maintaining the practice of completing these assessments in out-of-home settings, typically in hospitals. This results in individuals in crisis being removed from their homes prior to an initial assessment and before the crisis teams' efforts to de-escalate. Being removed from the home is also a factor contributing to the significant increase in the institutionalization of children and adults with ID/DD being treated for psychiatric or behavioral conditions. Yet another factor is the current crisis stabilization programs are often not available due to the lack of available beds. This is due, in part, because individuals routinely remain longer than the thirty-day stay limit in the Agreement due to the lack of a permanent community placement. The Commonwealth now projects January 2019 opening dates for two transitional homes for adults and two therapeutic homes for children, both of which will allow longer stays.

During the eleventh and twelfth review periods, the Commonwealth maintained compliance with all the discharge planning and transition provisions that it had previously accomplished. It also achieved compliance with three additional related Discharge and Transition Planning from Training Centers. Almost all of the individuals with intense needs who transitioned from Training Centers moved to smaller, more integrated, accessible and well-maintained homes. Many positive healthcare outcomes were found for virtually all the individuals studied. The Post-Move Monitor (PMM) visits occurred as expected and extra PMM follow-up visits occurred to confirm resolution, if concerns were identified. DBHDS also demonstrated an effective quality improvement process by making improvements to the transition process based on areas of concern that were previously identified. The remaining areas of concern with discharge planning reflect systemic challenges that exist throughout the Commonwealth's community-based service system, i.e. insufficient day programs for individuals with intense needs and the lack of integration opportunities.

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 Appendices. 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: an Individual Services Review (ISR) study of individuals with intense behavioral needs; mobile crisis services; Integrated Day Activities/Supported Employment; Regional Support Teams (RST); Quality and Risk Management; Licensing and Human Rights Investigations; Provider Training; and Mortality Review.

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

II. SUMMARY OF COMPLIANCE

Settlement Agreement Reference	Provision	Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	**Compliance ratings for the eighth, ninth, eleventh, and twelfth periods are presented as:** 8th period (9th period) 11th period **12th 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-vii	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community … vii. In State Fiscal Year 2018, 90 waiver slots	(Compliance) Compliance **Compliance**	The Commonwealth created 100 Community Living waiver slots during FY 2018, ten more than the minimum number required for individuals to transition from Training Centers.
III.C.1.b.i-vii	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) … vii. In State Fiscal Year 2018, 325 waiver slots.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth created 424 new waiver slots in FY 2018 exceeding the total required for the former ID and IFDDS slots. Children have transitioned from one nursing facility; older children only have been transitioned from two living ICFs. For III.C.1. b. and c., only 32 of the180 (17.8%) prioritized slots have been used; an additional 30 non-prioritized slots have been used. See Findings III.B. for more information.

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III.C.1.c.i-vii	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) … vii. In State Fiscal Year 2018, 25 waiver slots, including 10 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 424 new waiver slots in FY 2018 exceeding the total required for the former ID and IFDDS slots. Children have transitioned from one nursing facility; older children only have been transitioned from two living ICFs. For III.C.1. b. and c., only 32 of the180 (17.8%) prioritized slots have been used; an additional 30 non-prioritized slots have been used. See Findings III.B. for more information.
III.C.2.a-b	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2018, a minimum of 1000 individuals will be supported.	Non Compliance (Non Compliance) **Non Compliance**	The Commonwealth continues to meet the quantitative requirement. DBHDS completed a strategic plan which outlines a path to compliance; implementation will not be evident until 2019.
III.C.5.a	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	(Compliance) Compliance **Compliance**	70 (100%) of the individuals reviewed in the individual services review studies during the 10th, 11th, and 12th periods had case managers and had current Individual Support Plans.
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.i.	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	Non Compliance Non Compliance	*The Individual Services Review and Case management studies found continuing inadequacies in case management performance.*
III.C.5.b.ii	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	Non Compliance Non Compliance	*See comment immediately above.*

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III.C.5.b.iii	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	Non Compliance Non Compliance	*See comment regarding III.C.5.b.i.*
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 (Deferred) Non Compliance **Non Compliance**	The Individual Services Review studies during the 10th, 11th and 12th periods found that case managers had offered choices of residential and day providers, but whether 53 (67%) of 70 individuals were offered a choice of case managers was not documented.
III.C.5.d	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	(Non Compliance) Non Compliance	*The DBHDS licensing regulations and 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**	This is an overarching provision. Compliance will not be achieved until the Commonwealth is in compliance with the components of Crisis Services as specified in the provisions of the Agreement.
III.C.6.b.i.A	The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	(Compliance) Compliance **Compliance**	CSB Emergency Services are utilized. REACH hotlines are operated 24 hours per day, 7 days per week, for adults and for children with ID/DD.

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III.C.6.b.i.B	By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.	(Compliance) Compliance **Compliance**	REACH trained 2,173 CSB staff and 607 ES staff during the past three years. The Commonwealth requires that all ES staff and case managers are required to attend training.
III.C.6.b.ii.A.	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	Non Compliance Non Compliance **Non Compliance**	The CSB – ES are not typically dispatching mobile crisis team members to respond to individuals at their homes. Instead the CSB-ES continues the pre-Agreement practice of meeting individuals in crisis at hospitals or at CSB offices. This practice prevents the provision of supports to deescalate crises.
III.C.6.b.ii.B	Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.	Non Compliance Non Compliance **Non Compliance**	See comment immediately above re: III.C.6.b.ii.A
III.C.6.b.ii.C	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.	Compliance (Compliance) Compliance **Compliance**	During the past three years, REACH children's and adult programs have trained 3,288 law enforcement personnel.
III.C.6.b.ii.D	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	((Compliance) Compliance **Compliance**	REACH Mobile crisis teams for children and adults are available around the clock and respond on-site at all hours of the day and night.
III.C.6.b.ii.E	Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	(Compliance) Compliance **Compliance**	Four Regions provided adults with ID/DD with more than an average of three days in-home supports. Region I provided only an average of two days of support.

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III.C.6.b.ii.H	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	(Compliance) Compliance **Compliance**	The Commonwealth did not create new teams. It added staff to the existing teams. REACH teams in all five Regions responded within the required average annual response times during the eleventh review period.
III.C.6.b.iii.A.	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services	(Compliance) Compliance **Compliance**	All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults 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.	(Non Compliance) Non Compliance **Non 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 **Non Compliance**	Each Region's crisis stabilization program continues to routinely have stays that exceed 30 days, which are not allowed. Transitional and therapeutic homes that allow long- term stays are being developed.
III.C.6.b.iii.E.	With the exception of the Pathways Program at SWVTC … crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth does not have sufficient community-based crisis stabilization service capacity to meet the needs of the target population in the Region.
III.C.6.b.iii.F.	By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.	(Compliance) Compliance **Compliance**	Each Region developed and currently maintains a crisis stabilization program for adults with ID/DD.

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III.C.6.b.iii.G.	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth has determined that it is not necessary to develop additional "crisis stabilization programs" for adults in each Region. It has decided to add, but not yet developed two programs statewide to meet the crisis stabilization needs of adults who require longer stays. Children's crisis stabilization programs are also planned but developments have again been delayed.
III.C.7.a	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	(Non Compliance) Non Compliance	*This is an overarching provision. Compliance will not be achieved until the component provisions of integrated day, including supported employment, are in compliance.*
III.C.7.b	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy… (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in the ISP.	(Non Compliance) Non Compliance **Non Compliance**	The Individual Services Review study found that employment services and goals were not developed and discussed for 34 of 59 individuals (57.6%). ISPs frequently include checked boxes that indicate employment was discussed, but there were no records that possible goals were developed and discussed, which would ensure a meaningful discussion.
III.C.7.b.i.	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreation opportunities, and other integrated day activities.	Non (Compliance) Compliance	*The Commonwealth had previously developed a plan for Supported Employment. It has revised and improved its implementation plan with stronger and required elements for integrated day opportunities/activities.*
III.C.7.b.i.A.	Provide regional training on the Employment First policy and strategies through the Commonwealth.	(Compliance) Compliance	*DBHDS continued to provide regional training on the Employment First policy and strategies.*

Settlement Agreement Reference	Provision	Rating	Comments
III.C.7.b.i. B.1.	Establish, for individuals receiving services *through the HCBS waivers*, annual baseline information regarding:	Compliance	*The Commonwealth has significantly improved its method of collecting data. For the third consecutive period, data were reported by 100% of the employment service providers. It can now report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a, b, c, d, and e below.*
III.C.7.b.i. B.1.a.	The number of individuals who are receiving supported employment.	(Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.b.	The length of time individuals maintain employment in integrated work settings.	(Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.c.	Amount of earnings from supported employment;	(Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.d.	The number of individuals in pre-vocational services.	(Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.e.	The length-of-time individuals remain in pre-vocational services.	(Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.2.a.	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	Non Compliance (Compliance) Non Compliance	*The Commonwealth set targets to meaningfully increase the number of individuals receiving waiver-funded services. It did not make substantial progress toward achieving the targets. During the most recent six-month period, the number of individuals in supported employment declined. The Commonwealth has not identified or addressed the systemic obstacles to increasing employment.*
III.C.7.b.i. B.2.b	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	Compliance (Compliance) Compliance	*The Commonwealth has improved data collection. 84% of the individuals had worked at their job for at least twelve months, one percent short of its goal of 85%.*

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III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. … shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly … Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	(Compliance) Compliance	*The RQCs met during each quarter of the tenth and eleventh review periods. They consulted with the DBHDS Employment staff, both members of the SELN (aka EFAG). The RQCs completed required quarterly reviews.*
III.C.7.d.	The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.	(Compliance) Compliance	*The RQCs reviewed the employment targets and the State's progress for FY 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.	(Non Compliance) Non Compliance	*A review found that DMAS /Broker have implemented previous recommendations and DMAS added them to its RFP, which it has had to reissue. Sustained improvements and a functioning quality improvement program will not be able to be evaluated until 2019.*
III.C.8.b.	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.	Non Compliance (Non Compliance) **Non Compliance**	DBHDS has developed a multi-part plan for publishing guidelines. Guidelines for the IFSP resources and strategies have not yet been developed and published, but the Commonwealth has made good progress.
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	*This is an overarching provision. The need for more integrated settings will not be resolved until full implementation of the redesigned waivers and additional provider development, especially to serve individuals with intense needs.*

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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 Compliance	*The Commonwealth has created 553 independent housing options and is almost a year ahead of its goal to achieve 847 new options by FY2021.*
III.D.3.	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	Compliance (Compliance) 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	*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	*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.*
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 and Completed**	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds have been provided permanent rental

Settlement Agreement Reference	Provision	Rating	Comments
			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**	Family-to-family and peer programs were not active for individuals who live in the community and their families, however, DBHDS is making progress.
III.D.6	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	Non Compliance Non Compliance **Non Compliance**	Children were placed in ICFs, without the prior review of the CRC or the Regional Support Teams. The Commonwealth has recently created a single-entry point for ICFs. It must review obstacles to more integrated placements, and address and resolve them.
III.D.7	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home …	Compliance (Compliance) Compliance	*The Commonwealth included this term in its performance contracts with CSBs. This offer is outlined in the ISP which is acknowledged, approved and signed by the individual/Authorized Representative.*
III.E.1	The Commonwealth shall utilize Community Resource Consultant ("CRC") positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office…The CRCs shall be a member of the Regional Support Team ...	(Compliance) Compliance **Compliance**	Community Resource Consultants (CRCs) are located in each Region, are members of the Regional Support Teams, and are utilized for these functions.
III.E.2	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	Non Compliance Non Compliance	*Case Managers frequently did not submit referrals, as required, to allow the CRCs and the RSTs to review cases prior to the placement. DBHDS reports that 18%-48% of referrals were late during the four quarters of 2017. Late referrals largely nullify the purpose of the RST review.*

Settlement Agreement Reference	Provision	Rating	Comments
III.E.3.a-d	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	(Compliance) Compliance **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 eighth, ninth, eleventh, and twelfth periods are presented as:** 8th period (9th period) 11th period **12th period**	***Note: The Independent Reviewer gathered information about individuals who transitioned from Training Centers and rated compliance during the fifth, seventh, ninth and twelfth review periods.*** ***The Comments in italics below are from the period when the compliance rating was determined.***
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	(Compliance) **Compliance**	The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It has continued to implement improvements in response to concerns 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**	This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Discharge section are determined to be in compliance.
IV.B.3.	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	(Compliance) **Compliance**	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	(Non Compliance) **Non Compliance**	Discharge plan goals did not include measurable outcomes that promote integrated day activities. None (0.0%) of the 19 individuals studied were offered integrated day opportunities and none (0.0%) had typical days that included regular integrated activities.
IV.B.5.	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan will be developed within 30 days prior to discharge.	(Compliance) **Compliance**	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans are well documented. All individuals studied had discharge plans.
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	(Compliance) **Compliance**	The documentation of information provided was present in the discharge records • for 45 (100%) of the individuals studied during the ninth and twelfth review period.
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	(Compliance) **Compliance**	The discharge plans included this information.
IV.B.5.c.	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	(Compliance) **Compliance**	• for 95 of 96 individuals (99.0%) studied during the fifth, seventh, ninth and twelfth review periods, the discharge records included these assessments.
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	(Compliance) **Compliance**	The PSTs select and list specific providers that provide identified supports and services.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	(Compliance) **Compliance**	The Training Centers document barriers in six broad categories as well as more specific barriers.
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	(Compliance) **Compliance**	The severity of the disability has not been a barrier in the discharge plans.
IV.B.5.e.ii.	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	(Compliance) **Compliance**	DBHDS has identified the factors that led to readmission and has implemented steps to support individuals with intensive needs.
IV.B.6	Discharge planning will be done by the individual's PST…Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	(Non Compliance) **Non Compliance**	The Individual Services Review Study found that the discharge plans lacked recommendations for services in integrated day opportunities.
IV.B.7	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	(Compliance) **Compliance**	The Commonwealth's discharge plans indicate that individuals with complex needs can live in integrated settings.
IV.B.9.	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	(Compliance) **Compliance**	The Individual Services Review studies during the fifth, seventh, ninth and twelfth review periods found that □ 97 (100%) of individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST.
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	(Compliance) **Compliance**	Discharge records included evidence that the Commonwealth had offered a choice of providers.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the … community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	(Compliance) **Compliance**	The ninth and twelfth individual services reviews found that • 39 of 45 individuals (86.7%) and their ARs did have an opportunity to speak with individuals currently living in their communities and their family members. All 100% received a packet of information with this offer, but discussions and follow-up were not documented for four individuals.
IV.B.9.c.	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	(Compliance) **Compliance**	PST's and case managers assisted individuals and their Authorized Representative. For 100% of the 45 individuals studied in the 9th and 12th ISR studies, providers were identified and engaged; provider staff were trained in support plan protocols.
IV.B.11.	The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	(Compliance) **Compliance**	During the fifth, seventh, ninth and twelfth review periods, the reviews found that • 89 of 97 individuals /Authorized Representatives (91.8%) who transitioned from Training Centers were provided with information regarding community options.

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

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.1	Once a specific provider is selected by an individual, the Commonwealth shall invte and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.	(Compliance) **Compliance**	The Independent Reviewer found that the residential staff for • 100% of the 45 individuals participated in the pre-move ISP meeting and were trained in the support plan protocols.
IV.C.2	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	(Compliance) **Compliance**	During the fifth, seventh, ninth, and twelfth periods, the Independent Reviewer found that • 94 of 97 individuals (96.9%) had moved within 6 weeks, or reasons were documented and new time frames developed.
IV.C.3	The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	(Compliance) **Compliance**	The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions. • for 95 (100%) individuals PMM visits occurred. The monitors had been trained and utilized monitoring checklists. The look-behind process was maintained during the seventh period.
IV.C.4	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	(Compliance) **Compliance**	The Individual Services Review studies during the ninth and twelfth review periods found that • for 44 of 45 individuals (97.8%), 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) **Compliance**	The Individual Review study found that essential supports were in place prior to discharge for 21of the 26 individuals (80.8%) in the ninth period, which improved to 18 of the 19 individuals (94.7%) who were studied during the twelfth review periods.
IV.C.6	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.	(Compliance) **Compliance**	The discharge records reviewed in the ninth and twelfth review periods indicated that individuals who moved to settings of five or more did so based on their informed choice after receiving options.
IV.C.7	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	(Compliance) **Compliance**	The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans.
IV.D.1	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	(Compliance) **Compliance**	Community Integration Managers are working at each Training Center.
IV.D.2.a	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	(Compliance) **Compliance**	CIMs reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals.

Settlement Agreement Reference	Provision	Rating	Comments
IV.D.3	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	(Non Compliance) **Compliance**	The Individual Services Review study found that during the ninth period, that for 6 of 14 (42.9%) individuals referred to the RST, there was insufficient time for the CIM and RST to resolve identified barriers. Improvement was found during the twelfth review period when 2 of 2 (100%) individuals in the ISR study were referred timely and the reports showed that 92 referrals from Training Centers were on time.
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	(Compliance) **Compliance**	The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.
V.	**Quality and Risk Management**	**Compliance ratings for the eighth, ninth, eleventh, and twelfth periods are presented as:** 8th period (9th period) 11th period **12th period**	***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	*This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Quality section are determined to be in compliance.*
V.C.1	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	(Non Compliance) Non Compliance	*The Commonwealth is charting a new course. It will work with the CSBs and providers to build a risk management system of triggers and thresholds at all levels of the service system.*

Settlement Agreement Reference	Provision	Rating	Comments
V.C.2	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	Compliance Compliance	*DBHDS implemented a web-based incident reporting system. Providers now report 87% of incidents within one day of the event. Some late reports are duplicates of reports submitted timely.*
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	*The DBHDS Licensing investigations do not align with the requirements of the Agreement. Investigation oversight and follow-up has improved.*
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	*The Commonwealth is charting a new course on how it will identify individuals at risk. It is moving away from identifying triggers and thresholds based on harm that has occurred to a more proactive approach.*

Settlement Agreement Reference	Provision	Rating	Comments
V.C.5	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The …mortality review team … shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death; … (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems … and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	(Non Compliance) Non Compliance	*A Mortality Review Committee (MRC) has significantly improved its data collection, data analysis, and the quality of mortality reviews. It has begun a quality improvement program. The MRC rarely completed such reviews within 90 days; and it did not include a member, who was independent of the State.*
V.C.6	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider.	(Non Compliance) Non Compliance	*DBHDS cannot effectively use available mechanisms to sanction providers, beyond use of Corrective Action Plans. DBHDS is making progress by increasingly taking "appropriate action" with agencies which fail to report timely.*

Settlement Agreement Reference	Provision	Rating	Comments
V.D.1	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	(Non Compliance) Non Compliance	*This is an overarching provision that requires effective quality improvement processes to be in place at the CSB and state level, including monitoring of participant health and safety.*
V.D.2.a-d	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement.	(Non Compliance) Non Compliance	*DBHDS continues to expand and improve its ability to collect and analyze consistent, reliable data. These are first steps. Data elements must be defined so they can be objectively measured.*
V.D.3.a-h	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	(Non Compliance) Non Compliance	*DBHDS defined relevant measures for each domain. Staff report that efforts to produce reports based on the indicators in the eight domains are in their infancy.*
V.D.4	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	(Non Compliance) Non Compliance	*This is an overarching provision. It will be 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.*

Settlement Agreement Reference	Provision	Rating	Comments
V.D.5	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	(Non Compliance) Non Compliance	*DBHDS shared and RQCs reviewed data including: employment, OLS, OHR, and other data. The RQCs, however, had limited and frequently unreliable data available for review.*
V.D.5.a	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	(Compliance) Compliance	*The five Regional Quality Councils include all the required members.*
V.D.5.b	Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	(Non Compliance) Non Compliance	*The RQCs met quarterly, but had limited discussion. 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	*The Commonwealth is restructuring its website. DBHDS expects that its updated public reporting page will be available after March 2018.*
V.E.1	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program including root cause analysis that is sufficient to identify and address significant issues.	(Non Compliance) Non Compliance	*The Commonwealth has not yet informed providers that they are required to implement QI programs or root cause analysis.*
V.E.2	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	(Non Compliance) Non Compliance	*The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS does not yet require reporting through the risk management and provider QI programs.*

Settlement Agreement Reference	Provision	Rating	Comments
V.E.3	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	(Non Compliance) Non Compliance	*The Commonwealth's contractor completed the second annual QSR process. There are problems with the validity of the contractor's tools and process and, therefore, with the reliability of data collected and the accuracy of the results.*
V.F.1	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	Compliance Compliance **Compliance**	The eleventh period case management study found that 24 of the 25 case managers (96.0%) were in compliance with the required frequency of visits. The ninth and twelfth studies found that 45 of 46 (97.8%) completed the required visits. DBHDS reported data that some CSBs are below target.
V.F.2	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs….	(Non Compliance) Non Compliance	*The study of case management confirmed a high percent of discrepancies between the services individuals are receiving and those described in his/her ISP. All essential supports were not listed in the ISP. The behavioral supports study found that inadequacies in implementation of BSPs had not been identified, or corrective actions steps had not been taken.*
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 ninth and twelfth studies found that 45 of 46 (97.8%) completed the required visits.

Settlement Agreement Reference	Provision	Rating	Comments
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**	DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to capture case manager/support coordinator findings regarding the individuals they serve.
V.F.6	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	Compliance Compliance	*The Commonwealth developed the curriculum with training modules that include the principles of self-determination. The modules are being updated.*
V.G.1	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	Compliance Compliance	*OLS regularly conducts unannounced inspection of community providers.*
V.G.2.a-f	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Compliance Compliance	*OLS has maintained a licensing inspection process with more frequent inspections.*
V.G.3	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	(Non Compliance) Non Compliance **Non Compliance**	The DBHDS Licensing regulations and protocols do not align with the Agreement's specific requirements.

Settlement Agreement Reference	Provision	Rating	Comments
V.H.1	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	(Non Compliance) Non Compliance	*The Commonwealth has created a plan and has made progress developing and disseminating competencies. Some training requirements and identified competencies cannot be consistently measured and, therefore, cannot be effectively implemented, monitored, or result in reliable reporting.*
V.H.2	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	(Non Compliance) Non Compliance	*Same as V.H.1 immediately above.*
V.I.1.a-b	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	(Non Compliance) Non Compliance **Non Compliance**	It was not possible to determine the reliability and validity of the data gathered or the effectiveness of the proposed QSR process when fully implemented.
V.I.2	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting	(Non Compliance) Non Compliance **Non Compliance**	*Same as V.I.1. immediately above*
V.I.3	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	(Non Compliance) Non Compliance	*The Commonwealth's contractor completed the second annual QSR process. There are problems with the validity of the contractor's tools and process and, therefore, with the reliability of data collected and the accuracy of the results.*
V.I.4	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	(Compliance) Compliance	*The Commonwealth's contractor completed the second 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 Intervener's counsel.	(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**	The Independent Reviewer has determined that the Commonwealth did not maintain sufficient records to document proper implementation of the provisions, including case 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 by:

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

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

- Discharge Planning and Transition of Individuals with Complex Medical and Behavioral Needs from Training Centers;
- HCBS Waiver Slots;
- Children Living in Nursing Facilities and the Largest Private ICFs;
- Individual and Family Support, Family Guidelines, and Family and Peer Programs;
- Case Management Monitoring; and
- Crisis Services and Admissions to Psychiatric Hospitals

The Independent Reviewer retained nine independent consultants to conduct the reviews and evaluations of these prioritized areas. For each study, the Independent Reviewer asked the Commonwealth to provide all records that document that it has properly implemented the related requirements of the Agreement. Information that was not provided for the studies is not considered in the consultants' reports or in the Independent Reviewer's findings and conclusions regarding the status of the Commonwealth fulfilling the requirements of the Agreement. The consultants' reports are included in the Appendices of this Report.

For the twelfth 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 focused on the status of discharge planning and transition services for individuals who moved from the Central, Southwestern and Southeastern Virginia Training Centers to live in community-based settings in all of DBHDS's Division of Developmental Services' five Regions. Nineteen individuals were selected randomly from the list of twenty-two individuals whose Support Intensity Scale (SIS) evaluations indicated that they had intense medical or behavioral needs and who moved between September 30, 2016, and September 30, 2017. The random selection of nineteen individuals provides the Independent Reviewer a ninety percent confidence factor that the study's findings can be generalized to the cohort.

The other studies completed by the Independent Reviewer's consultants for this Report examined the status of the Commonwealth's progress toward achieving or sustaining compliance with specific prioritized provisions that were targeted for review and evaluation. The Independent Reviewer shared with the Commonwealth the planned scope, methodology, site visits, document review, and/or interviews and requested any suggested refinements to the plans for the studies.

The Independent Reviewer's consultants reviewed the status of program development to ascertain whether the Commonwealth's initiatives had been implemented sufficiently for measurable results to be evident. The consultants conducted interviews with selected officials, staff at the State and local levels, workgroup members, providers, families and staff of individuals served, and/or other stakeholders. To determine the ratings of compliance, the Independent Reviewer considered information provided prior to May 15, 2018. This information included the findings and conclusions from the consultants' studies, the Individual Services Review study, the Commonwealth's planning and progress reports and documents, and other sources. The Independent Reviewer's compliance ratings are best understood by reviewing the comments in the Summary of Compliance table, the Findings section of this Report, and the consultant reports, which are included in the Appendices.

During the thirteenth 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 twelfth period. These provisions include: services to individuals, including those with autism spectrum disorders, with intense behavioral needs; mobile crisis and crisis stabilization services; Integrated Day Activities, including Supported Employment; Quality and Risk Management; Licensing and Human Rights Investigations; implementation of new Licensing Regulations; and Mortality Review.

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

B. Compliance Findings

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

Rating Compliance for the Required Number of Redesigned HCBS Waiver Slots

Following submission of his December 13, 2017, Report to the Court, the Commonwealth requested the Independent Reviewer to review the changes in the redesigned HCBS waiver programs to determine the criteria to fulfill the quantitative requirements of the Settlement Agreement's provisions: III.C.1.b.vii-ix and II.C.1.c.vii-ix. The Independent Reviewer has previously reported that the Commonwealth's former waiver programs hampered its ability to comply with the provisions and to achieve the goals of the Agreement; these programs were inflexible and included financial incentives for providers to serve individuals in large congregate day and residential settings. The Commonwealth subsequently redesigned and amended its existing intellectual disabilities (ID), Individual and Family Developmental Disabilities Support (IFDDS), and Day Support waivers. The redesign made all waivers open to individuals with either ID or developmental disabilities (DD) other than intellectual disabilities. The redesign also restructured and merged the ID and IFDDS waitlists. The restructuring included merging and restructuring the individuals on the waitlists into three new categories using a

consistent set of criteria to define who was considered to be "most in need." Redesign of the waivers also included many defining new types of services that create opportunities for recipients to receive supports that promote increased independence and community integration.

To complete this review, the Independent Reviewer examined:

- The services currently being utilized by individuals who have HCBS waiver slots;
- The number of individuals on the priority one waitlist, the names of those presented by the CSBs as most in need of waiver-funded services, and these individuals'/Authorized Representatives' initially expressed interests, including the extent to which these services could be met with waiver-funded services exclusively available through the Commonwealth's Community Living waiver;
- The new residential support services that are now available through the redesigned waivers;
- The budgeted cost for slots in each waiver program before and after the redesign; and
- The number of slots that "turnover" and became available during Fiscal Year 2016 and 2017.

The Independent Reviewer determined that the substantial modifications to the former waiver programs, the addition of a new waiver services, and the merging and restructuring of the waitlists referred in the Agreement require new criteria to determine whether the Commonwealth is fulfilling the requirements of the Agreement to create a certain number of new waiver slots during Fiscal Year 2018 through Fiscal Year 2021.

Findings

1. More than four out of every ten individuals with current Community Living (CL) waiver slots receive waiver-funded services that could all be provided through the Family and Individual Support (FIS) or the Building Independence (BI) waivers. Of all the individuals on the CL waiver, 43% do not currently utilize the congregate residential services (i.e. group home residential and sponsored residential services), which are the service types that are offered exclusively through the CL waiver program. Of the 975 individuals who received a HCBS waiver slot (new, turnover, or emergency/reserve) during FY 2017 and who had an authorized service as of September 30, 2017, only 309 individuals (31.7%) had authorizations for congregate residential services. Whereas, 532 individuals (54.6%) were authorized to receive lower per-person cost, and typically more integrated, residential support type services. These more integrated residential service models (i.e. Supported Living, Shared Living and Independent Living Supports) are new types of residential services that are now offered through the redesigned FIS or BI waiver programs. As of October 1, 2017, the beginning of the twelfth review period, the Commonwealth also had created 553 new independent living residential options for members of the target population. All the individuals in these more independent settings receive services that can be provided through either the FIS or BI waiver programs.

2. Based on the DBHDS survey of the 1,120 individuals who are on the priority one waitlist and are identified as most in need of waiver-funded services, only 299 (27%) initially expressed interest in congregate residential services. Of the 3,044 individuals on the total priority one waitlist, 82.4% were under age twenty-six and 38.7% were under age sixteen. Younger individuals are more likely to utilize the array of services funded through the FIS or BI waivers and to transfer to the Community Living waiver as they age and their needs change.

3. Throughout the remaining period of the Settlement Agreement's waiver slot requirements, through June 30, 2021, it appears that a sufficient number of CL waiver slots will become available annually through "turnover" to meet their increased needs of individuals on the FIS or BI waivers. Slots turnover, and become available due to individuals leaving the waiver program, when individuals with slots no longer choose to utilize waiver-funded services, move out of state, or pass away. The Commonwealth will be able to transfer individuals whose needs increase from the FIS and BI waivers to the CL waiver program. The Commonwealth anticipates that, as individuals age, some will need more intense supports and physically accessible environments, which are more prevalent in congregate residential settings, which are exclusively offered through the CL waiver. However, the percentage of individuals who need such transfers in any one year will be limited. For example, substantial changes in need are not typical among the young and middle-aged who comprise a substantial portion of the individuals currently on the FIS and BI waivers.

As of Fiscal Year 2020, the Commonwealth will have created 2,122 FIS and BI waiver slots. Based on the age profile of the current cohort, the range of their support needs, and the percentage of individuals with intense medical needs, it is the opinion of the Independent Reviewer that, in one year, not more than 120 will need and chose to transfer from the FIS and BI waivers to a congregate residence . Whereas, 270 CL slots turned over and became available during Fiscal Year 2017. With approximately 11,000 Community Living Waiver slots, there was an approximately 2.5% turnover rate of existing CL slots during Fiscal Year 2017, which was substantially similar to the turnover rate for Fiscal Year 2016.

Total Waiver Slots Created by the Commonwealth

In its recently approved budget, the General Assembly provided funds for 628 wavier slots in Fiscal Year 2019 and 1,067 waiver slots in FY 2020. The budget stated that "as of July 1, 2017, the CL waiver authorizes 11,302 slots … FIS waiver authorizes 1,762 slots, and the BI waiver authorizes 360 slots. Between Fiscal Year 2012 and 2020, the Commonwealth has approved 5,504 waivers. It is commendable that this is 1,769 more waivers than the Settlement Agreement required 3,735 during that period. Because of the Commonwealth's waiver redesign, however, these numbers are not directly correlated.

Conclusion

The specific quantitative requirements of the Agreement's provisions that previously dictated the number of waiver slots that the Commonwealth was required to create each year no longer align with the redesigned waiver programs or waitlists. Until the parties agree to revise the language of the Settlement Agreement to align with the Commonwealth's redesigned waiver programs, the Independent Reviewer will utilize the criteria listed below to determine whether the Commonwealth is fulfilling the requirements for the number of waiver slots created pursuant to provisions III.C.1.a.vii-ix, b.vii-ix, and c.vii-ix.

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

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

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

2. *Children with ID/DD in Nursing Facilities and Large Private ICFs*

Background

The Independent Reviewer retained two expert consultants to review the status of children with ID/DD in two nursing facilities (NFs) and two large private Intermediate Care Facilities (ICFs). To assess the DBHDS's efforts to divert and transition children from these four facilities, the consultants randomly selected a total of twenty-six children who had either been admitted to, or discharged from, one of these facilities during 2017. In addition, the consultants conducted a follow-up review of sixteen children who resided in these four facilities and who were evaluated by the Independent Reviewer's Individual Services Review study in 2016.

As previously reported, for children with ID/DD who are referred for admission to NFs, the Commonwealth has implemented effective processes to prevent unnecessary institutionalization. As the Independent Reviewer noted in 2016, DBHDS established a structure and processes in its Office of Integrated Health (OIH) to screen children with ID/DD prior to admission to a nursing facility and to facilitate discharge and transition planning, if a child is admitted. These steps include:

- The child's relationship with the CSB is formalized when an admission to a NF is proposed;
- A single-point-of-entry process is implemented that utilizes the PASARR Federal requirement;
- For children who are admitted, the 90-day Resident Review is managed directly by DBHDS;
- Post-admission family education is initiated to ensure parents and guardians are aware of more integrated care and support options;
- Linkages are made with the Health Support Network and community health supports;
- DBHDS funding allows up to an additional ninety days of discharge case management services;
- A post-move monitoring process is implemented; and
- The responsible CSB is affirmed for individual placements.

For children living in ICFs during the 2016 review, there were no similar single-point-of entry or discharge processes in place to divert admissions or to facilitate discharge.

Subsequently, DBHDS established a Community Transition Team (CTT) to monitor admissions and discharges of children from the four institutions where children with ID/DD reside: two NFs and two

ICFs. The CTT team and the OIH staff work to identify barriers and system improvements needed to ensure children live in the most integrated setting possible. The consultants identified that the OIH staff have developed constructive relationships with the four facilities.

Single-Point-of-Entry for Nursing Facilities (NFs)

For children referred for admission to NFs, the Commonwealth's single-point-of-entry PASRR process involves identifying the obstacles to the child being supported in the individual's family home and determining the available alternatives for addressing and resolving them, so that needed supports can be arranged. Arranging for needed services frequently allows the child to be supported in his or her family's home or in an alternative community-based setting. (Generally, the family is the most efficient, compassionate service delivery system; and, if children cannot live with their biological families, alternative community-based arrangements that allow these children to participate in community living is preferable.)

The realigned PASRR process appears to fill a similar role to the required RST process and to facilitate similar desired outcomes. The consultant's study found that, for example, retrospective reviews of NF admissions since early 2015 show twenty-two admissions out of thirty-four children referred, which suggests that twelve children were diverted from NF admissions. Prior to DBHDS realigning its PASRR process such referrals almost always resulted in admissions. DBHDS has been effective diverting children from unnecessary placement in the two NFs and in arranging for alternative community-based alternative support services, usually in the individuals' family homes.

Single-Point-of-Entry for Intermediate Care Facilities (ICFs)

For children proposed for admission to large private ICFs, none were diverted during the twelfth review period that ended on March 31, 2018. The Commonwealth did not provide evidence that it had enforced the Agreement's requirement that placements into the ICFs first be reviewed by the single-point-of-entry process required by the Agreement, that is, review by the Community Resource Consultants (CRC) and RSTs.

Since, however, the Commonwealth has created a single-point-of-entry process for ICFs. This involved gaining approval by the Centers for Medicaid and Medicare Services (CMS) of a State Plan Amendment, which became effective May 1, 2018, and which, DBHDS reports, will be further addressed through regulation. The Commonwealth has not yet established that its newly created single-point-of-entry process for ICFs will effectively fill a similar role and ensure similar desired outcomes as the CRC/RST process. The OIH staff expect that this process will have a positive impact on these children and families by redirecting them to community-based waiver-funded and other services.

Discharge from Nursing Facilities

DBHDS has worked to facilitate the discharge of children from NFs. Since 2014, of the twenty-three children admitted to NFs, fourteen have been discharged. This was effective during calendar year 2017 in one of the NFs from which six were discharged. However, more work needs to be done with the second NF where none of the children were discharged.

Discharge from Intermediate Care Facilities

DBHDS prioritized eighteen to twenty-one year-olds for active discharge and successfully transitioned several of this subgroup from ICFs to community-based settings. This is the age group for whom discharge planning has accelerated historically due to the impending threat of aging out and the program no longer being funded to serve them. During calendar year 2017, the ICFs discharged nine children, seven from this age group and two children between age eleven through seventeen. On average, these nine children had lived in the ICFs for six years and three months. Although the discharge process was successful for these children, the Commonwealth has not prioritized for discharge and therefore has not been ineffective at facilitating the transition of very young children (i.e. under ten years old) to their family homes or to alternative community-based settings.

Utilization of prioritized waiver slots

During the six years, Fiscal Years 2013 - 2018, DBHDS utilized only thirty-two (17.8%) of the 180 waivers slots that had been prioritized for children to transition from these large facilities. While it had used only eighteen slots (10%) in the first five years of this period, an average of 2% each year, during the sixth year, Fiscal Year 2018, the Commonwealth used an additional fourteen slots (7.8%), which represents a significantly increased utilization rate of the prioritized waiver slots.

During these six years, DBHDS reports that CSBs utilized nine non-prioritized waiver slots and a variety of other funding sources (i.e. Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Early Intervention, Elderly and Disabled Consumer Directed (EDCD), Tech and DD waiver slots) to transition children from NFs and ICFs to return to their families' homes or to alternative community settings. Although non-waiver-funded services have been effectively utilized to divert some children from unnecessary admission to institutions and to allow for discharge. Other children, some of whom could be effectively served with waiver-funded services, have not been offered the 82.2% (148 of 180) of prioritized slots that were not used.

There are two factors that contribute to the underutilization of DDS prioritized waiver slots to prevent institutionalization: the availability of these prioritized slots is not well known at the CSB level; and children at one of the NFs and younger children at the two ICFs have not been prioritized for discharge.

The slot reservation strategy called for in the Agreement (*"dedicated waiver slots to prevent or transition from a placement in an NF or ICF")* is not clearly understood by either the CSBs or the parents. Without knowledge of the availability of prioritized waiver slots to prevent institutionalization, CSBs often inform parents considering out-of-home placement that the alternative to admission to these institutions is for their child's name to be placed on the CSB Waiver slot waitlist. Most individuals on these waitlists will remain there for years before receiving a waiver slot that will provide funding for sufficient in-home services or an out-of-home placement in a community-based setting.

This lack of awareness of prioritized wavier slots frequently contributes to desperate families applying for facility admission and to CSBs tacitly supporting or facilitating such admissions. In many cases while waiting for a waiver slot, families may be offered modest services as an alternative in order to prevent admission. These services are frequently inadequate or under-resourced, which puts the family in the position of needing to apply for facility admission.

As a consequence, some CSB case managers actively facilitate the admission of young children into the very institutions (i.e. ICF placements) that the Agreement prioritizes slots to prevent. During the process of facilitating placement of children into these private institutions, the CSB case managers are generally overlooking, or ignoring, the CSB obligation to refer such cases to their respective CRC or RST. The core motivation of these CSB case managers may very well be to address the urgent needs of the child and his or her family, and geographic proximity to these institutions may be an important consideration in their decisions.

Their actions, however, are also consistent with financial and workload incentives for the CSBs. The financial incentive is that CSBs are not required to use one of their limited waiver slots to secure a residential placement for an individual with intense support needs. The workload incentive is that once the child is placed in one of these institutions, most CSBs cease to provide the child with case management services.

It is noteworthy that seventy-seven percent of the children who live in the four institutions reviewed are from twenty-five percent (10) of the CSBs. These ten CSBs that have a significantly above average number of children living in these institutions are clustered in the northern and southeastern Regions (II and V). However, another twenty-five percent (10) of the CSBs that are clustered in the western and southwestern Regions (Region I and III) do not have any children living in these four institutions. Unfortunately, the Commonwealth did not provide information about any successful strategies used by the CSBs with no children living in these institutions.

Conclusion

As a result of the Commonwealth's efforts described above, the consultants found that DBHDS is effectively diverting children from unnecessary placement in the two NFs. The Commonwealth's single-point-of-entry process for NFs also ensures that admissions of children with ID/DD are for clearly determined and short-term purposes (i.e. medical rehabilitation, respite, and hospice) rather than for long-term care.

DBHDS has facilitated the transition of twelve children from the two ICFs to return to live in the community. However, it is underutilizing its prioritized waiver slots.

In summary, as of the time of this study, the most significant factors contributing to the Commonwealth's successful reduction in the census of children living in these four facilities are:

- Successful diversion from admission to NFs;
- Periodic reviews of whether children in NFs can be supported in community-based settings;
- Effective transition planning and placement process at one NF; and
- Active discharge process for eighteen to twenty-one-year olds who live in the ICFs.

Although the Commonwealth has made substantial progress, it remains in non-compliance with Sections III.C.1.b.i-viii and c.i-vii.

3. Individual and Family Support Program, Family Guidelines, and Family and Peer Programs

The Agreement requires the Commonwealth to create an Individual and Family Support program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be at the most risk of institutionalization. The Independent Reviewer previously reported that the Commonwealth had not met the qualitative requirements for the IFSP. He reported that:

1) the Commonwealth's IFSP did not include a comprehensive and coordinated set of strategies to ensure access to person and family-centered resources and supports, as required by the program's definition in Section II.D.; and

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

The Independent Reviewer again retained the same independent consultant who had completed previous studies of the IFSP during the sixth and eighth review periods. The consultant documented in the IFSP study reported in June 2016 that DBHDS had initiated a redesign of its IFSP and had acknowledged its awareness of the issues that resulted in the non-compliance described. DBHDS had developed a task force, led by its Director of Administrative and Community Operations, to address many of the issues. Working with the Task Force, DBHDS indicated at that time its intent to reorganize the IFSP into a program that would be based in its Regions and overseen by non-profit organizations, which would be directed by individuals/families. Overall, the eighth period review indicated that additional planning and deliberation with stakeholders were needed, through a strategic planning process, to develop a clear plan that would address the requirements of the Agreement. That plan would include goals, objectives and timelines as well as a set of planned outcome and performance measurement indicators and a data collection methodology.

For this twelfth Report to the Court, the Independent Reviewer again prioritized further study of the Commonwealth's compliance with the qualitative aspects of the Commonwealth's IFSP. DBHDS previously informed the Independent Reviewer that the development and implementation of its redesigned IFSP would not be fully evident by March 2018, during this review period. This study, therefore, was designed to focus on whether the Commonwealth's current design for its IFSP, and any early implementation efforts, address the requisite elements of the related Agreement criteria, and whether the components of the Commonwealth's current strategic plan could be reasonably expected to fulfill the requirements once fully enacted.

