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, 2019 – March 31, 2020

Respectfully Submitted By

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Independent Reviewer
June 6, 2020

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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's sixteenth Report on the status of compliance with the provisions of the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress and compliance during the sixteenth review period from October 1, 2019 – March 31, 2020.

During this period, the Commonwealth accomplished an important milestone. It transitioned the last remaining individuals with Intellectual and Developmental Disabilities (IDD) who were living at the Central Virginia Training Center (CVTC). This fulfilled the Commonwealth's goal to cease residential operations at four of Virginia's five Training Centers, and was done before the deadline and earlier than projected.

The Commonwealth has had a long-standing policy to transition individuals with IDD from an institutional model of care to a comprehensive community-based service system. Beginning in Fiscal Year 2012, the Commonwealth implemented a wide range of new discharge and transition planning policies, procedures and operational systems to facilitate the transition of most of the remaining residents of Virginia's Training Centers. During the following years, these efforts brought the Commonwealth into sustained compliance with the Agreement's Section IV regarding Discharge and Transition Planning provisions. The Commonwealth maintained a well-organized, executed, and documented discharge and transition planning system through the sixteenth review period, and will continue these policies and processes at the one remaining facility still open, the South Eastern Virginia Training Center (SEVTC).

These accomplishments did not result in new ratings of compliance during this review period, because the Commonwealth had achieved compliance previously.

Other improvements were found in Virginia's community-based service system for individuals with IDD. There appears to be a slow but steady trend toward fewer individuals on waivers living in congregate settings of five or more, with more living in smaller settings of four or fewer individuals. The Individual Services Reviews (ISRs) continue to document positive health care outcomes for more than nine of every ten individuals studied. The Department of Behavioral Health and Developmental Services (DBHDS) has retained a new contractor, who has committed to complete Quality Service Reviews (QSRs) with a more expeditious approach, and with the intention to correct problems that undermined the reliability of previous QSR findings.

During the fifteenth and sixteenth review periods, the Parties completed negotiations of compliance indicators for all the Agreement's provisions with which the Commonwealth has not yet achieved compliance. Agreeing to these indicators represents a critical flection point in the implementation of the Agreement. The Court had asked the Parties to state in "precise measurable terms what the Commonwealth must do to comply with each remaining provision" in noncompliance. The Parties have now done so. At last, precise measures will direct the work of the managers of DBHDS, the Department of Medical Assistance Services (DMAS) and their sister agencies.

Establishing a comprehensive set of compliance indicators is an essential precursor to achieving compliance. Now the Commonwealth's managers know what documentation does and does not need to be gathered and maintained to demonstrate compliance. Yet, completing this vital step presents a duality. It will certainly be easier for Virginia's managers to accomplish requirements that are stated in measurable terms. However, these managers now have many more specific requirements about which documentation must be collected regarding each new measure. Managers will no longer wonder, and the Parties will no longer debate whether terms such as "increase," "most," and "improved" require a lot or not much change. The multitude of indicators to which the Parties finally agreed in April 2019 and January 2020 require the Commonwealth to modify and create many additional initiatives to document the achievement of compliance indicators.

An additional challenge is that the remaining provisions of the Agreement are those with which the Commonwealth had the most difficulty achieving compliance during the first eight years of the Agreement. In the previous (fifteenth) Report, the Independent Reviewer listed six systemic obstacles as the primary reasons for the Commonwealth's lack of progress. These systemic problems persist, and must be resolved:

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

In addition, the Coronavirus is understandably likely to delay the implementation of various Commonwealth initiatives to come into compliance, especially in the quality and risk management system. The Commonwealth has taken prudent actions to mitigate the spread of COVID-19 among the vulnerable IDD population and the private and public staff who support these individuals, by temporarily suspending current and planned onsite activities. Due to the appropriateness of taking this step, the Independent Reviewer is not removing a previously awarded rating of compliance.

However, the Independent Reviewer is not awarding a new rating of compliance until the Commonwealth demonstrates and documents achievement of previously noncompliant provisions and their associated indicators, even if some of the required activities have had to be temporarily and appropriately suspended.

Where the Agreement's provisions specify that they occur, onsite visits with their face-to-face assessments function as the hub of the required quality and risk management processes. Together, these assessments and evaluations ensure that supports and services for individuals are adequate and appropriate, and that if concerns are identified, needed remedies are undertaken. Essential assessment and evaluation information is gained from on-site interviews with staff or family caregivers, and also from observations of the individual, of supports being provided, of environmental factors and of the availability and functioning of adaptive equipment. Without this essential on-site information, the core of these quality and risk management processes cannot function effectively, nor meet the requirements of the applicable provisions and associated indicators.