The consultant's study, which is included at Appendix D, also reports on whether the Commonwealth has complied with the quantitative requirement to support a minimum of 1000 individuals during Fiscal Year 2018. The Independent Reviewer's sixth and eighth Reports and the consultant's previous studies' findings and recommendations are referenced in the attached report, as these inform the basis for evaluating progress toward compliance. In addition to the sections of the Agreement reviewed in the previous studies, this version includes an examination of requirements under:

- Sections IV.B.9.b. and III.D.5., which require the Commonwealth to establish a family-to-family and peer-to-peer program to facilitate opportunities to speak with providers, visit community placements and programs, and to facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options.
- Section III.C.8.b., which requires the Commonwealth to 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.

Since the 2016 review, the Commonwealth has devoted appreciable resources and effort in the area of individual and family supports. This had resulted in DBHDS having taken considerable strides by March 31, 2018, the end of this period, in planning for an IFSP to address the related provisions of the Agreement. Examples included:

- As had been recommended in previous reports, DBHDS, in collaboration with the IFSP Council developed an overall strategic plan for individual and family supports. "Virginia's Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities, November 17, 2017", is focused on four goals (see 1. – 4. below) that are consistent with the Agreement requirements, with concomitant objectives and strategies.
- In conjunction with its planning process, DBHD created an IFSP Community Coordination Program in addition to the existing IFSP Funding Program. The Community Coordination Program is focused on the development and coordination of additional community resources for individuals and families and on ensuring stakeholder involvement.
- Through the Community Coordination Program, DBHDS made good progress toward the development of an IFSP State Council and Regional Councils. These entities would serve, in part, as vehicles for sharing information about individual and family supports with, and obtaining input from, stakeholders. The State Council also was to provide guidance that reflects the needs and desires of individuals and families across Virginia. The Community Coordination Program has also been working to expand other outreach opportunities, such as the "My Life My Community" (MLMC) website.
- DBHDS incorporated feedback from the IFSP Councils to continue making modifications to its funding program as well as leveraging technology to streamline the application and distribution processes. DBHDS substantially exceeded its obligation to serve a minimum of 1,000 individuals/families in each of the three years through its IFSP Funding Program, serving 2,943 in Fiscal Year 2016, 2,674 in Fiscal Year 2017 and 3,049 in Fiscal Year 2018.
- A Memorandum of Agreement (MOA) was pending between the Commonwealth and an external entity with subject matter expertise at the time of the consultant's review. The MOA would lead to building upon its existing parent-to-parent program toward establishment of

family-to-family and peer programs, as required under Sections IV.B.9.b. and III.D.5. of the Agreement. This proposed collaboration has good potential to support DBHDS in addressing these requirements.

Each initiative described above is positive, however, work remains to be accomplished. The needed work was often still in the preliminary planning or early implementation stages. For example, DBHDS often needed to firm up the specific work plans and to project timelines related to the measurable milestones to achieve its goals. Still, the planning and early implementation has laid out a path that has good potential for moving the Commonwealth toward fulfilling the Agreement's requirements for individual and family support.

The strategic plan developed for IFSP, "Virginia's Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities, November 17, 2017" (IFSP State Plan) described a considerably more comprehensive vision for individual and family supports. It focused on four goals which were consistent with the Agreement requirements:

1. Ensuring that the IFSP funding serves individuals with developmental disabilities (DD) and their families by braiding and blending resources to focus on the needs of the whole person, with emphasis on prioritizing those with the greatest needs and at most risk of institutionalization;
2. Creating a robust and holistic state-level family support program model that furthers the goal of continued residence of an individual with DD in his/her own home or the family home;
3. Enhancing the knowledge of families, individuals with DD and community agencies about the IFSP through effective, coordinated, and comprehensive outreach; and,
4. Administering a transparent and effective IFSP that seeks to incorporate the input of individuals with disabilities and families to ensure access to supports for all Virginians, regardless of their waitlist status.

For the Commonwealth's current plans to be successful, and as previously recommended, DBHDS still needs to focus additional attention on several areas:

- DBHDS has not yet made a clear determination about how to define those considered to be "most at risk for institutionalization" for the purposes of the IFSP. The Department has drafted pending administrative rule changes to remove a statutory requirement to fulfill funding requests from individuals and families on a "first come-first served basis." The proposed rule changes also call for allowing DBHDS to define administratively "most in need" and any prioritization criteria, with the advice of the IFSP State Council. DBHDS needs to clarify whether its recent prioritization of the waiver waitlist into three priority levels of those considered to be "most in need" would also be applicable to the IFSP Funding Program. According to DBHDS, due to the regulatory calendar, any changes would not be expected to take effect until mid-2019, after the fourteenth review period. DBHDS would still need ample time before that date to fully consider what prioritization criteria should apply and to prepare to implement any agreed-upon alternative.

- While DBHDS continues to extend outreach efforts to those on the waiting list regarding the IFSP Funding Program, stakeholders still express concern that everyone on that list did not receive direct notification with guidance regarding current information about this funding opportunity. Individuals and family members need to know when, where and how to look for the on-line announcements to be able to participate; without that direct notification, there remains concern that those who lack a current and ongoing connection to the service system are least likely to be informed about available funding. Stakeholders view this as perpetuating a system in which people who already have access to information and resources obtain additional access to the IFSP Funding Program, by virtue of their ongoing connections, while others did not.
- The Commonwealth still needs to examine the role of case management in ensuring access to and coordination of individual and family supports that might be available outside of the waiver programs. In conjunction with its waiver re-design process, DBHDS has issued emergency regulations, providing that individuals on the waitlist "may" receive case management services. The Department of Medical Assistance Services (DMAS), however, has not yet established the criteria through which case management will be available outside the waivers, and guidelines for accessing these services have not been provided to members of the target population who are on waitlists The Commonwealth reports that DMAS, whose regulations establish eligibility criteria for case management, will work with the IFSP program at the state and local levels to provide clear and accessible information regarding case management requirements for individuals who are not on the DD waivers.
- DBHDS still needs to identify indicators to adequately assess performance and outcomes of the IFSP and to develop the capacity for the collection and the analysis of the needed data. At the least, the Department needs to develop indicators related to: access, comprehensiveness and coordination of individual and family supports; the program's impact on the risk of institutionalization; and individual and family satisfaction. While this current review continues to find that performance and outcome indicators have not yet been developed, DBHDS staff did report plans to begin this process in the near future. As the pace of IFSP implementation continues to quicken, and policy and procedural decisions are made, having an effective system for data collection and analysis will become even more crucial.

Publishing Guidelines for Families Seeking Services

For families seeking ID/DD services, the Agreement requires the Commonwealth to publish guidelines explaining how and where to apply for and obtain services and to update these guidelines annually. These guidelines are to be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.

DBHDS has developed a multi-part plan, in conjunction with the IFSP State Plan, for publishing guidelines that can be used effectively to direct individuals in the target population to the correct point-of-entry to access services. Components of the overall communication plan include:

- IFSP Funding Program Guidelines: As described earlier, DBHDS Funding Program staff have continued efforts to apprise individuals and families of any changes through a variety of venues. These include a user manual, which is available on-line, as well as instructional and FAQ documents about the use of the debit card and timelines/procedures for submission of required receipts. The DBHDS website continues to have a separate webpage for IFSP information, with links and downloadable documents. The outreach plan does not yet have a clear methodology for ensuring that everyone on the waitlist is notified of current information regarding funding opportunity. The guidelines that are required by the Agreement must be updated annually to ensure that they provide current information. This remains a significant gap.
- IFSP Regional Councils: One of the primary roles envisioned for the IFSP Regional Councils is to identify and/or develop local resources and to share these with their communities. Each Regional Council has developed its own regional work plan to this effect and is experimenting with various implementation strategies. In addition to the single staff person who has been supporting the work of the Councils and the facilitation of the IFSP State Plan development, DBHDS is planning to create another staff position in order to provide more hands-on logistical support for Regional Council activities and to develop needed marketing, outreach and informational materials. .
- Navigating the Developmental Disability Waivers: DBHDS had issued a set of updated guidelines in October 2017, collectively entitled "Navigating the Developmental Disabilities Waivers, Sixth Edition", which provides information to help direct individuals in the target population to the correct point of entry to access for waiver services. This included several pieces, including *The Details*, *The Basics*, *In One Page* and *The Workbook*, and covered topics such as eligibility, the waiting list, a description of the waivers, an overview of waiver services and a listing of other contacts and resources. The document did provide brief mention of individual and family support, stating "In addition, individuals on the waitlist can apply through DBHDS for the Individual and Family Support Funding Program once each year. Details regarding this yearly option can be obtained online by searching for "IFSP" at dbhds.virginia.gov."
- My Life My Community (MLMC) Website: DBHDS is collaborating with the Senior Navigator to re-brand and expand upon the MLMC website, which currently provides information to individuals and families on the recent changes to the waiver programs. The MLMC site will serve as a centralized on-line portal for families to access relevant information on a variety of topics. Initial plans for the MLMC include incorporating information about family supports, housing, and service providers. The Commonwealth reports that the new website will feature new content and links to other trusted resources, as well as a searchable database that is location specific. The Senior Navigator expects to have the revised website published by September 2018.

Perhaps the biggest challenge relative to ensuring that individuals and families are guided to the correct point for access to services is in the identification of individuals and families who have not yet been provided guidelines with current information. Since the first years of the Agreement, the Commonwealth has notified individuals and their families of IFSP resources when the individual is placed on the waitlist. However, significant changes in the program have typically occurred annually, including the deadlines and the method of applying for funds. For example, when DMAS clarifies the eligibility criteria for access to case management services for individuals on the waitlist, the Commonwealth will need to provide updated guidelines so individuals who are on the waitlist and need such coordination are able to gain access. DBHDS is aware of a need to provide updated information to individuals on the waitlist and their families. It has some plans underway, or pending, to address it. For example, one of the objectives in the IFSP State Plan is to draft a strategy for sharing current information with families based on their connectedness to resources. DBHDS reported that its IFSP staff would soon begin managing data entry and updating the waitlist. IFSP staff believed this access to waitlist information would facilitate better direct outreach to all members of the target population.

DBHDS has not yet fulfilled the requirements of, and remains in non-compliance with, Section III.C.8.b. However, it has made good progress.

Family-to-Family and Peer Programs

The Agreement requires the Commonwealth to develop family-to-family and peer programs to facilitate opportunities to provide individuals, their families, and, where applicable, their Authorized Representatives with opportunities to speak with providers, visit community placements 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.

Pursuant to these proposed strategies in its IFSP State Plan, DBHDS developed a white paper entitled "Engaging Individuals and Families, September 19, 2017" outlining its intent to develop family-to-family and peer support programs in collaboration with Virginia Commonwealth University's (VCU's) existing Partnership for People with Disabilities Family-to-Family Program. This effort would also build upon the family and peer mentoring programs DBHDS has already implemented for individuals transitioning from the Training Centers. Specifically, the most recent draft of the pending MOA provided for review, describes two of the purposes of the DBHDS/VCU collaboration as: 1) to implement evidence-informed supports to families of people with developmental disabilities receiving or waiting to receive home- and community-based services; and, 2) to determine a feasible evidence-informed peer support model for people with disabilities receiving or waiting to receive home- and community-based services. The Commonwealth defined a broad scope of work for these objectives, which is described in Appendix D.

In community settings, DBHDS reports its intent to use the revised Informed Choice form to document that a case manager has offered the individuals and their families opportunities to talk with other individuals who are receiving waiver services. DBHDS staff further report that the Informed Choice form was recently revised. Going forward, the CSB case managers will complete this form on an annual basis as part of the annual ISP planning/development process. The proposed collaboration between DBHDS and VCU has good potential as a framework for enhancing the Commonwealth's efforts to address these last two requirements. The initiative, as planned, will expand the family and

peer resources available to be matched with those who express an interest. The current provisions of the MOA are broadly stated, however, and do not specify how the proposed program would interface with the annual individual service planning and informed choice processes, or how these interfaces might serve to increase the number of individuals and families who choose to participate. DBHDS staff indicate that a more detailed work plan is to be developed once the contract has been finalized. To move toward compliance, DBHDS should ensure that the work plan provides for these specific interfaces. The work plan should also address the performance and outcome indicators that need to be tracked to ensure program efficacy and a quality improvement program.

DBHDS remains in non-compliance with III.C.8.b. and III.D.5. Although it has not yet fulfilled the requirements of this section for individuals living in the community, DBHDS is making progress.

4. Case Management Monitoring

The Independent Reviewer retained an independent consultant to review the effectiveness of the multiple case management monitoring mechanisms used by the Commonwealth. These include the DBHDS OL) the DMAS's Quality Management Review (QMR) process, the DBHDS Quality Management Division's (QMD) recently restarted support coordination/case management reviews, the external Quality Service Review (QSR) process, the DBHDS Data Dashboard data tracking system, and the Division of Developmental Services (DDS)'s electronic supervisory review/QRT (Quality Review Team). Note that some CSBs refer to case management as support coordination. Case Management is the term used in the Agreement and the term that will be used throughout this Report.

The consultant's study was one source of facts and analysis related to the Commonwealth's case management monitoring systems in the Independent Reviewer's assessment of whether these systems are fulfilling the requirements of the Agreement. Sections III.C.5.c., III.C.5.d., and V.G.3. require the Commonwealth to include a term in its Performance Contract with the CSBs related to case management, to establish a mechanism to monitor compliance with performance standards for case management, and to ensure that the DBHDS licensure process assesses the adequacy of the individualized supports and services.

The consultant's study goal was to crosswalk the Commonwealth's case management monitoring mechanisms and their stated purposes, to identify the flow of quality information on case management from these mechanisms, and to pinpoint any overlaps, duplications, conflicts, information stoppage, mechanism outputs, corrective actions, etc. among the processes.

The Commonwealth's monitoring mechanism for the case management system is complex because:

- Case management is a state plan service directly managed by DMAS;
- There are forty CSB case management agencies operated across the Commonwealth;
- The DBHDS, DDS operation of its waiver is linked through case management.

Office of Licensing (OL) remains the backbone of the DBHDS system for monitoring the performance of case management services. It ensures the minimal performance that complies with the DBHDS regulatory requirements for case management including assessment, service planning, accessing services, and monitoring services. OL does not typically monitor for ensuring choice,

education, counseling, developing and discussing employment goals, and advocacy, which are expectations of case management. The Commonwealth's other centralized monitoring processes seek to ensure the performance of the more complex case management activities. The proposed revision of the DBHDS Licensing regulations (July 2017) included detailed expectations of the Case Managers' responsibilities during face-to-face meetings. OL has sustained its recent increased focus on the case management services at the CSB level. Notwithstanding the turnover of leadership at OL, this emphasis has continued and is reflected in the number of its citations of regulatory violations by CSB case management. The feedback that OL provides to CSBs is generally clear and relatively timely. Corrective action plans are required when appropriate and OL follows up to ensure that these action plans have been implemented. Current DBHDS Licensing regulations still do not align with the requirements of the Agreement, particularly as to Section V.G.3, evaluating the adequacy (quality) of individual supports and services. The Agreement specifically requires that the "adequacy of services" be a responsibility of the DBHDS licensing process.

DMAS Quality Management Review (QMR) process is required due to the funding of case management as a State Plan service, rather than as a DBHDS-operated waiver. The QMR conducts annual reviews, but only reviews each CSB's case management services, generally every two to three years. The review by a DMAS team includes an onsite record review for the presence of eligibility assessments, choice documentation, risk evaluation, timely/appropriate ISPs, monthly contact notes, and quarterly reviews. It also includes checks on case manager qualifications and completion of ongoing training. QMR feedback to CSBs is generally clear and relatively timely. DMAS requires corrective action plans when appropriate. QMR data results related to the performance measures as approved by CMS are discussed at DBHDS Quality Review Team meetings (see below). The outputs of the QMR process, the letters of findings to the CSBs, however, are shared with DMAS's Division of Developmental Disabilities and Behavioral Health and with DBHDS's Community Resource Consultants, but not with DBHDS leadership, the individuals served, their Authorized Representatives, or other stakeholders. Recent QMR citations included inadequate case manager monthly contact notes, missing annual risk assessments, and the failure of case managers to complete or document their face-to-face visits with individuals receiving services.

DBHDS Quality Management Division (QMD)'s recently revised process of CSB visitations, which include QMD staff providing compliance feedback and concurrent technical assistance, has been very well received. In this cycle of reviews, the QMD process is focusing on ensuring that CSBs use "valid" data to improve the case management process, including supporting CSBs to complete root cause analyses to identify reasons why they are not meeting reporting targets.

One of the hoped-for outcomes of this process is an improvement in CSB and DBHDS attention to, and use of, the Data Dashboards (see below). The nature of each visit is well described in the QMD follow-up reports to the CSBs. As reported previously, when the data are complete and accurate and the findings are aggregated and trends identified, this process could become an effective ongoing component of the case management performance monitoring system.

DBHDS Data Dashboard was previously reviewed by the Independent Reviewer's consultant whose reports identified strengths and weaknesses in its use. On the positive side, the Dashboard is a clear metric for several Agreement requirements: face-to-face case management, case management visits to the home, and five major outcome indicators. On the negative side, the consultant has continued to identify questions about the reliability of the five outcome metrics as currently measured and the DBHDS failure to utilize the face-to-face metrics to motivate improvements in the most basic of case management functions. Regular face-to-face contact with an individual by a case manager and

regular probing of the home and day environments in which an individual lives are basic ingredients to an effective support relationship between a case manager and a recipient of services. In the Independent Reviewer's December 13, 2017 Report, the consultant reported that a number of CSBs had not consistently achieved 86% (the DBHDS target) on the face-to-face case manager visits measure over a two-year period. The latest available Data Dashboards indicated that of the eleven underperforming/underreporting CSBs that were identified last year, six CSBs were still consistently at or below target for the latest three-month period reported (August, September and October 2017) at the time of this study. It appears that some CSBs ignore the metrics. After receiving technical assistance on the metrics, coding, etc., DBHDS should hold underperforming CSBs accountable for these most basic case management functions, particularly given the fact that OL and DMAS/QMR findings have validated the existence of this problem.

Table 1
Data Dashboard Metric
Face-to-Face Support Coordination/Case Management

CSB	August 2017	September 2017	October 2017
1	69%	57%	83%
2	50%	68%	83%
3	11%	0%	46%
4	67%	65%	86%
5	0%	0%	3%
6	52%	44%	47%
7	74%	68%	86%

CSB Case Management Supervisory Quarterly Reviews These reviews include quarterly probes of a sample of case management records at each CSB. The survey asks supervisors to conduct specific record reviews and to assess the presence of documentation of eligibility assessments; face-to-face visits; consumer education on options, including choice of providers and case managers; assessment of Enhanced Case Management status; and the timeliness and appropriateness of the ISP, including updates when warranted by changes. The results of these reviews are submitted and compiled via Survey Monkey and are reviewed by the Quality Review Team (QRT). DDS does not routinely provide any feedback on the CSB's performance, but the QTR may on occasion request a corrective action plan. The CSBs are expected to use their experience in completing the surveys to institute quality improvements related to the performance of individual staff or systems. This approach is commonly used around the country, but its effectiveness depends on local CSB managers to bring about needed improvements. These processes in the Commonwealth are currently undergoing revision based on negotiations with CMS.

Quality Service Reviews (QSR) An external organization, the Delmarva Foundation**,** pursuant to a contract with DBHDS, conducts QSRs of individuals who receive at least one waiver service. These reviews include the impact of case management. This QSR process reviews a random sample of around 400 individuals over a twelve-month period. Although Delmarva assesses many areas already assessed by other systems, it is somewhat unique in probing qualitative, higher order case management tasks that focus on actualizing the capacities and maximum independence of an individual receiving services. These case management activities are not required of CSBs in DBHDS Licensing regulations or DMAS expectations; and DBHDS has clarified that some of these expectations represent best practices toward which all CSBs should strive. The DBHDS Quality Improvement Committee (QIC)

reviews Delmarva reports and establishes system recommendations. The Independent Reviewer has raised questions (see Appendix G) about whether the QSR auditors are qualified to make clinical judgments, the reliability of the data gathered, and the validity of Delmarva's findings.

The CSB Performance Contract aligns with the case management requirements of the Agreement, as was noted in the Independent Reviewer's Reports to the Court in 2015 and 2016. In fact, in the Fiscal Year 2018 Contract Renewal and Revision, not only does the contract specifically require that case managers give individuals or Authorized Representatives their choice of providers, but it details, in Section 4.e., a complete list of the Agreement's expectations for case management in the section titled, *Department of Justice Settlement Agreement Requirements***.** In 2015, QMD was making limited, but high-quality efforts to formally audit the CSBs' performance on case management in regards to the Agreement's expectations through the Operational Review process. This approach has since been discontinued and the Operational Review is now focused primarily on administrative activities, internal controls, and fiscal services. However, the availability of the Exhibit D process in its Performance Contracts gives DBHDS the contractual wherewithal, when warranted, to provide a CSB with a formal notice to cure case management, and other, problems. Although DBHDS has not utilized the Exhibit D process for this purpose, this process could be utilized in situations where OL or other corrective actions have not been successful in achieving needed CSB improvements.

Coordination of Findings and Corrective Actions

Table 2 below displays the array of quality assurance monitoring mechanisms that cover the various components of the Commonwealth's case management monitoring functions.

Table 2
Crosswalk: Support coordination/case management Monitoring
(*Who looks at what?)*

Tasks	**OLS**	**QMD**	**Data Dashboard**	**DMAS- QMR**	**CSB Quarterly Super. Review**	**Delmarva**
Basic Tasks						
Regular face-to-face visits	-	P	M	T	Q	A
Regular face-to-face visits at home	-	P	M	-	-	-
Service Authorization and Re-authorization	-	-	-	-	-	-
Essential Tasks						
Assessment	T	P	-	T	Q	-
Coordinating planning/tear	T	-	-	-	Q	A
Accessing services and supp	T	-	-	-	Q	A
Monitoring services & Well being	T	P	M	T	Q	A
Updating services and plan	T	P	-	T	Q	A
Actualizing tasks						
Navigating	-	-	-	-	-	A
Educating	-	-	-	-	Q	-
Coaching	-	-	-	--	-	A
Advocacy	-	-	-	-	-	A

A – Annual sample, M - Monthly report, Q – Quarterly sample, T- Triennial sample, and P – Periodic sample

It should be noted that half of these processes described in Table 2 are multi-dimensional. That is, they examine the broader service delivery system beyond case management. The CSB Supervisory Review, the Data Dashboard reports, and the QMD onsite visits, however, are exclusively focused on case management.

The Quality Review Team (QRT) is a group co-chaired by DMAS and DBHDS. It reviews waiver performance, including case management, against CMS assurances from the QMR audits, the CSB Supervisory Quarterly Review, CHRIS reports, and OL citations. These assurances include performance measures that are reported to CMS as part of the joint agency oversight (DBHDS and DMAS). Past reviews by the Independent Reviewer's consultant have identified a lack of improvement activity on the part of QRT and recently the QRT has been involved in waiver renewal discussions with CMS about the appropriateness of some measures and processes; the Appendix H revisions in particular look positive. QRT data are organized annually but are collected quarterly. Planned and proposed revisions to the assessment tools should be reflected after July 1, 2018. This data report is entitled the "DD Waiver Quality Assurances Reporting Grid". The QRT has not met during the past year, although data continue to be collected in anticipation of the Waiver Evidentiary Report, which the Commonwealth is required to submit to CMS periodically. The consultant verified that there is little knowledge of, or receipt of, QRT findings at the CSB level. The use of the QRT, therefore, is primarily a vertical report to CMS and not intended as feedback to CSBs.

Although the QRT may have the potential to aggregate all findings from the six monitoring processes and to coordinate overall systemic strategies, without substantial modification to its mission, purpose, and action planning processes, the Commonwealth may need a separate but focused case management mechanism to aggregate the various quality inputs on case management and to recommend system improvements. A separate entity focused on case management performance would allow for the prioritization of case management as the linking mechanism it is for each recipient and for all services and supports. Creating a separate entity focused on case management performance would also preserve the QRT's current focus on assurances for CMS.

System improvement efforts around case management are underway or are on the drawing board. For example, a planned training initiative on the ISP includes an emphasis on risk assessment, which emerged from QMR reviews as a weakness in many ISPs, as well as from Independent Reviewer Reports to the Court. VCU's Center of Excellence in Developmental Disabilities has completed its baseline study of case management. It is planning to generate, by the end of 2018, additional tools, including an orientation manual, review tool, and revised training modules. In addition, DBHDS has constructed a crosswalk of governing regulations for case management across waiver rules, Office of Licensing rules, and the CSB Performance Contract in order to clarify the authorities for case management performance monitoring.

Finally, and most importantly, during this period, the DBHDS Commissioner has focused CSB attention on their implementation, and the need for continuing improvement, of case management services. His January 26, 2018, correspondence discussed the various roles of the case manager, including higher order, best practice functions. His correspondence solicited from each CSB a Case Management Self-Assessment and a proposed plan for local improvements based on their results of self-assessment. Later this year, DBHDS will convene a workgroup to identify cross-state themes and to monitor the progress of improvement efforts towards a "case management transformation."

There are a number of CSBs that are using some best practices in overseeing case management responsibilities. All CSBs should be brought up to a level wherein case management supervisors exercise quality assurance strategies in advance of audits and other external reviews. There are also several instances where the performance improvement strategies currently being implemented from the Division of Developmental Services (DDS), from the Quality Management Division (QMD) and the Department of Medical Assistance Services (DMAS) are appropriate and timely.

The Commonwealth is not in need of more quality management monitoring processes for case management. Rather, it is in need of an entity in the system that is responsible for and has the organizational tools to effectively bring coherence and clarity to improvements that are proposed; that prioritizes improvements that are needed; and that conveys a clear direction in, and coordination of, case management performance improvement for CSBs. The Commonwealth must also effectively utilize the available Exhibit D mechanism in its Performance Contracts with CSBs to hold CSBs accountable and to bring about needed improvements in CSB performance, especially when its other monitoring mechanisms fail to do so.

The Commonwealth remains in non-compliance with Sections III.C.5.d., III.C.5.c, and V.G.3.

5. Crisis Services

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

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

This study focused on the findings from the year-long study that was completed during the tenth and eleventh review periods and the recommendations made by the Independent Reviewer in his December 23, 2017, Report to the Court. The consultant's review included a qualitative assessment of the crisis supports and other needed and related community services for forty-three individuals who were admitted to psychiatric hospitals; of these, twenty were children and twenty-three were adults. The focus for the qualitative review was to determine the reasons for the increase in hospitalizations among children and adults with ID/DD; the impact of the location of pre-screening on the outcome; the involvement of Regional Education Assessment Crisis Services Habilitation (REACH) staff in prescreening, hospitalization and discharge; and providing crisis supports. This review was intended to determine what services these individuals needed and were provided, the effectiveness of those supports, and whether community service capacity was sufficient to assist individuals to remain in their homes with appropriate ongoing services.

There has been sufficient history with the implementation of the REACH crisis services program to compare data and trends since 2015. The consultant's report (see Appendix F) is based on data for three years the seventh through the twelfth review periods. Each of the three years corresponds with two of the Agreement's six-month review periods, rather than either calendar or fiscal years. The data have been cumulated as follows:

- Year 1: fourth quarter (Q4) Fiscal Year 15 through the third quarter (Q3) of Fiscal Year 16;
- Year 2: fourth quarter (Q4) Fiscal Year 16 through the third quarter (Q3) of Fiscal Year 17;
- Year 3: fourth quarter (Q4) Fiscal Year 17 through the third quarter (Q3) of Fiscal Year 18.

Review of the Status of Crisis Services for Children and Adolescents

The Number of Children Served

The number of children who were referred to the Children's REACH crisis services programs increased over the three years. In Year 2, 870 children were referred, which increased by 45.9% to 1,269 in Year 3. There was also a 50.6% increase in the number of crisis calls, from 929 in Year 2, to 1,617 in Year 3. Families, providers and other stakeholders also make non-crisis and information calls regarding individuals served by these programs. The number of non-crisis calls increased by 146% from 2,449 in year 2 to 6,027 in Year 3.

Table 3: Total Children's Calls

Year	Crisis	Non-crisis	Informational Calls
Year 1	134	304	399
Year 2	617	2449	854
Year 3	929	6027	1183

The Children's REACH Program continues to serve a high and increased percentage of individuals with DD, other than ID. In Year two 451 (52%) individuals with this diagnosis were referred, whereas 834 (65%) such referrals occurred in Year 3. This increase is evidence of REACH's successful outreach, and the usefulness of REACH services, to this population, most of whom have autism spectrum disorders.

In all five Regions review during this review period, the REACH staff responded onsite within the required average response times. In fact, all Regions except Region V had an average response time of sixty-five minutes or less. In Year 3, the three Regions that DBHDS has designated as "rural", which requires a response within two hours, responded to all crisis calls and arrived onsite and on-time for 94% of the requests. The Regions designated as "urban," Regions II and IV, are required to respond onsite within one hour. Region IV did so for 91% of calls; whereas, Region II responded on-time to only 79%. This was an improvement for Region II, however, from responding to only 60% on-time in Year 2. In previous periods, the traffic congestion in Region II was identified as contributing to its delayed responses. Overall, during Year 3, the Commonwealth's timely onsite response rate was 90% with 836 of the 925 calls responded to within the required one- or two-hour timeframes. This compares positively to Years 1 and 2 when only 87% and 86% of the calls, respectively, were responded to on-time.

The locations where the Commonwealth's statewide mobile crisis assessments occur are increasingly contrary to the requirements of the Agreement. Increasingly more initial assessments of children occur out of the home, typically at hospitals or CSB-ES offices. This is not what was planned, desired, or considered effective at preventing the institutionalization of children when the statewide crisis service system was designed and created. As more individuals are removed from their homes to receive the initial assessment, a smaller percentage receive mobile crisis support services and crisis stabilization services and a higher percentage are admitted to psychiatric hospitals. In Years 1, 2, and 3, 53%, 61%, and 67% of the assessments, respectively, occurred at out-of-home locations. Whereas, the percentage conducted in a families'/individuals' homes has steadily declined. Hospitals were the out-of-home locations where 49% of the assessments occurred in Year 3 while only 25% occurred at hospitals in Year 1. The increased use of these out-of-home locations for the initial assessments has resulted in an increased number and percentage of children being admitted to hospitals.

The Commonwealth's crisis service system is not being implemented consistent with the requirement that the CSB-ES component of the statewide crisis system dispatch mobile crisis team members to individuals' homes. It is a fact that individuals who receive their initial assessments at out-of-home locations are much more likely to be hospitalized and much less likely to receive community-based alternative crisis services. This is evidence that, since the Agreement was approved, the CSB-ES component of Commonwealth's statewide crisis system has not changed the location of its assessments and therefore has not contributed to preventing the individuals from being removed from his or her home/current placement.

Mobile Crisis Support Services

As with the number of referrals and calls, DBHDS reports that there has been an overall increase in the number of children who were initially assessed at the time of a crisis, from 603 children in Year 2 to 928 in Year 3, an increase of 53.9%. Unfortunately, following the assessments in Year 3, a smaller percentage of the children remained home, regardless of whether they received mobile supports. More children, and a higher percentage of those assessed at the time of crisis, were hospitalized, from 152 children being hospitalized in Year 2 to 330 in Year 3, a 117% increase. In Year 2, 25% of the children who were assessed during a crisis were hospitalized, whereas, in Year 3, 36% were hospitalized. Unfortunately, as the operations of the REACH crisis service for children matured, a higher percentage of children were hospitalized at the time of the crisis assessment.

Far more children who remained at home in Year 3 benefitted from mobile crisis support services. In Year 2, 168 (38%) of the 443 children who were assessed used mobile supports remained home. Whereas, in Year 3, of the 583 children who were assessed and remained at home, 52% (304) used mobile support. This significant increase in both the number and percentage of children using mobile support at the time of a crisis is an indication that families were more willing to accept REACH services for their children and that REACH programs were able to provide a needed service. DBHDS must monitor this growing need and response from REACH and take needed steps to ensure that the programs have adequate resources to continue to provide these essential mobile support services.

Table 4: Disposition at the Time of Crisis Assessment

Year	Psychiatric Admission	Other	Crisis Stabilization Programs	Home with Mobile Supports	Home without Mobile Supports	Total
1*	13	5	0	28	10	**56**
2	152	11	7	168	275	**613**
3	330	8	7	304	279	**928**

* The low numbers in year 1 indicates that very few data were available

The REACH programs report that the vast majority of children, 82% to 86% in Year 3, were able to continue to live at home at the completion of receiving mobile crisis supports. However, the hospitalization of 14% of the children who received mobile supports in Year 3 was almost double the 7% in Year 1 and 8% in Year 2.

It remains highly concerning that as the REACH crisis services programs for children have matured and experienced an increase in the number of referrals, that a larger percentage of these children were hospitalized. The increase in hospitalizations after REACH programs have been involved is the opposite outcome than was expected or desired when the REACH crisis services programs were designed and created. DBHDS should carefully study this unexpected negative outcome and determine what changes are needed to improve the use of community-based alternative services and to thus reduce unnecessary psychiatric admissions. Part of the solution will involve making systemic changes to the training and practices of the CSB-ES programs to increase the number and percentage of children who receive the initial assessment at the children's homes, rather than at out-of-home locations. It is also evident that it is critical to have the required crisis stabilization (Crisis Therapeutic Home) settings available for children as an alternative to hospitalization.

Number of Days of Mobile Supports

For children and adolescents, REACH is expected to provide up to three days of mobile crisis support with the possibility of up to an additional three days. The average number of days provided by the five Regions provided varied considerably. Region I provided an average of two days; whereas Region 3, which provided these services to the fewest number of children, provided an average of thirteen days. During the twelfth review period, four Regions provided an average of at least three days or more of mobile supports; only Region I provided less.

The Commonwealth's mobile crisis support services include comprehensive evaluation, Crisis Education and Prevention Plans (CEPP), consultation, and family/provider training. DBHDS requires that a CEPP and consultation be provided each individual who receives mobile support services. DBHDS reports that 94% of the number of children served in Year 3 received evaluation or consultation and 88% received CEPP, but only 81% received provider training from the REACH children's programs. The lack of provider training is of particular concern. The importance of this concern is supported by the findings of the qualitative review of children who were hospitalized during the review period. It was not evident that all the parents or other providers were actually trained in the elements and strategies of the CEPPs that were written to help prevent future crises. To improve the chances of avoiding future crises, it is essential that family members and other caregivers be trained in crisis prevention and intervention methods.

Training of Stakeholders

As depicted in Table 5 below, the Children's REACH Programs conduct a significant amount of training. More than 1,000 police officers and nearly 600 CSB - ES staff have been trained during the past three years. A significant percentage of the 2,173 CSB staff trained was case managers. The 2,264 "Others" include school personnel. There are noticeable differences, however, between Regions in the number of stakeholders who are trained.

Regions I and II consistently train far fewer police officers. Region III trained the most hospital staff. Generally, Region I staff provided training to the fewest stakeholders, and Region IV and V provided training to the most. It is heartening that 2,239 providers, the most in any distinct category, have been trained. The training of providers should help contribute to more stabilized living situations.

Table 5: Children's REACH Training of Stakeholders

Year	CIT/Police	CSB	ES	Providers	Hospital	Family	Other
Year 1	46	558	113	132	11	132	390
Year 2	529	982	342	583	61	238	1214
Year 3	584	464	137	1524	357	1855	794
Totals	**1159**	**2,004**	**592**	**2,239**	**429**	**2225**	**2,398**

Overall, the Commonwealth is continuing to provide training to a high number of police officers and other stakeholders. However, with the data that the Commonwealth has provided, it is not possible to determine whether each Region met the training needs of its communities' stakeholders. It is not possible to make this determination without information regarding the total number of stakeholders that may need to be trained or information about turnover in these job categories. It is likely, however, that all Regions have more similar than different training needs in these groups. The wide variation, and very low numbers of some stakeholders who have been trained in some Regions, likely indicates that some REACH teams are not providing sufficient training.

Crisis Stabilization Programs (aka Crisis Therapeutic Homes – CTH)

DBHDS has had plans to develop two crisis out-of-home alternatives to institutionalization. It issued Request For Proposals (RFP) on May 1, 2016 to develop out-of-home crisis therapeutic prevention host-home services during FY17; it had plans to open two CTHs early in calendar year 2018. However, both of these scheduled developments have been delayed.

DBHDS has funding available to develop the two CTH homes, each with the capacity to serve six children. With delays, these homes are now scheduled to be open by January 2019. The architectural plan of the CTH for adults in Region IV will be used for both of the CTHs for children. The building sites for both of these homes have been selected. The Richmond CSB, which operates the adult and children's REACH programs, will also operate Virginia's southern CTH for children. The Rappahannock/Rapidan CSB will develop and operate the northern CTH for children.

At the time of this study, because DBHDS did not receive suitable responses to its RFP, DBHDS was planning to execute sole source contracts (i.e. non-competitive procurements, which are used when an

RFP did not result in an acceptable proposal) for the provision of out-of-home therapeutic prevention host-homes. The Department hopes to pilot this program model and demonstrate its viability and financial sustainability to providers that are located in other parts of the Commonwealth.

DBHDS believes that the two planned CTH homes, when supplemented with prevention services and therapeutic host-home options, will be sufficient to meet the needs of Virginia's children. Receiving crisis support services and having time to stabilize out of their families' homes will often allow these children to return home with mobile crisis supports in place.

Psychiatric Admissions of Children

DBHDS reported a trend of significant increases in the number of children with ID/DD who were admitted to psychiatric hospitals every year since at least 2014. In Year 3 alone, 447 children with ID/DD were admitted for psychiatric or behavioral reasons. The represents an 88.6% increase in one year from the 237 children admitted in Year 2.. This very troubling and significant increase in each of the most recent six reporting periods is the opposite result than was expected and desired when the statewide crisis services were designed, planned and implemented. is the one significant driving factor in this increase. The CSB-ES practice of having children removed from their homes to receive initial assessments in hospitals or CSB office settings has led to a steady increase in the number and percentage of children with ID/DD who have been admitted to hospitals. It is the considered opinion of the Independent Reviewer that, unless DBHDS changes this CSB-ES practice this negative outcome will continue. The Commonwealth must ensure that the initial assessments completed by the CSB-ES occurs prior to children being removed from their homes if the Commonwealth is to succeed stabilizing children in their home placements. Otherwise, the very high rate of admitting children with ID/DD to psychiatric institutions will continue.

The CSB-ES practice of completing initial assessments in out-of-home locations also appears to result in an increased involvement of law enforcement when children with ID/DD are in crisis. In Year 3, when a higher percentage of initial assessments were completed out-of-home, police were involved with 44% of the crisis responses, which is double the rate of 22% in the previous year. Police are involved when the initial assessment is completed at hospitals because, when families or service providers call 911, police accompany ambulances that transport the children to hospitals, The high number of crisis responses that involve police officers is strong support for the need for REACH staff to continue to train police officers to be better prepared to address crises that involve children with an ID/DD, especially individuals with autism spectrum disorders.

Table 6: Children's Admissions to Hospitals

Year	***Referrals***	***Active Cases***	***Total***
1	42	25	67
2	146	88	237
3	254	133	387

Review of the Status of Crisis Services for Adults

The number of adults who were referred to the Adult REACH crisis services programs increased over the past three years. The number of adults referred increased by 34.5% from 1247 in Year 2 to 1677 in Year 3. The number of crisis calls increased by 117% from 963 in Year 2 to 2,093 in Year 3. Non-crisis calls increased even more, by 145% from 2,690 in Year 2 to 6,584 in Year 3. The significant difference in the number of calls versus referrals reflects that some families/providers make multiple crisis calls to REACH about a single adult.

Although the number of referrals and crisis and non-crisis calls increased dramatically, the number of adults who received mobile crisis supports decreased from both Years 1 and 2. Fewer adults used the CTHs in Year 3 than during Year 1. This decrease in the amount of mobile crisis supports provided would is an indication that there are insufficient staff to meet the crisis needs of the increased number of individuals being served. As with children, the consultant found that an increased number of adults were hospitalized at the time of the crisis assessment during Year 3. The total number of hospitalizations of adults with ID/DD at the time of crisis assessment increased dramatically, by 183% from 210 in Year 1 to 595 in Year 3.

The consultant's study again found that REACH provides critically important crisis supports, which, when made available at the time of the crisis assessment, reduces the number of adults with ID/DD who are admitted to hospitals. During the twelfth review period, a substantially higher percentage (31%) of adults who did not use mobile crisis supports or crisis stabilization services were hospitalized at the time of assessment compared with only 4% of adults who used REACH mobile crisis support services and 6% who used crisis stabilization services. It is noteworthy that, after receiving REACH services, fewer adults with ID/DD were hospitalized in Year 3 than in Year 2. when were hospitalized compared with hospitalized. This decrease from sixty-six to forty-eight adults, from Year 2 to 3, occurred even though the total number of adults who used REACH services was similar. The consultant also found that, while more adults with ID/DD were hospitalized in Year 3, that fewer adults were provided alternative residential options. Whereas, eighty-four adults used such alternatives in Year 1, only seventy-four adults used them in Year 3.

This lack of availability of new residential options with quality behavioral support services for individuals who experience a crisis may contribute to longer stays at the CTH or to the increase in psychiatric hospitalization of individuals after they receive REACH mobile crisis supports. The data support that many more individuals retain their home setting and avoid hospitalization if they receive REACH mobile supports or use the crisis stabilization homes/CTH program. Fewer individuals, and a significantly smaller percentage, who used REACH services were admitted to hospitals than individuals who did not use them. The support of either mobile crisis services, or the crisis stabilization services at the CTHs, appears to have helped stabilize individuals who experienced a crisis without being admitted to psychiatric hospitals. Overall, the number of adults who were hospitalized continued to increase. While many of these individuals may have required hospitalization, it is apparent from the information gleaned in past years' reviews and from this year's qualitative study, that there has been a lack of alternative services in the quantity and quality needed. The CTH crisis stabilization programs are not consistently available as alternatives to hospitalization when individuals are first screened in response to a crisis.

Psychiatric Hospitalizations of Adults

The number of adults with ID/DD who have been hospitalized due to a crisis has continued to increase from 647 in Year 2 to 832 in Year 3, a one-year increase of 185 (28.5%).

Of those hospitalized It is positive that the percentage of active participants who received REACH services has decreased each year while the number of individuals who were hospitalized at the time of the crisis and had not used REACH services has increased. This difference may indicate the contributions of REACH services to reducing the need for hospitalization among REACH service recipients.

The over 200% increase in the actual number of new referrals since Year 1 is significant. That most of these new referrals to REACH occur at the time of a crisis has limits REACH's ability to help divert an admission to alternative community-based services. In such circumstances, REACH has no existing relationship with the family or provider and no knowledge of the individual's needs, behaviors or medical conditions. This lack of information impacts the program's ability to intervene, especially if REACH is contacted after the individual has already been removed from home to meet the CSB-ES staff at the hospital or ES office. In these out-of-home assessment situations, REACH staff cannot help to stabilize the situations at the individual's home, or to develop prevention strategies and plans, or to arrange alternative community-based services. As a result, psychiatric admissions become much more likely.

The REACH programs were aware of 90% of the admissions to psychiatric facilities during Year 2. This declined to 77% of the admissions during Year 3. Disparities are striking between the Regional REACH programs awareness of adults with ID/DD who are admitted. For example, Region I knew about all of its admissions, whereas Region II knew of only 47%.

REACH's lack of awareness of hospitalizations indicates that individuals have likely been removed from their homes and transported to the hospital, usually by ambulance and frequently with police involvement. Once at the hospital, it appears that hospital and CSB-ES staff, especially in Region II, may be contacting REACH staff less frequently at the time of emergency crisis assessments or for the screening of voluntary admissions. It is essential that CSB-ES teams notify REACH of individuals with ID/DD who will be assessed and that initial assessments, as called for in the Agreement, occur whenever possible within the individual's home setting. Doing so will allow the REACH teams to offer community-based crisis supports or out-of-home crisis stabilization services alternatives to hospital admission, when clinically appropriate. When REACH is involved prior to an admission, it can immediately begin proactive discharge planning that may result in shorter stays in the facilities. It is equally important for REACH staff to be involved with voluntary hospitalizations. REACH staff can provide ID/DD clinical expertise to hospital staff, home- and community-based alternative services, and, for those admitted, to begin planning for crisis intervention and stabilization services that can be in place at the time of discharge.

Individuals are routinely staying at crisis stabilization homes for longer than the 30-day maximum allowed by the Agreement. This results in crisis stabilization beds not being availability as alternative for an individual who otherwise will be hospitalized, or to individuals who were hospitalized and are now ready to be discharged to a step-down program.

Training of Stakeholders

As depicted in Table 6 below, the REACH quarterly reports document that the REACH Adult Programs continue to provide extensive training to a range of stakeholders. The five Regional REACH programs trained 4,747 individuals during Year 3, a 37.3% increase since 3,458 were trained in Year 1. DBHDS has partnered with the Department of Criminal Justice Services, the Virginia Board of People with Disabilities and Niagara University to develop comprehensive training for law enforcement. The Commonwealth's plan is to use a train-the-trainers model. The training of the law enforcement trainers will begin in May 2018. These trainers will then be responsible to train other law enforcement staff in their Region. With the data available, it is not possible to know what percentage of police, ES staff, provider and relevant hospital staff have been trained, since the total number needing training in these groups is not identified.

Table 6: Training by REACH Adult Program Staff

Year	CIT/Police	CSB	ES	Providers	Hospital	Family	Other	Total
Year 1	727	967	153	307	250	0	1,054	3,458
Year 2	659	1061	347	885	101	27	862	3,942
Year 3	743	712	189	584	437	1524	558	4,747
Total	**2,129**	**2,740**	**689**	**1,776**	**788**	**1551**	**2,474**	**12,147**

Serving individuals with developmental disabilities

Outreach to the DD community resulted in an increased percentage of those served by REACH programs during this period being individuals with DD, other than ID,. In Year 3, 379 individuals were referred with this diagnosis. This was 23% of the total number of individuals referred, and more than a 100% more than the 186 individuals referred in Year 2. The most recent increases may also be a consequence of the CSBs now being responsible to provide or arrange for case management for these individuals.

Elements of the Crisis Response System

The REACH programs in all Regions continue to be available 24 hours each day and the REACH mobile crisis staff respond to crises onsite, although the site may be a hospital or CSB – ES office.

The DBHDS standards for the REACH programs require comprehensive staff training consistent with set expectations for the topics to be addressed within 30, 60 and 120 days of hire. All REACH staff must complete and pass an objective comprehension test. Ongoing training is required. The National Center for START Services at University of New Hampshire (UNH) continued to provide training to the REACH staff in Region I. The other four Regions use a training program that was developed by REACH leaders to provide similar training; DBHDS reviewed and approved the curriculum. Each REACH staff must have clinical supervision, including shadowing and observation, conduct a case presentation and receive feedback from a licensed clinician on their development of Crisis Education and Prevention Plans.

The REACH team members typically, and increasingly, do not respond to individuals at their homes. A smaller percentage of individuals with mobile services, supports, treatment to de-escalate crises, and crisis stabilization services in a CTH. In part this is a result of an increasing percentage of individuals having been removed from their current placement to be transported to and assessed at a hospital or CSB-ES office.

The percentage of individuals who used mobile crisis support at the time of the crisis was 16% in Year 1, but reduced to 13% in each of Years 2 and 3. The percentage of the adults who used the out-of-home crisis stabilization services at the time of crisis was 9% in Years 1 and 2, which reduced to 7% in Year 3. The crisis stabilization services (CTHs) have not only been used by a smaller percentage of all individuals after a crisis, but by fewer individuals, as well. The number of individuals who used the CTHs for stabilization declined 46.1% from 321 in Year 1 to 173 in Year 3. The CSB-ES and mobile crisis teams are not functioning as required by the Agreement. They do not typically respond to individuals at their homes, are not providing sufficient supports and services to de-escalate crises in the home, and are frequently not offering out-of-home crisis alternatives to institutionalization. In part, since the CSB-ES practice continues to not respond to individuals in their homes and the REACH teams are not functioning as required, the number of individuals with ID/DD who were hospitalized increased from 383 in Year 1 to 832 in Year 3.

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

6. Discharge Planning and Transition: Individuals with Intense Needs Who Moved from Training Centers

The Independent Reviewer has completed six Individual Services Review (ISR) studies of Discharge Planning and Transition from the Commonwealth's Training Centers. Each ISR study focused on the discharge planning process and on the outcomes for individuals who transitioned. For each ISR study, the Independent Reviewer selected a cohort of individuals who had transitioned at least two months prior to the study. The cohorts for the six studies included a total of 254 individuals who had moved from all five of the Commonwealth's Training Centers to all five of the DBHDS, DDS's Regions. Of the 254 individuals who met the criteria that the Independent Reviewer established for the cohorts, a total of 157 individuals were randomly selected to be studied. The number of individuals who were randomly selected for the sample from the cohort was determined to provide a 90% confidence interval so that the studies' findings for the selected samples could be generalized to the cohorts.

The most recent ISR study randomly selected individuals who had transitioned from the Central Virginia Training Center (CVTC), the Southwestern Virginia Training Center (SWVTC), or Southeastern Virginia Training Center (SEVTC). The cohort for the study included the individuals who transitioned from these facilities between September 30, 2016, and September 30, 2017, and who also had SIS scores that placed them in levels six or seven, the categories that indicate intense medical or behavioral support needs. Of the selected sample, six individuals (31.6%) moved from SWVTC, twelve (63.2%) moved from CVTC, and one (5.3%) moved from SEVTC. Although there were exceptions, the study of individuals who transitioned from Training Centers to community settings found the following themes and examples of positive outcomes and areas of concern.

The discharge planning and transition processes continue to be well organized and well documented. The selected residential providers were involved in the discharge planning process; 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. DBHDS also demonstrated an effective quality improvement process by making improvements to the transition process based on areas of concern that were previously identified by the Independent Reviewer.

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 nineteen individuals (94.7%) transitioned to settings of four or fewer individuals, the standard established in the Agreement for smaller, more integrated settings. This represents a dramatic improvement from previous ISR studies that found that approximately seven of ten individuals who moved from Training Centers transitioned to community settings with five or more residents with disabilities.

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. Per physicians' orders, all individuals were being monitored for fluid and food intake, tube feedings, weight fluctuations, positioning protocols, and bowel movements. With rare exceptions, all monitoring results had been reviewed and changes were made when necessary. Improved outcomes were found in eight areas compared with the most recent ISR study of individuals who transitioned from Training Centers. This success was particularly notable because nearly all of the individuals studied had intense medical needs.

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 now experiencing significantly fewer and less severe incidents.

The individuals who moved from the Training Centers lacked community integration opportunities. The Commonwealth successfully transitioned individuals with intense medical and behavioral needs from a Training Center to live in a community home. Most of these individuals moved to smaller homes with fewer disabled residents. Both of these accomplishments create increased opportunities for these individuals to engage and to participate in their communities. However, very few opportunities have been created. Employment goals were not developed or discussed with any of them. More than a quarter did not consistently participate in a community outing weekly. Only two were participating in community engagement programs that were integrated and none had typical days that involved integrated activities.

The ISR study that was conducted during the 12th review period found that the Commonwealth continued to fulfill almost all of the discharge planning and transition provisions. It also found that the Commonwealth had achieved improvements in some areas that the Independent Reviewer had previously identified as areas of concern.

This sixth ISR studies of the Training Center transition processes again found that the Commonwealth has created a well-organized and well-documented discharge planning and transition process. In addition, the Commonwealth has made improvements in these processes based on areas of concern that its own reviews and the Independent Reviewer's ISR findings have identified. The changes made by the Commonwealth have resulted in more positive outcomes for the individuals and fewer areas of concern. The remaining areas of concern reflect systemic challenges that exist throughout the Commonwealth's community-based service system. The Commonwealth's achievements and the remaining areas of concern in its discharge planning and transition process are detailed in the findings of the ISR study below. The criteria and parameters for the six ISR studies of discharge planning and transitions and the demographics of the individuals whose services were reviewed are included in Appendix A.

The Commonwealth has newly achieved compliance with IV.B.15, IV.C.5, and IV.D.3. It has remained in compliance with Sections IV, IV.B.3, IV.B.5, IV.B.5.a-e.ii, IV.B.6, IV.B.7, IV.B.9, IV.B.9.a-c, IV.B.11, IV.B.11a-b, IV.B.15, IV.C.1-4, IV.C.6-7, IV.D.1, IV.D.2.a, and IV.D.4. The Commonwealth has remained in non compliance with IV.A., IV.B.4, and IV.B.6.

7. Quality Service Reviews

The Independent Reviewer and an independent consultant reviewed the Commonwealth's documents that describe revisions to one of the four Key Performance Areas around which the Commonwealth organized its QSRs. An external organization that contracts with DBHDS, working in collaboration with DBHDS staff, designed these revisions to respond, at least in part, to the Independent Reviewer's comments and concerns about the QSR process included in his December 2017 Report to the Court. Although these documents were in draft form and addressed only one of the Key Performance Areas, the review was sufficient to determine that the Commonwealth had not yet achieved compliance with two QSR provisions during this period. Below are the standards that the Independent Reviewer previously reported to the Court as areas of needed improvement; these were used as the basis for review of the revisions to Virginia's QSR plans and processes:

- Definition of Standards/Terms **-** The standards in audit tools should be well defined to clearly articulate expectations for providers and to ensure inter - rater reliability. If specific licensing regulations or DBHDS policies drive the expectations, then they should be cited. If not, then clear standards should be set forth.
- Definition of Methodology - The audit tools should consistently identify the methodology that auditors would use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation).
- Criteria for Compliance - The audit tools should explain how standards for fulfilling requirements, such as "met" or "not met," would be determined.
- Auditor Qualifications - Auditors who assess clinically driven indicators (i.e. behavior support plans, adequate nursing care, sufficient medical supports, etc.) must be qualified to make such determinations.

- Components - The audit tools, particularly for clinical services, should comprehensively address services and supports to meet individuals' needs. These should include indicators to assess the quality of both clinical assessments and service provision.

In April 2018, the Independent Reviewer provided the Commonwealth with comments and questions regarding the documents that DBHDS submitted. The Independent Reviewer's full response is attached at Appendix G. Highlights are below:

The "Virginia Quality Service Reviews"_document provides a helpful overview of the process. Clarification was requested.

The "Health Needs Assessed and Met, Final Draft 2-2018" document (hereinafter, audit tool) shows that DBHDS made good progress revising the QSR audit tools. To ensure that the results of the QSRs are valid and reliable, however, further work is needed. Comments, questions, and suggestions were provided. These include:

- Definition of Standards/Terms – DBHDS made progress in defining standards/terms. In particular, the Guiding Questions and Criteria are helpful in defining the standards that Quality Assurance Reviewers (QARs) will use. Work is still needed, however, to address inconsistencies or areas that require interpretation. For example:

    - In defining preventative care, the document references a website which requires interpretation. In some instances, the website says consultation with an MD is needed.
    - The audit tool includes "Rationale for Indicator." Notations include: "DBHDS Standard," or "Quality Outcome." If a specific DBHDS licensing, policy or other standard exists that requires providers or CSBs to meet an indicator, it would be helpful to cite the standard
    - A number of indicators use the term "assesses" (e.g. "the person's current physical, mental and behavioral health," "person's health ongoing"). Given that the overall topic of the audit tool is healthcare, the term "assessment" has a specific connotation. In the provision of healthcare services, staff who complete assessments must be qualified to complete such requisite analysis and to make subsequent judgments.

- Definition of Methodology – The revised audit tool showed good improvement in defining how QARs will obtain the needed information to evaluate the various indicators. Substantive aspects of the methodology, however, remain undefined. Some of the examples provided were:

    - For the individual interview, the instructions do not define who can act as a proxy if an individual is not able to provide responses to the questions. The instructions do not state that it is important for a proxy to be someone who knows the individual well and who is objective. It is important for the reliability of the information provided that the proxy does not have a vested interest in the answer because of conflicts of interest. Individuals who have participated in the development or implementation of the plan or services are likely to have a substantive positive bias.
    - For the provider staff interview, it is unclear who will be interviewed. For example, a provider nurse or health care coordinator might provide a different response than a direct support professional for the Guiding Questions related to the following indicator:

"Staff is aware of the person's current health related issues or concerns." If for some reviews a nurse is interviewed and for others a direct support professional is interviewed, this practice could skew the results.
  - Whenever possible, the audit tool should cite the source of information the auditor will use to determine an individual's needs. In the revised audit tool, the sources of information are often identified, but not always.

- Criteria for Compliance – It is positive to see that for each indicator, the audit tool identifies "criteria," and instructions to the QARs. The criteria for positive scores, however, remain unclear in certain instances. For example:

  - It remains unclear what formulas the auditors will use to calculate scores for some indicators, and/or how it will use the information gathered.
  - Some "criteria" do not appear to be valid measures of the stated indicator. For example, the Score Guide and Criteria columns indicate the monthly progress notes and quarterly reviews should show the Service Coordinator is "determining whether the person is receiving services from medical specialists when necessary," and then cites a website that provides very general advice about specialists. Without clinical training, it would seem to be outside of the Support Coordinator's scope of expertise to "determine" the specialty care that an individual needs.
  - The audit tool does not always appear to require quality for indicators to meet criteria. For example: "There is a plan/protocol in the ISP developed to monitor each identified risk." The indicator, the Score Guide, and/or the Criteria do not require a quality plan(s), or define the required elements of an adequate plan, but rather only the presence of a plan(s).
  - For some questions, the level of required adherence to the standards is not clear.
  - Some indicators include measurements of more than one item, which has the potential to confound the validity of the results.

- Components – Based on review of the audit tool, it appears that the definition of "healthcare" is very broad and includes medical, nursing, psychological/behavioral, psychiatric, and allied health (e.g., Occupational and Physical Therapy). If this is the case, Delmarva should add several components to address these various areas.

  - The audit tool references, at times, various types of health care (e.g., behavioral health, allied health). If the tool is expected to cover the wide variety of topics covered under the overall topic of healthcare, then more indicators should be added to measure specific aspects of health care.
  - For individuals with intellectual and developmental disabilities, in addition to assisting in making appointments and providing transportation, an important role that providers frequently play is attending medical and other health care appointments with individuals, and/or providing written or verbal information to health professionals. Such information includes, but is not limited to, history, current signs and symptoms of illness, data (e.g., intake and output, vital signs, behavioral data for psychiatry appointments, pain scale data), side effect monitoring information, etc. The audit tool does not appear to measure this role(s). If this is what is meant when some of the indicators reference "assisting" individuals to access healthcare, it is not clear from the

indicators, score guide, or criteria. Consideration should be given to adding indicators to evaluate the various roles providers fulfill in the healthcare process.

- Definition of Auditor Qualifications – The addition of a nurse to the QSR process will be helpful. However, it is unclear whether one nurse is sufficient to meet the Commonwealth's needs. In addition, some indicators require expertise that goes beyond that of a generalist or a nurse. For example, the Policy and Procedure Review section includes the following indicators regarding risk management, corrective actions, and quality improvement plans. Auditors assessing these indicators should have sufficient expertise in risk management and quality improvement, as well as the expectations of the Agreement and DBHDS' related policy and procedures. Based on the Independent Reviewer's experience, to be effective, it will be essential for such a review to be critical and thorough with specific feedback provided to CSBs and providers.

In summary, the revised QSR audit tool is not sufficient to gather valid and reliable information to measure the outcome: health needs are assessed and met. Although this draft shows good progress, additional work is needed to define standards/terms, clarify some of the methodology, strengthen criteria for compliance, add content, and ensure auditor qualifications are adequate to complete the assessments and clinical judgments that are required.

The "QSR Health Questionnaire 2-22-18 Final"_questionnaire has been improved. However, it is necessary to identify the information that needs to be gathered and whether any additional audit tools that will be used, as well as to ensure that auditors have "adequate training" to complete assessments and make the determinations that are required to complete the Questionnaire: Examples cited include:

- The Questionnaire does not explain how the Nurse Reviewer will make "General Findings Based Upon Clinical Assessment." For example, it is unclear whether, in addition to completing the questionnaire, QARs also will collect documentation to facilitate the Nurse Reviewer's review. If so, what information will be collected on a standard or as-needed basis (e.g., medical assessments, consultation summaries, Emergency Room and hospital discharge information, medication orders with dosages, etc.); will the Nurse Reviewer use another audit tool and assess specific measurable indicators, and will the Nurse Reviewer interview provider nursing staff routinely or when certain criteria are met?

- A number of the Questionnaire indicators require the QARs to make judgments that appear to exceed the scope of knowledge/expertise of most generalists. Examples cited include:

    - The Scoring Guide requires the QAR to assess the need for, presence/quality of behavior supports, as well as the data collection, analysis, and monitoring of the plan. As indicated in the Consultant's last report, psychologists – Board Certified Behavior Analyst (BCBA)s would have adequate training to make these determinations and should participate in the audit tool development as well as the auditing of behavioral supports.
    - One of the questions that the QAR needs to answer is whether the adaptive equipment is the proper fit for the individual. Particularly for individuals with complex physical and nutritional management needs, an Occupational Therapist (OT) or Physical Therapist (PT) would have adequate training to answer this question.

- Similarly, the question whether the person needs any special supports or equipment not currently available to assist in mobility, drinking liquids or eating food or communication, would likely require an OT, PT, or Speech and Language therapist to answer this question.

The "Proposal for Inclusion of Clinical Components in the Person Centered Review (PCR) Process" document, which includes a nurse in the process, represents a positive step. However, significant concerns remain:

- The proposal discusses "a Registered Nurse" as the Nurse Reviewer. It is unclear whether a single nurse only is proposed or whether the Clinical Review described would apply to all 400 individual reviews.

- The proposal does not specify whether the Nurse Consultant would participate in the 50 reviews of providers, including the review of provider policies and the provider's guidelines for healthcare protocols.

- This document does not clarify the relationship between the Nurse Reviewer and a consulting Behavior Analyst. It is outside of a nurse's scope of practice to assess behavioral supports.

In summary, the proposed plan does not set forth a process for the review of the broad topic of "healthcare" that addresses the Agreement's requirements. As previously reported, the Agreement specifically requires the staff conducting the QSRs to "interview professional staff," to "review treatment records," and "to evaluate whether the individual's needs have been met." The most recently submitted draft audit tool and questionnaire require QARs to make a number of assessments and judgments about individuals' healthcare and clinical services. The Agreement requires that these staff be "adequately trained" to make these judgments. Based on the documents provided, the Nurse Reviewer's role in reviewing treatment records, interviewing professional staff, and evaluating whether individuals' needs have been met remains unclear. In addition, it is concerning that the revised plans for the QSRs would expect a generalist QAR or a nurse to assess behavioral health supports, therapeutic supports, and assistive/adaptive equipment that are outside a nurse's scope of practice.

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

IV. CONCLUSION

During the twelfth review period, the Commonwealth through its lead agencies, DBHDS and DMAS, and their sister agencies, sustained compliance with many provisions of the Agreement. It also newly achieved compliance with three additional provisions related to discharge planning and transition from Training Centers. The Commonwealth has continued to provide funding to create HCBS waiver slots and to provide individual and family support funding for more individuals and families than is required by the Agreement. It has also kept on implementing its redesigned HCBS waiver programs. This effort, and the Commonwealth's realigned single-point-of-entry process for nursing facilities, has resulted in more individuals with ID/DD living in integrated residential settings and being engaged in communities and fewer children living in large congregate private institutions (i.e. nursing facilities and ICFs).

The Commonwealth has continued to make substantive and important progress in other areas as well, including some where it has not yet achieved compliance. It developed and began implementing a strategic plan to develop a coordinated and comprehensive set of strategies for individual and family support resources for individuals who are not yet receiving for HCBS waiver-funded services. The Commonwealth has also facilitated discharge of children from one nursing facility and of older children from two large ICFs; and it has improved crisis services.

Unfortunately, as of March 31, 2018, the end of this twelfth review period, the Commonwealth had still not revised its DBHDS Licensing Regulations. In the fall of 2014, three and a half years ago, the Independent Reviewer reported to the Court that "The Commonwealth's current regulations and historical practices are often obstacles to achieving compliance." The Commonwealth has long acknowledged the need to revise its DBHDS Regulations. to move toward compliance with many of the Quality and Risk Management provisions. Since March, the draft emergency Licensing Regulations have been approved by four Virginia Departments and forwarded to the Governor's Office for final approval. The Governor's approval, after which the emergency Regulations will be immediately implemented, is critically important. However, his approval is only a first step toward implementing needed and systemic and statewide changes. Following approval, an extensive effort will be required to effectively implement the revised Regulations. DBHDS, CSBs and providers will need to put quality improvement and risk management programs in place, to begin gathering and submitting reliable quality data, to identify patterns and trends, and to determine needed safety and other improvements. The OL will need to begin assessing the adequacy of services provided and case managers will need to assess whether the services described in ISPs are being appropriately implemented and remain appropriate to the individuals. Effectively implementing these requirements of the Agreement will provide important safeguards to individuals with ID/DD and their families.

The Commonwealth has recognized its ongoing shortcomings in fulfilling the Agreement's case management requirements. In January 2018, it began a broad multi-faceted statewide initiative to bring about needed improvements at the local CSB and statewide levels. These initiatives will become more specific in July 2018 following completion of CSB self-assessments and the develop local improvement plans. At that time, DBHDS will form a committee to determine priorities for statewide case management improvement initiatives. The Commonwealth has already begun planning and development of other complimentary case management improvement projects with the assistance of external entity. The measurable impact of these improvements, however, will not

be evident until the spring of 2019, and therefore will not be studied until the fourteenth review period.

The historical CSB-ES practice of arranging for initial assessments of individuals in crisis to occur at hospitals or the CSB offices is contributing to more children and adults with ID/DD being admitted to psychiatric hospitals. The CSB-ES component of the Commonwealth's statewide crisis services system is not dispatching members of the mobile crisis team to complete assessments at the individuals' homes, as required. This practice of completing assessments after individuals have been removed from their homes is an obstacle to the REACH staff being able to contribute their expertise and resources to deescalate crises and to offer alternative community-based services. Without the Commonwealth requiring changes to this historical CSB-ES practice, the REACH crisis services will not be able to fulfill the purposes for which they were created.

For children and adults with intense medical and behavioral needs who live at home, families and provider agencies continue to have great difficulty in recruiting and retaining nurses and direct support professions to provide needed and approved in-home services. Providing such services in the individuals' homes is the preferred approach for most children. However, it is frequently not a viable approach for many families. The shortage of these staff is the result of the current low rates of pay and the unreimbursed time and cost of travel, especially in more rural areas of Virginia.

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

V. RECOMMENDATIONS

The Independent Reviewer's recommendations to the Commonwealth regarding services for individuals in the target population are listed below. The Independent Reviewer requests a report regarding the Commonwealth's actions to address these recommendations and the status of implementation by September 31, 2018. 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 fourteenth review period (September 30, 2018 - April 1, 2019).

Children in Nursing Facilities, Large ICFs, and Other Institutions

1. For the children whose childhoods are still ahead, the Commonwealth should prioritize transition planning for the youngest residents of large ICFs to live with their own or host families with needed supports.

2. The Commonwealth should utilize its influence to ensure that the nursing facility (#2 in Dr. Zaharia's study) fulfills its responsibility to support children with ID/DD to transition to integrated community-based living arrangements.

3. The Commonwealth should review and identify Virginia's "other institutions" where children who are likely to be members of the target population and implement diversion and transition strategies, so that these children also benefit from the provisions of the Agreement.

Emergency Licensing Rules and Regulations

4. The Commonwealth should carry out a formative evaluation to provide feedback regarding whether the outcomes of implementing its emergency DBHDS Licensing Rules and Regulations, have the planned and intended outcomes. It should determine whether providers that have put into effect quality improvement and risk management programs; and utilize root cause analysis and complete reviews of deaths and whether CSB's case managers are completing assessments during face-to-face visits to determine whether ISPs are being implemented appropriately. If these improved outcomes have not been achieved by ninety -five percent of providers and CSB's then the Office for License should make needed adjustments to its approach to implementing the revised regulations.

Case Management Monitoring

5. The Commonwealth should review and determine its overall organizational approach to coordinating case management monitoring, data and information reporting, and formalizing performance improvement activities. It should consider creating and authorizing an entity to fill these roles.

6. The Commonwealth should consider stablishing regional support case management quality units to support participation in ongoing CSB assessment and improvement activities following the model used by the DBHDS Quality Management Division.

Individual and Family Support

7. The Commonwealth should examine its definition of "most at risk for institutionalization". In the process, DBHDS should consider whether the current prioritization of the waiver waitlist is, or should be, applicable to IFSP and amend the administrative rules to eliminate the first come-first served requirement for IFSP funding.

8. DBHDS should clearly define expectations of case management options available to individuals on the waitlist, as these relate to facilitating access to the IFSP Funding Program as well as to the broader array of individual and family supports for which they might be eligible.

9. DBHDS should ensure the work plan for the family-to-family and peer programs provide specific methodologies for interfacing with the annual service planning process, which offers these opportunities. The work plan should also address the development of performance and outcome indicators and the data gathering and analysis process to track and ensure program efficacy.

10. DBHDS should identify indicators needed to adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports, impact on the risk of institutionalization, and individual and family satisfaction. DBHDS should implement collection and analysis to determine whether its planned and desired outcomes are being achieved.

Crisis Services

11. To reduce avoidable psychiatric hospitalizations, the Commonwealth should inform the CSBs that its Emergency Services programs are expected to comply with the Agreement's requirements that initial assessments be completed in the home of the individual in crisis whenever possible.

12. The Commonwealth should require that CSB – ES staff involve REACH staff when individuals with ID/DD are being voluntarily admitted to psychiatric hospitals.

Quality Service Reviews

13. Prior to finalizing and implementing the annual Quality Service Reviews, the Commonwealth should:

- define the standards in audit tools to clearly articulate expectations for providers and to ensure inter - rater reliability. If specific licensing regulations or DBHDS policies drive the expectations, then they should be cited. If not, then, clear standards should be set forth.

- define the audit tools should consistently identify the methodology that auditors would use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation).

- include in the audit tools explanations of the criteria for determine whether requirements, such as "met" or "not met", will be determined.

- ensure that Auditors who assess clinically driven indicators (i.e. behavior support plans, adequate nursing care, sufficient medical supports, etc.) must be qualified to make such determinations.

I. APPENDICES

APPENDIX A.

SIX INDIVIDUAL SERVICES REVIEW STUDIES OF INDIVIDUALS WHO TRANSTIONED FROM TRAINING CENTERS TO COMMUNITY SETTINGS

October 1, 2011 - September 30, 2017

Completed by:
Donald Fletcher, Independent Reviewer/Team Leader
Elizabeth Jones, Team Leader
Rebecca Wright, Team Leader
Marisa Brown, RN, MSN
Barbara Pilarcik, RN BSN
Shirley Roth, RN MSN
Kimberly Chavis, RN BSN
Julene Hollenbach, RN BSN NE-BC

Six Individual Services Review (ISR) Studies Of Individuals Who Moved *From* Training Centers *To* Community-based Settings							
		Selection Criteria					
ISR Review Period	**Fiscal Year when moves occurred**	**Cohort # who moved**	**Randomly selected sample**	**Training Centers Individuals *moved from***	**Regions Individuals *moved to***	**Other**	**Other**
First	FY 2012	58	32	CVTC SVTC	I,II,III,IV,V	N/A	N/A
Third	FY 2013	42	28	NVTC SVTC	IV,V	N/A	N/A
Fifth	FY 2014	42	28	CVTC NVTC SWVTC	I,II	Maximum of two of the individuals who live in any one home	N/A
Seventh	FY 2015	42	24	CVTC NVTC	I,II	Maximum of two of the individuals who live in any one home	N/A
Ninth	FY 2016	40	26	CVTC NVTC SWVTC	I, II, III	N/A	N/A
Twelfth	FY 2017 and FY 2018	22	19	CVTC SEVTC SWVTC	I,II,III,IV,V	Maximum of two of the individuals who live in any one home	SIS scores indicate intense needs
Total		**246**	**157**				

Demographic Information

Individuals who transitioned from Virginia's Training Centers
between 10/1/2011 and 9/30/2017

NOTE: The Independent Reviewer completed six Individual Services Review Studies of the service outcomes for individuals who completed the discharge planning and transition process from the Commonwealth's Training Centers. The 157 individuals studied transitioned from all Training Centers to live in community-based homes. They were selected from a cohort of 254 individuals who moved from Training Centers between October 2011 and September 2017. The random selection of 157 individuals gives 90% confidence that the findings from these studies can be generalized to the larger cohorts.

ISR 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	**12th period** 9/30/16 - 9/30/17	**Totals 3/6/12- 9/30/17**
# of studied	32	28	28	24	26	19	**157 individuals studied**
(#) in the cohort	(58)	(42)	(42)	(42)	(48)	(22)	**findings generalized to 254**
Gender # (%) males	21 (65.6%)	16 (57.1%)	13 (46.4%)	16 (66.7%)	15 (57.7%)	10 (52.6%)	**81 (58.7%) males**
Age # (%) fifty-one or older	20 (62.5%)	21 (75.0%)	22 (78.5%)	17 (70.9%)	17 (65.4%)	14 (73.7%)	**97 (70.3%) age 51 or older**
Mobility # (%) use wheelchairs	12 (37.5%)	13 (46.4%)	11 (39.3%)	9 (37.5%)	13 (50.0%)	17 (89.5%)	**75 (47.7%) use wheelchairs**
# (%) use gestures, vocalizations, or facial expressions as highest level of **Communication**	25 (78.1%)	19 (67.8%)	18 (64.3%)	17 (70.8%)	15 (57.7%)	17 (89.5%)	**111 (70.1%) use gestures**
Type of Residence # (%) live in congregate residential programs	info not collected	24 (85.7%)	26 (92.9%)	21 (87.5%)	24 (92.3%)	18 (94.7%)	**113 (90.4%) Live in congregate residences**
Relationship w/ AR or guardian is individual's parent or sibling	info not collected	21 (75%)	24 (85.7%)	22 (91.6%)	18 (79.2%)	13 (68.4%)	**98 (78.4%) is parent or sibling**

APPENDIX B.

INDIVIDUAL SERVICES REVIEW
DISCHARGE PLANNING AND TRANSITION
FROM TRAINING CENTERS

October 1, 2016 – September 30, 2017

Completed by:
Elizabeth Jones, Team Leader
Marisa Brown RN, MSN
Barbara Pilarcik RN BSN
Shirley Roth, RN MSN

Demographic Information

Sex	n	%
Male	10	52.6%
Female	9	47.4%

Age ranges	n	%
Under 21	0	0.0%
21 to 30	1	5.3%
31 to 40	2	10.5%
41 to 50	2	10.5%
51 to 60	7	36.8%
61 to 70	6	31.6%
71 and over	1	5.3%

Relationship with Authorized Representative	n	%
Parent or Sibling	13	68.4%
Other Relative	2	10.5%
Other e.g. friend	1	5.3%
Public Guardian	3	15.8%

Type of Residence	n	%
ICF-ID	0	0.0%
Group home	19	100%
Sponsored home	0	0.0%
Own home	0	0.0%

Levels of Mobility	n	%
Ambulatory without support	0	0.0%
Ambulatory with support	2	10.5%
Uses wheelchair	17	89.5%
Confined to bed	0	0.0%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	1	5.3%
Limited spoken language, needs some staff support	1	5.3%
Communication device	0	0.0%
Gestures	8	42.1%
Vocalizations	5	26.3%
Facial expressions	4	21.1%
Other	0	5.3%

Discharge Planning Items				
Item	**n**	**Y**	**N**	**CND**
Did the individual and, if applicable, his/her Authorized Representative participate in discharge planning?	19	100.0%	0.0%	0.0%
Was the discharge plan updated within 30 days prior to the individual's transition?	19	100.0%	0.0%	0.0%
Was it documented that the individual, and, if applicable, his/her Authorized Representative, were provided with information regarding community options?	19	100.0%	0.0%	0.0%
Did person-centered planning occur?	19	100.0%	0.0%	0.0%
Were essential supports described in the discharge plan? a. Did the discharge plan include an assessment of the supports and services needed to live in most integrated settings, regardless of whether such services were currently available?	19 19	100.0% 100.0%	0.0% 0.0%	0.0% 0.0%
Were barriers to discharge identified in the discharge plan?	19	94.7%	5.3%	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?	19	89.5%	10.5%	0.0%
Was the moving timeline followed or were explanations documented?	19	100.0%	0.0%	0.0%
If a move to a residence serving five or more individuals was recommended, did the Personal Support Team (PST) and, when necessary, the Community Integration Manager (CIM) and the Regional Support Team (RST) identify barriers to placement in a more integrated setting?	2	100.0%	0.0%	0.0%
Was placement, with supports, in affordable housing, including rental or housing assistance, offered?	19	100.0%	0.0%	0.0%
Did discharge occur within six weeks after completion of trial visits?	19	100.0%	0.0%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	19	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?	19	100.0%	0.0%	0.0%
Did the Post-Move Monitor, Licensing Specialist, and Human Rights Officer conduct post-move monitoring visits as required?	19	100.0%	0.0%	0.0%
Were all essential supports in place before the individual moved?	19	89.5%	10.5%	0.0%
Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists?	19	94.7%	5.3%	0.0%

Individual Support Plan Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the individual's support plan current?	19	100.0%	0.0%	0.0%
Is there evidence of person-centered (i.e. individualized) planning?	19	100.0%	0.0%	0.0%
Are essential supports listed?	19	100.0%	0.0%	0.0%
Does the individual's Support Plan/Plan of Care address barriers that may limit the achievement of the individual's desired outcomes?	19	100.0%	0.0%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	19	100.0%	0.0%	0.0%
Medical	19	100.0%	0.0%	0.0%
Dental	19	94.7%	5.3%	0.0%
Health	19	100.0%	0.0%	0.0%
Recreation	19	100.0%	0.0%	0.0%
Mental Health (behavioral supports)	8	87.5%	12.5%	0.0%
Transportation	17	88.2%	11.8%	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?	19	0.0%	0.0%	100.0%
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%
Does the Individual's Support Plan/Plan of Care have specific and measurable outcomes and support activities?	19	52.6%	47.4%	0.0%
If yes, do they lead to skill development?	10	100.0%	0.0%	0.0%

Individual Support Plan Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Did the Case Manager/Support Coordinator provide education annually about less restrictive services?	4	0.0%	100.0%	0.0%
Was the individual or family given a choice of service providers, including the Case Manager/Support Coordinator?	19	0.0%	100.0%	0.0%
Does the Individual's Support Plan/Plan of Care have specific and measurable outcomes and support activities?	19	52.6%	47.4%	0.0%
If yes, do they lead to increased integration?	10	10.0%	90.0%	0.0%
If applicable, were employment goals and supports developed and discussed?	19	0.0%	100.0%	0.0%
If yes, were they included?	0	0.0%	0.0%	0.0%
If no, were integrated day opportunities offered	19	0.0%	100.0%	0.0%
Does typical day include regular integrated activities?	19	0.0%	100.0%	0.0%

Residential Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the support person supporting the individual as detailed (consider the individual's Behavior Support Plan or ISP regarding the level of support needed)?	19	100.0%	0.0%	0.0%
Is there evidence the support person has been trained on the desired outcome and support activities of the Individual's Support Plan/Plan of Care?	19	100.0%	0.0%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's likes and dislikes?	19	100.0%	0.0%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's talents/contributions and what's important to and important for the individual?	19	89.5%	10.5%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	19	100.0%	0.0%	0.0%
Are services and supports available within a reasonable distance from your home?	19	100.0%	0.0%	0.0%
Do you have your own bedroom?	19	94.7%	5.3%	0.0%
Do you have privacy in your home if you want it?	19	94.7%	5.3%	0.0%
Has there been a transfer to a different setting from which he/she originally transitioned?	19	0.0%	100.0%	0.0%

Residential Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Is there evidence of personal décor in the individual's room and other personal space?	19	68.4%	31.6%	0.0%

Environmental Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the individual's residence clean?	19	89.5%	10.5%	0.0%
Are food and supplies adequate?	19	100.0%	0.0%	0.0%
Does the individual appear well kempt?	19	100.0%	0.0%	0.0%
Is the residence free of any needed repairs?	19	89.5%	10.5%	0.0%
Has there been a Licensing Visit that checked that smoke detectors were working, that fire extinguishers had been inspected, and that other safety requirements had been met?	19	100.0%	0.0%	0.0%
Does the individual require an adapted environment?	19	89.5%	10.5%	0.0%
If yes, has all the adaptation been provided?	17	100.0%	0.0%	0.0%

Integration Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
If applicable, were employment goals and supports developed and discussed?	19	0.0%	100.0%	0.0%
If yes, were they included?	0			
If no, were integrated job opportunities offered?	19	0.0%	100.0%	0.0%
Does typical day include integrated activities?				
Within the last quarter, have you participated in community outings on a consistent weekly basis?	19	73.7%	26.3%	0.0%
Do you go out primarily with your housemates as a group?	19	100.0%	0.0%	0.0%
Do you have problems with transportation?	19	15.8%	84.2%	0.0%
Is attending religious services important to you/your family	19	26.3%	0.0%	73.7%
If yes or CND, do you have the opportunity to attend a church/synagogue/mosque or other religious activity of your choice?	19	31.6%	68.4%	0.0%
Do you belong to any community clubs or organizations?	19	31.6%	68.4%	0.0%
Do you participate in integrated community volunteer activities?	19	10.5%	89.5%	0.0%
Do you participate in integrated community recreational activities?	19	15.8%	84.2%	0.0%
Do you participate in grocery shopping?	19	36.8%	63.2%	0.0%

Healthcare Items - positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Were appointments with medical practitioners for essential supports scheduled for and, did they occur within 30 days of discharge?	19	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?	19	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?	19	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?	19	94.7%	5.3%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	18	94.4%	5.6%	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	100.0%	0.0%	0.0%
If ordered by a physician, was there a current physical therapy assessment?	5	100.0%	0.0%	0.0%

Healthcare Items - positive outcomes				
Item	**n**	**Y**	**N**	**CND**
If ordered by a physician, was there a current occupational therapy assessment?	4	100.0%	0.0%	0.0%
If ordered by a physician, was there a current speech and language assessment?	6	100.0%	0.0%	0.0%
If ordered by a physician, was there a current speech and language assessment?	6	100.0%	0.0%	0.0%
If ordered by a physician, was there a current nutritional assessment?	6	100.0%	0.0%	0.0%
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?				
OT	4	100.0%	0.0%	0.0%
PT	5	80.0%	20.0%	0.0%
Speech/Language	4	100.0%	0.0%	0.0%
Psychology	8	100.0%	0.0%	0.0%
Nutrition	19	100.0%	0.0%	0.0%
Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	18	94.4%	5.6%	0.0%
Is lab work completed as ordered by the physician?	19	100.0%	0.0%	0.0%
If applicable per the physician's orders, Does the provider monitor fluid intake?	11	100.0%	0.0%	0.0%
Does the provider monitor food intake?	4	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?	19	100.0%	0.0%	0.0%
Does the provider monitor seizures?	16	100.0%	0.0%	0.0%
Does the provider monitor positioning protocols?	15	100.0%	0.0%	0.0%
Does the provider monitor tube feedings?	14	100.0%	0.0%	0.0%
If applicable, is the dining plan followed?	3	100.0%	0.0%	0.0%
If applicable, is the positioning plan followed?	16	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?	19	94.7%	5.3%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	17	94.1%	5.9%	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?	1	100.0%	0.0%	0.0%
Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	8	100.0%	0.0%	0.0%
Is there any evidence of administering excessive or unnecessary medication(s) (including psychotropic medication.	19	0.0%	94.7%	5.3%
Healthcare Items - positive outcomes - continued				

If applicable, is there documentation that caregivers/clinicians				
Did a review of bowel movements?	19	100.0%	0.0%	0.0%
Made necessary changes, as appropriate?	10	100.0%	0.0%	0.0%
After a review of food intake,	5	100.0%	0.0%	0.0%
Made necessary changes were made, as appropriate?	3	100.0%	0.0%	0.0%
After a review of fluid intake,	11	100.0%	0.0%	0.0%
Made necessary changes were made, as appropriate?	5	100.0%	0.0%	0.0%
After a review of tube feeding,	14	100.0%	0.0%	0.0%
Made necessary changes were made, as appropriate?	11	100.0%	0.0%	0.0%
After a review of seizures,	14	100.0%	0.0%	0.0%
Made necessary changes were made, as appropriate?	8	100.0%	0.0%	0.0%
After a review of weight fluctuations,	19	94.7%	5.3%	0.0%
Made necessary changes were made, as appropriate?	10	100.0%	0.0%	0.0%
Does the individual require adaptive equipment?	19	94.7%	5.3%	0.0%
If yes, is the equipment available?	18	100.0%	0.0%	0.0%
If no, has it been ordered?	0			
If available, is the equipment in good repair and functioning properly?	18	88.9%	11.1%	0.0%
Has the equipment been in need of repair more than 30 days?	2	100.0%	0.0%	0.0%
Has anyone acted upon the need for repair?	2	100.0%	0.0%	0.0%
Is the support staff present, knowledgeable and able to assist the individual to use the equipment?	18	100.0%	0.0%	0.0%
Is the support staff present, assisting the individual to use the equipment as prescribed?	18	100.0%	0.0%	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)	5	80.0%	20.0%	0.0%
Are there needed assessments that were not recommended?	19	31.6%	68.4%	0.0%
Is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	9	55.6%	44.4%	0.0%
Have there been any events related to the individual's high-risk factors (i.e. aspiration, choking, constipation, falls, etc.)	19	26.3%	73.7%	0.0%
If yes, are those who support the individual aware of any BDHDS alert about the risk factor(s)?	7	42.9%	42.9%	14.3%
If yes, have any protocols or procedures been created or modified as a result?	7	42.9%	57.1%	0.0%

APPENDIX C.