During the sixteenth period, the Commonwealth made considerable efforts, progressed in some areas, and provided documentation that showed achievement across many compliance indicators. Descriptions of this important progress can be found in the Compliance Findings section and in the various independent consultants' reports in the Appendices. The Independent Reviewer has not verified all the facts in the Commonwealth's reports, but has made a determination regarding the Commonwealth's status and progress in developing reports this period that align with the new compliance indicators. Since the Commonwealth did not report that it met all the compliance indicators for any one of the noncompliant provisions, new compliance was not achieved.

Despite this, the Independent Reviewer would like to acknowledge and praise the concerted team efforts made by the Commonwealth thus far. Achieving compliance, given all the indicators for just a single provision, is often an enormous undertaking: one that requires the Commonwealth to address and resolve many challenges, frequently including one or more of the six systemic obstacles listed above.

In turn, meeting the indicators requires many steps that must first be developed and initiated, followed by collecting and documenting reliable and valid data regarding the extent to which new work processes lead to desired change. The improvements needed to document progress require creating new or modifying existing authorizations, regulations, policies, procedures and protocols, as well as effectively implementing associated training, technical assistance, data gathering and reporting. In addition, achieving some indicators involves completing phased cycles of sequential activities. For example, QSRs and QIPs involve a sequence of four phases (i.e., Plan – Do – Study – Act) during which objectives are defined, the plan is carried out and data are collected, data are analyzed and the needed corrective actions or quality improvement initiatives are identified, and those prioritized for the next cycle are implemented.

The Commissioner of DBHDS recognizes the considerable management challenge facing the Commonwealth that this work involves. In March 2020, DBHDS engaged project management consultants to help complete an assessment of the impact and complexity of the 328 indicators for provisions not yet in compliance. The assessment was subsequently completed, and DBHDS then implemented new project management processes with focused work plans, due to be completed in April 2020.

During this sixteenth period, the Independent Reviewer and consultants have reported on the status of the Commonwealth's documentation, in relation to each of the indicators for the provisions studied. After the eighteenth review period (i.e., by March 31, 2021), the Independent Reviewer plans to report on the status of Virginia's meeting the relevant indicators and compliance with these same provisions. This assumes that the necessary documentation will be in place.

Meanwhile, for the seventeenth review period, in order to demonstrate progress toward meeting the indicators, the Commonwealth must begin collecting performance data by July 1, 2020, in the following areas that the Independent Reviewer has prioritized for study:

- Serving Individuals with Intense Behavioral Needs
- Case Management Face-to-Face Assessments
- Integrated Day Activities and Supported Employment
- Regional Support Teams
- Transportation
- Investigations: Office of Licensing/Office of Human Rights
- Licensing Process: Assessments of Adequacy
- Quality and Risk Management
- Mortality Review
- Provider Training
- Quality Service Reviews

The Independent Reviewer will adjust the scope of these studies, depending on COVID-related temporary suspensions.

Throughout the sixteenth period, the Commonwealth's staff have been accessible, forthright and responsive. Attorneys from DOJ gathered information that has helped to accomplish ongoing effective implementation of the Agreement; they have worked collaboratively with the Commonwealth in negotiating and finalizing compliance indicators for the provisions. Overall, the willingness of both Parties to openly and regularly discuss implementation issues and any concerns about progress towards shared goals has been critical and productive. The involvement and contributions of the advocates and other stakeholders have helped the Commonwealth make measurable progress.

The Independent Reviewer greatly appreciates the assistance that was so generously given by the individuals at the heart of this Agreement and their families, their case managers and their service providers.

II. SUMMARY OF COMPLIANCE

Settlement Agreement Reference	Provision	Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	**Compliance ratings for the eleventh, twelfth, thirteenth, fourteenth, fifteenth, and sixteenth periods are presented as:** 11th period 12th period (13TH period) *14th period* 15th period **16th period**	**Comments include example(s) to explain the ratings and status. The Findings Section and attached consultant reports include additional explanatory information re: indicators of compliance.** ***The Comments in italics below are from a prior period when the most recent compliance rating was determined.***
III.C.1.a.i.-ix.	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 … ix. In State Fiscal Year 2020 35 waiver slots	Compliance *Compliance* **Compliance**	The Commonwealth created sixty Community Living waiver slots during FY 2020, twenty-five more than the minimum number required for individuals to transition from Training Centers.
III.C.1.b.i.-ix.	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) … ix. In State Fiscal Year 2020, 355 waiver slots.	Non Compliance *Compliance* **Compliance**	The Commonwealth created 1017 new waiver slots in FY 2020 exceeding the total required for the former ID and IFDDS slots. The Parties agreed to consider the effectiveness of the discharge and transition process at NFs and ICFs as an indicator of compliance for III.D.1.