CHILDREN IN NURSING FACILITIES AND PRIVATE ICF

By Ric Zaharia, Ph.D

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

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

By

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

May 1, 2018

Executive Summary

The Independent Reviewer requested a follow-up of DBHDS plans/efforts to reduce the numbers of children living in Nursing Facilities (NFs) and large, private Intermediate Care Facilities (ICFs), including transition and diversion efforts. The Settlement Agreement requires:

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

We focused on two samples of children with intellectual and developmental disabilities (IDD), one admitted and another discharged during 2017 from four facilities (two NFs and two private ICFs). The final sample size was twenty-six (26) children. The children with IDD who reside and receive pediatric long-term care services in a fifth institution have not previously been identified as members of the target population because, according to the Commonwealth, its Health Department licenses it as a "long term care hospital". The sample allowed us to assess the Department's most recent efforts to divert and transition children from the four facilities that the Commonwealth previously identified.

In addition to the above review, we conducted a 'follow-up' of 16 children who were evaluated by the Independent Reviewer's Individual Services Review study in 2016. To the degree possible, we conducted a document review, an AR conversation, a case manager or CSB contact conversation, and, if feasible, an onsite visit with the child. This approach provided a second marker as to the Department's longer-term efforts to transition children, who have been institutionalized for extended periods, out of large congregate facilities into home-based, more integrated community settings.

DBHDS is diverting children from unnecessary placement in the two previously identified NFs. DBHDS is working well with one NF to return children to their families or home communities. The transitioning of children back home does not function as well with the second NF. DBHDS is also successfully transitioning 18-21year olds out of ICFs. However, it is ineffective at diverting unnecessary ICF placements or transitioning very young children to return to their family home or alternative community-based settings. This ineffectiveness since the Agreement began has resulted in many children spending large portions of their childhoods living in institutions. The Commonwealth expects that its newly created single point of entry processes will have a positive impact on these children and families by redirecting them to community-based Waiver-funded and other services.

The purpose of this study was to evaluate the Department's efforts to divert NF/ICF admissions and facilitate the transition of children to live in the family's home or in the most integrated setting following an out-of-home placement in an NF/ICF.

Methodology:

- Identified children under age 18 known to DBHDS or DMAS who meet DD wait list criteria and were admitted to, or discharged from, NFs or large private ICFs in 2017;
- Assessed the current status of 16 children who were reviewed for the Independent Reviewer's 8th Report to the Court, June 6, 2016;
- Reviewed the Commonwealth's processes and plans to transition children from NFs and ICFs to home- and community-based settings;
- Reviewed known services for children discharged from NFs/ICFs in 2017;
- Conducted site visits to two large NFs and two large private ICFs; interviewed the senior staff person whose duties include oversight of discharge planning at each of these four facilities;
- Reviewed current discharge plans for the children in the selected samples;
- Reviewed any available CSB planning documentation for children placed at an NF or a large private ICF;
- Interviewed CSB staff regarding admission, transition, and discharge of children to and from NFs or large private ICFs;
- Interviewed DBHDS and DMAS staff regarding admission of children to NFs or large private ICFs.

Children in Nursing Facilities/Intermediate Care Facilities-Individuals with Developmental Disabilities

Findings

In 2016 the Independent Reviewer examined Settlement Agreement expectations regarding children in NFs/ICFs. At that time DBHDS identified 196 children who resided in nursing facilities or private ICFs during 2015.

In the June 2016 Independent Reviewer Report to the Court, 18 children living in these facilities were evaluated through Individual Service Reviews (ISR). The report concluded, among other things, that:

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

DBHDS reports today that as of March 31, 2018, there is a total census of 171 children in the two nursing and two private ICF facilities (see Attachment 1). This is a reduction from 196 in 2015 and appears to have resulted from the Department's efforts at NF diversion, NF discharge planning at one NF, and ICF discharge planning for individuals age 18-21. Transition planning efforts undertaken by the Department in the last year in these four facilities are expected to enhance and accelerate placements into community settings. In addition, the creation of a single-point-of-entry for the ICFs will divert many individuals who are referred to receive needed supports in the community. A similar review, if completed in 2021, should show a census well under 100 in these children's facilities.

Plans for diverting admissions and transitioning of institutionalized children from ICFs include Division for Developmental Services (DDS) activities to:

a) establish centralized tracking,
b) establish a single point of entry for ICFs,
c) administer a Level of Functioning tool (VIDES) for admission to ICFs,
d) prioritize discharge planning for 18-year olds at ICFs,
e) annual review by DBHDS staff of individual Level of Care determinations using the DMAS Quality Review Tool,
f) education of families on options for institutionalized children,
g) emphasize the requirements for CSB referral to the RST/CRC process,
h) educate ICF facility staff on community options,
i) enhance connections of CSBs with their institutionalized children, and
j) implement a post-move monitoring process for those discharged.

Many of these activities are well underway. Given the statutory Medicaid provision that admission to an ICF is a State Plan entitlement, DBHDS and DMAS are taking appropriate steps to ensure families understand their options and that admitted children need facility level active treatment.

As the Independent Reviewer noted in 2016, DBHDS established in its Office of Integrated Health (OIH) a structure and processes to screen children with IDD prior to admission to a nursing facility. A 'single point of entry' of IDD children into NFs was established at DBHDS; the Preadmission Screening and Resident Review (PASRR) federal requirement was invigorated and is now directed centrally at DBHDS; a 90-day individual Resident Review is managed directly by DBHDS; CSB relationships are formalized once a child is proposed for NF admission; family education is initiated post-admission to ensure parents and guardians are aware of their options; a post-move monitoring process was implemented; linkages with the Health Support Network and community health supports and the responsible CSB are affirmed for individual placements.

DBHDS has established a Community Transition Team (CTT) to monitor admissions and discharges of children from NFs and ICFs. This Team works to identify barriers and system improvements needed to ensure children live in the most integrated setting possible. For example, retrospective reviews of NF admissions since early 2015 show 22 admissions for 34 children who were referred; this suggests 12 children were diverted from an NF admission.

Although serious efforts are underway to ensure that transition planning occurs for children admitted to ICFs, nothing is specifically planned to divert very young children (<10) from being admitted to these institutions. In fact, parents considering out-of-home placement are often told that the alternative to admission to these facilities is for their child's name to be placed on CSB Waiver slot waitlist, which frequently may not even be the Urgent Wait List. Most individuals on these waitlists will wait for years before receiving a waiver slot that will provide funding for sufficient in-home services or an out-of-home placement. The slot reservation strategy called for in the Settlement Agreement (*"dedicated waiver slots to prevent or transition from a placement in an NF or ICF")* is not clearly understood by the CSBs or parents. This lack of awareness frequently contributes to desperate families applying for facility admission and to CSBs tacitly supporting or facilitating such admissions. In many cases while waiting for a waiver slot, families may be offered modest services as an alternative in order to

prevent admission. These services are frequently inadequate or under-resourced, which puts the family in the position of applying for facility admission. Many of these services appear to be local uses of Waivers for Elderly/Disabled Persons and Consumer Directed Services.

Again, because the availability of DDS waiver slots to prevent institutionalization is unknown at the local level, some CSBs are actively case managing the admission of young children into the very institutions (i.e. ICF placements) that the SA prioritizes waiver slots to prevent such placements. During the process of facilitating placement of children into these private institutions, the CSB case managers are generally overlooking, or ignoring, the CSB obligation to refer such cases to their respective CRC or RST. Although DBHDS has continued to educate and reinforce with CSBs regarding the obligation to refer to CRC or RST, no evidence was provided that DBHDS has enforced the Settlement Agreement requirement that these placements be first reviewed by the CRC and RST. Furthermore, based on our concurrent case management study and visit with five CSBs, once these children are placed in these institutions, most CSBs cease to provide them with active case management services. Although some CSBs report that they track and periodically check the status of individuals on their institutional caseloads most appear to not even do that minimum unless DBHDS prompts them to do so with specific requests.

Finally, Attachment 1 details the current point in time placement of children at the four children's facilities, two NFs and two ICFs. A fifth facility that provides pediatric long-term care services was not included. DBHDS reports that, because this institution is not licensed as a nursing facility, but rather as a "long term care hospital", these children are not covered by the Agreement's provision related to individuals with developmental disabilities under 22 years of age who reside in institutions other than the Training Centers.

Several observations seem noteworthy about Attachment 1: one quarter of the CSBs do not have any children living in these four facilities; these CSBs are clustered in the Western and Southwestern Regions (Region I and III), which likely indicates these areas may have developed and implemented other strategies. The Commonwealth did not provide information regarding how these CSBs prevent the admission of children to these facilities or what alternatives they utilize to divert potential admissions.

<u>Suggestions for Departmental Consideration</u>

Given the known negative effects of institutional care on young children[1], DBHDS should consider a policy direction to CSBs that indicates the Department's preference that young children belong in families, and that affirms its commitment to the goals of the Settlement Agreement to serve children in the most integrated setting. Everything else being equal, the family is the most efficient, compassionate service delivery system, and if the child cannot live with his/her biological family, an alternative community-based arrangement that allows the child to participate in community living is preferable.

As a corollary, DBHDS should consider asking CSBs to reserve a percentage of allocated slots to prevent the institutionalization of young children.

[1] Skeels & Dye, A study of the effects of differential stimulation on mentally retarded children, *Proceedings and Addresses of the American Association on Mental Deficiency*, 1939, 44, 114-136.
Nelson et al, (2014) *Romania's Abandoned Children: Deprivation, Brain Development, and the Struggle for Recovery,* Cambridge, MA: Harvard University Press.

DBHDS should clarify to CSBs the slot reservation strategy that it uses to comply with the Agreement.

DBHDS should consider focused analysis and queries to identify the underlying reasons some CSBs do not use these facilities to institutionalize children. DBHDS should share statewide the strategies that these Regions have utilized successfully to divert children, or to reduce their lengths of stay, so these children are able to receive needed supports in their home communities.

Since CMS considers the fifth facility that provides pediatric long-term care services a "Nursing Home", DBHDS should implement procedures to divert children from admission to this facility. It should also verify whether PASRRs are needed or can be implemented on any current residents who might have an intellectual or developmental disability (IDD) diagnosis and facilitate transitions to preferred alternative community-based arrangements,

Because there were several reports that CSB staff are often required by ICF staff to get parental consent to visit or receive information about these children, DBHDS should clarify with these facilities that the Commonwealth and CSBs have a statutory authority to track and monitor the welfare of these children.

Children with IDD in NFs/ICFs Reviewed in 2016

Findings
Transition and diversion efforts are now led by three staff at OIH and one at DDS. These staff coordinate PASRRs, ninety-day and LOC quality reviews, maintain liaison with facility contacts, and facilitate transition plans with CSBs. We identified that these staff have constructive relationships with the four facilities that had been previously identified.

Table I captures a brief snapshot of the 2016 cohort reviewed by the Independent Reviewer. Three (3) of the cohort of sixteen (16) reviewed in 2016 have been discharged. Of the group remaining in facilities since March 2016, thirteen remain living in these institutions: six (37.5%) are placed in NFs and seven (43.7%) are placed in ICFs. These individuals range in age from 4 to 21 yrs. The range for their lengths of stay is from 2 to 17 years. CSB involvement is spotty in that only five (5) of those remaining in a facility have an assigned case manager; reportedly this is due to the lack of case management reimbursement, until 30 days prior to placement. The Department is attempting to increase the provision of active case management by allowing reimbursement for 90-days prior to placement.

Currently discharge planning falls to the internal facility treatment teams and DBHDS staff. Some CSBs have identified the resources to monitor and maintain a case management assignment for those living in facilities, regardless of reimbursement. Discharge planning for those living in these children's ICFs does accelerate at age 18 when the threat emerges of aging out, i.e. when the program will no longer be funded to serve the child. DBHDS has prioritized its planning and waiver slots around this group.

Table I 2016 ISR Cohort Status 2018				
Discharged	**Active Discharge Planning**	**CSB has assigned Case manager**	**Average Age**	**Average Length of Stay**
3/16 (19%)	8/13 (62%)	5/13 (38%)	14.1 yrs.	7.8 yrs.

At the time of this study in March 2018, the sixteen children had an average length of stay of nearly eight years, more than half of their average age. At the current rate of discharge, most of these thirteen individuals may well remain institutionalized for the remainder of their childhood years before being provided supports that allow them to return to their families or home communities.

Suggestions for Departmental Consideration

Concurrent with implementation of the single point of entry process, DBHDS should consider again reinforcing with the CSBs (and facilities) that potential ICF placements are required to go through the CRC/RST process. These requirements should be placed in an Exhibit D of their Performance Contract when CSBs chronically ignore this expectation.

Children with IDD in NFs/ICFs Admitted/Discharged in 2017

Findings

All children under age 22 admitted to or discharged from the four facilities during 2017 were identified by DBHDS. Children with IDD who were admitted to or discharged from the fifth institution, which is licensed as a long-term care-facility, were not identified. The authors then randomly selected a sub-sample from each of the four facilities where available. This resulted in a total sample size of 26. Table II identifies the size of the cohorts reviewed for this study of 26 children.

Table II Sample Selection Distribution		
	2017 IDD Admissions	**2017 IDD Discharges**
NF1	2	6
NF2	2	0
ICF1	4	5
ICF2	3	4
Total	**11**	**15**

As can be seen in Table III, the average age of the children admitted was 8.1 years, but surprisingly the age range for the ICF subgroup was a very young 6.4 years. None of the children in the selected sample who were admitted to an ICF appeared to have been referred to the CRC or RST. CSBs facilitated two of the seven (28.8%) ICF admissions.

The lack of, or inconsistent, home nursing supports was the most commonly stated reason given by the facility, CSB and family for admission of a child to an ICF. Fewer than half of the children in the sample who currently live in a facility are engaged in CSB discharge planning or have an assigned case manager assigned. Reimbursement for case management work on discharge planning begins during the last 30 days before placement; DBHDS reports that it is planning to increase this to the last 90 days before placement. Given the typical discharge planning timeline, the actual discharge plan would need to be developed, refined and completed before the case manager is involved. Consequently, DBHDS staff and the facilities themselves have to carry most of the load of discharge planning.

Table III
2017 ID/DD Admissions

	Male	**Female**	**Average Age**	**Active CSB Discharge Planning**	**CSB Case manager**	**RST/CRC Referral**
NFs	3	1	11.0 yrs.	1/4	2/4	0
ICFs	2	5	6.4 yrs.	4/7	2/7	0
Total	**5**	**6**	**8.1 yrs.**	**5/11**	**4/11**	**0**

As can be seen in Table IV, the children with IDD in the sample who were discharged in 2017 had an average length of stay of 47 months. However, because only NF1 discharged children in 2017 the average length-of-stay of 3.2 months reflects only on NF1, whose discharge pattern is what would be expected from a short stay medical facility. As Table II above shows NF2 discharged no children in 2017, so no length of stay could be calculated. Therefore, NF2's discharge pattern is not what would be expected from a short stay medical facility usage; its pattern is more like that of a long-term care facility.

Table IV
2017 ID/DD Discharges

	M	**F**	**Home**	**Group Home**	**Spons. Res.**	**Other***	**Avg. Age**	**Avg. Length of Stay**
NFs**	1	5	5	-	1	2	6.2 yrs.	3.2 mon.
ICFs	5	4	1	5	-	1	18.4 yrs.	76.4 mon.
Total	**6**	**9**	**6**	**5**	**1**	**3**	**13.5 yrs.**	**47.0 mon.**

*ICFs, adoption, out of state
**NF1 only

The average age of the children discharged in 2017 was 13.5 years with a range of 1-22 years. However, demonstrating the impact of the threat of "aging out" for those ages 18 to 22, the seven (7) discharged from ICFs had an average age of 18.4 yrs. NF1 discharged 5 of 6 children back to their homes, which indicates a program that actively works to train families and to facilitate the child returning to his or her family home with needed support services. Most of the children who were discharged were returned to community-based settings with nursing and ancillary health supports that were funded through the DDS Waiver. Of the seven (7) children who were discharged from the ICFs, five moved to group homes, one to an adult ICF, and one to a sponsored residential home.

Suggestions for Departmental Consideration

DBHDS should consider prioritizing transition planning the youngest children (<10) placed in ICFs.

The Commonwealth should utilize its influence to ensure that NF2 fulfills its responsibility to support children with IDD to transition to integrated community-based living arrangements.

Summary

The goal of this study was to assess the Commonwealth's efforts to divert NF/ICF admissions and to facilitate the transition of children out of institutional placements to live in the family's home or, if that is not an immediate option, in the most integrated community setting when temporary out-of-home placement is warranted in an NF/ICF. DBHDS is effective at diverting children from unnecessary placement in the two identified NFs and at working with one NF to return children to their families or home communities. This latter mechanism, transitioning children home, does not yet function well with the second NF, which did not discharge any children with IDD during 2017. DBHDS is also effective at transitioning 18-21year olds out of ICFs but, without the single point of entry controls or the required referral to the RSTs, is ineffective at diverting unnecessary ICF admissions. The Commonwealth has not fulfilled its obligation to ensure that any proposed placement of members of the target population into an ICF be first reviewed by the CRC and, if needed, the RST. Hopefully, single point of entry processes will have a positive impact on these children and families by redirecting them to community-based IDD Waiver-funded services.

Currently, a family struggling with a young child who has significant medical or behavioral needs has few home-based service options is frequently not able to secure sufficient or sustainable in-home nursing and/or direct support professional assistance. Although, these families have the right to an institutional placement, they should be afforded a real choice between adequate and sustainable home- and community-based services and being separated from their families and communities by being placed in an institution.

Attachment 1
Number of IDD Children from each CSB* - March 2018

	Nursing Facilities		**Private ICF/IID**		
CSB	NF1	NF2	ICF1	ICF2	**TOTAL**
1	0	0	18	7	**25**
2	2	0	15	2	**19**
3	2	0	11	3	**16**
4	0	0	11	4	**15**
5	11	0	1	0	**12**
6	0	7	2	0	**9**
7	1	0	5	2	**8**
8	0	0	6	2	**8**
9	5	0	2	0	**7**
10	1	5	0	1	**7**
11	2	1	3	0	**6**
12	4	0	2	0	**6**
13	1	2	2	1	**6**
14	1	1	2	0	**4**
15	0	3	0	0	**3**
16	1	0	1	1	**3**
17	0	0	1	1	**2**
18	0	2	0	0	**2**
19	1	0	0	1	**2**
20	0	1	0	0	**1**
21	0	0	1	0	**1**
22	0	0	0	1	**1**
23	1	0	0	0	**1**
24	1	0	0	0	**1**
25	0	1	0	0	**1**
26	0	0	1	0	**1**
27	1	0	0	0	**1**
28	1	0	1	1	**3**
29	0	0	0	0	**0**
30	0	0	0	0	**0**
31	0	0	0	0	**0**
32	0	0	0	0	**0**
33	0	0	0	0	**0**
34	0	0	0	0	**0**
35	0	0	0	0	**0**
36	0	0	0	0	**0**
37	0	0	0	0	**0**
38	0	0	0	0	**0**
39	0	0	0	0	**0**
40	0	0	0	0	**0**
TOTAL	**36**	**23**	**85**	**27**	**171**

*CSB assignment often fluctuates based on family relocations

APPENDIX D.

CASE MANAGEMENT MONITORING

BY: Ric Zaharia, Ph.D.

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

Case Management/Support Coordination Requirements

By

Ric Zaharia, Ph.D.

May 1, 2018

Executive Summary

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a review of the system that the Commonwealth uses to monitor compliance with performance standards for support coordination/case management. The Settlement Agreement requires:

> *III.C.5.d - The Commonwealth shall establish a mechanism to monitor compliance with performance standards [for support coordination/case management].*
>
> *III.C.5.c - Support coordination/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.*
>
> *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.*

This study focused on the effectiveness of the multiple case management/support coordination monitoring mechanisms used by the Commonwealth: the DBHDS Office of Licensing (OL), the DMAS (Department of Medical Assistance Services) Quality Management Review (QMR) process, the DBHDS Quality Management Division's (QMD recently restarted support coordination/case management reviews, the external Delmarva Quality Service Review (QSR) process, the DBHDS Data Dashboard data tracking system, and the Division of Developmental Services (DDS) electronic supervisory review/QRT (Quality Review Team). The study goal was to crosswalk these mechanisms and their stated purposes, identify the flow of quality information on case management/support coordination from these mechanisms, and pinpoint any overlaps, duplications, conflicts, information stoppage, etc. among the processes.

Because case management/support coordination is a state plan service directly managed by DMAS, because there are 40 CSB case management/support coordination agencies operated across the state, and because DDS operation of its waiver is linked through support coordination/case management, the Commonwealth's case management/support coordination system is complex. It is also fragmented and uncoordinated, because there is no single point of accountability. The system, as currently composed, is in need of:

a) an entity that is responsible for the coordination of the intake and processing of case management/support coordination data and information and
b) a formalized performance improvement process managed by this coordinating entity.

The Office of Licensing remains the backbone of the DBHDS system for monitoring the performance of case management/support coordination; it assures the minimal performance that complies with the DBHDS regulatory requirements for case management/support

coordination services. The Commonwealth's other centralized processes seek to assure the performance of the more complex activities of support coordination/case management.

There are a number of CSBs that are using some best practices in overseeing case management/support coordination responsibilities. All CSBs should be brought up to a level wherein CM supervisors exercise quality assurance strategies in advance of audits and other external reviews. There are also several instances where the performance improvement strategies currently being implemented from the Division of Developmental Services (DDS), from the Quality Management Division (QMD), and from the Department of Medical Assistance Services (DMAS) are appropriate and timely.

The Commonwealth is not in need of more quality management monitoring processes for case management/support coordination. Rather, it is in need of an entity in the system that is responsible for and has the organizational tools, to effectively bring coherence and clarity to improvements that are proposed, that prioritizes improvements that are needed, and that conveys a clear direction in case management/support coordination performance improvement for CSBs.

The Commissioner of DBHDS has recently focused CSB attention on their implementation of case management/support coordination and the need for continuing improvement of those services. The Commissioner solicited from each CSB a Case Management/Support Coordination Self-Assessment and a proposed plan for local improvements based on their results of self-assessment. These reports and plans are expected by early summer at which time a workgroup will be convened to identify statewide themes and to monitor the progress of improvement efforts towards a hoped for and needed "case management/support coordination transformation".

The challenge the Commonwealth has is the proverbial, 'getting everyone on the same page.' This challenge has been placed front and center by the Commissioner in his January 26, 2018, letter to the CSBs.

Methodology:

- Reviewed OL citations for case management/support coordination in CSBs for the period July – December, 2017;
- Reviewed QIC (Quality Improvement Committee) minutes, July 2017- March 2018;
- Reviewed QMR reports and corrective actions for the period July-December, 2017;
- Reviewed DBHDS Performance Contract evaluations of CSB compliance for the period January-December, 2017;
- Reviewed available Data Dashboards for the period July-December, 2017;
- Reviewed reports for the restarted support coordination/case management process at QMD for the period July-December, 2017;
- Reviewed Delmarva reports February 2018, September 2016;
- Reviewed *"Regulatory Crosswalk Comparison for the DD Waivers/OL/Performance Contract*";
- Reviewed Dinora & Bogenschutz, Virginia Commonwealth University (VCU), "*A Study of Intellectual and Developmental Disability Support Coordination/Case Management in Virginia*," March 2018;
- Interviewed VCU's P. Dinora;
- Interviewed DBHDS staff who oversee support coordination/case management services regarding continuous improvement activities including QMD staff, Data Dashboard managers, QRT managers;
- Interviewed DMAS managers regarding the QMR review process;
- Interviewed five representative IDD directors from CSBs in Regions 2, 4, 5.

Office of Licensing (OL)

The DBHDS Office of Licensing is the backbone of the case management/support coordination performance monitoring system because of its authority (Virg. Leg. Code, ch. 4 § 37.2-404) and ultimate ability to delicense. OL is focused in regulation (12VAC35-105-1240) of case management/support coordination services including assessment, service planning, accessing services, and monitoring services; ensuring choice, education, counseling, and advocacy are identified as case management/support coordination expectations but are not typically assessed by OL; proposed revised regulations (July 2017) included a detailed expectation of the CMs responsibilities during face-to-face meetings.

OL has sustained its recent emphasis on increased focus on the case management/support coordination service at the CSB level. Notwithstanding the turnover of leadership at OL, this emphasis has continued and is reflected in the number of its citations of regulatory violations by CSB case management/support coordination. The feedback that OL provides to CSBs is generally clear and relatively timely. Corrective action plans are required when appropriate and OL follows up to ensure that these action plans have been implemented. Finally, it is interesting to note that several citations to CSBs in 2017 were made under *Monitoring* requirements for *gaps in face-to-face contact with the individual receiving services*.

Current regulations still do not align with the Settlement Agreement, particularly as to Section V.G.3, evaluating the adequacy (quality) of individual supports and services. The Settlement Agreement specifically requires that the "adequacy of services" be part of the licensing process. However, if the proposed emergency regulations receive final approval for implementation (specifically Sec. 1245), DBHDS will have successfully aligned regulations

with the Settlement Agreement. Until then, the Commonwealth makes the case that it has other processes to assess the adequacy of individual supports and services.

DMAS Quality Management Review (QMR)

The QMR process is required of DMAS due to the funding of case management/support coordination as a state plan service, rather than as a DBHDS-operated waiver. The QMR is conducted by a DMAS team and includes an onsite record review for the presence of eligibility assessments, choice documentation, risk evaluation, timely/appropriate ISPs, monthly contact notes, and quarterly reviews. This QMR review also includes checks on case manager qualifications and completion of ongoing training.

The QMR team attempts to visit each CSB every 2-3 years and surface quantitative, and some qualitative, issues that arise in case management/support coordination services. Individual samples at each CSB are pulled randomly from DMAS claims data. Feedback to CSBs is generally clear and relatively timely. DMAS requires corrective action plans when appropriate.

QMR data results are discussed at QRT meetings (see below) but the outputs of the QMR process, the letters of findings to the CSBs, are shared with DMAS's Division of Developmental Disabilities and Behavioral Health and with DBHDS's regional Community Resource Consultants. They are not shared, however, with DBHDS leadership, the individuals served, their Authorized Representatives, or other stakeholders.

Recent QMR citations of CSBs have included inadequate case manager/support coordinator monthly contact notes, missing annual risk assessments, and, interestingly, *the failure of case managers/support coordinators to complete or document their face-to-face visits with individuals receiving services*.

QMD review process

DBHDS's recently revived QMD process of CSB visitations, which include QMD staff providing compliance feedback and concurrent technical assistance has been very well received. In this cycle of reviews, the QMD process is focusing on ensuring that CSBs use valid data to improve the case management/support coordination process. One of the hoped-for outcomes of this process is an improvement in CSB and DBHDS attention to and use of the Data Dashboards (see below). The nature of each visit is well described in the QMD follow-up reports to the CSB.

Fifteen of forty planned CSB visits by QMD have occurred, and QMD expects to visit all CSBs once by the end of summer 2018. As we have said in previous year's reports, when the aggregation of findings and more CSBs are included, this process could become an effective, ongoing component of the case management/support coordination performance monitoring system. Trending reports will be useful as time goes on, in order to aggregate the findings trends identified by the QMD team.

Indeed, the benefits of this on-the-ground, in-your-face assessment of case management/support coordination performance and the provision of immediate feedback and technical assistance, could be enhanced by a regional establishment of additional, comparable staff to ensure more proximate and more frequent reviews and visits.

DBHDS Data Dashboard

We have previously identified strengths and weaknesses in the Department's use of the Data Dashboard. On the positive side it is a clear metric for several Settlement requirements: face-to-face case management/support coordination, case management/support coordination visits to the home, and five major outcome indicators (Health and Well Being, Inclusion, Choice, Living Arrangement, and Day Activity). On the negative side we have raised questions about the reliability of the five outcome metrics as currently measured and the failure to utilize the face-to-face metrics to motivate improvements in the most basic of case management/support coordination functions.

Regular face-to-face contact with an individual by a case manager and regular probing of the home and day environments in which an individual lives are basic ingredients to an effective support relationship between a case manager/support coordinator and a recipient of services. In the Independent Reviewer's December 13, 2017, report we noted that a number of CSBs had not consistently achieved 86% (the DBHDS target) on the face-to-face case management/support coordination measure over a two-year period. The latest available Data Dashboards (August, September and October 2017) indicate that of the eleven underperforming/underreporting CSBs which we identified last year, six CSBs were still consistently *at or below target for the latest 3-month period for face-to-face visits with the individual receiving services*.

Table 1
Data Dashboard Metrics
Face-to-Face Support Coordination/Case Management

CSB	August 2017	September 2017	October 2017
1	69%	57%	83%
2	50%	68%	83%
3	11%	0%	46%
4	67%	65%	86%
5	0%	0%	3%
6	52%	44%	47%
7	74%	68%	86%

It appears that "some CSBs ignore the metrics". This is a drag on high performing CSBs. After receiving technical assistance on the metrics, coding, etc., DBHDS should hold underperforming CSBs accountable for these most basic of case management/support coordination functions, particularly given the fact that OLS and DMAS/QMR findings have validated the existence of this problem.

CSB Case Management Supervisors Quarterly Reviews

The CSB Case Management Supervisors complete quarterly review via Survey Monkey. This process provides DDS with probes a sample of case management/support coordination records at each CSB quarterly. The survey asks supervisors to conduct specific record reviews and to assess the presence of documentation of eligibility assessments, face-to-face visits, consumer education on options, including choice of providers and case managers, assessment of Enhanced Case Management status, and the timeliness and appropriateness of the ISP, including updates when warranted by changes.

CSBs do not routinely receive any feedback on their performance, but may on occasion receive a request for a corrective action from the QTR and the CSBs expected to use their experience in completing the surveys to institute quality improvements around individual staff or systems. Outcome data, however, are included in a number of performance measures reviewed by the QRT in its report, *DD Waiver Quality Assurances Reporting Grid.*

This approach is one that is commonly used around the country, but its effectiveness depends on local agency managers/supervisors to bring about needed improvements. These processes in the Commonwealth are currently undergoing revision based on negotiations with CMS, but the quarterly data survey continues.

Delmarva Quality Service Reviews (QSR)

The Delmarva Foundation, an external entity, contracts with DBHDS to conduct QSR reviews of individuals receiving at least one Waiver service, including the impact of case management/support coordination. This process uses a random sample of around 400 individuals who are reviewed over a 12-month period by an external review team. Although Delmarva assesses many of the areas already assessed by other systems, it is somewhat unique in probing qualitative, higher order case management/support coordination tasks that focus on actualizing the capacities and maximum independence of an individual receiving services.

To the extent that these case management/support coordination activities are not required in Licensing regulations, DMAS expectations, etc., the Delmarva reviews of case management/support coordination have introduced some dissonance at the CSB level due to the absence of similar standards in Licensing and other reviews. DBHDS has clarified that some of these expectations represent 'best practice' toward which all CSBs should strive. The DBHDS Quality Improvement Committee (QIC) reviews Delmarva reports and establishes system recommendations.

CSB Performance Contracts

As we noted in our reports on this subject from 2015 and 2016, the CSB Performance Contract aligns with the case management/support coordination requirements of the SA. In fact, in the FY2018 Contract Renewal and Revision not only does the contract specifically require that case managers give individuals or ARs their choice of providers, but it details in Section 4.e. a complete list of the SA's expectations for support coordination/case management in the section titled, *Department of Justice Settlement Agreement Requirements***.**

In 2015 QMD was making limited, but high-quality efforts to formally audit the CSBs performance on case management/support coordination to the SA expectations through the Operational Review process. This approach has since been discontinued and the Operational Review is now focused primarily on administrative activities, internal controls, and fiscal services.

However, the availability of the Exhibit D process in Performance Contracts, gives DBHDS the contractual wherewithal to provide a CSB a formal notice to cure a case management/support coordination, and other, problems. It is surprising that the Exhibit D process has not been used to date for this purpose. This could be utilized in situations where OL or other corrective actions have not been successful in achieving needed CSB improvements.

Coordination of Findings and Corrective Actions

Table II attempts to display the array of quality assurance monitoring mechanisms covering the various components of the case management/support coordination function.

Table II
Crosswalk: Support coordination/case management Monitoring
(*Who looks at what?)*

Tasks	**OLS**	**QMD**	**Data Dashboard**	**DMAS-QMR**	**CSB Quarterly Super. Review**	**Delmarva QSR**
Basic Tasks						
Regular face-to-face visits	-	P	M	T	Q	A
Regular face-to-face visits at home	-	P	M	-	-	-
Service Auth and Re-auth	-	-	-	-	-	-
Essential Tasks						
Assessment	T	P	-	T	Q	-
Coordinating planning/team	T	-	-	-	Q	A
Accessing services and supports	T	-	-	-	Q	A
Monitoring services & Well being	T	P	M	T	Q	A
Updating services and plan	T	P	-	T	Q	A
Actualizing tasks						
Navigating	-	-	-	-	-	A
Educating	-	-	-	-	Q	-
Coaching	-	-	-	--	-	A
Advocacy	-	-	-	-	-	A

M - Monthly report, Q – Quarterly sample, T- Triennial sample, P – Periodic sample, A – Annual sample

It should be noted that half of these processes are multi-dimensional. That is, they examine the broader service delivery system beyond just case management/support coordination. The DDS Supervisory Review, the Data Dashboard reports, and the QMD onsite visits are exclusively focused on case management/support coordination.

The Quality Review Team (QRT) is a group co-chaired by DMAS and DBHDS. It reviews Waiver performance, including case management/support coordination, against CMS assurances from the QMR audits, the CSB Supervisory Review, CHRIS reports, and OL citations. These assurances include performance measures which are reported to CMS as part of joint agency oversight (DBHDS and DMAS). Past reviews have identified a lack of improvement activity on the part of QRT and recently the QRT has been involved in Waiver renewal discussions with CMS about the appropriateness of some measures and processes; the Appendix H revisions in particular look positive. QRT data is organized annually but collected quarterly. Planned and proposed revisions to the assessment tools should be reflected after the spring quarter this year. This data report is entitled the *DD Waiver Quality Assurances Reporting Grid*.

The QRT has not met during the past year, although data continues to be collected in anticipation of the Waiver Evidentiary Report, which the Commonwealth is required to submit to CMS periodically. We verified that there is little knowledge of, or receipt of, findings at the CSB level. The use of the QRT, therefore, is primarily a vertical report to CMS and not intended as feedback to CSBs.

Although the QRT may have the potential to aggregate all these findings and coordinate overall systemic strategies, without substantial modification to its mission and purpose, the Commonwealth may need a separate but focused case management/support coordination mechanism to aggregate the various quality inputs on case management/support coordination and to recommend system improvements. A separate entity focused on case management/support coordination performance would allow for the prioritization of case management/support coordination as the linking mechanism it is for all services and supports. This would also preserve the focus of QRT on assurances for CMS.

System improvement efforts around case management/support coordination are underway or are on the drawing board. For example, a planned training initiative on the ISP includes an emphasis on risk assessment, which emerged from QMR reviews as a weakness in many ISPs, as well as from Independent Reviewer reports. VCU's University Center of Excellence in Developmental Disabilities has completed its baseline study of case management/support coordination. It is planning to generate additional tools, including a manual, review tool, and revised training modules. In addition, DBHDS has constructed a crosswalk of governing regulations for case management/support coordination across Waiver rules, Office of Licensing rules, and the CSB Performance Contract, in order to clarify the authorities for case management/support coordination performance monitoring.

Finally, and most importantly, the Commissioner of DBHDS has recently focused CSB attention on their implementation of case management/support coordination and the continuing improvement of those services. His January 26, 2018 correspondence discussed the various roles of the case manager, including higher order, best practice functions. Finally, his correspondence solicited from each CSB a Case Management/Support Coordination Self-Assessment and a proposed plan for local improvements based on their results of self-

assessment. Later this year a workgroup will be convened to identify cross-state themes and to monitor the progress of improvement efforts towards a hoped for "support coordination/case management transformation".

Suggestions for the Commonwealth's Consideration

Create an entity which coordinates all case management/support coordination monitoring and improvement activities, perhaps as a subpart of QIC. Authorize this entity to propose a few performance improvement plans, which the whole system will promote annually, perhaps in coordination with the Commissioner's planned workgroup.

Establish regional support coordination/case management quality units to support participation in ongoing CSB assessment and improvement activities following the model used by QMD.

Summary

The Commonwealth uses multiple case management/support coordination monitoring mechanisms: the DBHDS Office of Licensing, the DMAS Quality Management Review process, the DBHDS Quality Management Division restarted case management/support coordination reviews, the Delmarva QSR process, the DBHDS Data Dashboards reporting process, and the Division of Developmental Services electronic quarterly supervisor review through their QRT process.

Because case management/support coordination is a state plan service directly managed by DMAS, because there are 40 CSB case management/support coordination agencies operated across the state, and because DDS's operation of its waiver is linked through case management/support coordination, the Commonwealth's case management/support coordination system is complex. It is also fragmented and uncoordinated, because there is no single point of accountability. The system, as currently composed, is in need of a coordinating entity for the intake and processing of case management/support coordination performance data with a formalized performance improvement process managed by this coordinating entity.

The Commonwealth is not in need of more quality management monitoring processes for case management/support coordination; it is in need of an entity in the system that brings coherence and clarity to improvements that are needed, that prioritizes improvements that are needed, and that conveys a clear direction in case management/support coordination performance improvement for which CSBs can be held accountable.

There are a number of CSBs that are approaching best practice for local quality improvement in case management/support coordination, notwithstanding multiple incoming messages. There are also several instances where performance improvement strategies from DDS, from QMD, and from DMAS have been effective. The Commonwealth has the task of 'getting everyone on the same page' to support coordination/case management performance.

The Commissioner of DBHDS has recently focused CSB attention on their implementation of support coordination/case management. Perhaps the workgroup planned around this effort can be the springboard for the needed coordination.

APPENDIX D.

INDIVIDUAL AND FAMILY SUPPORT PROGRAM

and

FAMILY GUIDELINES AND FAMILY AND PEER PROGRAMS

BY: Rebecca Wright, MSW, LICSW

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

INDIVIDUAL AND FAMILY SUPPORTS

By

Rebecca Wright, MSW, LICSW
Consortium on Innovative Practices

May 1, 2018

EXECUTIVE SUMMARY

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to create an Individual and Family Support program (hereinafter IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. The Independent Reviewer's sixth and eighth Reports to the Court, dated June 6, 2015 and June 6, 2016, found the Commonwealth had not met the qualitative requirements for the IFSP. He reported that 1) the Commonwealth's individual and family support program did not include a comprehensive and coordinated set of strategies to ensure access to person and family-centered resources and supports, as required by the program's definition in Section II.D., and 2) the Commonwealth's determination of who is most at risk of institutionalization was based on a single very broad criterion and did not prioritize between individuals on the urgent and non-urgent waitlists or those with greater or more urgent needs. This reviewer documented in the IFSP study included with the Independent Reviewer's eighth Report that the Department of Behavioral Health and Developmental Services (DBHDS) had initiated a redesign of its individual and family support program, acknowledging its awareness of issues resulting in the non-compliance described at that time. DBHDS had developed a task force, led by its Director of Administrative and Community Operations, to address many of the issues. Working with the Task Force, DBHDS indicated at that time its intent to reorganize the IFSP program into a regionally based program that would be overseen by non-profit organizations, which would be directed by individuals/families. Overall, the review indicated additional planning and deliberation with stakeholders were needed, through a strategic planning process, to develop a clear plan that addresses the requirements of the Settlement Agreement with goals, objectives and timelines as well as with a set of planned outcome and performance measurement indicators and data collection methodology.

For this twelfth Report to the Court, the Independent Reviewer's monitoring priorities again included studying the Commonwealth's compliance with the qualitative aspects of the Commonwealth's IFSP. DBHDS previously informed the Independent Reviewer that the development and implementation of its redesigned IFSP would not be fully evident by March 2018, during this review period. This study, therefore, focused on whether the current IFSP design, and any early efforts at implementation, address the requisite elements of the related Settlement Agreement criteria. The study also reports on whether the Commonwealth has complied with the quantitative requirement to support a minimum of 1000 individuals during Fiscal Year 2018. The Independent Reviewer's sixth and eighth Reports and this reviewer's previous studies' findings and recommendations are referenced, as those inform the basis for evaluating progress toward compliance. In addition to the sections of the Settlement Agreement reviewed in the previous studies, this version includes an examination of requirements under Sections IV.B.9.b. and III.D.5., which require the Commonwealth to establish a family-to-family and peer-to-peer program to facilitate opportunities for individuals who may be considering

sponsored homes or congregate settings to receive information about integrated community services/placements.

Since the 2016 review, the Commonwealth had devoted appreciable resources and effort in the area of individual and family supports. As of the end of the twelfth review period, March 31, 2018, this had resulted in considerable strides in planning for an IFSP to address these provisions of the Settlement Agreement. Examples included:

- As had been recommended in previous reports, DBHDS had developed an overall strategic plan for individual and family supports. *Virginia's Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities*, *November 17, 2017* focused on four goals consistent with the Settlement Agreement requirements, with concomitant objectives and strategies.
- In conjunction with that planning process, DBHD created an IFSP Community Coordination Program in addition to the existing IFSP Funding Program. The Community Coordination Program was focused on development and coordination of additional community resources for individuals and families and ensuring stakeholder involvement.
- Through the Community Coordination Program, DBHDS had made good progress toward the development of an IFSP State Council and Regional Councils as vehicles for sharing the information with and obtaining input about individual and family supports from stakeholders. The Community Coordination Program was also working to expand other outreach opportunities, such as the My Life My Community (MLMC) website.
- DBHDS had incorporated feedback from the IFSP Councils to continue making modifications to its funding program, leveraging technology to streamline the application and distribution processes. DBHDS also substantially exceeded its obligation to serve a minimum of 1,000 individuals/families in each of the three years through its IFSP Funding Program, serving 2,943 in FY16, 2,674 in FY17 and 3,049 in FY18.
- A memorandum of agreement (MOA) with Virginia Commonwealth University (VCU) was pending at the time of this review to build upon its existing parent-to-parent program toward establishment of family-to-family and peer programs as required under Sections IV.B.9.b. and III.D.5. of the Settlement Agreement. This proposed collaboration had good potential to support DBHDS in addressing these requirements.