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III.C.1.c.i.-ix.	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) … ix. In State Fiscal Year 2020, 50 waiver slots"	Non Compliance *Compliance* **Compliance**	See Comment re: III.C.1.b.i-ix
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 2020 a minimum of 1000 individuals will be supported.	Non Compliance *Non Compliance* **Non Compliance**	The Commonwealth continues to meet the quantitative requirement by providing financial support to more than 3,028 individuals through the first three quarters of Fiscal Year 2020, but has not fulfilled or documented achieving the IFSP compliance indicators.
III.C.5.a.	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	(Compliance) *Compliance* **Compliance**	153 (100%) of the individuals reviewed in the individual services review studies during the tenth, eleventh, twelfth, thirteenth, fourteenth, fifteenth, and sixteenth periods had case managers and current Individual Support Plans.
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.i.	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	Non Compliance *Non Compliance* **Non Compliance**	The case management CM) study of thirty-five individuals found that the DBHDS initiatives have improved case management functioning. The Commonwealth has not provided sufficient data, analysis and documentation that aligns with the compliance indicators and demonstrates that the requirements and the indicator measures of the have been achieved.

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III.C.5.b.ii.	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	Non Compliance *Non Compliance* **Non Compliance**	See comment immediately above.
III.C.5.b.iii.	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	Non Compliance *Non Compliance* **Non Compliance**	See comment regarding III.C.5.b.i.
III.C.5.c.	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	(Non Compliance) *Compliance* Compliance **Compliance**	The Individual Services Review studies during the tenth, eleventh, twelfth, thirteenth, fifteenth and sixteenth periods found that case managers had offered choices of residential and day providers. DBHDS has implemented a Choice Form of all case managers are expected to use as part of the annual ISP meeting process.
III.C.5.d.	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	Non Compliance (Non Compliance) Non Compliance **Non Compliance**	The Commonwealth has not provided sufficient data, analysis and documentation that aligns with compliance indicators and cannot demonstrate that the indicator requirements and the measures have been achieved.

Settlement Agreement Reference	Provision	Rating	Comments
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 IDD.
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 CSB staff and staff during the past five years. The Commonwealth requires that all ES staff and case managers are required to attend training**.**
III.C.6.b.ii.A.	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	Non Compliance *Non Compliance* **Non Compliance**	The CSB-ES are not typically dispatching mobile crisis team members to respond to individuals at their homes. Instead the CSB-ES continues the pre-Agreement practice of meeting individuals in crisis at hospitals or at CSB offices. This practice prevents the provision of supports to de-escalate crises.
III.C.6.b.ii.B.	Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.	(Non Compliance) *Non Compliance* **Non Compliance**	See comment immediately above re: III.C.6.b.ii.A. During the fifteenth and sixteenth review period, REACH developed fewer Crisis Education and Prevention Plans, when compared with the substantial increase in individuals in crisis.

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III.C.6.b.ii.C.	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.	Compliance *Compliance* **Compliance**	During the fifteenth and sixteenth review periods law enforcement personnel were involved in 45 percent (1,899 of 4,001) of REACH crisis responses; an additional 828 received training by REACH.
III.C.6.b.ii.D.	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	Compliance *Compliance* **Compliance**	REACH Mobile crisis teams for children and adults are available around the clock and respond on-site at all hours of the day and night.
III.C.6.b.ii.E.	Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	(Compliance) *Compliance* **Compliance**	In each Region, the individuals provided in-home mobile supports received an average of three days of support. Days of support provided ranged between a low of one and a high of fifteen days.
III.C.6.b.ii.H.	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	(Compliance) *Compliance* **Compliance**	The Commonwealth did not create new teams. It added staff to the existing teams. REACH teams in all five Regions responded within the required average annual response times during the fourteenth review period.
III.C.6.b.iii.A.	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services	Compliance *Compliance* **Compliance**	All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults.
III.C.6.b.iii.B.	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	Non Compliance *Non Compliance* **Non Compliance**	For adults with IDD who are offered or admitted to the programs, crisis stabilization programs continue to be used as a last resort. Crisis stabilization programs, however, were not yet fully operational for children.

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III.C.6.b.iii.D.	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	Non Compliance *Non Compliance* **Non Compliance**	The Regions' crisis stabilization programs continue to routinely have stays that exceed 30 days, which are not allowed. Transitional and therapeutic homes have been developed but did not yet eliminate stays longer than 30 days.
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.
III.C.6.b.iii.G.	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	Non Compliance *Non Compliance* **Non Compliance**	The Commonwealth determined that it is not necessary to develop additional "crisis stabilization programs" for adults in each Region. It has decided to add two programs statewide to meet the crisis stabilization/transitional home needs of adults who require longer stays. Children's crisis stabilization programs are only partially operational.
III.C.7.a.	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	Non Compliance (Non Compliance) Non Compliance	*This is an overarching provision. Compliance will not be achieved until the component provisions of integrated day, including supported employment, are in compliance.*
III.C.7.b.	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The	Non Compliance (Non Compliance) Non Compliance	*The Qualitative Review study found that:* • *the discussions required by (3) had not occurred for 27 percent of eligible individuals studied.*

Settlement Agreement Reference	Provision	Rating	Comments
	Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in the ISP. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.		• *The ISP checked box, where the case manager self-reports that this discussion occurred, did not consistently indicate that a discussion, or an adequate discussion, had occurred. The data from the checked boxes were reported to DBHDS.* • *Other than the ISP checked boxes, the Individual Services Review study did not find case manager notes indicating that employment services and goals were developed and discussed.* *The Commonwealth did not have an employment service coordinator during the fifteenth review period.*
III.C.7.b.i.	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreation opportunities, and other integrated day activities.	Non Compliance (Compliance) Compliance	*The Commonwealth had previously developed plans for both supported employment and for integrated community activities. It has reviewed, revised and improved its implementation plans.*
III.C.7.b.i.A.	Provide regional training on the Employment First policy and strategies through the Commonwealth.	Compliance (Compliance) Compliance	*DBHDS continued to provide regional training.*

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 (Compliance) Compliance	*The Commonwealth has sustained its improved method of collecting data. For the third consecutive full year, data were reported by 100 percent of the employment service organizations. They continue to report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a, b, c, d, and e below.*
III.C.7.b.i. B.1.a.	The number of individuals who are receiving supported employment.	Compliance (Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.b.	The length of time individuals maintain employment in integrated work settings.	Compliance (Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.c.	Amount of earnings from supported employment;	Compliance (Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.d.	The number of individuals in pre-vocational services.	Compliance (Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.e.	The length-of-time individuals remain in pre-vocational services.	Compliance (Compliance) Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.2.a.	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	(Non Compliance) Non Compliance **Compliance**	The Parties agreed in January 2020 that this provision is in sustained compliance and that meeting these targets will be measured in III.D.1.
III.C.7.b.i. B.2.b.	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	Compliance (Compliance) Compliance	*Of the number of individuals who were employed in June 2018, 90 percent had retained their jobs twelve months later in June 2019, which exceeded the 85 percent target set in 2014.*

Settlement Agreement Reference	Provision	Rating	Comments
III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. … shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly … Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	Compliance (Compliance) Compliance	*The RQCs continue to meet each quarter, to consult with the DBHDS Employment staff, both members of the SELN (aka E1\AG), and to review progress toward targets. Continuing compliance will require evidence that the RQC's consult with providers.*
III.C.7.d.	The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.	Compliance (Compliance) Compliance	*In FY 2019, the five RQCs all reviewed employment data and targets.*
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	Non Compliance Non Compliance	*DMAS/Broker successfully implemented many improvements. The rate of complaints by users with IDD regarding late pickup and delivery are substantially higher than for individuals without disabilities and for the MCOs transportation. The transportation quality improvement program is not sufficient to identify and address this most significant issue/outcome for IDD users.*
III.C.8.b.	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access	Non Compliance *Non Compliance* **Non Compliance**	DBHDS has developed, launched, and provided activity reports re: "My Life, My Community" website with information and guidelines for families. It has not yet distributed the website resource to a list of organizations and entities with likely contact with individuals who may meet the criteria for the waiver waitlist and their families.

Settlement Agreement Reference	Provision	Rating	Comments
III.D.1.	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	Non Compliance *Non Compliance* **Non Compliance**	The Commonwealth has not provided sufficient data, analysis and documentation that aligns with compliance indicators and cannot demonstrate that the indicator requirements and the measures have been achieved. Infants with complex medical needs are being placed directly into a large institution without the family being offered an informed choice of alternative community-based options.
III.D.2.	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources.	Compliance *Compliance* **Compliance**	As of 12/31/19, the Commonwealth had created new options for 1034 individuals who are now living in their own homes. This is 691 more individuals than the 343 individuals who were living in their own homes as of 7/1/15. This accomplishment is 86% of its goal of 1,205 by 6/30/20.
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 has a dedicated housing service coordinator. It has developed and updated its housing plan with these representatives and with others.

Settlement Agreement Reference	Provision	Rating	Comments
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. It established the required baseline, updated and revised the Housing Plan with new strategies and recommendations, and tracks progress toward achieving plan goals.
III.D.4.	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing from a one-time fund of $800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii.	**Compliance and Completed**	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds received permanent rental assistance.
III.D.5.	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	Non Compliance *Non Compliance* **Non Compliance**	The Commonwealth has not provided sufficient data and documentation that aligns with compliance indicators and cannot demonstrate that the indicator requirements and the measures have been achieved.
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	*Although DBHDS has sustained and added substantive process improvements and Case Managers submitted a higher percent of RST referrals on-time, too many continue to be submitted late (after or concurrent with the individual's move), which nullifies the purpose of the RST review.*
III.D.7.	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home …	(Compliance) *Compliance* Compliance **Compliance**	The Commonwealth included this term in the performance contracts, developed and provided training to case managers and implemented an ISP form with education about less restrictive options.