In each instance described above, while positive, work remained to be accomplished and was often still in the preliminary planning or early implementation stages. For example, DBHDS often needed to firm up the specific work plans and projected timelines. Still, the planning and early implementation laid out a path that had good potential for moving the Commonwealth toward compliance with the Settlement Agreement requirements for individual and family support.

For these plans to be successful, DBHDS still needed to focus additional attention on several areas:

- DBHDS had not yet made a clear determination about how to define those it considered to be "most at risk for institutionalization" for the purposes of the individual and family support program. This remained an unresolved issue about which stakeholders continued to express concerns and ambivalence, as this consultant has reported previously. The Department had drafted pending administrative rule changes to remove a statutory requirement to fulfill funding requests from individuals and families on a "first come-first served basis." The proposed rule changes also called for allowing DBHDS to define administratively "most in need" and any prioritization criteria, with the advice of the IFSP State Council. DBHDS needed to clarify whether its recent prioritization of the waiver waitlist into three priority levels of those considered to be "most in need" would also be applicable to the IFSP Funding Program. DBHDS had not determined, or really examined, whether this set of criteria, as promulgated in emergency regulations, would also apply to the IFSP Funding program. According to DBHDS, due to the regulatory calendar, any changes would not be expected to take effect until mid-2019, after the fourteenth review period. Still, the agency would need ample time before that to not only fully consider what prioritization criteria should apply, but also to be prepared to implement any agreed-upon alternative.
- While DBHDS continued to extend outreach efforts to those on the waiting list regarding the IFSP Funding Program, stakeholders still expressed concern that everyone on that list did not receive direct notification of the funding opportunity. Individuals and family members would have to know when, where and how to look for the on-line announcements to be able to participate; without that direct notification, there was concern that those who lacked a current and ongoing connection to the service system were those who were also least likely to be informed about available funding. Stakeholders viewed this as perpetuating a system in which people who had access to information and resources obtained additional access, by virtue of their ongoing connections, while others did not.
- As this consultant's previous reports have recommended, DBHDS still needed to examine the role of case management (or support coordination, as it is also known) in ensuring access to and coordination of individual and family supports that might be available outside of the waiver. In conjunction with its waiver re-design process, DBHDS had issued emergency regulations, providing that individuals on the waitlist "may" receive case management services. The criteria through which case management might be available were not formalized in policy or standardized processes and not well-publicized. The IFSP State Plan did not address the role of case management. DBHDS and the IFSP State Council needed to take this issue under advisement and address how case management options for individuals on the waitlist will be clarified and shared with everyone on the waitlist, and to further consider/envision how such options can contribute

to a comprehensive and coordinated set of strategies.

- Also, as previous reports have recommended, DBHDS still needed to identify indicators to adequately assess performance and outcomes of the IFSP and to develop the capacity for the collection and the analysis of the needed data. At the least, the Department needed to develop indicators related to access, comprehensiveness and coordination of individual and family supports, the program's impact on the risk of institutionalization and individual and family satisfaction. While this current review continued to find that performance and outcome indicators had not yet been developed, DBHDS staff did report plans to begin this process in the near future. As the pace of IFSP implementation continues to quicken, and policy and procedural decisions are made, having a nimble system for data collection and analysis will become even more crucial.

I. PURPOSE OF THE REVIEW

The purpose of this review was to determine the status of the Commonwealth's implementation of the qualitative requirements of the Settlement Agreement as they pertain to individual and family supports. Further, in the absence of substantial implementation, this study was intended to provide an assessment as to whether the components of the Commonwealth's current plan could be reasonably expected to fulfill the requirements once fully enacted. These requirements are as follows:

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

choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.
Section IV.B.9.b. *…The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.*

The study also evaluated whether the Commonwealth had complied with the quantitative requirement to support a minimum of 1000 individuals during Fiscal Year 2018.

II. STUDY METHODOLOGY

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

1. Will the design of the planned IFSP and other family supports to be provided under the Agreement result in a set of strategies that can be considered comprehensive in nature?
2. Will the planned design for individual and family supports to be provided under the Agreement result in coordination with other services and supports for which a family or individual may be eligible?
3. Will the planned design for individual and family supports adequately facilitate access to person-centered and family-centered resources, supports, services and other assistance?
4. Will the design of the planned IFSP provide a clear and sound definition of "most at risk of institutionalization," including whether the definition has been refined to reflect the priority of supports to those at greatest risk?
5. Will the design of the planned IFSP provide a clear and logical process? Will the process include prioritization criteria, for determining which individuals may be considered "most at risk of institutionalization," and, if so, whether the process and prioritization criteria will be implemented in a manner that is designed to address the risks of individuals who are most at risk of institutionalization?
6. Will the design of the planned IFSP define a performance and outcome measurement strategy? Will the plan include the methodology for data collection and record maintenance that are sufficient to determine whether the planned IFSP fulfills the Commonwealth's obligations under the Agreement?
7. Will the design of the planned IFSP include sufficient strategies to publish guidelines that are sufficient, in terms of detail, accuracy and accessibility? Will they guide individuals with developmental disabilities and their families, to an available and correct point of entry to access services?
8. Will the design of the planned IFSP include sufficient strategies to publish IFSP guidelines as required and update them as needed and at least annually?

9. Will the design of the planned IFSP include sufficient strategies to undertake appropriate outreach and dissemination processes to ensure individuals and families will have access to the guidelines on a timely basis?
10. Will the design of the planned IFSP include sufficient strategies to provide appropriate agencies with the guidelines on a timely basis?
11. Will the proposed design and early implementation of the family-to-family and peer programs support the facilitation of opportunities for individuals and families to receive options for community placements, services and supports?
12. Does the Commonwealth's annual individual service planning process document both an offer of family-to-family and peer-to-peer meetings and the discussion to facilitate community placement consistent with the individual's choice?
13. Does the Commonwealth offer families and/or individuals who may be considering different types of residential settings an opportunity to have discussions with families and/or individuals who have had such residential experiences; and if the family and/or individual expresses an interest, does the Commonwealth facilitate such family-to-family or peer-to-peer discussions?

In order to ascertain the status of adherence with each of the criteria, the study methodology included document review, DBHDS staff interviews, stakeholder interviews, and review and analysis of available data. A full list of documents and data reviewed is in Attachment A.

This consultant also interviewed DBHDS staff involved in the development and design of the IFSP Funding Program and Community Coordination Program; DBHDS staff responsible for day-to-day administration of the IFSP programs; stakeholders who are participating, or have participated, in the IFSP State and Regional Councils; and representatives of other relevant entities, as advocacy organizations and service organizations. A full list of individuals interviewed is included in Attachment B.

III. FINDINGS

Since this consultant's previous report, DBHDS has devoted considerable resources and effort toward enhancing its processes for distribution of IFSP funding and toward development of an overall strategic plan to address the qualitative requirements of the Settlement Agreement. The Department had also re-envisioned its individual and family supports framework to include two primary focus areas: the IFSP Funding Program and the IFSP Community Coordination Program. Various minutes and documents indicated DBHDS intended the development of the Community Coordination Program to reflect its commitment to a more comprehensive vision of individual and family supports that was not limited to the funding program. To provide context for this study's findings that follow this section, some of the pertinent activities are summarized below.

IFSP Community Coordination Program: Since the previous report on the status of the IFSP, DBHDS had continued to engage stakeholders in the planning for the IFSP re-design. During the 2016 General Assembly Session, DBHDS received authorization to hire a single staff position to support the work of proposed IFSP State and Regional Councils. DBHDS developed charters that described the roles and responsibilities of these respective councils. Per these documents, the intended goal of the State Council was to provide guidance to the state that reflects the needs and desires of individuals and families across Virginia. To increase services to individuals on the waitlist, the IFSP Regional Councils were envisioned as liaisons between the IFSP State Council and local efforts. In the summer of 2016, DBHDS solicited applications for membership to the state and regional councils. An internal DBHDS review committee screened the applications and made recommendations to the Commissioner for appointment to either the State or one of the Regional councils. Together these councils formed a joint State IFSP Advisory Committee that began to meet in October 2016 and has continued to meet regularly since that time.

The most significant accomplishment of this collaborative effort between DBHDS and the IFSP Councils was the promulgation of a strategic plan that described a considerably more comprehensive vision for individual and family supports. Finalized in November 2017*, Virginia's Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities*, *November 17, 2017* (IFSP State Plan) focused on four goals which were consistent with the Settlement Agreement requirements:

5. Ensuring that the Individual and Family Support Program (IFSP) funding serves individuals with developmental disabilities (DD) and their families by braiding and blending resources to focus on the needs of the whole person with emphasis on prioritizing those with the greatest needs and most at risk of institutionalization;
6. Creating a robust and holistic state-level family support program model that furthers the goal of continued residence of an individual with DD in his/her own home or the family home;
7. Enhancing the knowledge of families, individuals with DD and community agencies about the Individual and Family Support Program through effective, coordinated, and comprehensive outreach; and,
8. Administering a transparent and effective Family and Individual Support Program that seeks to incorporate the input of individuals with disabilities and families to ensure access to supports to all Virginians regardless of their waitlist status.

The IFSP State Plan also spelled out an ambitious array of objectives to be undertaken and products to be developed over the course of the next three to four years. The IFSP Regional Councils had also initiated regional and local projects to test various outreach and resource development options. These were in the early stages of implementation.

IFSP Funding Program: As it had in FY16 and FY17, the IFSP Funding Program in FY18 retained a single annual funding cycle and continued to limit the maximum amount an eligible individual or family could receive each year to $1,000. Applications continued to be funded on a first come-first served basis until all available funds were expended. DBHDS exceeded its obligation to serve a minimum of 1,000 individuals/families in each of the three years.

DBHDS reported that it made some changes to other processes during the FY18 funding period based on stakeholder feedback and in collaboration with the IFSP State and Regional Councils. These included implementation of an on-line application, including a smart-phone utility, and the use of a debit card for disbursement of approved funding. These changes represented a significant departure from previous funding cycles, requiring a concentrated effort to develop the IT infrastructure to accept the on-line applications and to finalize contractual plans and procedures for use of the debit cards. DBHDS undertook a campaign to apprise individuals and families of the changes. These included a collaboration with the Arc of Northern Virginia to offer a step-by-step training webinar and regional outreach events. IFSP staff at DBHDS also offered telephonic and email technical assistance throughout the process. DBHDS also developed a user manual, which was available on-line, as well as instructional and FAQ documents about the use of the debit card and timelines/procedures for submission of required receipts. As described in the Third Quarter IFSP Program Update FY18, dated April 15, 2018, DBHDS planned to make minimal changes to its processes for the Funding Program in FY19. The Department also indicated it would again seek the IFSP State Council's input on the application timelines for FY19.

Waiver Re-design: In addition to the IFSP-specific modifications and improvements since the time of the last study in 2016, as described above, DBHDS had also implemented a systemic re-design of its HCBS waivers. An analysis of the re-design was largely outside the scope of this study, but it did have impact on the waiver waitlist, which formed the basis for IFSP eligibility. As a part of that initiative, the ID and IFDDS waitlists were merged and prioritized into three categories through application of a consistent set of criteria, which defined who was considered to be "most in need." Prior to this time, DBHDS had prioritized the ID waitlist by urgent or non-urgent need, but had not applied prioritization criteria for the then- IFDDS waitlist. Per DBHDS staff, this prioritization process was developed by one of the Medicaid Waiver Redesign stakeholder sub-groups and presented to the larger stakeholder group for review. DBHDS then worked with the stakeholders to amend the criteria consistent with the recommendations.

Compliance Findings for Section II.D

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

Finding: DBHDS has not yet - fulfilled the requirements with this section, but had made progress toward envisioning a comprehensive set of strategies.

Indicators:

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

This consultant's 2015 and 2016 studies noted that funding through the IFSP should be viewed as only one component of a comprehensive individual and family support program. These studies further documented other components that might be included, such as other financial resources, peer supports, family to family support, information and referral, etc. The earlier reports found there were few concrete strategies in the design of the IFSP to complement, or to coordinate with, other available supports. The Commonwealth had not completed a needs assessment of individual and family supports available statewide. The Commonwealth had also not developed goals, objectives and timelines to ensure the presence and implementation of the required comprehensive and coordinated set of strategies. Both previous reports included recommendations that an overall strategic plan for individual and family supports should be developed through an inclusive stakeholder planning process.

Since that time, DBHDS has provided resources and support for stakeholders toward the development of the needed strategic plan, as described above. The resulting IFSP State Plan took a considerably more expansive approach to individual and family supports, describing goals and objectives that included a wide range of supports, financial and otherwise, as well as vehicles for ongoing stakeholder involvement. As described in further detail below, DBHDS had initiated a plan to develop and implement family-to-family and peer mentoring programs and had developed and begun to implement multiple strategies to increase access to information about available

supports and services. The IFSP Regional Councils were exploring opportunities for increasing locally available supports in their communities. DBHDS had also implemented initiatives for expanding available housing options and for person-centered planning which were being coordinated with the IFSP through the MLMC website.

2. **Will the planned design for individual and family supports to be provided under the agreement result in coordination with other services and supports for which a family or individual may be eligible?**
3. **Will the planned design for individual and family supports adequately facilitate access to person-centered and family-centered resources, supports, services and other assistance?**

At a systemic level, the IFSP Community Coordination Program was serving to coordinate the development and implementation of various DBHDS-led support programs and initiatives at a state level. Many, if not most, of these efforts focus on developing and increasing the availability of information for individuals and families. This study found the Commonwealth was making good progress in providing information to individuals and families and had plans to continue to expand their efforts, as detailed elsewhere throughout this report.

But, information-sharing alone will often not be enough to sufficiently facilitate access to and coordination of person-centered and family-centered resources, supports, services and other assistance. Access to and coordination of those resources depend in part upon having adequate information, but also frequently depends upon assistance from a knowledgeable guide to navigate the many confusing twists, turns and eligibility requirements. As defined in the DBHDS publication, *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: The Basics October 2017 Sixth Edition*, a support coordinator, or case manager, not only gives individual and families information about services, but also assists with accessing needed medical, psychiatric, social, educational, vocational, residential, and other services which are essential for living in the community and in developing his/her desired lifestyle. This definition is descriptive of the type of assistance that is often needed to facilitate both access and coordination.

As currently organized, neither the IFSP Regional Councils nor the proposed family-to-family and peer programs have sufficient manpower to meet such needs for individuals on the waiting list. However, as a part of its overall waiver re-design, DBHDS promulgated emergency regulations that indicated individuals on the waiting list could receive, or be eligible for, individual case management services from the CSBs. The pertinent section of the regulation reads:

2VAC30-50-455. Support coordination/case management for individuals with developmental disabilities (DD).
A. Target group. Individuals who have a developmental disability as defined in § 37.2-100 of the Code of Virginia shall be eligible for support coordination/case management.
1. An individual receiving DD support coordination/case management shall mean an individual for whom there is an individual support plan (ISP) in effect that requires monthly direct or in-person contact, communication, or activity with the individual and family/caregiver, as appropriate, service providers, and other authorized representatives including at least one face-to-face contact between the individual and the support coordinator/case manager every 90 days. Billing shall be submitted for an individual only for months in which direct or in-person contact, activity, or communication occurs and the support coordinator's/case manager's records document the billed activity. Service providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.
2. Individuals who have developmental disabilities as defined in state law but who are on the DD waiting list for waiver services may receive support coordination/case management services. (emphasis added.)

The regulations cited above did not provide specificity about the circumstances under which individuals on the waiting list "may" receive case management services. The DBHDS publication, *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: The Basics October 2017 Sixth Edition*, informed readers that individuals on the waiver waitlist may be eligible for case management/support coordination services, noting that there is the option for case management/support coordination that is not connected to waiver services. The Sixth Edition further indicated that those interested should contact their local CSB to find out if they might be eligible for Medicaid-funded case management or for private-pay services on a sliding scale. This document did not provide any further detail about how an eligibility decision would be made, but DBHDS staff provided the following set of circumstances under which individuals on the waitlist could receive case management:

- Individuals with DD on the wait list who do not have ID may receive case management services from the CSB if they have an "active" need. This means the case manager is addressing specific needs on limited time basis (until the need is resolved).
- Individuals with ID who are on the DD wait list may receive case management services if they have a need and request services and may also receive case management services for monitoring.
- Individuals who are eligible, on the DD wait list and request case management, but who do not currently qualify for Medicaid would be required to pay their own case management fees, which can be on a sliding scale based on income of the family.

- Individuals who are on EDCD or Tech Waiver are now covered under the CCC+ managed care waiver and may receive case management from the CSB if they have a need and request those services.
- Per DBHDS staff, an individual should be offered a choice of case management/support coordination agencies upon enrollment on the waitlist. DBHDS staff indicated the CSB would complete a screening at the time of enrollment and would then have a conversation about the individual's needs and need/desire for case management services.

For the purposes of facilitating coordination and access for individuals on the waitlist and their families, these options for case management have tremendous potential; however, these criteria and processes were not currently formalized in any policy or procedure. CSBs were not required to use a uniform screening tool or process when making determinations about needs that might indicate eligibility for case management. While DBHDS staff indicated an individual could contact the CSB regarding a need for case management at any time after enrollment, it did not provide guidance for individuals and families laid out what the qualifying needs might be or upon what criteria a decision would be based.

The current IFSP State Plan did not address how to integrate these options into an overall comprehensive set of strategies or provide individuals and families with clear information about how to access case management. DBHDS and the IFSP State Council should take this issue under advisement as a priority issue and publish an amendment to the IFSP State Plan that further considers/envision how these options can contribute to a comprehensive and coordinated set of strategies. It should also address how these case management options will be clarified and shared with everyone on the waitlist.

Findings for Section III.C.2.

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

Finding: DBHDS has not yet fulfilled the requirements for this section.

Indicator:

4. **Will the design of the planned IFSP provide a clear and sound definition of "most at risk of institutionalization," including whether the definition has been refined to reflect the priority of supports to those at greatest risk?**

At the time of this review, the Commonwealth had not yet fully addressed the "most at risk of institutionalization" definition. DBHDS continued to define eligibility for IFSP funding by placement on the waiver waitlist. As previously reported, this broad definition is consistent with one of the primary tenets of the traditional individual and family support programs that all

individuals with intellectual and developmental disabilities and their families need and deserve supports. They should not have to prove they are somehow more deserving than someone else. The previous studies documented a lack of stakeholder consensus about whether this broad criterion accurately reflected which individuals were "most at risk for institutionalization," however, and this continued to be the case during this review period.

Previous studies recommended that this definition be fully explored with stakeholders in the process of strategic planning, including whether it reflected the priority of supports to those at greatest risk. The Commonwealth had moved forward with a strategic planning initiative, as described in the Findings section above. The first goal of the resulting State Plan addressed the intent to enhance the IFSP Funding Program, including an emphasis on prioritizing those with the greatest needs and most at risk of institutionalization. The plan further tasked the State Council with identifying priority populations/needs to establish the priorities for the annual IFSP funding process. Thus far, the State Council had only completed a preliminary exercise toward this objective. DBHDS staff reported efforts to modify the current first come-first served distribution of funding toward one based on some prioritization of need could not be implemented until the existing IFSP administrative rules were likewise modified, as discussed further below. This should not be seen, though, as a barrier to undertaking any work that needs to be done to develop a broad consensus about what "most at risk for institutionalization" means for individual and family support in Virginia.

This was particularly true because DBHDS had recently completed a systemic HCBS waiver re-design, which was informed by broad stakeholder input and formalized in administrative rule through the Emergency Regulation process. In keeping with these regulations, DBHDS had merged the former ID and IFDDS waitlists and prioritized the combined list. The priority categories, developed through the stakeholder-informed planning process, are as follows:

Priority One was assigned to individuals determined to meet one the following criteria and require a waiver service within one year:

a. An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.
b. There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions: (1) The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports; or (2) There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports;
c. The individual lives in an institutional setting and has a viable discharge plan; or
d. The individual is a young adult who is no longer eligible for IDEA services and

is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.

Priority Two was assigned to individuals who meet one of the following criteria and a waiver service will be needed in one to five years:

a. The health and safety of the individual is likely to be in future jeopardy due to: (1) The unpaid primary caregiver or caregivers having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limit his ability to care for the individual; (2) There are no other unpaid caregivers available to provide supports; and (3) The individual's skills are declining as a result of lack of supports
b. The individual is at risk of losing employment supports;
c. The individual is at risk of losing current housing due to a lack of adequate supports and services; or
d. The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

Priority Three was assigned to individuals who meet one of the following criteria and will need a waiver slot in five years or longer as long as the current supports and services remain:

a. The individual is receiving a service through another funding source that meets current needs;
b. The individual is not currently receiving a service but is likely to need a service in five or more years; or,
c. The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

Current DBHDS data indicated there were 12,662 people on the waitlist. A total of 3,251 individuals were designated as Priority One, with 5,487 designated as Priority Two and 3,924 designated as Priority Three.

When asked about this prioritization of the waitlist and its current and/or future relevance to IFSP funding, DBHDS staff indicated they could not apply these criteria because the current IFSP administrative rules required the individuals on the waitlist be served on the first come-first served basis. There had not yet been a substantial discussion about whether these priorities would be applied to IFSP funding if and when proposed IFSP administrative rule changes take effect. It was not too early to begin this examination in earnest. While any regulatory change would not be expected to take effect until mid-2019, the Department will need ample time to not only fully consider what prioritization criteria should apply, but also to be prepared to implement any agreed-upon alternative.

5. **Will the design of the planned IFSP provide a clear and logical process, including prioritization criteria, for determining which individuals may be considered "most at risk of institutionalization," and, if so, whether the process and prioritization criteria will be implemented in a manner that is designed to address the risks of individuals who are most at risk of institutionalization?**

The existing Administrative Code related to the IFSP (§37.2-203) does not provide any prioritization criteria for determining which individuals may be most at risk for institutionalization beyond the requirement for being on the waiver waitlist. The Code stipulates only that applications submitted by individuals and families would be considered on a first come-first served basis. In previous study periods, there was almost universal uneasiness among stakeholder interviewees as to whether the design of the IFSP, particularly with a first come-first served approach, may be inherently unfair to those who need it the most.

At the time of the last study in 2016, DBHDS had drafted a proposed revision to the Administrative Code that would remove the first come-first served requirement, but these changes had not been pursued since then. At the time of this report, the IFSP Administrative Code regulations were undergoing a mandatory periodic review, per Commonwealth requirements. As a part of this review process, DBHDS had drafted another set of revisions to the regulations. Among other things, these draft regulations proposed to remove the first come-first served requirement and to allow DBHDS to define most-at-risk through administrative processes, with the advice of the IFSP State Council. This regulatory review process was projected to take until July 2019 before any revised regulations could become effective.

This remained an unresolved issue. The State Advisory Committee had not yet formally addressed the subject of "most at risk of institutionalization" beyond a preliminary discussion, but all the members were cognizant of the need to do so. Overall, stakeholders interviewed during this review continued to express concerns around this topic, as they had during previous study periods. In addition, the initial public comment period in the regulatory review, which began in December 2017 and ended in February 2018, resulted in two sets of comments, both from advocacy organizations. Both recommended receipt of funding be prioritized on some basis other than the current first come-first served.

6. **Will the design of the planned IFSP define a performance and outcome measurement strategy, including data collection and record maintenance methodologies, sufficient to determine whether the planned IFSP fulfills the Commonwealth's obligations under the Agreement?**

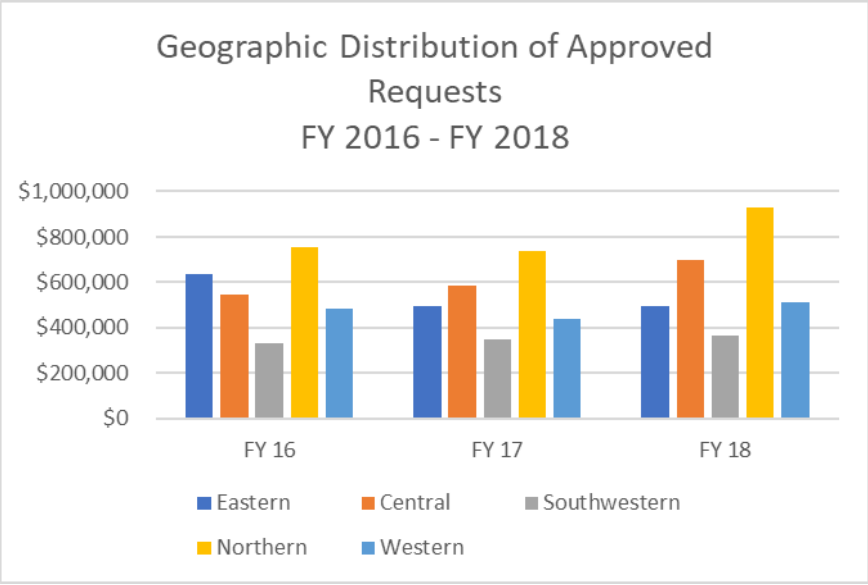
At the time of previous studies, DBHDS had not developed outcome, performance or satisfaction indicators. With the exception of a baseline satisfaction survey in June 2015, DBHDS had neither completed any satisfaction surveys or any analysis of the impact of IFSP funding. Both previous studies recommended that DBHDS identify indicators to adequately assess performance and

outcomes related to access, comprehensiveness and coordination of individual and family supports. Recommendations were also made to determine the impact on the risk of institutionalization and to develop capacity for collection and analysis of the needed data. The reports also suggested that in order to develop a useful quality improvement system for individual and family support, DBHDS needed to identify and adopt a set of both outcome and performance indicators that would allow it to determine not only whether a goal is achieved, but also to analyze why or why not.

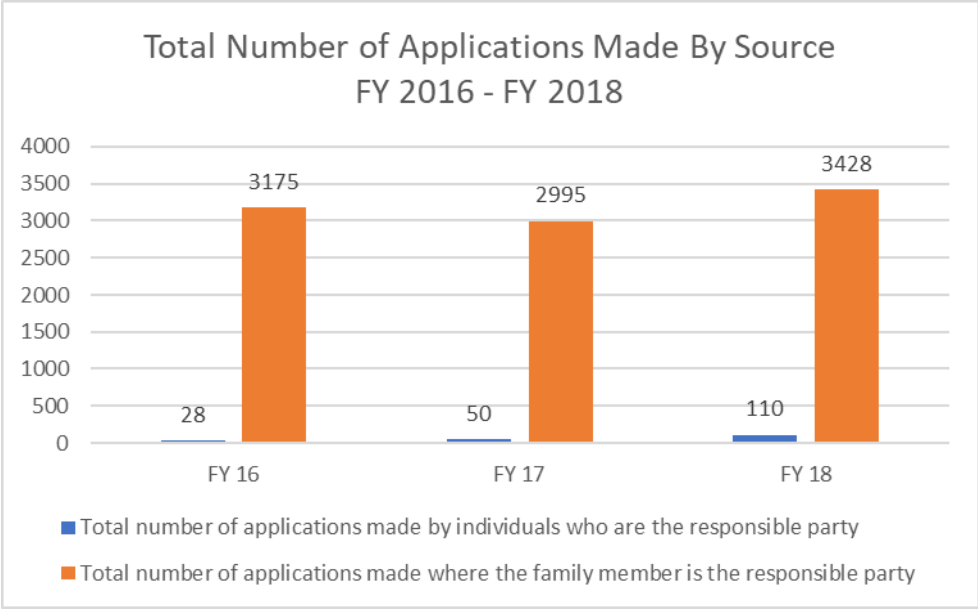
This current review continued to find that DBHDS had not yet developed performance and outcome indicators. DBHDS staff did report, however, plans to tap resources in the Department's re-organized Office of Support Services (OSS) in the near future to assist with developing and implementing a performance and outcome measurement strategy. According to the Third Quarter IFSP Program Update FY18, IFSP staff plan to soon begin an analysis of historical application data, with initial findings due in mid-July 2018. They also plan to engage the State Council in developing a satisfaction survey to assess the FY18 funding process beginning at the April 2018 meeting, with release planned for July 2018 and data analysis in August 2018. These will be good first steps and should be considered a high priority for implementation. Future programmatic changes under consideration need to be based on accurate data collection and analysis.

Over the years this consultant has reviewed the IFSP funding program, its staff have consistently reported challenges with data collection, which they described as barriers to analysis. Still, DBHDS has collected a consistent, albeit limited, set of data points related to the funding application and distribution processes. Even these data, with their limitations, should be reviewed and analyzed for possible lessons to be learned or further questions to be asked. This level of review would not require a sophisticated analyst or technology and need not be postponed until such resources are available. As a part of this review, this consultant aggregated the available data sets for FY16, FY17 and FY18 and created a simple set of graphic charts. While not exhaustive, the following examples demonstrate how the available data could lead to some questions that bear further examination.

Data provided for geographic distribution of funding by region showed limited or flat growth in Eastern and Southwestern regions, in stark contrast to the growth in Northern and Central regions. This should lead DBHDS to consider whether additional outreach needs to be undertaken to inform individuals and families in those former areas.



Another chart pictured the very low number of individuals who make application on their own behalf, as opposed to those made by family members. This should engender a discussion about, for example, the accessibility of the application process for individuals on the waitlist and how that could be expanded.



Findings for Section III.C.8.b.

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

Finding: DBHDS has not yet fulfilled the requirements with this section, but had made good progress.

Compliance Indicators:

7. **Will the design of the planned IFSP include sufficient strategies to publish guidelines that are sufficient, in terms of detail, accuracy and accessibility to the population, to be effectively used to direct individuals in the target population to the correct point of entry to access services?**
8. **Will the design of the planned IFSP include sufficient strategies to publish IFSP guidelines as required and update them as needed, at least annually?**
9. **Will the design of the planned IFSP include sufficient strategies to undertake appropriate outreach and dissemination processes to ensure individuals and families will have access to the guidelines on a timely basis?**
10. **Will the design of the planned IFSP include sufficient strategies to provide appropriate agencies with the guidelines on a timely basis?**

DBHDS had developed a multi-part plan, in conjunction with the IFSP State Plan, for publishing guidelines that could be effectively used to direct individuals in the target population to the correct point of entry to access services. Components of the overall communication plan included:

- **IFSP Funding Program Guidelines**: As described earlier, DBHDS Funding Program staff have continued efforts to apprise individuals and families of the changes through a variety of venues. These included a user manual, which was available on-line, as well as instructional and FAQ documents about the use of the debit card and timelines/procedures for submission of required receipts. The DBHDS website continued to have a separate webpage for IFSP information, with links and downloadable documents. The outreach plan did not yet have a clear methodology for ensuring everyone on the waitlist was notified of the funding opportunity, however, and this remained a significant gap.
- **IFSP Regional Councils**: One of the primary roles envisioned for the IFSP Regional Councils is to identify and/or develop local resources and share those with their communities. Each Regional Council has developed its own regional work plan to this effect and were experimenting with various strategies, including informational workshops and fairs, social media, coordination with local schools and organizations and personal

contacts with individuals and family members. In addition to the single staff person who had been supporting the work of the councils and the facilitation of the IFSP State Plan development, DBHDS was planning to create another staff position who would be able to provide more hands-on logistical support for regional council activities and develop needed marketing, outreach and informational materials. This staff person was also expected to coordinate information internally at DBHDS and work with Senior Navigator to update articles and information featured on the MLMC website and the IFSP Regional Council pages.

- **Navigating the Developmental Disability Waivers:** DBHDS had issued a set of updated guidelines in October 2017, collectively entitled "Navigating the Developmental Disabilities Waivers, Sixth Edition", that provided information to help direct individuals in the target population to the correct point of entry to access services. This included several pieces, including *The Details, The Basics*, *In One Page* and *The Workbook*, and covered topics such as eligibility, the waiting list, a description of the waivers, an overview of waiver services and a listing of other contacts and resources. The document did provide brief mention of individual and family support, stating "In addition, individuals on the waitlist can apply through DBHDS for the Individual and Family Support Funding Program once each year. Details regarding this yearly option can be obtained online by searching for "IFSP" at dbhds.virginia.gov."

- **My Life My Community Website:** DBHDS was collaborating with Senior Navigator to re-brand and expand upon the My Life My Community (MLMC) website, which currently provides information to individuals and families on the recent waiver changes. The MLMC site will serve as a centralized on-line portal for families to access relevant information on variety of topics. Initial plans include incorporating information about family supports, housing, and providers. The new website will feature new content and links to other trusted resources, as well as a searchable database that is location specific. Senior Navigator expects to have the revised website published by September 2018.

Perhaps the biggest challenge relative to ensuring individuals and families are guided to the correct point for access to services is in the identification of individuals and families who have not yet been reached. DBHDS was aware of a need in this area and had some plans underway, or pending, to address it. For example, one of the objectives in the IFSP State Plan was to draft a strategy for sharing information with families based on their connectedness to resources. This would include aligning notifications of IFSP funds with communications to families upon entry to the waiver waitlist. Along that line, DBHDS reported IFSP staff would soon begin managing data entry and updating for the waitlist and believed this access to waitlist information would facilitate better direct outreach to all members of the target population.

Often the IFSP Council members interviewed during this study also indicated concerns about effective outreach to individuals and families who were not as well-connected to the service system as others. They were diligently working to develop additional strategies to address these concerns, as described above. Having access to relevant data could help the Council members, as well as DBHDS, to focus their outreach plans. For example, the IFSP Funding Program had experienced some incremental growth in the number of applications, from 3,203 in FY16 to 3,538 in FY17, but consistently hovered at less than 30% of the eligible population. Those data alone would indicate that current outreach efforts may not have been effective. Thus far, DBHDS had not analyzed application and distribution data to assess penetration of their outreach efforts and make needed adjustments. For example, such an analysis could determine how many applications received, and disbursements made, were new applicants for each succeeding funding period vs. those who made repeated applications.

Findings for Sections III.C.8.b. and 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.*
>
> *… The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.*

Finding: DBHDS has not yet fulfilled requirements with this section for individuals living in the community, but was making progress.

Compliance Indicators:

11. **Will the proposed design and early implementation of the family-to-family and peer programs support the facilitation of opportunities for individuals and families to receive options for community placements, services and supports?**

Overall, the IFSP State Plan included many strategies for building capacity to gather and share information with individuals and families about options for community placements, services and supports, as described above. As it relates to this indicator, goal three of that plan referred to a particularly relevant strategy to develop community ambassadors who could serve as peer support providers for families and individuals who are not connected to services and/or resources.

Pursuant to these proposed strategies, DBHDS developed a white paper entitled *Engaging Individuals and Families, September 19, 2017* outlining its intent to develop family-to-family and peer support programs in collaboration with Virginia Commonwealth University's (VCU's) existing Partnership for People with Disabilities Family to Family Program. This effort would

also build upon the family and peer mentoring programs DBHDS had already implemented for individuals transitioning from the Training Centers. The white paper, as provided for review, indicated this newly designed family and peer-mentoring program would use the IFSP state and regional councils to serve as the family voice to guide implementation. It further anticipated the program would provide an expanded network of families and peers that could provide feedback on services and policies, inform outreach and provide families with information on critical resources.

Specifically, the most recent draft of the pending MOA provided for review, describe two of the purposes of the DBHDS/VCU collaboration as: 1) to implement evidence-informed supports to families of people with developmental disabilities receiving or waiting to receive home and community-based services; and, 2) to determine a feasible evidence-informed peer support model for people with disabilities receiving or waiting to receive home and community based services. A broad scope of work for these objectives included recruiting and training family navigators to provide informational and systems navigational support to families of individuals receiving or on the wait list; to maintain on a database of individuals with developmental disabilities who may be interested in participating in peer to peer program, with quarterly reports to DBHDS; and, to provide planning, training and marketing supports for the expansion and implementation of Peer Mentor Supports, a new waiver service.

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

In community settings, DBHDS staff reported it has primarily used the Informed Choice form to document that a case manager had offered the individual and his/her family of an opportunity to talk with other individuals receiving waiver services and living in the community. Until recently, case managers have reviewed the Informed Choice form with an individual and his/her Authorized Representative (as appropriate) when an individual is new to the waiver; anytime there is a request for change in services; anytime an individual is dissatisfied with services; and anytime an individual was referred to the Regional Support Team (RST) for review. DBHDS staff further reported that the Informed Choice form was recently revised. Going forward, the CSB case managers will complete this form on an annual basis as part of the annual ISP planning/development.

At present, any individual or family member who expresses interest in having an opportunity to talk with another individual or family about waiver services is connected with a Family Resource Consultant (FRC.) The FRC will work with them to find a match with a Family or Peer Mentor. DBHDS reported it did not currently have an automated way to determine how many referrals were made to the FRC, but available reports indicated there were 5 total referrals made during

FY17 and thus far in FY18. Two individuals have been linked to a Peer Mentor, one in FY17 and one in FY18. One parent was linked to a volunteer Community Living Contact (CLC), for a discussion opportunity. DBHDS staff reported the agency has received anecdotal feedback from CSBs that most families do not choose to take this option when offered, which is consistent with these data.

The proposed collaboration between DBHDS and VCU has good potential as a framework for enhancing the Commonwealth's efforts to address these last two requirements. The initiative, as planned, will expand the family and peer resources available to be matched with those who express an interest. The current provisions of the MOA were broadly stated, however, and did not specify how the proposed program would interface with the annual individual service planning and informed choice processes, or how these interfaces might serve to increase the number of individuals and families who choose to participate. DBHDS staff indicated a more detailed work plan was to be developed once the contract was finalized. To move toward compliance, DBHDS should ensure the work plan provides for these specific interfaces. The work plan should also address the performance and outcome indicators that need to be tracked to ensure program efficacy.

IV. CONCLUSIONS AND RECOMMENDATIONS

DBHDS had made substantial progress toward meeting some of the individual and family support provisions of the Settlement Agreement. The following recommendations are offered as additional steps toward fulfilling the requirements of the Agreement. For the most part, these recommendations remain much the same as those included in previous reports.

1. The definition of "most at risk for institutionalization" should continue to be examined as DBHDS seeks to amend the administrative rules to eliminate the first come-first served requirement for IFSP funding. In the process, DBHDS should consider whether the current prioritization of the waiver waitlist is, or should be, applicable to IFSP.

2. DBHDS should clearly define expectations of case management options available to individuals on the waitlist, as these relate to facilitating access to the IFSP Funding Program as well as to the broader array of individual and family supports for which they might be eligible.

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

4. DBHDS should ensure the work plan for the family-to-family and peer programs provide specific methodologies for interfacing with the annual service planning process, which offers these opportunities. The work plan should also address the performance and outcome indicators that need to be tracked to ensure program efficacy.

ATTACHMENT A: DOCUMENTS/DATA REVIEWED

1. Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: The Details, October 2017 Sixth Edition
2. Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: The Basics, October 2017 Sixth Edition
3. Virginia's Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities, November 17, 2017
4. Logic Models for Values, Needs and Post-Recommendations
5. Summary of Family Engagement Initiative 10-16-17
6. IFSP Agenda January 2017-FINAL-for release
7. IFSP March 2017 Meeting Notes-FINAL
8. IFSP February 2017 Meeting Notes-FINAL
9. IFSP March 2017-Agenda- FINAL
10. IFSP February 2017-Agenda- FINAL
11. IFSP Council Prioritizing Most at Risk Exercise, November 2016
12. IFSP Council Outreach Exercise, November 2016
13. November 2016 IFSP Council Slide Deck and Meeting Notes
14. Family Mentor Network of Virginia Manual REVISION 3
15. Family Mentor Network of Virginia Manual, 1st Quarter Revision
16. IFSP State and Regional Council Charters
17. FY18 membership state and regional process summary
18. FY18 State and Regional Council Overview
19. FY18 Membership Rosters
20. FY18 Council Application
21. Interview Agenda-FINAL
22. State and Regional Council Overview
23. IFSP Program Background and Authority, Draft, dated 2-8-17
24. Updated IFSP Funding Program Guidelines August-Final FY18, FY17
25. Updated Receipt Policies: FY17, FY18
26. 2017 August Pre-Announcement
27. FY18 Communication Plan
28. FY18 Application final-revised
29. FY17 Receipt Instructions, Questions and Answers-final
30. IFSP Funding Program Questions and Answers-revised
31. IFSP Funding Program Quick Tips final
32. IFSP Funding Program Quick Tips revised
33. IFSP Funding Program On-line Application User Guide
34. IFSP On-line Application Training Webcast PowerPoint, dated September 22, 2017
35. Summary Data for IFSP Funding FY16-FY18
36. IFSP Web Portal Detail
37. My Life My Community Website Diagram
38. My Life My Community Project Schedule, dated 2.24.18
39. Senior Navigator Timeline
40. Senior Navigator Decision Brief
41. Family to Family Budget Narrative
42. F2F Work plan 1-22-18
43. F2F revised budget 1-22-18
44. Leadership Empowerment for Abuse Program (LEAP) 2107-18

45. My Life My Community System Integration Proposed Project Goals, dated 1/19/2018
46. Memorandum of Agreement with VCU's Partnership for People with Disabilities Family to Family Program, 4/16/18
47. Draft Amendments to Operation of the Individual and Family Support Program (Chapter 230), revised 12/21/17
48. Periodic Review of the Operation of the Individual and Family Support Program [12 VAC 35 - 230] (http://townhall.virginia.gov/L/ViewPReview.cfm?PRid=1619)
49. Public Comments to Periodic Review Notice from the Arc of Northern Virginia/Virginia Ability Alliance and Virginia Association of Centers for Independent Living
50. Waiver Re-Design Emergency Regulations (https://townhall.virginia.gov/L/ViewStage.cfm?stageid=7420)
51. Job Descriptions for the IFSP Community Coordinator and proposed Program Administration Specialist
52. IFSP Program Overview Timeline, dated 4/17/18
53. IFSP Multi-Year Goals with all Programmatic Areas Included, dated 9/19/17
54. Draft Goals and Objectives for IFSP State Plan, dated March 28, 2018
55. Current Waitlist data
56. Quarterly IFSP Report, dated April 15, 2018

ATTACHMENT B: INTERVIEWS & STAKEHOLDER INPUT

57. Peggie Balak, DBHDS DOJ Settlement Agreement Advisor
58. Beverly Rollins, DBHDS Director of Administrative and Community Operations
59. Erika Jones-Haskins, DBHDS IFSP Community Coordinator
60. Bob Villa, DBHDS IFSP Funding Program Manager
61. Roxie Lyons, DBHDS IFSP Staff
62. Sandra Brown, DBHDS IFSP Staff
63. Eric Williams, DBHDS Director of Provider Development
64. Eric Leabaugh, DBHDS Housing Specialist
65. Twila Washington, Parent, IFSP Council Member
66. Angel Myers, Parent, IFSP Council Member
67. Juanita Williams, Parent, IFSP Council Member
68. Jackie Hampton, Parent, IFSP Council Member
69. Gail Dickens, Parent, IFSP Council Member
70. Debe Fults, Parent, IFSP Council Member; Executive Director disAbility Resource Center
71. Lauren-Nicole Jinier, Parent, IFSP Council Member
72. Marilyn McCombe, Parent, IFSP Council Member
73. Kathy Adams, Parent, IFSP Council Member
74. Mari Jacobs, Parent, IFSP Council Member
75. Pamela Adams, Parent, IFSP Council Member
76. Allene Pack, Parent, IFSP Council Member
77. Tonya Miling, Executive Director, Arc of Virginia
78. Lucy Cantrell, Director of Information and Referral, Arc of Virginia
79. Parthy Dinora, Director of Research and Program Development, Virginia Commonwealth University Partnership for People with Disabilities
80. Dana Yarbrough, Director, Center for Family Involvement, Virginia Commonwealth University Partnership for People with Disabilities, Parent

CRISIS SERVICES

By: Kathryn du Pree, MPS

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

PREPARED BY KATHRYN DU PREE, MPS
EXPERT REVIEWER
May 12, 2018

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SECTION 1: OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer, has contracted with independent consultant, Kathryn du Pree, as the Expert Reviewer, to perform the review of the crisis services requirements of the Settlement Agreement. This review is for 10/1/17-4/30/18, the twelfth review period. It will include a qualitative study of forty-three individuals who were admitted to hospitals due to behavioral and/or psychiatric issues. This review will analyze the Commonwealth of Virginia's status toward implementing the following requirements: The Commonwealth shall:

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

SECTION 2: PURPOSE OF THE REVIEW

This, the follow-up review of crisis services and prevention, will focus on the findings from the Phase I and II study that was completed during the tenth and eleventh review periods and the recommendations made by the Independent Reviewer in his December 23, 2017, Report to the Court.