Settlement Agreement Reference	Provision	Rating	Comments
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 (Compliance) Compliance	*DBHDS has sustained improved RST processes. When case managers submit timely referrals, CRCs and the RSTs continue to fulfill their roles and responsibilities and the Regional Support Teams frequently succeed at their core functions.*
III.E.3.a.-d.	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	Compliance (Compliance) Compliance	*DBHDS established the RSTs, which meet monthly. The CRCs continue to refer cases to the RSTs as required.*
IV.	**Discharge Planning and Transition**	**Compliance ratings for the twelfth and fourteenth periods are presented as:** 12th period *14th period* **16th period**	**Note: The Independent Reviewer gathered information about individuals who transitioned from Training Centers and rated compliance during the first, third, fifth, seventh, ninth, twelfth and fourteenth review periods.** ***The Comments in italics below are from the period when the compliance rating was determined.***
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	Compliance *Compliance* **Compliance**	The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It has continued to implement improvements in response to concerns identified.

Settlement Agreement Reference	Provision	Rating	Comments
IV.A.	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	Non Compliance *Non Compliance* **Non Compliance**	For the one area of noncompliance – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve to the measures of compliance for IV.A.
IV.B.3.	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	Compliance *Compliance* **Compliance**	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, 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* **Non Compliance**	For the one area of noncompliance – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve to the measures of compliance for IV.B.4.
IV.B.5.	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan will be developed within 30 days prior to discharge.	Compliance *Compliance* **Compliance**	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision and its sub provisions a.-e.i.i. The discharge plans are well documented.
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	Compliance *Compliance* **Compliance**	See comment re: IV.B.5.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	Compliance *Compliance* **Compliance**	See comment re: IV.B.5.
IV.B.5.c.	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	Compliance *Compliance* **Compliance**	See comment re: IV.B.5.
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	Compliance *Compliance* **Compliance**	See comment re: IV.B.5.
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	Compliance *Compliance* **Compliance**	See comment re: IV.B.5.
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	Compliance *Compliance* **Compliance**	See comment re: IV.B.5.
IV.B.5.e.ii.	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	Compliance *Compliance* **Compliance**	See comment re: IV.B.5.
IV.B.6.	Discharge planning will be done by the individual's PST…Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	Non Compliance *Non Compliance* **Non Compliance**	For the one area of noncompliance – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve to the measures of compliance for IV.B.6.
IV.B.7.	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	Compliance *Compliance* **Compliance**	The Commonwealth's discharge plans indicate that individuals with complex/intense needs can live in integrated settings. Documents reviewed indicate that this process remains in place.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.9.	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	Compliance *Compliance* **Compliance**	The Individual Services Review studies during the fifth, seventh, ninth, twelfth, and fourteenth review periods found that 124 (100%) of individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST. Documents reviewed indicate that this process remains in place.
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	Compliance *Compliance* **Compliance**	Discharge records included evidence that the Commonwealth had offered a choice of providers. Documents reviewed indicate that this process remains in place.
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* **Compliance**	The ninth, twelfth and fourteenth individual services reviews found that 39 of 45 individuals (86.7%) and their ARs did have an opportunity to speak with individuals currently living in their communities and their family members. Documents reviewed indicate that during the sixteenth period this process remains in place. All individuals/ARs received a packet of information with this offer.
IV.B.9.c.	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	Compliance *Compliance* **Compliance**	PSTs and case managers assisted individuals and their Authorized Representative. For 100 percent of the 72 individuals studied in the ninth, twelfth and fourteenth ISR studies, providers were identified and engaged; provider staff were trained in support plan protocols. Documents reviewed indicate that during the sixteenth period this process remains in place.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.11.	The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	Compliance *Compliance* **Compliance**	During the fifth, seventh, ninth, twelfth and fourteenth review periods, the reviews found that 116 of 124 individuals /Authorized Representatives (93.5%) who transitioned from Training Centers were provided with information regarding community options. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.B.11.a.	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	Compliance *Compliance* **Compliance**	The Independent Reviewer confirmed that training has been provided via regular orientation, monthly and ad hoc events with while SWVTC and CVTC remained open. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.B.11.b.	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches … will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	Compliance *Compliance* **Compliance**	The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training. All Training Centers had person-centered coaches. While SWVTC and CVTC remained open there were regularly scheduled opportunities to meet with mentors. Documents reviewed indicate that during the sixteenth period this process remains in place.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.15.	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	Compliance *Compliance* **Compliance**	See Comment for IV.D.3.
IV.C.1.	Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.	Compliance *Compliance* **Compliance**	The Independent Reviewer found that for the ninth, twelfth, and fourteenth ISR studies, residential staff for all 72 individuals participated in the pre-move ISP meeting and were trained in the support plan protocols. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.C.2.	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	Compliance *Compliance* **Compliance**	During the fifth, seventh, ninth, twelfth, and fourteenth periods, the Independent Reviewer found that 121 of 124 individuals (97.6%) had moved within 6 weeks, or reasons were documented. Documents reviewed indicate that during the sixteenth period this process remains in place.

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.3.	The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	Compliance *Compliance* **Compliance**	The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions. During the fifth, seventh, ninth, twelfth and fourteenth review periods, the ISR studies found that for 124 (100%) individuals, PMM visits occurred. The monitors had been trained and utilized monitoring checklists. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.C.4.	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	Compliance *Compliance* **Compliance**	The Individual Services Review studies during the ninth, twelfth and fourteenth review periods found that: For 71 of 72 individuals (98.6%), the Commonwealth updated discharge plans within 30 days prior to discharge. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.C.5.	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential. supports are in place at the individual's community placement prior to the individual's discharge.	Compliance *Compliance* **Compliance**	The Personal Support Teams (PSTs), including the Authorized Representative, had determined and documented, and the CSBs had verified, that essential supports to ensure successful community placement were in place prior to placement. Documents reviewed indicate that during the sixteenth period this process remains in place.

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.6.	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.	Compliance *Compliance* **Compliance**	The discharge records reviewed in the ninth, twelfth, and fourteenth review periods indicated that all twenty-six individuals (100%) who moved to settings of five or more did so based on their informed choice after receiving options. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.C.7.	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	Compliance *Compliance* **Compliance**	The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.D.1.	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	Compliance *Compliance* **Compliance**	Community Integration Managers (CIMs) worked at each Training Center, and similar to the other DBHDS discharge and transition planning policies and practices a CIM position is assigned to SEVTC. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.D.2.a.	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	Compliance *Compliance* **Compliance**	CIMs reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals. Documents reviewed indicate that during the sixteenth period this process remains in place.

Settlement Agreement Reference	Provision	Rating	Comments
IV.D.3.	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	Compliance *Compliance* **Compliance**	During the twelfth period, there were improvements in the timeliness of referrals to the RST, which is essential to allow sufficient time for the CIM and RST to resolve identified barriers. During the fourteenth period, the ISR study of individuals who moved from Training Centers, found that 11 of 12 (91.3%) were referred timely. Documents reviewed indicate that during the sixteenth period this process remains in place.
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	Compliance *Compliance* **Compliance**	The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.
V.	**Quality and Risk Management**	**Compliance ratings for the eleventh, twelfth, thirteenth, fourteenth, fifteenth, and sixteenth periods are presented as:** 11th period 12th period (13TH period) *14th period* 15th period **16th period**	***The Comments in italics below are from a prior period when the most recent compliance rating was determined.***
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	Non Compliance (Non Compliance) Non Compliance	*This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Quality section are determined to be in compliance.*

Settlement Agreement Reference	Provision	Rating	Comments
V.C.1.	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	Non Compliance (Non Compliance) Non Compliance	*The Commonwealth does not yet have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks.*
V.C.2.	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	Compliance (Compliance) Compliance	*DBHDS implemented a web-based incident reporting system. Providers report 89 percent of incidents within one day of the event. Some duplicate reports are submitted late.*
V.C.3.	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	Non Compliance (Compliance) Compliance	*DBHDS revised its regulations, increased the number of investigators and supervisors, added expert investigation training, created and Investigation Unit, includes double loop corrections in CAPs for immediate and sustainable change, and requires 45-day checks to confirm implementation of CAP s re: health and safety.*
V.C.4.	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	Non Compliance (Non Compliance) Compliance	*DBHDS has provided guidance and in-person training. The DBHDS regulations now require that licensed providers to use Root Cause Analysis in internal investigations for Level II and III incidents.*

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) Non Compliance	*A Mortality Review Committee (MRC) has significantly improved its data collection, data analysis, membership, and attendance with improved processes and quality of mortality reviews. It has begun a quality improvement program. The MRC completed only 44 percent of its reviews within 90-days during FY 19, but 91.8 percent during the final three months. The newly recruited member, who is independent of the State, attended only 4 of 17 (24%) of the MRC meetings.*
V.C.6.	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider.	Non Compliance (Non Compliance) Non Compliance	*DBHDS cannot consistently use available mechanisms to sanction providers, beyond use of Corrective Action Plans to require consistent provider compliance with minimum standards.*
V.D.1.	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	Non Compliance (Non Compliance) Non Compliance	*This is an overarching provision that requires effective quality improvement processes to be in place at the CSB and State level, including monitoring of participant health and safety.*

Settlement Agreement Reference	Provision	Rating	Comments
V.D.2.a.-d.	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement.	Non Compliance (Non Compliance) Non Compliance	*DBHDS quality and risk management system does not yet have consistently reliable and valid data throughout its system.*
V.D.3.a.-h.	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	Non Compliance (Non Compliance) Non Compliance	*DBHDS has not resolved significant challenges with the reliability and validity of the data still throughout the system.*
V.D.4.	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	Non Compliance (Non Compliance) Non Compliance	*This is an overarching provision. It will be not be rated in compliance until reliable data are provided from all the sources listed and cited by reference in V.C. and in V.E-G.*
V.D.5.	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	Non Compliance (Non Compliance) Non Compliance	*DBHDS shared and RQCs reviewed data including: employment, OLS, OHR, and other data. The RQCs, however, had limited and frequently unreliable data available for review. See comment re: V.D.5.b. below.*
V.D.5.a.	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	Compliance (Compliance) Compliance	*The five Regional Quality Councils include all the required members.*