All areas of the crisis services requirements for both children and adults will be included and reported on in terms of accomplishments and progress toward fulfilling the requirements of the Settlement Agreement (Agreement). Additionally, it will include the summary of a qualitative review of the crisis supports and other needed and related community services for forty-three individuals including twenty children and twenty-three adults who were hospitalized and referred to REACH. The focus for the study is to determine the reasons for the increase in hospitalizations among children and adults with intellectual and developmental disabilities (IDD); the impact of the location of pre-screening on the outcome; the involvement of REACH in prescreening, hospitalization and discharge, and providing crisis support. The overarching goal is to determine whether the Commonwealth's community service capacity is sufficient to assist individuals with IDD who have behavioral and/or mental health co-occurring conditions to remain in their homes with appropriate ongoing services and minimize hospitalizations and the lengths-of-stay.

The focus of this review will be on:

- The Commonwealth's ability to provide crisis prevention and intervention services to children with intellectual or developmental disabilities (IDD), including the status of providing out-of-home crisis stabilization services.
- The Commonwealth's plan to reach out to law enforcement and criminal justice personnel to effectively work with individuals with intellectual and developmental disabilities to address crises and crisis intervention services to prevent unnecessary arrests or incarceration.

- The quality of crisis services that individuals are receiving from the six Regional REACH programs. Four Regions have combined their REACH programs for children and adults under one administration. Region I maintains separate programs for children and adults.

SECTION 3: REVIEW PROCESS

The Expert Reviewer reviewed relevant documents and interviewed key DBHDS administrative staff, REACH administrators, REACH staff, Community Service Board (CSB) Emergency Services (ES) staff, hospital staff, and families to gather the data and information necessary to complete this study. The information gathered was analyzed to determine the current status of implementation of the requirements of the Agreement. The documents reviewed included those provided by the Commonwealth that it determined demonstrated its progress toward fulfilling the requirements of the Agreement.

Documents Reviewed:

1. Children's REACH Quarterly Report: FY18 Q2
2. Children's REACH Quarterly Report: FY18 Q3
3. Adult REACH Quarterly Report: FY18 Q2
4. Adult REACH Quarterly Report: FY18 Q3
5. DBHDS Quarterly Qualitative Reviews of Children's and Adults REACH Programs for FY18 Q2
6. Temporary detention order/ emergency custody order
7. Records of the twenty children and twenty-three adults selected for the qualitative study

Interviews with DBHDS and REACH staff: I interviewed Heather Norton, Director, Community Support Services; Sharon Bonaventura, DBHDS REACH Regional Crisis Manager for Regions I and II, Nathan Habel, DBHDS REACH Regional Crisis Manager for Regions III, IV and V; Denise Hall REACH Program Director for Region III; Autumn Richardson, REACH Program Director for Region IV; numerous staff from the REACH teams in Regions III and IV; hospital staff; and ES pre-screeners. The staff was all interviewed as part of the qualitative study of the forty -three individuals who received REACH services during this reporting period. Heather Norton is to be commended for arranging the onsite week for this consultant including numerous interviews with hospitals and ES teams. I also appreciate the REACH Directors involvement to coordinate the schedules for all of these interviews and the time that everyone gave to contribute important information for this review.

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

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

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

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

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

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

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

A. <u>Review of The Status of Crisis Services to Serve Children and Adolescents</u>

The information provided below includes information from the two Children's REACH Quarterly Reports that DBHDS provided for Fiscal Year 2018, Quarters 2 and 3. These reports cover the time periods October 1-December 31, 2017, and January 1-March 31, 2018. These data are reflected as part of the data for Year 3.

REACH Referrals- The number of children who were referred to the Children's REACH crisis services programs continued to increase. There were 205 children referred in Year 1, 870 referred in Year 2 and 1269 referred in Year 3. There was a significant increase in overall referrals in both Year 2 and Year 3.

The number of crisis calls has dramatically increased from 134 in Year 1, 617 in Year 2, and 929 in Year 3. Non-crisis calls also increased each year from only 304 in Year 1, to 2449 in Year 2, and to 6027 in Year 3. The percentage of crisis versus non-crisis calls declined. Crisis calls represented 16% of the calls in Years 1 and 2, and decreased to 11% of the calls in Year 3. The significant difference in the number of calls versus referrals reflects in part that some families make multiple calls about a single child.

Crisis calls are consistently a much lower percentage of the calls in Regions I and V where they represent only 5-8% of the total calls during the past two years. The growing number

and percentage of non-crisis calls across the state demonstrates that the REACH Children's programs are becoming more known throughout their communities and are a source of information and support for families during crises and for preventive services. It will be important that the state maintain a sufficient number of staff to effectively respond to the number of calls that are being received, especially those that result from a crisis.

CSB's Emergency Services (ES) were the primary sources of crisis referrals for REACH services in Years 2 and 3, accounting for 41% and 39% respectively of the total referrals. Hospitals have consistently referred 11% of children for crisis services. Families make direct referrals for 25% of the children who are referred in each of the three years summarized in this report. Families, however, account for a higher percentage of the referrals in Regions II, IV and V, and a consistently lower percentage in Regions I and III. Case managers refer between 13% and 19% of the children to REACH.

Conclusion: These data indicate that there continues to be referrals from all of the expected referring entities and that ES and hospital personnel are aware of the need and do contact REACH when a referral for a hospital admission is made**.** The sources of the referrals are remaining very constant across reporting periods.

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

Table 1: Total Children's Calls

Year	***Crisis***	***Non-crisis***	***Informational Calls***
Year 1	*134*	*304*	*399*
Year 2	*617*	*2449*	*854*
Year 3	*929*	*6027*	*1183*

Time of Referral- The REACH programs track the time and dates of referral calls. The calls that were received during weekdays have increased from 72% of the calls in Year 1 to 81% and 85% of the calls respectively in Years 2 and 3. More calls being made during weekdays are consistent with a higher percentage of calls being made in non-crisis situations.

REACH programs do not report whether the time of the day during which calls are received is different on weekdays versus weekend days. Previously each call was recorded to have been received in one of four-time periods, however, this was reduced to three time periods during Year 3. These three periods reflect the three shifts that staff works. The data do not distinguish calls that were made after 5 PM in any reporting period. In Years 1 and 2 92% of the calls were received between 8 AM and 8PM. In Year 3 93% of the calls were received between 7 AM and 11PM; the remaining calls were received between 11PM and 7AM, accounting for 7%- 8% over the three years. The overall number of calls, however, has increased. This includes an increase from 3 to 90 calls overnight during Year 3. The data are not currently displayed this way because the REACH reports reflect the hours of the three shifts of REACH crisis call coverage.

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

Referrals for Individuals with ID and DD- The Children's REACH Program continues to serve a high percentage of individuals with developmental disabilities, other than intellectual disabilities, versus individuals with intellectual disabilities. These data are broken out by three categories: intellectual disability only (ID-only); ID and DD; and a developmental disability only (DD-only). During the three years, the percentage of children referred with an ID only diagnosis ranged from 15%-20%; referred with both ID and DD ranged from 15%- 28%; and ranged from 52% -65% for children with a diagnosis of DD only. There was a marked increase from 52% of the referrals with DD-only in Years 1 and 2 to 65% in Year 3. This increase in the actual number of children referred with DD-only from 451 in Year 2 to 830 (+84%) in Year 3 is significant and is evidence of this program's outreach and usefulness to this population.

Conclusion: The REACH Children's Program continues to receive an increased number of referrals in each reporting period. The number increased by 50% between Year 2 and Year 3. These increases demonstrate that the program's efforts to reach out are connecting children in need with the statewide children's crisis services. The Commonwealth's outreach efforts are reaching individuals with diagnoses that are across the spectrum of intellectual and developmental disabilities.

The Children's REACH programs also receive many other non-crisis and information calls. Non-crisis calls are included in Table 1 above. Informational calls alone accounted for 854 calls in Year 2 and 1183 calls in Year 3. REACH has increased the number of staff positions assigned to the REACH programs in the past two years. Suitable staffing is critical as the referrals to the program increase, especially referrals of a crisis nature to ensure that each REACH Children's program has sufficient staffing resources to answer these calls and to meet the needs of these children and their families.

The distribution of diagnoses for the first time shows an increase of children with DD only, which has always been the prevalent diagnosis. This percentage was 52% of the diagnosis of the children and increased to 65% of the diagnosis for the children. This pattern may indicate that there are a higher number of children with autism or mental health diagnoses than there are in among adults. This is borne out by the diagnosis of many of the children in the qualitative study. This may have implications for the training REACH staff will need and the type of community resources and clinical expertise that will be needed to maintain children in their home settings.

Response Time- In all five Regions, and in both quarters of this review period, the REACH staff responded onsite within the required **average** response times. In fact, all Regions except Region V have an average response time of 65 minutes or less in FY18 Q2 and all responded in 64 minutes or less in FY18 Q3.

DBHDS has designated Regions I, III and V, as rural. Also, part of Region II is designated as rural effective January 2017. This designation requires these Regions to respond onsite to crisis calls within two hours. In Year 3, these three Regions, responded on-time 94%, 98%, and 95% of the time, respectively. Region IV, an urban region, which is expected to respond onsite within one hour, met this expectation 91% of the time during Year 3. Region II had the most significant difficulty responding to calls within the one-hour expected timeframe in its urban area, but is improving from a percentage of 62% in Year 1 and 60% in Year 2, to 79% of on-time responses in Year 3. DBHDS does not provide information as to the reason for the delays when they occur.

Over the past four periods, DBHDS has reported a breakdown of response time in 30-minute intervals. This is useful information as it helps to determine how many of the calls can be responded to fairly quickly. While the Agreement requires a one or two-hour response time depending on urban or rural designation, these expectations may not be consistent with the time needed to actually have a REACH staff respond on site in time to participate fully in the crisis screening. During this review period REACH staff responded onsite to crisis calls within 30 minutes for 21% of the calls; within 60 minutes for 43%; within 90 minutes for 20%; within 120 minutes for 12%. The remaining calls (4%) were not responded to within the required two-hour timeframe. When responding to a crisis in a family's home, the consequence of responding in more than thirty minutes is that the crisis may not have been stabilized there and the child may be in route to the hospital to be screened by the CSB ES staff.

Overall, the Commonwealth's timely onsite response rate was 90% with 836 of the 925 calls responded to within the expected one-hour or two-hour timeframes in Year 3. This compares positively to Year 1 and 2 when only 87% and 86% of the calls respectively, were responded to on-time. This is particularly noteworthy because 210 more calls required a face-to-face on-site response during Year 3 compared to Year 2.

All Regions continue to respond onsite to every crisis call. The number of crisis calls responded to is higher than the number of crisis referrals during the period because a number of responses were for individuals who experienced a crisis who had already been involved with REACH. The number of mobile crisis assessments that were completed during Year 3 was 926, which is a 47% increase over the 631 assessments conducted during Year 2. Only 104 crisis assessments were conducted in Year 1, which covers only a six-month period of time.

The locations where mobile assessments occur are also included in the data provided. Hospitals, where 454 (49%)of the 926 assessments occurred, remained the most frequent assessment setting in both Years 2 and 3. Only 25% of the assessments in Year 1 occurred at hospitals. However, it must be noted that the ES staff were not required to notify REACH of the assessment of a child with IDD who was referred for crisis screening. When hospitals are combined with the ES CSB office locations, there has been a steady increase in the percentage of assessments that occur in these out-of-home locations, in Years 1, 2, and 3, 53%, 61%, and 67% of the assessments, respectively. Whereas, the percentage conducted in a family's home has steadily declined from 40% in Year 1, to 34% in Year 2, and to 27% in Year 3.

Conclusion: The fact that the number and percentage (63%) of assessments are conducted in out-of-home settings, either hospital and the ES/CSB locations, is evidence that the Commonwealth crisis service system is not being implemented to achieve the goal of the Agreement that crisis services respond onsite to prevent the individual from being removed from the home. The additional fact that individuals who receive their initial assessments at these out-of-home locations are much more likely to be hospitalized is evidence that the crisis system is not preventing the individual from being removed from his or her home/current placement. These data points do indicate that REACH continues to be notified of the pre-admission screenings by CSB ES staff and are able to respond. The REACH Children's programs continue to experience a significant increase in both referrals and requests for mobile crisis assessments. REACH is being informed of possible psychiatric admissions for far more individuals now that the program is more established and the Commonwealth's outreach efforts have continued.

Mobile Crisis Support Services- In Year 1 there were only 123 children who received mobile supports over the six-month period. The number of children receiving mobile supports in Years 2 and 3 is remarkably consistent: 601 and 603 respectively. The Regions vary considerably in terms of how many individuals receive mobile crisis supports. The number of children served by region is depicted in Table 2 below.

Table 2: Children Receiving Mobile Supports

Region	Year 2 Admission	Year 2 Readmission	Year 2 Total	Year 3 Admission	Year 3 Readmission	Year 3 Total
RI	154	9	163	237	2	239
RII	160	17	177	159	31	190
RIII	29	1	30	31	3	34
RIV	75	10	85	84	12	96
RV	131	15	146	44	0	44
Totals	**549**	**52**	**601**	**555**	**48**	**603**

The data are quite revealing. Regions I and II have consistently provided mobile support to the most children. Statewide, Region V supported only 8% of the children with mobile support in Year 3, but 24% of the total number of children who received mobile supports in Year 2. Region III consistently provided mobile support to fewer of the children than the other four Regions, supporting only about 5% of the total number of children. The Commonwealth has not explained the reasons for these variations. One explanation may be that there is insufficient staff to meet the entire need for mobile support. The staffing of the Regions' programs is discussed in the Summary section of the report.

Admissions to hospitals include children newly receiving mobile supports while readmission is defined as children who are receiving mobile supports for a subsequent time. The percentage of readmissions is under 10% for both years. It may be inferred that mobile supports have been successful and that the children's situation stabilized with other community supports thereby not necessitating follow-up mobile supports.

The numbers of the children who receive mobile crisis supports, as detailed in Table 2 above, are all higher than the number of children who were reported to have used REACH as a result of a crisis assessment, as described in Table 3 below. The number of children who receives mobile crisis supports includes open cases and non-crisis cases, as well as the number of children who were served as the result of a crisis assessment during the review period.

DBHDS reports on the disposition at both the time of the crisis assessment and of the completion of the mobile support services. There has been an overall increase in the number of children assessed at the time of a crisis from Year 2 when 613 children had a crisis assessment to Year 3 when 928 children had a crisis assessment. Unfortunately, a smaller percentage of the children remained home regardless of whether they did or did not receive mobile supports. Both a more significant number and percentage of the children are being hospitalized. The number has increased by 178 children between Years 2 and 3 and now represents 36% versus 25% of the children who are assessed for a crisis. Unfortunately, the maturing of the REACH crisis service for children did not result in reducing the percentage of children who were hospitalized at the time of the crisis assessment. Many more children are being referred for crisis assessment and support. Far more children who did remain at home in Year 3 benefitted from mobile support. In Year 2, 72% of the children who were assessed remained home and of these 443 children, 168 (38%) used REACH mobile support. In Year 3, 583 of the children who were assessed remained at home and 304 (52%) of them used mobile support. This significant increase in both the number and percentage of children using mobile support at the time of a crisis is an indication that families are more willing to accept REACH services for their children and that REACH programs are more able to provide a needed service. DBHDS must monitor this growing need and response from REACH and take needed steps to ensure that the programs have adequate resources to continue to provide needed supports. Table 3 below illustrates the disposition at the time of assessment across Years 1, 2, 3.

Table 3: Disposition at the Time of Crisis Assessment

Year	Psychiatric Admission	Other	Community Crisis Stabilization Program	Home with Mobile Supports	Home without Mobile Supports	Total
1	42	0	0	51	66	**180**
2	152	11	7	168	275	**613**
3	330	8	7	304	279	**928**

The REACH reports include data regarding the disposition for individuals at the completion of mobile crisis supports. The data demonstrate that the vast majority of children, 82% to 86% in Year 3, are able to continue to live at home. The percentage varies from. This includes a small number of children and families who continue mobile support. The continuation of mobile support was the highest in Year 3 when it was only 30 of the 604 children. However, the hospitalization of 14% of the children who received mobile supports in Year 3 is higher than in the previous two years, almost doubling the 7% in Year 1 and 8% in Year 2.

It remains highly concerning that as the REACH Children's programs have matured and experienced an increase in referrals that a larger percentage of children were hospitalized. All of the Regions, except Region V, experienced increases in the number of children hospitalized after their REACH programs provided services. Regions I and II had the highest number of children hospitalized in Year 3 with 36 and 22 children hospitalized, respectively. While Region III had only eight children hospitalized in Year 3, this represents 24% of the children who received mobile supports, which is by far the highest percentage of children hospitalized post-mobile supports in any Region. Only one child was hospitalized in Region V after receiving REACH mobile supports.

The increase in hospitalizations after REACH programs have been involved is the opposite outcome that was expected and desired by the creation of the REACH teams. DBHDS should carefully study this negative outcome and determine what changes are needed to the response to crises and the provision of crisis services to reduce psychiatric admissions. Making systemic changes that are needed to increase the number and percentage of children who receive the initial assessment at the children's homes, rather than at hospitals after a child has been removed from the home, is a critical component of making substantial progress. It is also evident that it is critical to have crisis stabilization (Crisis Therapeutic Home) settings for children that are available as an alternative to hospitalization.

Table 4: Disposition at the Completion of Mobile Supports

Year	Psychiatric Admission	Alternative Residential	Home with Extended Mobile Supports	Home without Mobile Supports	Other	Totals
1	8	3	12	97	0	**120**
2	42	6	15	458	3	**524**
3	82	1	30	489	2	**604**

Number of Days of Mobile Support- REACH is expected to provide three days of mobile crisis support on average for children and adolescents. All Regions except Region I did provide at least an average of three days of mobile support in Year 3. The average ranged from 2-13 days. However, Region I averaged 2 days throughout the year. It was the only Region that did not achieve the average of three days during the twelfth review period. Region III served the fewest children but continues to provide the highest average number of thirteen days of mobile supports in Year 3 and never provides fewer than five days of mobile crisis support. Region IV and V provided an average of four and 3.5 days respectively

The mobile crisis support services include: comprehensive evaluation: crisis education prevention plan (CEPP); consultation; and family/provider training. The CEPP and consultation are required elements of service for all REACH participants. It is difficult from the presentation of the data to determine if everyone received a CEPP who should have one because the child may have had a CEPP completed during an earlier interaction with REACH. The following table is comprised from two data sets in the REACH quarterly reports. The column that is labeled Mobile Supports

is from the table in the REACH quarterly reports that summarizes the total number of children who received mobile supports. The data regarding evaluations, CEPPs, consultation and provider training are derived from the table in the REACH quarterly reports that summarizes all of the service elements the REACH team provides to participants. Table 5 portrays this information below.

Table 5: Children Receiving Mobile Supports and CEPP

Year	Mobile Support	Evaluation	CEPP	Consultation	Provider Training
1	125	58	66	84	84
2	605	472	430	400	375
3	603	568	539	568	487

The number of children who received mobile crisis supports in the review period may be higher than the number who have a CEPP developed, because some children have been REACH participants before the reporting period, had previously been evaluated, and already had a CEPP completed. However, everyone who receives mobile support is required to have an evaluation and consultation each time REACH is used. The reports from Regions I, III and V in Year 3 reflect compliance with this requirement. These three Regions have evaluated everyone who received mobile supports and provided them with consultation. The data from Regions II and IV included the most variation in the total number of children who received mobile supports compared to those who received any of the service elements.

Conclusion*:* Of the number of children served in Year 3:
94% received the required evaluation or consultation that DBHDS requires
89% received a CEPP
81% did receive provider training

The lack of provider training is of particular concern. The importance of this concern is supported by the findings of the qualitative review of children who were hospitalized during the review period. It was not evident in all of the records that parents or others were actually trained in the elements and strategies of the CEPP. This will be discussed in greater detail in the summary of hospitalizations. However, to improve the chances of successfully avoiding future crises, it is essential that both family members and other caregivers be trained in crisis prevention and intervention methods.

Training- Children's REACH staff continue to provide extensive training to stakeholder groups. Table 6 summarizes the training that has occurred over the past three years.

Table 6: Training by REACH Children's Program Staff

Year	*CIT/Police*	*CSB*	*ES*	*Providers*	*Hospital*	*Family*	*Other*
Year 1	46	558	113	132	11	132	390
Year 2	529	982	342	583	61	238	1214
Year 3	584	464	137	1524	357	1855	794
Totals	**1159**	**2,004**	**592**	**2,239**	**429**	**2225**	**2,398**

The Children's REACH Programs conduct a significant amount of training. Almost 1,200 police officers and almost 600 ES staff have been trained. Trained CSB staff includes case managers. The Other category includes school personnel. However, there are noticeable differences across the Regions in the number of stakeholders who are trained.

Regions I and II consistently train fewer police officers. Region I trained none in Year 1, twenty-five in Year II, and twenty-four officers in Year 3. Region II did not train any police officers until Year II when staff trained seventy police officers. Region III trained the most hospital staff. Generally, Region I staff provide the least training and Region IV and V provide the most training opportunities. It is heartening to see how many providers have been trained. The training of providers should help contribute to more stabilized living situations.

Conclusion: With the data provided it is not possible to determine whether each Region met the training needs of its communities without information about the total number of CSB, provider, ES or hospital staff that may need to be trained or information about turnover in these areas. However, it is likely that all Regions have more similar than different training needs in these groups. The wide variation, and very low numbers in the amount of training that has been accomplished indicates that some Regions' REACH teams are not meeting the training expectations of the program. This lack of training may contribute to difficulties with timely referrals, appropriate intervention by law enforcement, and families not being well informed about this resource for their children.

Crisis Stabilization Programs (aka Crisis Therapeutic Homes – CTH) The Children's REACH programs still do not have crisis stabilization homes in any of the Regions. DBHDS now calls these settings Crisis Therapeutic Homes (CTH). In the Agreement, the Commonwealth committed to develop such programs for children as of June 30, 2012. DBHDS issued an RFP on May 1, 2016, to develop out-of-home crisis prevention services during FY17. There is funding available to develop two homes in the Commonwealth; each will have the capacity to serve six children. DBHDS believes that these two homes when supplemented with prevention services and therapeutic host home options will be sufficient to meet the needs of children who need time out of their family homes to stabilize and for mobile supports to be put in place, if needed. DBHDS has finalized contracts with providers, properties have been purchased for the two homes in Regions II and IV, and construction is scheduled to begin in May 2018.

DBHDS reported in the spring of 2017 that out-of-home prevention services will be available in the fall of 2017 and that two CTHs will open early in calendar year 2018. However, both of these scheduled developments have been delayed. The planned opening of the two CTHs is now scheduled to be open in January 2019, twelve months later than was projected during the eleventh reporting period. The architectural plan of the CTH for adults in Region IV will be used for both of the CTH's for children. The sites for both of the CTHs have been selected. Richmond Behavioral Health Authority, which operates the adult and children's REACH programs, will also operate Virginia's southern CTH for children. The Rappahannock/Rapidan CSB will develop and Fairfax/Falls Church will operate the northern CTH for children.

DBHDS was planning to execute sole source contracts for the out-of-home therapeutic prevention host homes, because it did not receive suitable responses to the RFP. DBHDS projected in the eleventh period that these services would become available no later than June 2018. DBHDS and

Richmond Behavioral Health (RBHA) are now working with three potential providers in the greater Richmond area. The Department hopes to pilot this program model and demonstrate its viability and financial sustainability to other providers in different parts of the state. Currently DBHDS is yet not projecting a start date.

Psychiatric Admissions- DBHDS reported that 387 children with IDD were admitted to psychiatric hospitals in Year 3 and more than half of them were admitted in the most recent six months of the review period. This continues the trend of significant increases in psychiatric hospitalizations every year since at least 2014. There were 67 children admitted to psychiatric hospitals in Year 1 and 234 children in Year 2. The increase between Year 2 and 3 represents an 65% increase in admissions. The fact Virginia has experienced steady increases over the most recent six reporting periods is very troubling. The only promising change is the decrease in the percentage of children admitted to hospitals who were active with REACH prior to the crisis. The children who were hospitalized who had previously received assistance from REACH, represented 38% of all admissions in Years 1 and 2 but represents 34% of the hospital admissions in Year 3. This may indicate the benefit of REACH services to prevent first time admissions or readmissions to hospitals by first providing mobile supports. Table 7 summarizes this data regarding hospital admissions.

Table 7: Children's Admissions to Hospitals

Year	*Referrals*	*Active Cases*	*Total*
1	42	25	67
2	146	88	234
3	254	133	387

Conclusion: The Children's REACH programs continue to be involved with almost all children with IDD once they are admitted to psychiatric institutions. There are a few examples in the qualitative study where this did not happen, but when REACH was not involved with the child it was because REACH was not contacted at the time of the hospital screenings. REACH was still not able to offer crisis stabilization homes as a diversion to hospital admission for children. Without the availability of these settings, it is impossible to determine if any of the admissions of children to psychiatric hospitals could have been appropriately prevented, or if the length of time a child was hospitalized could have been reduced. It is particularly troubling that these settings remain undeveloped in light of the dramatic and steady increase in the number of hospitalizations for behavioral and/or psychiatric reasons over the past three years. The Commonwealth should carefully study the factors that have and continue to contribute to an increased number of children being hospitalized, and determine what corrective actions might be taken. One factor that needs to be addressed and is discussed in more detail in the summary of the qualitative study is the fact that screenings for hospitalization are always conducted at the ES office or more frequently, a hospital Emergency Room (ER). This systemic approach practiced by emergency services consistently results in children being removed from their homes to be hospitalized rather than being provided services to stabilize the home situation or offered an alternative as a diversion from being institutionalized. The current systemic approach to providing initial assessment outside the home situation clearly leads to the exact opposite result that what the Commonwealth agreed was desired and to pursue. Clearly an additional contributing factor to the increased

institutionalization of children with IDD is insufficient diversion opportunities without any CTH program for children.

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

Involvement of Law Enforcement-DBHDS reports the number of crisis responses that involve police officers. This percentage was 44% for Year 3 compared to 22% when DBHDS began reporting this data a year ago. During this past year, Law enforcement was involved in the highest percentage of the crisis calls in Regions III and V, an average of 63% in Region III and 60% in Region V, respectively. It is unclear what the involvement of law enforcement indicates about the crisis system, since police always accompany ambulances that transport an individual to a hospital and families may call them to respond to an emergency. The high number of crisis cases that involve police officers is strong support for the need for REACH staff to continue to train police officers so they are better prepared to address crises involving children with an I/DD, especially individuals with autism spectrum disorders.

B. Reach Services for Adults

REACH Referrals- the number of referrals to the Adult Region REACH Programs continues to increase. Regions received total of 1677 referrals of adults with I/DD during Year 3, as compared to 1247 and 705 referrals in Year 2 and 1, respectively. The number of referrals received in Year 3 is a 34% increase from the previous year. The number of referrals of adults per review period has continued to increase since DBHDS established the REACH programs.

DBHDS reports that a total of 1,024 adults received REACH services in Year 3: 486 of these individuals had received mobile crisis support services and 538 adults had used the crisis stabilization homes (CTH). This is the fewest number of individuals, not just counting the individuals who use REACH after a crisis assessment, to have received mobile supports during the past three years and the second fewest who used the CTH. The utilization of both of these crisis services will be described in greater detail later in this report and is described in Table 14. The above numbers are not an unduplicated count of individuals because they include both admissions and readmissions.

Overall 53% of the referrals to Adult REACH Programs were of a crisis nature, which is similar to the percentage of crisis calls in the previous year. (This data was not reported in Year 1.)

Table 8 depicts the number of calls and the nature of the call.

Table 8: Total Adult Referrals

Year	Crisis	Non-crisis
Year 1	Not reported	Not Reported
Year 2	647	600
Year 3	888	789

Calls to REACH are reported separately from referrals. There were 2093 calls in Year 3, as compared to 963 calls in Year 2, and 696 calls in Year 1.

CSB Emergency Services made the majority of the referrals (40%) to REACH. ES and hospitals together made 49% of all referrals compared to 42% of the referrals in Year 2 and only 19% of referrals in Year 1. In addition, of the individuals in Year 3, Case Managers referred 26%, and families 11%, both percentages are consistent with Year 2. Case Managers were the primary source of referrals in Year 1 making 56% of the referrals. The increase in referrals from ES and hospitals in Years 2 and 3 is an indication that the requirements on these providers to notify REACH of any prescreening for hospitalization, which is being implemented. Six referrals were made by law enforcement. These are the first year referrals that have been made by police officers.

The number of individuals who received mobile crisis supports decreased from both Years 1 and 2, whereas the number of adults using the CTH was higher than that from Year 2 but fewer individuals than used the CTH in Year 1. It is surprising that utilization of these crisis services is not continually increasing in light of an increase in the number of referrals, of both a crisis and non-crisis nature, and increase in the number of hospitalizations. This will be discussed later in this report. The decrease in the amount of mobile crisis supports provided would be an expected indicator of insufficient staff to meet the crisis needs of the increased number of referral and individuals being served by the REACH programs.

The number of calls the REACH programs receive continues to increase each year, including those calls that are for information only. The data in the REACH reports include all non-crisis calls as well as calls seeking only information support. The total number of calls received is more than the number of referrals. This occurs when the same individual is the subject of multiple crisis calls and, therefore, is counted more than once. The total number of calls statewide during the review period, including calls for information only, was 11,258 compared to 5,101 and 4525 in the previous two years. Of these calls, 6,584 were non-crisis calls compared to 2,690 and 2052 in the previous two years, whereas 1906 were crisis calls, which was an increase of 64% over the 1159 crisis calls in Year 2. There were 1380 crisis calls in Year 1, a higher number than in Year 2. The remaining 2,768 were calls for information. This number more than doubled the 1,252 information-only calls received in Year 2. In Year 1 there were 1093 of these calls.

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

DBHDS reported the dispositions for adults who experienced a crisis and were assessed. The following two tables provide information regarding the dispositions for individuals referred for crisis services. Table 9 provides the disposition after the individuals' initial assessments by REACH.

At the time of disposition, a majority of the individuals served by REACH continues to retain the residential setting where they lived at the time of the initial assessment. In Year 3 this was 1,135 (60%), compared to 869 (56%) in Year 2 and 736 (69%) in Year 1. This illustrates the continued increase in the number of individuals referred to REACH. This includes the individuals who retain their setting with and without REACH mobile crisis supports. While the percentage of individuals who used mobile crisis support at the time of crisis assessment is similar across the possible outcomes of crisis assessment, the actual number who used such services increased by 18% between Year 1 and Year 2, and 21% between Year 2 and Year 3. There continues to be an increase in the number of individuals who are hospitalized at the time of the crisis assessment although the percentage, which was 20% in Year 1 and 33% of the population in Year 2, decreased slightly to 31% of the adults who were assessed for a crisis. The total number of hospitalizations, however, has increased significantly over the three years from 210 in Year 1 to 595 in Year 3. The increase more than doubled in the first two years and then increased by 15% between Years 2 and 3.

Table 9 illustrates the disposition at the time of assessment across Years 1, 2, 3.

Table 9: Disposition at the Time of Crisis Assessment

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

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

Table 10 below shows the outcomes for individuals at the completion of their crisis services. The "Retain Setting" row indicates individuals who did not require or receive REACH mobile support services. The number of individuals who retained their home setting with the assistance of mobile support services is captured in the "Mobile Support" row.

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

A higher percent (31%) of individuals were hospitalized at the time of assessment compared with the 4% who were hospitalized after receiving REACH mobile crisis support services and the 6% who were hospitalized after using the CTH program. These percentages are comparable to the percentages of individuals hospitalized after REACH services in Years 1 and 2. Eighty-one individuals either continued to use the CTH's past this reporting period (49) or after receiving mobile supports (32), compared to sixty-one individuals who continued to use the CTH in Year 2 and the 102 adults who continued to use the CTH in Year 1. It is noteworthy that there were fewer hospitalizations after REACH services were provided, in Year 3 (48) than in Year 2 (66), even though the total number of individuals who used REACH was similar.

Table 10 also indicates that the use of alternative residential options represents a similar percentage across all three years but the number has decreased as follows:

- *84 (8.5%) in Year 1*
- *77 (10.1%) in Year 2*
- *74 (9.8%) in Year 3*

This lack of availability of new residential options with quality behavioral support services for individuals who experience a crisis may contribute to longer stays at the CTH or to the psychiatric hospitalization of individuals after providing REACH mobile crisis supports.

Table 10 below illustrates the disposition at the end of REACH crisis services (mobile crisis supports or CTH) for Years 1, 2, and 3, or where the individual was living at the end of the reporting period. The numbers in the CTH column include both individuals who continued using the CTH at the end of the reporting period and those who transitioned from mobile crisis support to the CTH at the end of receiving mobile crisis supports.

Table 10: Disposition at the Completion of REACH Crisis Services

Year	Psychiatric Admission	Alternative Residential	Home without REACH Supports	CTH	Jail	Other	Total
1	79	84	994	102	0	35	1294
2	66	77	760	61	5	19	978
3	48	74	754	81	3	29	989

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

Overall the number of adults who are hospitalized continues to increase. While many of these individuals may require hospitalization, it is apparent from the information gleaned in past years' reviews and this year's qualitative study that there is a lack of sufficient diversionary services in the quantity and quality that is needed. The CTH Crisis Stabilization programs are not consistently available to divert individuals from hospitalization when they are first screened in response to a crisis.

Psychiatric hospitalizations-DBHDS provides an addendum to its quarterly reports. The addendum reports additional data on the outcomes for individuals who are hospitalized as a result of crises. DBHDS also reports whether these are new or active cases. DBHDS is to report whether these individuals eventually return home or whether an alternative placement needed to be and was located. In *Tables 9 and 10*, the total number of individuals who had contact with REACH were reported to have been admitted to psychiatric hospitals. The addenda provide different data regarding psychiatric hospitalizations and the known dispositions of individuals who were admitted. These data, which also reported all hospitalizations including recurrences, indicate that DBHDS was aware of 383, 647, and 832 psychiatric hospitalizations of individuals with ID/DD in Years 1, 2, and 3, respectively.

The Department notes that these data do not reflect, and that the Department does not know, the total number of individuals with IDD who are admitted to private psychiatric institutions. However, these numbers may vary from the numbers in the previous tables because the numbers in the addenda can include voluntary admissions; admissions to private psychiatric hospitals if the families at some point contacted REACH; and individuals with multiple admissions. The number of hospitalizations in the REACH report is broken down by active cases and new referrals. The number of hospitalizations of individuals with IDD has continued to increase as has been presented earlier in this report. These data indicate that the number of individuals who were hospitalized increased by almost 200 individuals between Years 2 and 3, which is a 29% increase in the adults with IDD who were hospitalized for a crisis. The increase in the number of crisis assessments between Year2 and Year 3 was 330, which is a 21% increase in the number of adults with IDD who required a crisis assessment as reflected in *Table 9* above.

It is positive that the percentage of active participants who received REACH services and were hospitalized has decreased each year while the number of individuals who were hospitalized and were newly referred at the time of the crisis increased. This difference may indicate the value of REACH services and the effectiveness of the linkages provided by REACH reduce the need for hospitalization among REACH participants. The increase in the actual number of new referrals by over 200% since Year 1 is significant. The increase in the number of new referrals to REACH at the time of a crisis has implications for the opportunity for REACH to actually avert a hospitalization from occurring. In such circumstances, REACH has no existing relationship with the family or provider and no knowledge of the individuals' needs, behaviors or medical conditions. This lack of information will impact the programs' ability to intervene, especially if REACH is contacted after the individual is at the ES office or hospital. In these situations, REACH staff cannot help to stabilize the situation at the individual's home. Table 11 below depicts this data.

Table 11: Number of Hospitalizations for Active REACH Participants vs. New Referrals

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

Year 3 is the third consecutive year in which the REACH programs were aware of more than 75% of the individuals who were admitted to psychiatric facilities in the Commonwealth. However, the REACH programs were only aware of 77% of the admissions during Year 3, whereas it was aware of 90% of the admissions to psychiatric facilities during Year 2, and 75% during Year 1. These percentages are derived from comparing the number of individuals who are reported by DBHDS as hospitalized at the time of the crisis assessment, depicted in *Table 9* to the numbers in *Table 11*. There are striking disparities across the Regions. For example, Region I knew about all of its admissions, whereas Region II knew of only 47%. Region III knew of 75%; Region IV knew of 85%; and Region V knew of 71% of its admissions.

DBHDS reports that the difference in the two data sources is that the Addendum of Psychiatric Admissions includes all involuntary and voluntary admissions. Heather Norton explained that the CSB ES is not involved in screenings for individuals who are seeking voluntary admission, and that the hospitals do not always notify REACH of these admissions. A family member may inform REACH during or subsequent to the hospitalization. DBHDS and these Regions' REACH teams should work with hospitals to increase their awareness of the importance of informing REACH of these admissions so REACH staff can be involved in proactive discharge planning**.**

Conclusion: This lack of awareness by REACH teams of who was admitted indicates that hospitals may be contacting REACH staff less frequently at the time of emergency crisis assessments or the number includes some voluntary admissions. The CSB ES staff seems to be more routinely notifying REACH staff of the screenings for involuntary admissions. It is essential that CSB ES teams notify REACH, so the REACH teams can offer community-based crisis supports as an alternative to hospital admission, when clinically appropriate, and can begin proactive discharge planning that may result in shortened stays in the facilities for individuals with IDD who are admitted. It is equally important for REACH staff to be involved with voluntary admissions to provide IDD clinical expertise to hospital staff and to begin planning for crisis intervention and stabilization services that can take effect at the time of discharge.

The DBHDS report continues to identify fewer known dispositions than the known number of individuals who are admitted. This may be the result of one individual having multiple admissions, but only one final disposition. It is concerning, however, because DBHDS reports being aware of 832 individuals being hospitalized, but only knows of 747 dispositions. This number of 832 known dispositions is significantly higher than the 643 individuals reported in *Table 9.* DBHDS cannot report on how many individuals have actually been hospitalized, but rather on how many hospitalizations occurred during the

reporting period. Some individuals may have had multiple hospitalizations. It is necessary to have DBHDS be able to report specifically on the actual number of:

- Individuals admitted to psychiatric hospitals;
- Individuals with multiple hospitalizations and
- Hospitalizations for each individual with multiple admissions

The percentages of dispositions are fairly similar over the three-year period. Outcomes were not positive (remained hospitalized) for a growing number of individuals each year reaching 133 in Year 3 and ranged from13%-15% of all individuals hospitalized over the three years. The number of individuals remaining in the hospitals has increased but the percentage is relatively the same. The individuals who used the CTH after a hospitalization ranged from 8% to 12%. A comparable percentage (59% and Years 2 and 3) of individuals retained their residential setting in each of the three years. Table 12 below depicts these data.

Table 12: Disposition for Individuals Hospitalized

Year	Remain In Hospital #, (% Of Total)	Home with Mobile Supports	Home without Mobile Supports #, (% Of Total)	CTH	New Provider	Other	Total
1	56 (14%)	2	244, (61%)	46	24	25	**397**
2	105 (15%)	3	402, (59%)	54	52	68*	**684**
3	133 (13%)	1	437, (59%)	77	53	46*	**747**

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

These data do not provide sufficient information to determine whether the individuals who remain hospitalized need continued hospitalization or whether they remain in the hospital because of the lack of an appropriate and available residence, an available CTH bed, or other needed community supports. The individuals who are hospitalized for extended periods may benefit if the REACH programs are able to reduce the length-of-stays at the CTHs and by the development of the transition homes. By reducing the number of extended stays, the CTH programs will have more available beds to offer as alternatives for individuals who would otherwise be admitted to a psychiatric hospital or as a step-down option for individuals who are ready to be discharged.

DBHDS reports that the REACH programs remain actively involved with all individuals who are hospitalized when REACH staff is aware of their hospitalizations. DBHDS sets the expectations for the involvement of REACH staff during the hospitalization of an individual with IDD. The revised REACH standards require REACH to join with the ES staff for every admission screening and to stay involved with everyone who is hospitalized as a result of the screening. REACH staff participates in the admission, attends commitment hearings, attends treatment team meetings, and participates in discharge planning. The community-based service alternatives to institutionalization that the Agreement required be available cannot be effective unless the CSB ES and hospital's staff contact REACH for all psychiatric

screenings of individuals with I/DD, and unless the screenings occur at the individual's home whenever possible.

Training-The REACH quarterly reports document that the REACH Adult Programs continue to provide extensive training to a range of stakeholders. The five Regional REACH programs trained 4,747 individuals during the reporting period, compared to 3,942 in Year 2, and 3,458 in Year 1. This is summarized in Table 13 below:

Table 13- Training by REACH Adult Program Staff

Year	*CIT/Police*	*CSB*	*ES*	*Providers*	*Hospital*	*Family*	*Other*	*Total*
Year 1	727	967	153	307	250	0	1,054	3,458
Year 2	659	1061	347	885	101	27	862	3,942
Year 3	743	712	189	584	437	1524	558	4,747
Total	**2,129**	**2,740**	**689**	**1,776**	**788**	**1551**	**2,474**	**12,147**

DBHDS has partnered with the Department of Criminal Justice Services, the Virginia Board of People with Disabilities and Niagara University to develop comprehensive training for law enforcement. The focus of the training is disability awareness. The training was piloted in FY18 Q2 and the training was enhanced based on feedback from the pilot in FY18 Q3. The Commonwealth's plan is to use a train-the-trainers model. The training of the law enforcement trainers will begin in May 2018. Each Region was identified to have trainers trained. These trainers will then be responsible to train other law enforcement staff in their Region.

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

Serving individuals with developmental disabilities-The REACH programs continue in Year 3 to increase the number of individuals served with DD, other than ID, than has been reported during earlier review periods. REACH served 379 individuals with DD only, which was 23% of the total number of individuals referred. This is a more than a 100% increase over the 186 individuals with DD only who were referred in Year 2. Only forty-four individuals with DD only were referred in all of Year 1.

Conclusion: Outreach to the DD community has resulted in REACH serving more and an increased percent of individuals considered DD only. There may be greater outreach by CSBs who now have the responsibility to provide or arrange for case management for individuals who have a developmental disability that is not an intellectual disability.

Qualitative Study of Individuals Referred to REACH- The Independent Reviewer seeks to inform these reviews with a qualitative analysis of the supports and services that have been provided to individuals served by REACH. This qualitative analysis makes the findings of this

review more robust and not based solely on a review of documents, data and reports developed by REACH and DBHDS. The reports for the tenth and eleventh reporting periods included findings from a two-phase study. It included a study of sixteen children served by the REACH programs in Regions II and V, and twenty adults served by the REACH programs in Regions II, IV and V.

An additional qualitative review was completed as part of the twelfth review period study. This review focused on children and adults who were hospitalized between August 1 and November 30, 2017, and who lived in Region III or IV. The focus on individuals who were hospitalized was to review the effectiveness of the REACH programs and community behavioral, psychiatric, and program supports to de-escalate and prevent crises; to stabilize individuals who experience crises that result in hospitalization; and to provide successful in- and out-of-home supports that assist the individuals to retain their community residential settings post-hospitalization. The study, its results and conclusions are presented in Attachment 1.

SECTION 5: ELEMENTS OF THE CRISIS RESPONSE SYSTEM

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

The REACH programs in all Regions continue to be available 24 hours each day and to respond onsite to crises. DBHDS reported that there were 1677 calls during Year 3, compared to 1348 calls to REACH during Year 2; and 280 calls in Year 1. In Year 3, 20% of the 845 calls were received on weekends or holidays, which is an increase in the number and percentages for Years 1 and 2 when 10% and 13% respectively were received on weekends or holidays. In Year 3 eight percent (8%) of the calls were received between 11PM and 7AM, and 42% between 3PM and 11PM. The remainder of the calls was received from 7AM-3PM (50%). These data do not specify the calls that were received after 5PM because the calls are reported by the three REACH program shift hours. The data cannot be directly compared to Years 2 and 3 because of a change to the time periods used to report. The types of call are reviewed in greater detail earlier in this report.

Conclusion: REACH is available 24 hours a day, 7 days a week to respond to crisis calls.

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

The Regions' REACH staff continues to train CSB ES staff and to report on this quarterly. During Year 3 all five Regions provided training to CSB ES staff. The total ES staff trained during this review period was 189, compared to 347 and 153 ES staff trained respectively in Years 1 and 2. This training complements the online training about REACH that is required for ES staff.

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

ii. Mobile Crisis Teams

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

The National Center for START Services at UNH continued to provide training to the REACH staff in Region I. REACH leaders in Regions III, IV and V developed a training program to provide similar training for their staff that is used by these Regions and Region II. DBHDS has reviewed and approved the curriculum for use across the four Regions, as reported previously. The DBHDS standards for the REACH programs require comprehensive staff training consistent with set expectations for the topics to be addressed within 30, 60 and 120 days of hire. Staff must complete and pass an objective comprehension test. Ongoing training is required and each REACH staff must have clinical supervision, shadowing, observation, and must conduct a case presentation and receive feedback from a licensed clinician on their development of Crisis Education and Prevention Plans.

REACH staff is involved in a growing number of responses to crisis calls. REACH staff responded to 1,063 crisis calls in Year 1; 1574 crisis calls in Year 2; and 1904 crisis calls in Year 3. This trend represents a significant increase in workload since these crisis calls all require onsite responses. From the data in the Quarterly Reports, REACH services are providing preventative support services for a significant percentage of adults with IDD who are referred. The majority of individuals who receive mobile crisis services are maintained in their home settings as detailed in Table 10. In Year 3, 76% maintained their residential setting and 6% moved to a new appropriate community setting. These are similar percentages to those reported for Years 1 and 2. A small percentage each year, ranging from 5% to 7%, which was the lowest in Year 3, are hospitalized after receiving mobile crisis supports.

While the information above is positive, a relatively small percentage of the individuals screened return home with mobile crisis support or are diverted to a CTH. Furthermore, this percentage has decreased for both services over the three years. The percentages of individuals who used mobile crisis support at the time of the crisis was 16% in Year 1 and 13% in each of Years 2 and 3. The percentages of the adults using the CTH at the time of the crisis was 9% in Years 2 and 3, and reduced to 7% in Year 3. At the same time the number of adults who were hospitalized increased dramatically from 383 in Year 1; to 647 in Year

2; and further to 832 in Year 3. This continued increase in the number of hospitalizations over three review periods is deeply concerning.

While there has been an increase in the number of hospitalizations the Adult REACH Programs have been involved in screenings for more of the individuals but for a smaller percentage of all those who were hospitalized. REACH screened 595 of the 832 adults who were admitted to psychiatric hospital in Year 3, which represents 72% of the admissions. This compares to REACH screening 80% of the psychiatric admissions in Year 2 (515 of 647 admissions), and 55% in Year 1 (210 of the 383 admissions).

Conclusion: Many more screenings are being completed with REACH staff involved. REACH has provided mobile crisis support to more individuals each year. The number increased from 170, to 200, to 243 adults in Years 1, 2, and 3, respectively, but there was a decrease in the percentage of individuals who were screened and who retain their settings with mobile crisis support. Mobile crisis support seems effective when it can be provided, but it may be beneficial to more individuals and its availability and use has not reduced the number of individuals who were hospitalized.

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

The REACH teams continue to provide response, crisis intervention and crisis planning services. DBHDS reported that REACH provided these services to 1,024 individuals in Year 3 compared with 1,301 and 941 individuals in Years 1 and 2, respectively. The totals include duplicates for each individual who received more than one of these services or used one service multiple times. These totals represent the sum of the number of individuals who received: Mobile Crisis Support; Crisis Stabilization-CTH; Crisis Step Down-CTH or Planned Prevention-CTH. Each year since Year 1, the use of mobile crisis supports by all REACH participants (not just at the time of the crisis assessment) has declined and has declined for the number who used the CTH program overall. This is depicted in Table 14.

Table 14: Number of Adults Using Mobile Crisis Supports and the CTH Program

Year	Mobile Crisis Supports	CTH	Total
1	641	660	1,301
2	543	398	941
3	486	538	1,024

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

The DBHDS standards for REACH programs require that all individuals receive both an evaluation and crisis prevention follow-up services. All individuals must also have a Crisis Education Prevention Plan (CEPP), but they may already have a current one at the time of

referral. DBHDS reports on the number of individuals who receive these interventions by service category.

DBHDS reports that all of the REACH programs provided these required services to the majority of individuals using the mobile supports or the CTH. This is the highest level of compliance in this area in any review period. DBHDS reported the following rates of adherence to its requirements during Year 3: 94% of evaluations were completed; 84% of CEPPs; 96% of consultations; and 89% of provider trainings. For this particular review period, Regions I, III and IV were most consistently delivering these service elements to individuals who received either mobile crisis supports or used the CTH. *Table 15* summarizes this information over the three years below:

Table 15: Adults Receiving REACH Service Elements

Year	Number of Adults	Evaluation	CEPP	Consultation	Provider Training
1	1,301	679	838	908	689
2	941	714	558	700	507
3	1,024	963	860	981	910

Conclusion- The Adult REACH Programs continue to complete more of the service elements and for a greater percentage of the population served. Completion of these service elements was closer to 100% for the actual review period: FY18 Quarters 2 and 3.

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

The local REACH teams continue to train police officers through the Crisis Intervention Training (CIT) program. During Year 3, REACH teams trained a total of 743 police officers compared to 659 police officers trained in Year 2 and 727 officers trained in the Year 3. This training for law enforcement was provided in all five Regions. Regions II and V provided the training to the highest number of officers accounting for 56% of the law enforcement personnel trained by REACH staff in this period.

DBHDS has partnered with the Department of Criminal Justice Services, the Virginia Board of People with Disabilities and Niagara University to develop comprehensive training for law enforcement. The focus of the training is disability awareness. The training was piloted in FY18 Q2 and the training was enhanced based on feedback from the pilot in FY18 Q3. The plan is to use a train-the-trainers model. The training of the law enforcement trainers will begin in May 2018. Each region was identified to train trainers. These trainers will then be responsible to train other law enforcement staff in their region.

Conclusion: REACH staff continues to train law enforcement personnel. The plan to enhance training for law enforcement personnel is essential. Police officers respond to

many of the crises involving individuals with I/DD and have the authority to issue an Emergency Custody Order (ECO) that initiates a pre-screening for potential hospitalization.

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

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

In Year 3, 37% of the crisis assessments were conducted in the individuals' homes, day programs, or other community locations, which is comparable to the 36% performed in these locations in Year 2, but was significantly less than the 48% that were conducted in these settings in Year 1. It should be remembered that the ES staff were not required to inform REACH staff of prescreening in Year 1. Over 60% of initial assessments in Year 3 occurred at either a hospital/ER setting (50%) or at an ES/CSB (10%) location, which is comparable to Year 2 when hospitals completed 53% of the screenings and ES/CSB completed 7%. In Year 1, however, only 38% were performed at hospitals and 4% were performed at the ES/CSBs. This increase in out or home locations for the initial assessments is an indication that ES screeners informed REACH programs of a greater number of screenings for potential hospital admission. It is also an indication of a lessening of REACH's ability to stabilize crises within the individual's home, which would allow the individual to remain in his or her home setting. The steadily increasing number of hospital admissions over the three years supports this conclusion.

In Year 3, and for the first time, more individuals were assessed at provider locations than at family homes. REACH responded to 421 crisis calls at either residential or day provider locations and 285 crisis calls at family homes. This is an indication of the value that the providers place on the REACH programs to assist their staff when crises occur. The fact more families call REACH each year to respond to a crisis at their home is an indication of the knowledge families have about the program. The number of crisis calls from family homes grew from 191 in Year 1, to 232 in Year 2, and to 285 in Year 3.
DBHDS reports the number of crisis responses that involve law enforcement personnel. Law enforcement was involved in 406 of the crisis calls. It is difficult to draw any conclusions without knowing about the dispositions when law enforcement is involved. Law enforcement is routinely involved to assist with the response and to assure everyone's safety. Families may also call 911 during a crisis with a family member. It is beneficial that REACH participates in CIT training for law enforcement officers.

The trend of referrals being made primarily during normal business hours continues. REACH received a total of 1677 referrals during the reporting period. Three hundred thirty (20%)of these calls were received on weekends. The Regions received 701 calls (42%) between 3-11 PM and 134 calls (8%) between 11PM and 7 AM. Fifty percent (842) of all of the calls were made during the normal workday hours, which are reported now as 7AM – 3PM.

Conclusion: REACH staff responds appropriately to all crisis calls onsite and are available all days of the week and times of the dat.

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

DBHDS collects and reports data on the amount of time that REACH devotes to a particular individual. REACH is expected to provide three days of mobile crisis support on average for adults. Every Region did provide at least an average of three days of mobile support in Year 3. The days ranged from 1-15 days. Region III averaged more than thirteen days throughout the year.

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

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

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

REACH responded onsite to all of the 1906 crisis calls in Year 3 with the exception of one call in which Region V was informed to not attend while in transit. REACH responded to 1760 of the 1905 (92%) crisis calls within the required time periods (one hour in Regions that DBHDS has designated as urban, and two hours in Regions that it designated as rural). This is the same on-time response rate as occurred in Year 2. The on-time response was 93% in Year 1.

The average response time in all Regions was within the required timeframes. Regions I, III and V, the Regions that are required to respond to a crisis onsite within two-hours, averaged response time within 58-75 minutes in Year 3. Regions II and IV, the Regions that are required to respond to a crisis onsite within one-hour, averaged response time of 43-50 minutes. It should be noted, however, that DBHDS now reports two averages for Region II to include its recently acquired rural CSBs that were transferred from Region I. The average response time for Region II's rural section was 76 minutes in Year 3.

DBHDS does include specific information on the number of calls responded to in thirty minutes intervals as was referenced in the section about children's services. Across all

Regions, 160 (18%) of the calls were responded to within thirty minutes and an additional 428 (47%) had a response between 31- and 60 minutes. This indicates 65% of the calls were responded to within an hour across all five Regions.

Historically the rural Regions that have a two-hour window to respond to crisis calls have achieved a higher rate of success, making 94-99% of their responses on time. Region IV and II, being designated as urban areas, must respond within 60 minutes. Region IV has improved from 85% in Year 2 to 91% in Year 3, getting closer to their achievement of 93% in Year 1. Region II continues to struggle to be consistently responsive within the expected timeframe, falling to 79% in Year 3 after two years of 89% and 88% achievement. DBHDS did not provide reasons for these delays in its report, but delays in Region II have historically been attributed to congested traffic. It would be helpful to have the reason for the delayed responses reported in case there are other reasons for delays in response time.

***Conclusion*:** The REACH programs overall have maintained an on-time response rate of 92% in Year 3, but is not in compliance because Region II has responded on-time to only 79% of its calls this year. All regions met or exceeded the average response time requirement for urban and rural areas.

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

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

The Crisis Stabilization Program continues to provide both crisis stabilization and planned crisis prevention as the Commonwealth intended in its design of these programs. All Regions also use the CTH programs for individuals as a step-down setting after discharges from psychiatric hospitals. Overall use of the CTH has decreased over the past three years. Visits in Year 2 totaled 532 and increased slightly to 538 visits in Year 3. This remains,

however, substantially less than the 660 visits in Year 1. The total number of adults using the CTH has dropped more significantly when you subtract the number of readmissions. While there has been an increase in the number of adults using the CTH program between Years 2 and 3 there is a 23% decrease in utilization since Year 1. This may be a result of longer stays in the CTHs.

The decreased use of the CTHs is particularly troubling when occurring at a time of increased hospital admissions. This concern is supported by the data that the CTH has been used for fewer individuals as well as a smaller percentage of all individuals use the CTHs for stabilization after a crisis. The numbers of individuals using the CTHs for stabilization dropped from 321 in Year 1, to 173 in Year 3, a number slightly higher than the 145 individuals who used the CTHs for stabilization in Year 2. It is positive that more individuals are able to use the CTHs as a step-down from hospitalization. The use of the CTHs for this purpose has dramatically increased since Year 1 when only one adult used it for this reason. By Year 3, 129 individuals left hospitals for the CTHs, which represented 24% of the individuals who use the CTH. The use of the CTH for prevention has dropped from 303 adults in Year 1 to only 181 adults in Year 3. It is unknown whether this decline is because of fewer requests for this type of stay, or longer stays and an unavailability of beds.

Table 16 describes the various uses of the Crisis Stabilization Programs **(**CTH's) over the past three years.

Table 16: Use of the CTH

Year	Stabilization	Prevention	Step Down	Readmission	Visits	Total Individuals
1	321 (49%)	303 (46%)	1 (0%)	35 (5%)	660	625
2	188 (35%)	201 (38%)	115 (22%)	28 (5%)	532	504
3	173 (32%)	181 (34%)	129 (24%)	55 (10%)	538	483

The CTH is still used more often as a resource for stabilization and step-down which is appropriate. The use of the CTH to prevent a crisis is part of many individuals' crisis prevention plans. It is not known from the data whether the individuals who were re-admitted for step-down purposes had been re-hospitalized. These would be valuable data to keep and to analyze for future reviews. During Year 1 the CTHs were used more equally for stabilization and prevention purposes. However, the increased use of the CTH as an appropriate step-down program for individuals who are ready to be discharged from psychiatric hospitals has changed this ratio during both Years 2 and 3.

Table 17, Utilization of the CTH in Average Day Ranges, depicts the average lengths-of-stay at the CTH's for each purpose. The range for each describes the difference in the average lengths-of-stay across all five Regions. The goal, and the Agreement requirement, of the REACH CTH program is that no one stays longer than thirty days.

The Crisis Stabilization Programs (CTHs) were designed to offer short-term alternatives to institutionalization with stays greater than thirty days not being allowed. The premise of capping the length-of-stay is that the setting is most effective as a short-term crisis service. The averages

show the range for the five Region's CTHs for each year. DBHDS does not report on the number of stays longer than thirty days or the duration of these visits. However, Region V's average length-of–stay in Year 3 was thirty-five days and the average length-of-stay for step-down averaged thirty-six and thirty-five days respectively in Regions I and III in Year 3. The average length-of –stay for stabilization increased in Regions I, IV and V in Year 3. Region V dramatically increased its average length-of-stay for prevention from five to twenty-six days in Year 3. Increases in average length-of-stay for step down increased in Regions I, III, and IV in Year 3. Region II experienced longer average length-of-stay for both stabilization and step down in Year 2 of forty-two and thirty-nine days respectively. In Year 3, Region II has brought these averages down to twenty-five and twenty-eight days, respectively. These increased average lengths-of -stay contribute to the decrease in the number of individuals who were able to use the CTH in Year 3.

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

Conclusion: The CTHs will be more readily available for more individuals if the programs are able to achieve shorter average lengths-of-stays. DBHDS has not been able to open the two transition homes for adults that it had planned; one is planned to serve individuals in Regions I and II, and the other individuals in Regions III, IV, and V. DBHDS now anticipates opening these settings by January 2019. These settings will add to the Commonwealth's capacity to respond to crises by providing therapeutic alternative residences that can support individuals who need stays of more than thirty days for crisis stabilization to make a positive transition to a new permanent residence.

Table 17: Utilization of Crisis Stabilization Programs (CTH) - Average Day Ranges

Type of Use	Year 1 Average	Year 2 Average	Year 3 Average
Stabilization	12-21	14-42	19-35
Prevention	4-11.5	4.5-12	5-26
Step-down	N/A	19-39	16-36

DBHDS does not report the length of the actual stays in the Crisis Stabilization Programs (CTHs). It will be helpful going forward to have information about the number of stays greater than 30 days and the reasons for the prolonged use of the CTH program. These extended stays are expected to occur far less frequently once the DBHDS transition homes are opened.

DBHDS reports on the waiting lists for each Region's Crisis Stabilization Program's beds. Five individuals were on the waiting list in FY18 Q2, three who were in Region III waited for sixteen days. While waiting, two individuals accepted mobile supports; one stabilized at home and one was hospitalized.

Conclusion*:* DBHDS does not have sufficient capacity in its five Crisis Stabilization Programs. Individuals with IDD, who could have been diverted from hospitalization or who

were ready for discharge, continued to be institutionalized as a result of a lack of available beds in the existing Crisis Stabilization (CTH). Evidence that supported this concern was found in the qualitative study completed for the twenty-three selected adults in the twelfth review period who were referred for crisis services. The Regional REACH teams all acknowledged that it might have been possible to divert a few of the individuals who were hospitalized if the CTH had an available bed. Hospital and ES staff supports this supposition, and believed that more individuals could have been diverted from admission to hospitals. We found that ten of the twenty-three adults could have been diverted if a CTH bed had been available. It continues to be apparent that the numbers reported on the Waiting Lists do not fully reflect the number of individuals who could have been diverted from a hospital admission if a CTH opening was available.

It is evident from these data that the Crisis Stabilization Programs (CTHs) are improving their ability to be a source of short-term crisis stabilization, intervention and prevention as required by the Agreement. The longer stays of individuals who need crisis stabilization or step-down services increased in three Regions during Year 3. It is positive to see evidence of greater use of the CTH for individuals being discharged from hospitals. The fact that fifty-five individuals were able to use the CTH more than once for crisis prevention is evidence of the program's availability as originally intended. The ability of families to use this out-of-home support may assist them in being able to support their adult child for a longer period of time in their family home. However, it is concerning that fewer adults overall were able to use the CTH in Year 3 than were able to use the CTH option in Year 1.

DBHDS has planned and secured funding to develop two transition homes for adults who require extended stays. Each planned home will be able to serve up to six individuals at one-time. DBHDS plans to serve individuals who are in need of up to six months of supports in a temporary residential setting. One home will serve Regions I and II. The other home will serve Regions III, IV and V. DBHDS plans that both transition homes will open by January 2019.This is a six-month delay over the anticipated opening that DBHDS reported in the eleventh review period. These homes will be a critical component to the crisis service system. They should allow more individuals to be diverted, or stepped down, from hospitalization. Having an additional source for individuals who need a temporary residential setting will lessen the pressure on the existing CTHs, which have been the only residential resource for out-of-home diversion.

The REACH program continues to provide and to offer community–based mobile crisis support as the first option when appropriate. Timely mobile crisis support was provided to 486 individuals in Year 3 compared to 543 individuals during Year 2, and to 641 individuals in Year 1.

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

The Settlement Agreement requires DBHDS to determine if individuals in the target population require additional crisis stabilization programs. The addition of transition homes will help the Commonwealth address the transitional housing needs of individuals in the target population who otherwise would need an extended stay at the CTH until a permanent alternative residence is developed or located. The addition of these new homes will benefit individuals and are expected to allow other aspects of the service system to function as designed. I believe that DBHDS's determination to open transition homes to address the needs of adults in crisis who need a longer transition period is an important step toward addressing this requirement. The utilization data over the next few review periods will help determine whether two transition homes are sufficient.

SECTION 6: SUMMARY

The Commonwealth of Virginia continues to make progress to implement a statewide crisis system for individuals with I/DD. The Children's REACH program is fulfilling most requirements, but this does not yet include out-of-home crisis stabilization programs for use as a last alternative to children being admitted to institutions, including psychiatric hospitals.

During Year 3 the REACH Children's and Adult Program continued to experience an increased number of referrals and needed crisis assessments, while providing mobile crisis supports to fewer individuals. The CTH program is used increasingly for step-down and readmissions but its use for stabilization and prevention, while up slightly from Year 2, is decreased significantly from Year 1 utilization rates. REACH adult and children's programs were engaged in continuing to train case managers, ES and hospital staff, providers and law enforcement officers, although the number of stakeholders varies across regions.

The decrease in the use of mobile crisis supports among adults is concerning and may be attributed to a lack of staffing. I asked DBHDS for a staffing summary for the REACH community services of the adult and children programs from FY16, 17 and 18. The REACH programs for adults have now been combined with the programs for children in all Regions except Region I. Fortunately all of the Regions have added positions since the beginning of FY16. The numbers below indicate the positions that were added during FY17 and FY18, and the total number of positions now allocated to the REACH programs:

Region I: 5 for a total of 23
Region II: 15 for a total of 33
Region III: 4 for a total of 27
Region IV: 9 for a total of 23
Region V: 11 for a total of 26

At the time of this study, however, every Region had staff vacancies across clinicians, coordinators and in-home mobile staff. *Overall, the REACH programs were operating with thirty-three out of 132 REACH positions being vacant, a statewide vacancy rate of 25%.* The vacancies in each Region are as follows:

Region 1:4 (17%)
Region II: 13 (39%)
Region III: 10 (37%)
Region IV: 2 (9%) one is a per diem
Region V: 4 (15%)

All of the vacancies include in-home mobile support staff or coordinators. Staff in these roles may also provide in-home support and are responsible to develop CEPPs. Functioning effectively with an overall vacancy rate of 25% is extremely difficult and can be highly taxing on managers and on the current staff. With such a high number of positions being vacant, managers often must cut back on the quantity of services being provided. It is reasonable to conclude that the high number of staff vacancies is a significant contributing factor to the REACH program's decrease in the number of individuals for whom in-home mobile support services were provided, and, therefore to the increase in hospitalization. I recommend that DBHDS begin reporting on all staffing including the CTH in the thirteenth reporting period.

The Commonwealth now has better data regarding individuals who are admitted to psychiatric hospitals and the involvement of REACH, which occurs when the individuals are known to them. However, the number of individuals admitted to hospitals has continued to increase; and the data are not available to determine whether more of these individuals could have been diverted if the appropriate community resources, including sufficient CTHs and transition homes, were available. Hospital and CSB ES staff may more regularly inform REACH staff of crisis screenings, in light of the increased number of pre-screenings in Year 3. However, it is concerning that REACH was only involved in 72% of all hospitalizations of individuals with IDD reported in Year 3, which is less than the 80% of all hospitalizations reported in Year 2. This reduction must be addressed as one strategy to prevent unnecessary hospitalizations**.** DBHDS and REACH should analyze the increase in hospitalizations and determine what corrective actions can be taken to achieve the planned, expected and desired outcomes of the development of crisis services, as well as the linkages between hospitals and CSB ES programs of REACH crisis services. Completing initial assessments in the individuals' homes, and before they are removed to a hospital location, is critical to achieving the desired outcomes for these individuals.

The qualitative review study of a small sample of individuals found that REACH had consistently responded to crises and had maintained contact with individuals during their hospitalizations. Many of these individuals, however, particularly the adults, may have been able to be diverted. Also, the rural locations of some of the screenings may preclude timely involvement of REACH staff in the prescreening, unless REACH staff is deployed differently. REACH staff develops and implements plans and provides families with links to community resources. More families than may have been expected did not accept REACH services. The data reported by REACH indicate that the majority of those who did participate in REACH services generally had their needs for short-term crisis intervention and family training met. However, we were only able to interview six family members whose relatives were served by the REACH Program.

DBHDS has put significant effort into increasing the number of behavioral specialists. It must still be determined, however, whether the plans underway will provide sufficient capacity to meet the existing level of need. One finding of the study is that too few individuals who need a BSP have access to one. DBHDS's efforts to develop residential providers, which can support individuals with co-occurring conditions, have not yet been sufficient. Developing a sufficient number of residential providers that are competent to support individuals with intense behavioral needs will be critical to the system's success in reducing unnecessary hospitalizations and transitioning individuals in a timely way from crisis stabilization and psychiatric hospitalizations to community-based settings. I recommend DBHDS provide written reports regarding these efforts and the outcomes in future reporting periods.

Attachment 1

Qualitative Study of Psychiatric Hospitalizations

The number and percentage of individuals with I/DD who are hospitalized as a result of a crisis is increasing over the previous seven reporting periods, which began in 2015. The Independent Reviewer is deeply concerned about this increase in admission and the high number of individuals with I/DD whose initial assessment frequently occurs at hospitals rather than in the individuals' homes. A high percentage of individuals whose initial assessments occur at hospitals are admitted to psychiatric institutions rather than utilizing in-home supplemental supports or crisis stabilization services as alternatives to hospitalization. The practice of removing individuals from their homes and transporting them to a hospital for the initial assessments results in an increase in the number, and higher percentage, of children and adults with I/DD being admitted to psychiatric hospitals in Virginia. As a result of this concern, the Independent Reviewer directed a qualitative review to determine the reasons for the increase in admissions to psychiatric hospitals; the steps that DBHDS has taken to ensure that initial evaluations occur within individuals' homes, the consistency of engagement of REACH during the screening process; the specific involvement of REACH during hospitalizations; the effectiveness of discharge planning to reduce the length-of-stay (LOS) at the hospital; the REACH strategies and processes to ensure effective community supports that prevent future admissions; and the involvement of REACH post-hospitalization to prevent future crises and to successfully address crises when they occur.

I conducted a qualitative review of the REACH screening process; hospitalizations; and crisis services for forty-three individuals with I/DD in Regions III and IV who were hospitalized in selected state operated psychiatric facilities between 8/1/17 and 11/30/17. This study includes a review of the effectiveness of the REACH programs and community behavioral, psychiatric and psychological supports to de-escalate existing, and to prevent future, crises; to stabilize individuals who experience crises which result in a psychiatric hospitalization; and to provide successful in-home and out-of-home supports that assist the individual to retain his or her community residential setting post-hospitalization.

The qualitative study included a review of the records for twenty children and twenty-three adults from Regions III and IV who were admitted to one of the following psychiatric hospitals: Central State Hospital (CSH), Southern Virginia Mental Health Institute (SVMHI), or the Commonwealth Center for Children and Adolescents. The sample was selected from the list of admissions DBHDS produced of all children and adults who were admitted to a state operated psychiatric hospital between the dates listed above. To create a stratified sample for this study, the Independent Reviewer selected the facilities. DBHDS produced three lists and indicated if the individuals or their families accepted REACH services. The three lists included: individual on a waiver or waiver waiting list; individuals with a developmental disability but whose functional abilities had not been confirmed; and individuals suspected of a DD but who had no confirmation. I selected from the first two lists to attempt to insure all the individuals would be eligible for REACH services.

The following table indicates the waiver status of the individuals involved in the qualitative study.

Table A: The Waiver Status of the Children and Adults in the Qualitative Study

Age Group	Waiver Participant	Waiver Waiting List	Neither Waiver nor Waiting List
Children	9	5	6
Adults	17	0	6

The following table indicates the number and percentage of the individuals admitted to each state hospital in the time period who were reviewed as part of this qualitative study.

Table B: The Sample of Children and Adults by Psychiatric Facility

Facility	***Number Admitted***	***Number Reviewed***	***Percentage***
SVMHI	9	9	100%
CSH	18	14	89%
CCCA	25	20	80%

Interviews were conducted with Emergency Services (ES) screeners and supervisors in eight CSBs, hospital staff and REACH staff. There was contact information for thirty-nine families. Nine of the contact numbers provided were either no longer in service or had no ability to leave a message. Thus, thirty families were contacted with only six responding to calls who were then interviewed. Results of the interviews are described in a later section.

DBHDS was asked to produce the following documentation for each of the selected individuals:

REACH records;

Hospital medical and psychiatric assessments and inpatient plan for the individuals who were hospitalized including the screening for admission, medications prescribed and the discharge plan;

Individual Service Plan (ISP) if applicable; and

Names and contact information of a hospital contact, the family caregiver, Case Manager and REACH coordinator for the selected individuals.

Components of the Study

All records were reviewed. Generally, each person's record was comprised of hospital and REACH records. We were provided ISPs for a few individuals. The data helped us to understand the reasons for hospital admission, the involvement of REACH staff in the screening process, the course of treatment at the hospital and REACH's involvement in the discharge planning process as well as the supports REACH provided pre- and post-hospitalization. REACH was involved in the prescreening for thirty-six of the forty-three individuals including seventeen children and nineteen adults. The Region IV REACH program was involved in 100% of the screenings whereas Region III was involved in 65% of the screenings in their respective catchment areas.

We had the opportunity to interview staff at all three hospitals to which individuals were admitted: Commonwealth Center for Children and Adolescents (CCCA), Central State Hospital (CSH) and Southern Virginia Mental Health Institute (SVMHI). We met the administrators, interviewed social workers, and also interviewed a psychologist at SVMHI. The hospital staff reports that hospital admissions continue to increase each year. We also interviewed supervisors and emergency screeners at eight CSBs: five in Region IV and three in Region III. We discussed the individuals with hospital staff and asked all individuals we interviewed about the questions most pertinent to this study: the causes of the increase in admissions; the engagement of REACH in the screening process; the engagement of REACH during hospitalization and in discharge planning; and the availability of REACH services for diversion of admissions to hospitals. We also discussed the capacity of the existing provider community and community-at-large to meet the needs of individuals with I/DD and co-occurring conditions.

Increase in Admissions- Everyone interviewed acknowledged that admissions are greater among all populations served. Most staff believe that the increase is more substantial among individuals with only mental health diagnoses rather than individuals with I/DD and co-occurring conditions. The social worker at CSH provided specific statistics: There were ten admissions per month in 2014, thirty a month in 2016, and sixty a month in 2018 to CSH. All of the hospital and CSB staff we interviewed attributed this at least in part to the change in the emergency custody order law. There was a tragedy in 2014 involving a young man and his father. He had attacked his father and was taken for a prescreening and was determined to be in need of hospitalization. The time allowed to secure the hospitalization expired prior to the screener confirming that any bed was available for the son. He was, therefore, released and subsequently committed suicide. The publicity and outcry about this situation resulted in changes to the law 37.2-809 and related statutes. The statute *37.2-808 Emergency custody; issuance and execution of order* states the following in Sections N and O:

N. If an emergency custody order is not executed within eight hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing order….

O. (Expires June 30, 2018) In addition to the eight-hour period of emergency custody set forth in subsection G, H, or K, if the individual is detained in a state facility pursuant to subsection E of 37.2-809, the state facility and an employee or designee of the community services board …

may, for an additional four hours, continue to attempt to identify an alternative facility that is able and willing to provide temporary detention and appropriate care to the individual.

The amended law provides some additional time to secure a bed but creates an expectation that a bed will always be secured. Since the new law was enacted, emergency screeners have felt additional pressure to determine that a person who is presenting with aggressive, homicidal or suicidal ideation and is screened is in need of a Temporary Detention Order (TDO), which ensures that the system provides a safe environment where containment and stabilization is possible. Screeners have a deep sense of personal responsibility to achieve an outcome that keeps all concerned safe. At some level they believe that they will be held liable for any unfortunate outcome is the individual is not detained. This sense of responsibility, which has always been part of the job, has been heightened by the change in the law, has resulted in unintended consequences for the REACH program's goal of diverting hospitalization. Screeners are now under increased pressure to secure a bed in a timely manner. Securing a bed requires calling numerous hospitals; and, therefore, screeners now more routinely approach hospitals that are outside of their catchment area. Since the majority of the individuals who are screened arrive at the hospital with an Emergency Custody Order (ECO) the time limit for securing a bed is imposed immediately. The screener is often making the decision about a TDO before the REACH staff arrives at the hospital. REACH may not always have a diversion opportunity to offer, but by the time REACH can engage with the hospital staff the decision to hospitalize the individual may have already been determined.

The hospital screeners and hospital staff also all reported a general increase in the acuity of the needs of individuals screened for hospitalization, although this was not attributed directly to the individuals with I/DD. We reviewed forty-three individuals. All had one or more mental health diagnoses, most had a history of hospitalizations and many were suicidal. Of this number, seventeen (39%) were either on the waiting list for a waiver or were not yet identified as being eligible for a waiver. Without the availability of waiver-funded service, it is likely that these individuals did not have access to sufficient resources and supports to avert a hospitalization.

REACH's involvement in the screening process- All of the pre-screeners spoke positively about the REACH program. They believe that REACH is a positive addition to the network of community supports for individuals with I/DD. They also believe that the REACH program does not have sufficient resources, either staff or Crisis Stabilization (aka Crisis Therapeutic Home) settings, to meet the needs of individuals with I/DD who experience crises. REACH participated in the screenings of thirty-six (86%) of the forty–three individuals in the study. REACH was not involved with one child in Region III who was hospitalized from a residential treatment facility and was returning to the facility. The pre-screeners provided examples of the assistance REACH staff were able to provide and marveled at their willingness in certain situations to stay with the individual or family for hours until the matter was resolved.

All ES staff agreed that REACH staff provides invaluable information about the individuals, families and providers when they have been involved with them prior to the prescreening. REACH staff offers records and data as well as insights about the person and his or her

situation. REACH staff were also reported to be very helpful in engaging with the individual and family members. They may help the person calm down, or remain calm, and often explain the process to the family, which reduces their uncertainty and increases their understanding and comfort with the screening process. Provider staff often does not stay with the individual in the ER because of staffing coverage needs at the individuals' residences. It is particularly helpful to have REACH staff support these individuals who might otherwise be alone for what is often a lengthy process. REACH is also helpful in engaging with individuals who may be unknown to REACH at the time of the screening, just because of their familiarity with individuals with IDD who are in crisis, providing another resource to the screening process.

REACH staff, however, is not always in attendance, especially in emergency settings in areas that are not in close proximity to the REACH Coordinators offices or homes. For example, Danville is over two hours from the Region III office. The REACH Director for this Region reports she is unable to hire a coordinator who lives in Danville or within reasonable travelling of the Danville hospital. The manager of this ES screening team is sympathetic because the CSB has also had difficulty hiring qualified clinical staff in this area. One administrator commented that there was only one REACH team for a geographic area that was almost one half of Virginia. The problem of distance is greater in Region III than in Region IV, but the one CSB ES team we interviewed in a more remote section of Region IV also complained that REACH staff did not consistently respond onsite to participate in the screening. The inability to have staff located who can respond in a timely way to the crisis call in this and other rural areas may contribute to an increase in hospitalizations.

The location of hospital prescreening - the information about where mobile crisis assessments occur is addressed earlier in the report. Statewide during the past year REACH responded to 1909 crises calls for adults, of which 706 (37%) were at the individual's residence or day program, and 1141 (60%) were responded to at the CSB ES office or the hospital, with the hospital accounting for 50% of the overall pre-screenings. The locations of crisis assessments are even more skewed away from the home for children. Of the 926 prescreening of children, 31% were conducted at their homes or schools whereas 67% were conducted at the CSB ES offices or hospitals. This indicates REACH responds to individuals in their community settings about a third of the time. Overall, fewer than half of all of the adults (44%) and children (48%) who experienced crises were hospitalized, regardless of where the screenings occurred. Whereas, more than nine out of ten individuals who were screened at hospitals were admitted to a psychiatric facility. Of the 946 adults who were screened at the hospital in the year 832 (88%) were hospitalized and of the 454 children who were screened at the hospital 447 (98%) were hospitalized. These numbers and percentages are startling. They indicate that an individual has little chance of escaping hospitalization once he or she arrives at a hospital to be prescreened. There is no opportunity to have the assessment occur in the natural setting and to determine whether there are approaches that may de-escalate the crisis and avoid the need to be hospitalized. The CSBs' ES staff rarely, if ever, conducts a prescreening at the home or program of the individual. All of the ES staff who were interviewed reported that they do not conduct screenings other than at the ES office or hospital. This practice is not consistent with the Settlement Agreement requirement "to respond on site to crises".

REACH's involvement during the hospitalization- all of the hospitals interviewed reported it was useful that REACH now had hospital liaisons. Staff at CCCA and CSH reported greater involvement with REACH during hospitalization than did the staff at SVMHI. DBHDS staff describes this "liaison" role as one of coordination and tracking. The liaison tracks the individual's progress, coordinates treatment team meetings, and coordinates discharge meetings with the hospital discharge workers. If the person has not been previously referred to REACH, the liaison activates this referral with information from the hospital. REACH staff may visit the individual while s/he is in the hospital but is not required to do so. We did not see evidence of visits or of coordinating treatment team meetings, but did see evidence of tracking and participating in the discharge meetings when REACH was informed of, and invited to, the meeting. REACH staff often participate in discharge meetings by phone because of the distances to these three hospitals. The staff at CSH and CCCA was positive about REACH's involvement especially with patients who were already served by the REACH program. REACH staff offered information and stayed in communication during the hospitalization. Sometimes during the discharge meetings, REACH was able to offer the CTH as a step down from the hospital. The social workers at SVMHI were less positive about the engagement of REACH. Region III REACH staff was not involved in the discharge planning for four of the individuals at SVMHI. In some cases, the REACH team thought the individual was going to be placed outside of the Region, but the person was not and the Region III team did not seem to facilitate a transition to the proper REACH team if the move had occurred. Overall the Regions" REACH programs were involved in thirty of the forty-two hospitalizations that required their involvement, which is 71% overall. During hospitalizations, the REACH programs had slightly more involvement with the children than with the adults. Region IV, however, was more consistently involved with the hospitals during the admission and in planning the discharges. The Region IV REACH program met this expectation 84% of the time, whereas Region III REACH staff was involved in only 53% of the hospitalizations.

Hospital Diversions- this was not a study of individuals who had been diverted from hospitalization, but rather a study of individuals who were hospitalized at the time of crisis. The study tried to determine the number of individuals who may have been diverted if there had been an option available. We made this determination through the review of the crisis information, interviews with screeners and hospital staff, and conversations with the REACH teams in Regions III and IV. Many of the individuals in this study have the same types of diagnoses that are most prevalent in the population with IDD who are referred to REACH at the time of a crisis.

The most noted reasons for a REACH referral are aggression, suicide ideation, and an increase in mental health symptoms. In the current year aggression, which includes physical aggression, verbal threats and property destruction, is the primary reason for a crisis referral for both adults and children. Suicide ideation or attempts is the second most frequent reason for children's referrals and the third most cited reason for the referral of adults. An increase in mental health symptoms is the third reason for the referral of children and the second for adults.