Settlement Agreement Reference	Provision	Rating	Comments
V.D.5.b.	Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	Non Compliance (Non Compliance) Non Compliance	*The RQCs met quarterly, but had limited discussion. The RQC members do not have the training, tools or reliable and valid data to full the RQC role. The DBHDS Quality Improvement Committee directed the RQCs work.*
V.D.6.	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability … and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	Non Compliance (Non Compliance) Non Compliance	*DBHDS has not yet implemented its plans for public reporting .*
V.E.1.	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program including root cause analysis that is sufficient to identify and address significant issues.	Non Compliance (Non Compliance) Non Compliance	*The Commonwealth has approved new Regulations that require providers to have QI programs, and has issued guidance, including how DBHDS will monitor compliance. No reports were yet available regarding whether and to the extent providers have implemented QI programs.*
V.E.2.	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	Non Compliance (Non Compliance) Non Compliance	*The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS revised Licensing Regulations require providers to have risk management and QI programs, and Licensing has issued guidance. The Commonwealth has not reported the measures or the extent to which CSBs and providers are complying with risk management and QI reporting.*
V.E.3.	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	Non Compliance Non Compliance	*The Commonwealth has paused its QSRs until it completes an RFP process and selects a new vendor.*

Settlement Agreement Reference	Provision	Rating	Comments
V.F.1.	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	Compliance (Compliance) Compliance **Compliance**	The case management and the ISR study found compliance with the required frequency of 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* **Non Compliance**	The Commonwealth has not provided sufficient data, analysis and documentation that aligns with compliance indicators and cannot demonstrate that the indicator requirements and the measures have been achieved.
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, twelfth, fourteenth, and sixteenth ISR studies found that the case managers had completed the required monthly visits for 96 of 100 individuals (96.0%).
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 **Non Compliance**	The Commonwealth has not provided sufficient data, analysis and documentation that aligns with compliance indicators and cannot demonstrate that the indicator requirements and the measures have been achieved.

Settlement Agreement Reference	Provision	Rating	Comments
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**	The Commonwealth has not provided sufficient data, analysis and documentation that aligns with compliance indicators and cannot demonstrate that the indicator requirements and the measures have been achieved.
V.F.6.	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	Compliance	*The Commonwealth developed the curriculum with training modules that include the principles of self-determination. The modules are being updated.*
V.G.1.	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	Compliance (Compliance) Compliance	*OLS regularly conducts unannounced inspection of community providers.*
V.G.2.a.-f.	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Compliance (Compliance) Compliance	*OLS has maintained a licensing inspection process with more frequent inspections.*
V.G..3	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	Non Compliance (Non Compliance) Non Compliance	*The DBHDS licensing process has not yet incorporated protocols that include assessing the adequacy of the individualized supports and services provided.*

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) Non Compliance	*The Commonwealth developed and improved the statewide competency-based curriculum, and approved new waiver regulations that require DSP and supervisors in waiver-funded services to receive this training. It has not effectively monitored or enforced provider adherence to the requirement that all staff complete core-competency training.*
V.H.2.	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	Non Compliance (Non Compliance) Non Compliance	*Same as V.H.1 immediately above.*
V.I.1.a.-b.	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	Non Compliance (Non Compliance)	*As of 7/1/19, the Commonwealth has paused use of the QSRs. It has since issued an RFP with plans to revamp and renew the required annual QSR process once it selects a new vendor. The Independent Reviewer's annual review of the status of the Commonwealth's progress toward achieving the requirements of the QSR provisions was postponed because the Commonwealth acknowledged that it would not have a QSR provider under contract during the second half of the fifteenth review period.*
V.I.2.	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting .	Non Compliance (Non Compliance)	*Same as V.I.1. immediately above*
V.I.3.	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	Non Compliance (Non Compliance)	*Same as V.I.1. immediately above.*

Settlement Agreement Reference	Provision	Rating	Comments
V.I.4.	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	Compliance (Compliance)	*Same as V.I.1. immediately above.*
VI.	**Independent Reviewer**	**Rating**	**Comment**
VI.D.	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with the, … shared with Intervener's counsel.	*Compliance* Compliance **Compliance**	DBHDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.
IX.	**Implementation of the Agreement**	**Rating**	**Comment**
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 integrated day services and case management.