The individuals in this study posed similar reasons for crisis referrals as the overall group. Many were hospitalized for suicide ideation. Everyone in the study was admitted to the

hospital with a Temporary Detention Order (TDO). A TDO is determined by the hospital screener and indicates that the individual meets criteria for hospitalization as the result of being a threat to themselves or to others. Many of the individuals needed hospitalization because of the danger they presented, especially to themselves, and others needed medication changes that could best be undertaken in a hospital. However, we determined that ten (43%) of the adults and four (20%) of the children could have been diverted if there had been crisis supports including a CTH bed. Both hospital staff and ES screeners reported that the home or provider situation had deteriorated to the point where either the family of provider needed a break from their caregiving responsibilities or needed more intensive supports than were currently available in the home. At times the Region's REACH program was directly asked for a CTH bed. Although the REACH staff agreed in principle that a CTH bed was appropriate and would divert a hospital admission, there was no bed available at the time of the screening. It did not seem that crisis mobile support was an option for any of these individuals, although in a few cases the REACH team had been in the home earlier during the day of the crisis or the preceding day. At the time of crisis, the family or provider may often want the individual to be removed for at least a period of time. All of the groups with whom we spoke talked about a level of frustration or burnout among caregivers that often led to the need for some type of crisis respite, and if not available, hospitalization. However, there also seems to be a lack of adequate REACH staffing to reasonably meet the needs of individuals with I/DD who could benefit from in-home mobile crisis support. This has been discussed earlier in this report.

REACH Services- the following tables summarize the use of REACH mobile supports and the CTH by these individuals previous to or after hospitalization. REACH is responsible for completing a CEPP and for providing linkages for families and individuals. Providing in-home crisis mobile support and CTHs for adults would be reasonably expected for all individuals who experienced a crisis. The study included information on whether these services had been offered at any time during the review period. We used the designation of Not Applicable (NA) if the family refused REACH services and had not received this component of REACH support prior to refusing services. We also used this designation for Linkages if the individual had all necessary community supports and did not need REACH to provide this referral or outreach. This was true for some children in the study. The percentage of "Mets" ratings for these elements excludes the number of NAs form the total calculations.

REACH staff completed CEPPs for thirteen of the seventeen adults and for eleven of the fourteen children who had accepted REACH services. This is an overall achievement of 77.5%. However, Region IV completed these for seventeen of the eighteen individuals who accepted REACH services or did not refuse REACH until after the CEPP was done. Region III only completed the CEPP for seven of the thirteen individuals who should have received one. The CEPPs were very thorough and provided suggestions and strategies to address the needs of the individuals. However, it was difficult from reading the records and interviewing the REACH staff to ascertain if the caregiver had actually been trained to implement the strategies in the CEPP. The documentation approach used by REACH does not always reflect measurable objectives and specific and measurable information on progress. The style of reporting progress notes reflects a therapeutic orientation that summarizes the individual's state of mind and to some degree the interactions between

staff and individual and caregiver instead of a describing the actual supports provided and the outcomes the supports achieved; when and with whom CEPP training was conducted; and what specific linkages were made.

Mobile crisis supports were provided to eight of the thirteen children and to eleven of the seventeen adults who accepted REACH services. This is an overall achievement of 63.5%. However, Region IV provided mobile crisis support for fourteen (82%) of their seventeen individuals in the study. Whereas, Region III only offered mobile crisis support to five (45%) of the eleven individuals hospitalized in the Region who had accepted REACH services. The distance and location of some of these individuals and families and the staff vacancies in the Region seem to preclude ensuring that this service is always available.

CTH- Eight (47%) of the seventeen adults in the study used the CTH, some of them multiple times. Two individuals in Region IV were hospitalized during a CTH visit. Region III was able to offer this to only one (17%)of the six adults in its Region who accepted REACH services, while Region IV was able to offer it to seven (64%) of its eleven adults in its Region. Individuals who have been hospitalized have an equal if not greater need for the CTH for either diversion, step down or prevention than other REACH participants. It is unfortunate that it is not available to these individuals more routinely at the time of crises or as a crisis situation may be developing.

Linkages were provided to eleven (73%) of the individuals who accepted REACH services and needed additional linkages were to be arranged or referred by REACH. Many of the children in the study had received a wide range of community supports prior to their engagement with REACH or their hospitalization. Again, there is a significant difference in the linkages provided by the two Regions in the study. Region IV provided linkages to nine (90%) of its ten participants in the study who needed these linkages. Whereas, Region III was able to provide linkages to only two (40%) of the five individuals who needed assistance to coordinate and locate other community services.

Provider Capacity- We looked at provider capacity for adults in two ways. We tried to determine from the records for the adults whether the hospitalizations seemed to be a result of provider inadequacy to meet the individual's needs. We then reviewed whether the provider discharged the individual. Many of the adults in the study were being served by a provider. This included individuals with waiver funded services and also others who were not in the waiver program, but who lived in an Assisted Living Facility (ALF). Three of the adults who were hospitalized lived in ALFs at the time of the crisis. There were twenty-three adults in the study. Only seven (30%) of them had providers who seemed capable of meeting their needs and only seven retained their provider after the hospitalization. Providers in Virginia are allowed to discharge an individual at any time, including at the time of hospitalization. The provider does not need to offer notice, make sure there is another provider to support the individual, or assure a planful transition to the next setting. Providers often lack the ability to support an individual who has behavioral challenges or co-occurring diagnoses of I/DD and mental health. Individuals with these challenges will continue to be hospitalized and experience longer than necessary hospitalizations until the providers who support them have greater competence and expertise with these populations. Over the long term, the ability of the ongoing service provider to support

individuals with I/DD and a co-occurring mental health needs is more critical to the success of each individual's ability to live in the community and to participate in community life than the intermittent crisis support that REACH can provide.

All of the children who we studied, except one, lived at home at the time of the crisis. Overall, children have a much more robust community support system of services than adults. All of the children are in school and many have individualized in-home support and access to community mental health supports. While children have more supports and resources in place, chart review and interviews confirm that parents often did not have the ability, due to a number of factors, to effectively employ a safety plan that may have diverted a hospitalization.

Behavioral Supports-It is also noteworthy that only 30% of the adults and 10% of the children had access to Behavior Support Professionals (BSP). It was difficult to determine from the records if families and other caregivers had always been trained to provide behavioral strategies, if behavioral services reviews were taking place, and if revisions were made when necessary. These BSPs offer the expertise to analyze behaviors, develop behavioral plans, and train and mentor staff to implement more successful approaches and interventions. This is another critical factor of community capacity to keep individuals stable and assure families and caregivers have the tools and training to address the needs of this population successfully.

Psychiatrists- Most of the individuals in the study had a community psychiatrist. Many of the CSBs provided this to sixteen (69.5%) of adults who had psychiatric care. Sixteen (80%) of the twenty children have a psychiatrist.

Family Feedback-

Families of children reported:

- The Incident that led to the prescreening and hospitalization occurred at school. The mother contacted REACH and staff met her at the prescreening and provided support throughout the process. REACH did not offer any services at that time. REACH called her approximately one month later to see if all was stabilized. There was no Case Manager assigned until late last year.
- The incident that led to the prescreening occurred while REACH was at the home. REACH was present and provided support throughout the process. REACH came into the home briefly prior to hospitalization but had informed the mother that they were not able to continue services due to the child's level of physical aggression. This individual was sent directly to residential treatment from the hospital and remains there as of the date of the interview. REACH has requested to be involved in discharge planning so they can have supports in place when discharge occurs.
- This child's caregiver is his grandmother. She had a lot difficulty remembering events. She did recall REACH had been there three times within a month to calm him and to de-escalate the situation. She did not remember if any supports were offered or if there were further contacts with REACH. She seemed to indicate that she was waiting for him to be placed out of her home, as "he is too big and dangerous for me".
- This mother indicated that REACH was very helpful with de-escalation at the home on one occasion, which diverted a need for a prescreening and possible hospitalization. REACH was

also very helpful at a subsequent prescreening and remained throughout a very long process. She also spoke quite highly of REACH involvement during the hospitalization and discharge planning. REACH developed a plan and put supports in place at home on the day of discharge. REACH also arranged for linkages, including locating a new psychiatrist. Presently REACH is in the home once per week for 90-minute and also interfaces with his school. His mother noted that property destruction has decreased significantly. Her son has been able to sustain his school placement without incidents since coming home.

Families of adults reported:

- The mother indicated REACH was at the home a few times to attempt de-escalation, but were not successful. She attributed this to her son's level of aggression. Her view was that the techniques that REACH employed were unsuccessful because REACH staff did not "allow for adequate time for techniques to work before attempting another". REACH was quite helpful at the prescreening. She tried in-home mobile crisis support for a few weeks, 60-minute intervals at once per week, but it seemed to make him more agitated. She was very satisfied with his visit to the CTH. She reported it was quite beneficial to her son as well as herself upon his return home.
- The individual's brother is his guardian and was interviewed. He did not recall any involvement with REACH. He seems to remember someone calling him at the time of the hospitalization but could not remember who it was. He indicated that his brother has not lived with him for some time and went to a group home in another part of the state directly from the hospital.

Conclusion- The Independent Reviewer directed this study to gather information to help answer a series of questions surrounding hospitalization. The following offers some thoughts and conclusions for each of these issues that impact community support and psychiatric hospitalization for individuals with I/DD and co-occurring conditions.

Reasons for the increase in admissions to psychiatric hospitals- this seems directly related to the change on the laws guiding the prescreening of individuals in crisis; the lack of any provider for many individuals not yet receiving waiver services; the ability of providers to discharge individuals without a transition plan or other provider; the lack of qualified providers to address the needs individuals with co-occurring conditions present; the unavailability of out-of-home crisis stabilization, and the ongoing practice of CSB ES staff completing initial screenings at hospital locations rather than in the individuals' homes.

The steps that DBHDS has taken to ensure that initial evaluations occur within individuals' homes- it is evident from this study and the general data offered in the REACH supports that there is a significant decline in the percentage of evaluations that are conducted in individuals' homes. REACH responds if the individual is still home. However, there is the issue of the time it takes for REACH staff to get to the site of the crisis. The Settlement Agreement allows for this response to take two hours in three of the five regions. This is realistic and unavoidable unless the REACH teams are able to hire staff that live in different parts of their Regions. However, most families and providers are able to withstand an unresolved crisis for this length of time. It should also be noted that the crisis may have been developing over a period of time before the caregiver makes the crisis call, which lengthens the time everyone involved is dealing with an unstable time that may threaten the individual's or others' safety.

When hospitalization is being seriously contemplated or the individual cannot be calmed at home the individual is taken to the ES office or more frequently the local hospital ER. ES staff does not respond to crises in home settings. The data presented in this report validates that more than nine out of ten of the individuals screened for hospitalization at the ES office or hospital are hospitalized. The Commonwealth is not ensuring that CSB ES evaluations occur within individual's homes and this practice increases the percentage of individuals who are admitted to hospitals.

The consistency of engagement of REACH during the screening process- REACH staff proves to be helpful at the homes of individuals and during the prescreening process. If they know the individual the staff shares useful information and is a source of comfort for the individual and family. When they do not know the individual, they can often support them through the process, and offer information and explanation of REACH services to the family. However, this study found a potential that the Commonwealth has a problem assuring consistent engagement in the more rural parts of Virginia when staff can either not get to the prescreening at all or arrive late in the process, which limits their usefulness. Based on the information gathered in this study and the analysis of the high percentage of individuals in the REACH reports who were hospitalized after being prescreened at the ES office or hospital, REACH staff is frequently not able to offer a diversion option to an individual who has a TDO for hospitalization..

The specific involvement of REACH during hospitalizations- REACH's involvement with the hospital staff varies significantly by Region. Hospital staff are generally pleased that the REACH programs have created the position of hospital liaison. The involvement of REACH appears to consist primarily of telephone calls to intermittently check-in. This is considered reasonable by two of the three hospitals in the study. None of the hospitals reported any need for technical assistance or training to address the needs of patients with I/DD.

The effectiveness of discharge planning to reduce the length of stay at the hospital- REACH is usually involved in the discharge planning, although more consistently in Region IV than in Region III. REACH will most frequently plan to provide mobile crisis support for individuals upon discharge, which has often been effective. The hospital discharge planners have a reasonable sense of what the individual will need upon discharge. The needed supports are more readily available for children than for adults. Children almost always return home and have shorter stays on average at the hospital than their adult counterparts. However, the services identified for discharge are often not available for adults either because the individual does not have waiver funding, or because a new provider needs to be found. The hospitals indicated that individuals with longer stays remain in the hospital because there is no appropriate provider, not because they need continued hospitalization. When REACH can provide the CTH as a step-down option it does reduce the time of admission. The creation of the transition homes planned by DBHDS should also help to reduce admissions, but will only be available for twelve adults who are being discharged from hospitals at any given time.

The REACH strategies and processes to ensure effective community supports that prevent future admissions; and the involvement of REACH post-hospitalization to prevent future crises and to successfully address crises when they occur- Two of the adults remain hospitalized,

both were unable to document they had I/DD, so neither received ongoing support from REACH after the prescreening and initial hospital support. One however recently received a waiver slot and REACH is now becoming involved in the discharge planning.

Seven (30%) of the adults (including one who remains hospitalized described above) and two (10%) of the children in the study were hospitalized more than once during the study period. Region III had two of the adults; one had a waiver slot and one did not have access to waiver-funded services. REACH was not involved with either for discharge planning and neither individual kept their provider. Region IV was involved during the hospitalizations for these individuals who were re-hospitalized but three of them lost their waiver provider. New providers have been found in all cases and REACH has offered support to the new providers where these individuals have stabilized. Both of the children who were re-hospitalized lived in Region III. One was placed in a residential treatment facility. The other returned home and has a CEPP completed by REACH.

REACH is providing CEPPs, mobile crisis supports, linkages and CTH visits (for adults) for the majority of the individuals who had only one hospitalization which is contributing to their continued community stability. However, neither the provider community nor REACH was able to successfully address the crisis when it occurred for the 43% of adults and 10% of the children who appear to have been able to have their hospitalization diverted.

Table C: Summary of Crisis and Community Services for Adult 12th Review Period

IND	Waiver Status	REACH Crisis Response	Hospital could be diverted	Hospital LOS (days)	Hospital Support	Refused REACH	Mobile Support	CTH	CEPP	Linkage	PSY	BSP	Provider Meets Needs	Kept Provider
01 (III)	NO	YES	NO	66	NO	YES	N/A	N/A	N/A	N/A	NO	NO	NO	NO
02 (III)	YES	YES	YES	4	YES	NO	NO	NO	YES	YES	YES	NO	YES	YES
03 (III)	YES	YES	NO	2	YES	YES	N/A	N/A	N/A	N/A	YES	NO	NO	YES
04 (III)	YES	YES	YES	11 &77	NO	NO	NO	NO	NO	NO	YES	NO	NO	NO
05 (III)	YES	NO	YES	18	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES
06 (III)	NO	YES	NO	73	YES	N/A	N/A	N/A	N/A	N/A	NO	NO	NO	NO
07 (III)	NO	NO	YES	14,2,8	NO	N/A	NO	NO	NO	NO	NO	NO	NO	NO
08 (III)	NO	NO	YES	59	NO	N/A	NO	NO	NO	NO	YES	N/A	NO	NO
09 (III)	YES	NO	NO	20	NO	NO	YES	NO	YES	N/A	YES	YES	NO	NO
10 (IV)	NO	YES	NO	Remains	YES	N/A	N/A	N/A	N/A	N/A	N0	NO	NO	NO
11 (IV)	YES	YES	NO	17,13,6 Months	YES	NO	YES	YES	YES	N/A	YES	YES	NO	NO
12 (IV)	NO	YES	N/A	8 & Remains	NO	N/A	N/A	N/A	N/A	N/A	NO	NO	NO	NO
13 (IV)	YES	YES	NO	6	YES	NO	YES	YES	YES	NO	YES	NO	YES	YES
14 (IV)	YES	YES	NO	10, 48	YES	NO	YES	YES	YES	YES	YES	NO	NO	NO
15 (IV)	YES	YES	YES	7	YES	NO	YES	NO	YES	YES	YES	YES	YES	YES
16 (IV)	YES	YES	NO	1,9,21 & 13	YES	NO	YES	YES	YES	YES	YES	YES	NO	NO
17 (IV)	YES	YES	YES	6	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES
18 (IV)	YES	YES	YES	1	NO	YES	N/A	N/A	N/A	N/A	NO	NO	NO	NO
19 (IV)	YES	YES	YES	7	YES	NO	YES	NO	YES	YES	YES	NO	NO	NO
20 (IV)	YES	YES	NO	3	YES	YES	YES	NO	YES	YES	YES	YES	YES	NO
21 (IV)	YES	YES	NO	8	YES	YES	NO	YES	YES	YES	YES	YES	NO	YES
22 (IV)	YES	YES	YES	9	YES	NO	NO	YES	NO	YES	YES	NO	NO	NO
23 (IV)	YES	YES	NO	45, 22	YES	NO	YES	NO	YES	YES	YES	NO	YES	NO
Total Met	17	19	10	N/A	16	13	11	8	13	11	16	7	7	7
% Met	74%	83%	43%	N/A	70%	56.5%	65%	62%	76%	73%	69.5%	30%	30%	30%

Table D: Summary of Crisis and Community Services for Children 12th Review Period

IND	Waiver Status	REACH Crisis Response	Hospital could be diverted	Hosp. LOS	Hospital Support	Refused REACH	Mobile Support	CEPP	Linkage	PSY	BSP	Retained Home
01 (III)	NO	N/A	NO	16	N/A	NO	N/A	N/A	N/A	YES	NO	NO
02 (III)	WL	YES	NO	5 & 1	YES	NO	NO	YES	NO	YES	NO	NO
03 (III)	YES	YES	YES	3	YES	NO	YES	YES	YES	YES	NO	YES
04 (III)	WL	YES	NO	23	YES	NO	YES	YES	NO	YES	NO	YES
05 (III)	YES	YES	NO	18	YES	NO	NO	NO	NO	NO	NO	YES
06 (III)	WL	YES	NO	6	YES	NO	YES	YES	YES	YES	NO	YES
07 (III)	NO	YES	NO	14	NO	NO	NO	NO	N/A	YES	NO	YES
08 (III)	WL	NO	NO	6	NO	YES	N/A	N/A	N/A	NO	NO	YES
09 (III)	YES	NO	NO	5,7, & 12	NO	NO	NO	NO	NO	NO	NO	YES
10 (IV)	NO	YES	NO	15	NO	YES	N/A	N/A	N/A	YES	NO	YES
11 (IV)	YES	YES	NO	7	YES	NO	YES	YES	N/A	YES	YES	YES
12 (IV)	WL	YES	NO	6	NO	NO	YES	YES	N/A	YES	NO	YES
13 (IV)	NO	YES	NO	4	YES	YES	YES	YES	N/A	YES	NO	YES
14 (IV)	YES	YES	YES	1	YES	NO	YES	YES	N/A	YES	YES	YES
15 (IV)	YES	YES	NO	13	YES	YES	N/A	N/A	N/A	YES	NO	YES
16 (IV)	WL	YES	NO	5	YES	YES	N/A	N/A	N/A	YES	NO	YES
17 (IV)	WL	YES	NO	7	YES	YES	YES	YES	YES	YES	NO	YES
18 (IV)	WL	YES	YES	4	YES	NO	NO	YES	YES	YES	NO	YES
19 (IV)	NO	YES	YES	8	YES	YES	N/A	N/A	N/A	YES	NO	YES
20 (IV)	NO	YES	NO	9	YES	YES	N/A	YES	N/A	YES	NO	YES
Total Met	6	17	4	N/A	14	8	8	11	4	16	2	18
% Met	30%	89%	20%	N/A	74%	40%	62%	79%	50%	80%	10%	90%

APPENDIX G.

By: Maria Laurence

And

Donald Fletcher

Comments on Delmarva Foundation
Quality Service Review Process

On February 28, 2018, the Commonwealth requested that the Independent Reviewer's Office provide comments on documents describing revisions to the process that Delmarva Foundation uses to conduct quality service reviews (QSRs). Delmarva, working with the Department of Behavioral Health and Developmental Services (DBHDS), designed these revisions to respond, at least in part, to the Independent Reviewer's Consultant's comments about the QSR process for his December 2017 report.

Below are standards that the Independent Reviewer has previously reported to the Court as areas of needed improvement. These standards can be utilized as the basis for review of revisions to Virginia's QSR plans and processes:
Basis for Review:

Definition of Standards/Terms - The standards in audit tools should be well defined to clearly articulate expectations for providers and to ensure inter - rater reliability. If specific licensing regulations or DBHDS policies drive the expectations, then they should be cited. If not, then, clear standards should be set forth.

Definition of Methodology - The audit tools should consistently identify the methodology that auditors would use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation).

Criteria for Compliance - The audit tools should explain how standards for fulfilling requirements, such as "met" or "not met", will be determined.

Auditor Qualifications - Auditors who assess clinically driven indicators (i.e. behavior support plans, adequate nursing care, sufficient medical supports, etc.) must be qualified to make such determinations.

Components - The audit tools, particularly for clinical services, should comprehensively address services and supports to meet individuals' needs. These should include indicators to assess the quality of both clinical assessments and service provision.

The Independent Reviewer's Office offers the following comments and questions on the documents DBHDS submitted:

Delmarva Foundation: Virginia Quality Service Reviews
This document provides a helpful overview of the process. One question for clarification:

- On page 3, in describing the Individual and Family Interview, the document indicates that The Partnership conducts these interviews. However, on page 4, under Onsite Review Activities, the document states: "The onsite activity starts with the interview with the person and legal representative." Is this another interview, or does this refer back to the Partnership's interview(s)? If it is more than one, which interview tool(s) will be used for each of these interviews?

KPA 2b - Health Needs Assessed and Met Final Draft 2-2018

Overall, this document (hereinafter, audit tool) shows that Delmarva and DBHDS made good progress revising the QSR audit tools. To ensure that the results of the QSRs are valid and reliable, however, further work is needed. The following comments are offered:

- Definition of Standards/Terms – Delmarva and DBHDS made progress in defining standard/terms. In particular, the columns that provide the Guiding Questions and Criteria are helpful in defining the standards that Quality Assurance Reviewers (QARs) will use. Work is still needed, however, to address inconsistencies or areas that require interpretation. For example:
    - In defining preventative care, the document references https://healthfinder.gov/myhealthfinder/. Based on the Consultant's review of this website, it requires interpretation (e.g., family history of certain diseases requires different screening than if no family history exists), and at times, the website says consultation with an MD is needed.
    - The audit tool includes a column entitled "Rationale for Indicator." Within this column, notations include: "DBHDS Standard," or "Quality Outcome." If a specific DBHDS licensing, policy or other standard exists that requires providers or Community Service Boards (CSBs) to meet an indicator, it would be helpful to cite the standard. It is unclear whether "Quality Outcomes" are defined elsewhere, or whether the QSRs are introducing them.
    - A number of indicators use the term "assesses" (e.g., Support Coordinator Interview Indicator #1: "Support Coordinator assesses the person's current physical, mental and behavioral health," Provider Interview Indicator #2: "Staff assesses person's health ongoing"). Given that the overall topic of the audit tool is healthcare, the term "assessment" has a specific connotation. In the provision of healthcare services staff who complete assessments must be qualified to complete such requisite analysis and to make subsequent judgements. In reviewing the Guiding Questions and Criteria for these indicators, it appears that the terms "monitor," "track," or "review" might be more accurate.
    - Outcome #2 in the Provider Record Review reads: "The provider addresses any untreated pain or health concerns within 24 hours of identification." Consideration should be given to adding "or sooner, depending on the severity or potential for harm."
    - Outcome #5 in the Provider Record Review section reads: "Provider determines whether the person has received a comprehensive medical exam in the last 12 months." "Comprehensive" is not defined, nor is the methodology for determining the answer to the question. Does the question mean an annual physical only? Does it include preventative testing/screening, which is referenced elsewhere?
    - The standard for breast cancer screening included in the audit tool is different than that included in the Health Questionnaire (i.e., annual screening beginning at age 50 versus age 40, respectively).

- Definition of Methodology – Again, the audit tool shows good improvement in defining how QARs will obtain the needed information to evaluate the various indicators. For example, in addition to identifying information that the QARs will obtain through interview versus various types of document reviews, the audit tool also often points the

QARs to specific documents, such as case notes, ISPs, medical assessments, etc. Substantive aspects of the methodology, however, remain undefined. For example:

- For the individual interview, the instructions do not define who can act as a proxy if an individual is not able to provide responses to the questions. The instructions do not state that it is important for a proxy to be someone who knows the individual well and who is objective. It is important for the reliability of the information provided that the proxy does not have a vested interest in the answer because of conflicts of interest. Individuals who have participated in the development or implementation of the plan or services are likely to have a substantive positive bias. For example:
  - Could/should the Service Coordinator or a staff member from a provider agency act as a proxy?
  - Will information collected through proxy be used in the same way as information obtained directly from individuals? For example, if an individual cannot communicate pain or not feeling well, how would the proxy accurately answer the first indicator? If reports Delmarva produces aggregate information from interviews that occur with individuals as well as those that proxies completed, then this distinction might be lost.
- For the provider staff interview, it is unclear who will be interviewed. Will more than one staff member participate in the interview? Are some of the questions designed to test certain staff's knowledge or activity? For example, a provider nurse or health care coordinator might provide a different response than a direct support professional for the Guiding Questions related to the following indicator: Staff is aware of the person's current health related issues or concerns. If for some reviews a nurse is interviewed and for others a direct support professional is interviewed, this practice could skew the results. Depending on what the indicator is designed to measure, it might be necessary to define which staff the QARs will interview for each indicator.
- Whenever possible, the audit tool should cite the source of information the auditor will use to determine an individual's needs. In the revised audit tool, the sources of information are often identified, but not always. For example, Indicator #7 of the Provider Record Reviews reads: "The provider assists person to access care from medical specialists when applicable, e.g., Psychiatry, Neurology, Endocrinology." Particularly if Delmarva plans to use generalists as opposed to auditors with medical expertise to assess this indicator, it would be helpful to cite where the auditor should identify the individual's needs for consultations (e.g., ISP, annual medical assessment, previous consultations, etc.).

- Criteria for Compliance – It is positive to see that for each indicator, the audit tool identifies "Criteria," and instructs the QARs to check all that apply. In calculating the "Yes" or "No" score, the audit tool further instructs the QARs: "If one or more of the criteria are checked, the indicator is scored as 'No.' If none of the criteria are checked, the score is 'Yes.'" The criteria for positive scores, however, remain unclear in certain instances. For example:
  - It remains unclear what formulas Delmarva will use to calculate scores for some indicators, and/or how it will use the information gathered. For example:
    - The following provides one of many examples in which it is unclear how Delmarva will reconcile information gathered. Within the Individual Interview section, Indicator #3 reads: "Person indicates seeing primary

care physician at least annually or when needed." Indicator #4 in the Provider Interview states: "Staff determines whether the person has received a comprehensive medical exam in the last 12 months." The Provider Record Review includes Indicator #5: "Provider determines whether the person has received a comprehensive medical exam in the last 12 months." Will Delmarva combine the information gathered from these various indicators to determine whether the individual had an annual primary care visit/comprehensive medical exam? If for example, the individual says he/she did not, but other documentation indicates he/she did, how will Delmarva reflect that in the findings? In other words, for information that Delmarva can objectively verify, how will Delmarva reconcile potentially conflicting information?

- Sometimes, different sections of the tool repeat indicators, and it is unclear how Delmarva will use the information to draw conclusions. The following provide a couple of examples where identical indicators are included in multiple sections of the tool (e.g., individual interview, provider staff interview, record review): "The person has received education and information related to health care assessments or services," and "Person receives care from health specialists when applicable, e.g., Psychiatry, Neurology, Endocrinology, Behavioral Supports."
    - Often, for these indicators, documentation would likely be necessary to confirm information obtained through interview. For example, in following up on preventative care, a staff person might be able to answer the question: "what do you do if the person is not receiving preventative healthcare as warranted?" However, is the expectation that staff would complete documentation to show what action the staff member took? If so, in thinking about findings that will end up in reports, the indicator from the provider interview section, should not then be reported separately from the indicator in the Provider Document Review section. It is important in the audit tool to make these connections.
    -

- Sometimes the items in the Criteria column do not appear to be valid measures of the stated indicator. For example:
    - Indicator #1 in the Support Coordinator Record Review implies that the Support Coordinator conducts a quality assessment: "Support Coordinator assesses the person's physical, mental and behavioral health." However, even if none of the boxes in the criteria column were checked, the Support Coordinator might not have done a thorough review, and identified concerns, if any. Further, it is unclear if the Support Coordinator is expected to document, report, and convene the ISP team to address it (i.e. as required by the Agreement) when problems and discrepancies are identified.
    - Indicator #3 in the Support Coordinator Record Review states: "Support Coordinator determines if the person receives care from needed medical specialists when applicable, e.g. Psychiatry, Neurology, Endocrinology. (Note: this is based upon best practice)." The Score Guide and Criteria columns indicate the monthly progress notes and quarterly reviews should

show the Service Coordinator is "determining whether the person is receiving services from medical specialists when necessary," and then sites a website that provides very general advice about specialists. Without clinical training, it would seem to be outside of the Support Coordinators scope of expertise to "determine" what specialty care that an individual needs. A valid indicator might be: Support Coordinator confirms that the identification of risks and that individual attends medical specialty assessments that the PCP orders/recommend s and/or that the ISP requires.

- Indicator #3 in the Provider Interview states: "Staff addresses person's health concerns." The wording of this indicator makes it sound as if the staff member is taking the identified/necessary steps to meet the individual's health needs. However, the guiding questions are more about following up on issues the individual raises about his/her health. It should be reworded to reflect the latter. For example: When the individual expresses a new health issue, staff report, document and take action to assist the individual in resolving it.

- The audit tool does not always appear to require quality for indicators to meet criteria. For example:
  - Indicator 2 in the ISP Checklist reads: "There is a plan/protocol in the ISP developed to monitor each identified risk." The indicator, the Score Guide, and/or the Criteria do not require a quality plan(s), or define the required elements of an adequate plan, but rather only the presence of a plan(s).
  - Indicator #1 in the Provider Record Review reads: "The provider consistently assesses for any potential health issues/concerns." This is a broad statement. In addition, although the standard articulated in the Criteria column is "at least monthly," this provides auditors with a lot of subjectivity with which to judge the quality of the provider's performance. One option would be for auditors to use the ISP as the roadmap for whether or not providers are meeting individuals' needs.
    - Indicator #9 in the Provider Record Review reads: "Provider ensures risk protocols are in place and tracked, if needed." It seems this indicator is a precursor to Indicator #1. It seems to evaluate whether the provider has a system in place to monitor itself monthly to determine whether the plans were implemented.
  - Indicator #5 and #6 in the Provider Record Review section relate to the provider "determining" whether the individual had annual medical and dental exams. The overall outcome the tool intends to measure is whether "Individuals health needs are assessed and met." Although these indicators might be meant to measure specific requirements for provider within, for example, regulations, the quality measure (i.e., what it would be important for the Commonwealth to know) is whether or not individuals have had annual physical and dental exams. In addition to measuring how many individuals have had annual exams, the quality of the provider's role might better be measured with an indicator that reads, for example: As defined in the individual's ISP, the provider offers the individual with needed assistance to complete an annual medical exam.

- Sometimes, the level of required adherence to the standards is not clear. For example:
  - It is sometimes not clear if all or some percentage of correct response is necessary to meet the criterion. As one example of several, for Indicator #1 in the Provider Interview section (i.e., "Staff is aware of the person's current health related issues or concerns"), one of the criteria for not meeting the indicator is "Staff is not aware of the person's current diagnoses." As discussed elsewhere, it is not clear if the QAR will use information gained from interview with the nurse or direct support professional staff to score this indicator. To this point, though, it is not clear if staff are expected to list all diagnoses or some percentage, and/or if the staff are allowed to use references to answer such questions.
  - Indicator #7 in the Provider Record Review provides another example in which a QAR might need to assess multiple occurrences, but it is not clear whether 100% adherence to the requirement is necessary or not. Indicator #7 reads: "The provider assists person to access care from medical specialists when applicable, e.g., Psychiatry, Neurology, Endocrinology." So, for example, if the Individual needed to see 10 specialists, and the provider assisted them with nine out of 10, how should the auditor score this indicator? How will Delmarva interpret these results in the report?
- Sometimes, indicators include measurement of more than one item, which has the potential to confound the validity of the results. For example:
  - Indicator #2 in the Provider Record Review reads: "The provider addresses any untreated pain or health concerns within 24 hours of identification." Criteria for this indicator include identifying the issue, attending to it, and ensuring it is resolved. It seems resolution, at least, should be pulled out from identifying and taking immediate or timely action. Possible wording for the indicators might be: 1) When the individual experienced new onset pain or a change in healthcare status, the provider took action within 24 hours, or sooner depending on severity; and 2) When the individual experienced new onset pain or a change in healthcare status, the provider sought healthcare supports through to resolution of the issue.
  - The Policy and Procedure Review section includes a few indicators that measure multiple activities. In order to provide enough information to identify where strengths and weakness lie throughout the system, it would be helpful to break these indicators into a number of sub-indictors. Examples of this problem include Indicator #2: "Provider has a written risk management plan to identify and describe risk," and Indicator #3: "Provider has a written corrective or quality improvement plans [sic] that addresses the risk and these actions are monitored to assess the impact of on the identified risks."

- Missing Components – Based on review of the audit tool, it appears Delmarva and DBHDS are defining "healthcare" broadly to include medical, nursing, psychological/behavioral, psychiatric, and allied health (e.g., Occupational and Physical Therapy). If this is the case, Delmarva should add several components to address these various areas in full. For example:
  - Consideration should be given to expanding the ISP Checklist. For example:

        - To measure one topic at a time, split out medical from behavioral health in Indicator #1.
        - Is there an expectation that the IDT meets and modifies the ISP when an individual's healthcare needs change? If so, an indicator should be added to measure whether this occurs.
    - The audit tool references, at times, various types of health care (e.g., behavioral health, allied health). If the tool is expected to cover the wide variety of topics covered under the overall topic of healthcare, then more indicators should be added to measure specific aspects of health care, such as:
        - Nursing supports, such as nursing assessments (annual/quarterly, as well as on an ongoing basis to address chronic and at-risk conditions), care plans, implementation of care plans, role in responding to acute issues, etc.
        - Dental supports, such as specialty dental care (e.g., periodontist, care using sedation), follow-up beyond annual dental exams, such as restorations, extractions, etc.
        - Behavioral health services, such as BCBA or behavioral health services staff's development and modifications of behavioral support plans, training of direct support staff, monitoring and summary of data, etc.
        - Psychiatric Services, such as provider's provision of data on psychiatric symptoms, side effects, etc.
        - Allied Health Services (PT, OT, SLP), such as development of physical and nutritional management plans, monitoring of staff's implementation of plans, monitoring of adaptive equipment, etc.
    - For individuals with intellectual and developmental disabilities, in addition to assisting in making appointments and providing transportation, an important role that providers frequently play is attending medical and other health care appointments with individuals, and/or providing written or verbal information to health professionals. Such information includes, but is not limited to history, current signs and symptoms of illness, data (e.g., intake and output, vital signs, behavioral data for psychiatry appointments, pain scale data), side effect monitoring information, etc. The audit tool does not appear to measure this role(s). If this is what is meant when some of the indicators reference "assisting" individuals to access healthcare, it is not clear from the indicators, score guide, or criteria. Consideration should be given to adding indicators to evaluate the various roles providers play in the healthcare process.
    - Additional indicators that Delmarva/DBHDS should consider include:
        - Provider records show that direct support professionals assigned to the individual successfully complete competency-based training on the individual's health needs.
        - Provider records show that direct support professionals assigned to the individual successfully complete competency-based training on the individual's health protocols.
        - Provider records show that direct support professionals assigned to the individual successfully complete competency-based training on identifying changes in health status.
        - Direct support professional staff articulates assigned steps in health protocols.

        - Direct support professional staff articulates requirements of behavior support plans.
        - Direct support professional staff articulates relevant medication side effects.
- Definition of Auditor Qualifications – The addition of a nurse to the process should be helpful. As discussed in further detail below, however, it is unclear whether one nurse is sufficient to meet the Commonwealth's needs. In addition, some indicators require expertise that goes beyond that of a generalist or a nurse. For example:
    - The Policy and Procedure Review section includes the following indicators: Indicator #2: "Provider has a written risk management plan to identify and describe risk," and Indicator #3: "Provider has a written corrective or quality improvement plans [sic] that addresses the risk and these actions are monitored to assess the impact of on the identified risks." Auditors assessing these indicators should have sufficient expertise in risk management and quality improvement, and should have a strong understanding of the expectations of the Settlement Agreement requirements for these areas, as well as DBHDS' related policy and procedures. Given the Independent Reviewer's Office's experience, it will be essential for such a review to be critical and thorough with specific (and often extensive) feedback provided to Community Service Boards (CSBs) and providers.

In summary, the QSR audit tool is not sufficient to gather valid and reliable information to measure the outcome: health needs are assessed and met. Although this draft shows good progress, additional work is needed to define standards/terms, clarify some of the methodology, strengthen criteria for compliance, add content, and ensure auditor qualifications/cl roles.

<u>VA QSR Health Questionnaire 2-22-18 Final</u>

- Overall, the questionnaire does not explain how the Nurse Reviewer will make "General Findings Based Upon Clinical Assessment" that the last page of the questionnaire references. For example:
    - It is unclear whether, in addition to completing the questionnaire, QARs also will collect documentation to facilitate the Nurse Reviewer's review. If so, what information will Delmarva collect on a standard or as-needed basis (e.g., medical assessments, consultation summaries, Emergency Room and hospital discharge information, medication orders with dosages, etc.).
    - Will the Nurse Reviewer use another audit tool and assess specific measurable indicators?
    - Will the Nurse Reviewer interview provider nursing staff routinely or when certain criteria are met (e.g., individual has experienced one or more of the "big seven," individual has been hospitalized more than once in a 12-month period, etc.)?
- Although it will be important for the Independent Reviewer's nurse consultants to review the content of the audit tool and questionnaire, the following concerns exist with the content:
    - The first question reads: "Health concerns were identified by the person, family or provider during the review." It then references four indicators in the Health Needs Assessed and Met audit tool. The third and fourth bullet do not seem to correlate with the question.
    - For Question #15, medication variances should include wrong texture/form.
    - For Question #16, which is related to preventative health screening:

        - The age for women to receive mammograms is different from what is included in the audit tool.
        - Colorectal cancer screening is identified as needed annually, which is different from the website the audit tool cites.
        - The Reason for Response column does not appear to provide an exhaustive list of immunizations (e.g., Hepatitis B, varicella).
    - Question #17 reads: "Has the person had any of the following within the last 12 months: unplanned weight gain of 10 or more lbs.; unplanned weight loss of 10 or more lbs.; two (2) or more falls; problems with skin breakdown?"
        - Often, when identifying triggers for weight loss or gain, percentages are used versus numbers of pounds to account for the differences in the potential severity of weight loss/gain in individuals across the weight range.
        - It is unclear why this question only addresses three risk areas, or how the Nurse Reviewer will use this information. For example, other high-risk health issues might include: choking, swallowing issues, aspiration pneumonia, multiple vomiting episodes, fractures, ileus, bowel obstructions, medication side effects, infections, etc.
- A number of the indicators require the QARs to make judgements that appear to exceed the scope of knowledge/expertise of most generalists. For example:
    - Question #3 reads: "Based upon the person's diagnoses or health complaints, has the person seen physicians and specialists within the past 12 months? (Select all that apply)." Although the questionnaire provides examples of why an individual might need to see certain specialists, this list is certainly not exhaustive. In fact, it overreaches in some cases (e.g., not all individuals with high blood pressure see a cardiologist) and leaves out some important criteria (e.g., individuals with histories of cancer often continue to see oncologists, not just individual with a current cancer diagnosis).
    - The Scoring Guide for Question #4 requires the QAR to assess the need for, presence/quality of behavior supports, as well as the data collection, analysis, and monitoring of the plan. As indicated in the Consultant's last report, psychologists/BCBAs should participate in the audit tool development as well as the auditing of behavioral supports.
    - Given that they need to assess medication administration/variances, are the QARs medication aide certified? In addition, the audit tool does not include indicators related to medication administration. So, it is unclear how/when QARs would gather this information for the questionnaire.
    - Question #21 reads: "Does the person have a need for any therapies or assessments not currently being rendered?" Will the Nurse Reviewer conduct any independent review to answer this question?
    - Question #22 reads: "The person's adaptive equipment is in good working condition." One of the questions that the QAR needs to answer is whether the adaptive equipment is the proper fit for the individual. Particularly for individuals with complex physical and nutritional management needs, an OT or PT should answer this question.
    - Similarly, the following question is outside of the scope of a generalist: "Does the person need any special supports or equipment not currently available to assist in mobility, drinking liquids or eating food or communication? Again, an OT, PT, or Speech therapist would need to answer this question.

Delmarva Foundation Proposal to Virginia DBHDS Inclusion of Clinical Components in the PCR Process

Although it is a step in the right direction to include a nurse in the process, the Consultant has the following concerns:

- The proposal discusses "a Registered Nurse" as the Nurse Reviewer. It is unclear whether Delmarva is proposing the use of a single nurse, and if so, whether the Clinical Review described would apply to all 400 individual reviews.
- What role would the Nurse Consultant play in the 50 provider reviews? For example, review of policies, etc.?
- It is outside of a nurse's scope of practice to assess behavioral supports. The document does not clarify the relationship between the Nurse Reviewer and the consulting Behavior Analyst.
- Not all nurses with experience with individuals with intellectual disabilities have expertise with physical and nutritional management supports. For many individuals in the Virginia system, this is a key component (or should be) of the supports in place to keep them safe and healthy. How does Delmarva anticipate addressing these needs?
- It remains unclear whether or not desk audits will suffice, particularly for individuals with complex medical needs.

In summary, Delmarva has not set forth a process for the review of the broad topic of "healthcare" that addresses the Settlement Agreement requirements. As noted in the Consultant's last report, the Settlement Agreement specifically requires the staff conducting the QSRs to "interview professional staff," to "review treatment records," and "to evaluate whether the individual's needs have been met." The most recently submitted audit tool and questionnaire require QARs to make a number of judgements about individuals' healthcare and clinical services, and the Settlement Agreement requires that these staff be "adequately trained" to make these judgments. Based on the documents provided, the Nurse Reviewer's role in reviewing treatment records, interviewing professional staff, and evaluating whether individuals' needs have been met remains unclear. In addition, it is concerning that Delmarva would expect a QAR or a nurse to assess behavioral health supports, as well as therapeutic supports and assistive/adaptive equipment.

Finally, it was not possible to assess, and therefore to determine, the reliability and validity of the data gathered or the effectiveness of the aspects of the proposed QSR process when fully implemented. Significant questions remain regarding how the provided documents fit into a planned overall approach to achieving a sufficient QSR system.

APPENDIX H.

LIST OF ACRONYMS

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

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