Notes: 1. The Independent Reviewer does not monitor services provided in the Training Centers. The following provisions are related to internal operations of Training Centers and were not monitored: *Sections III.C..9, IV.B.1., IV.B.2., IV.B.8., IV.B.1.2, 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

For this sixteenth review period, the Independent Reviewer prioritized the following areas to monitor the Commonwealth's compliance with the requirements of the Agreement:

- Creation of Waiver Slots;
- Individual and Family Support Services; Peer-to-Peer and Family Mentoring and Guidelines for Families;
- Case Management Services;
- Crisis Services;
- Services in Integrated Settings;
- Services for Individuals with Intense Behavioral Needs; and;
- Training Center Discharge and Transition Planning.

To analyze and assess the Commonwealth's performance across these areas, the Independent Reviewer retained ten independent consultants to assist in:

- 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;
- Interviewing individuals, families, provider staff, and stakeholders, and
- Determining the extent to which the Commonwealth maintains documentation that demonstrates that the Agreement's provisions and compliance indicators have been achieved.
- Placing the status of the Commonwealth's documentation into one of three categories:

    1. Documentation confirmed (i.e., report aligns with and shows achievement of the indicator);
    2. Pending with date (i.e., report aligns with the indicator, but additional progress or documentation to achieve it is expected by the date specified, and must be verified); or
    3. Pending (i.e., no report was provided that aligns with the indicator or substantiates progress).

The Independent Reviewer did not ask the consultants to complete independent reliability studies to verify the performance data in the Commonwealth's documentation. Such verification will occur during future studies, after the Commonwealth confirms the reliability of its data reports and completes associated inter-rater reliability studies.

For the sixteenth time, the Independent Reviewer utilized an ISR approach to evaluate the status of services for a randomly selected sample of individuals. Again, the size of the sample allows findings to generalize to the cohort with a ninety percent confidence factor. This period's ISR process, an Individual Services Retrospective Review (ISRR), involved a cohort of individuals who were part of a prior ISR study. This ISRR focused on services for individuals with intense behavioral needs. Its intention was to determine whether previous issues of concern identified and reported to the Commonwealth had subsequently been addressed. After carefully reviewing these findings, the Independent Reviewer has identified and reported themes, with findings ranging from positive outcomes to areas of concern.

To determine the ratings of compliance for the sixteenth period (October 1, 2019 through March 31, 2020), the Independent Reviewer considered information provided by the Commonwealth for the period prior to May 15, 2020. The Independent Reviewer also considered the findings and conclusions from the consultants' studies, the ISR study, the Commonwealth's planning and progress reports and documents, as well as other sources. The Independent Reviewer's compliance ratings are best understood by reviewing the comments in this Report's Summary of Compliance table, the Findings section, and the consultants' reports included in the Appendices.

For each study, the Commonwealth was asked to provide any additional records that document the proper implementation of the provisions being reviewed. Information that was not provided for the studies is not considered in the consultants' reports, nor in the Independent Reviewer's findings, conclusions, and compliance determinations. If the Commonwealth was not able to provide, or inform the Independent Reviewer that there was sufficient information to demonstrate that the compliance indicators had been achieved, then the Independent Reviewer determined a rating of non-compliance.

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

B. Compliance Findings

1. *Creation of Waiver Slots*

The maximum Training Center census of approximately 6,000 residents had declined to 1,084 as of July 1, 2011. This decline was the result of the Commonwealth's long standing policy of transitioning from an institution-based to a community-based services system. In the Agreement announced in January 2012, the Commonwealth committed to create over a ten-year period 805 HCBS (Home and Community-Based Services) waiver slots to facilitate the transition of a significant percent of the remaining individuals living in Training Centers to more integrated community-based homes. An additional 3,365 slots were also to be created during this period to provide community-based services for individuals who were on waiting lists or living in other institutions without access to needed community-based services. With this ongoing and significant census reduction, the Commonwealth announced that it would cease residential operations at four of its five Training Centers before June 30, 2021, the end of the ten-year Agreement schedule.

The Commonwealth's decision that operating these Training Centers was fiscally impractical allowed it to redirect funds from facility operations and services to provide HCBS waiver-funded services to thousands of individuals needing and waiting for community-based services. A portion of the new waiver slots were prioritized to facilitate the transition of children from institutions other than Training Centers (i.e., ICF/IIDs and Nursing Facilities). This plan would allow for a significant increase in the overall number of people with IDD who would receive waiver-funded services and a significant reduction in the number of people on waiting lists. Without this plan, Commonwealth officials and stakeholders worried that there would be few funds available for individuals waiting for many years for services, including the increased number of children diagnosed with Autism Spectrum Disorders.

Waiver Slots

Between Fiscal Year 2012 and 2017, the Commonwealth created 1,020 more slots (+forty-one percent) than the 3,385 required by the Agreement. Yet the waitlist continued to grow. In Fiscal Year 2018, with the Center for Medicaid and Medicare Services' (CMS) approval of the Commonwealth's redesigned HCBS waivers, the General Assembly created 144 more slots than the required 440. Many of the new slots were created for its two newly redesigned waivers, "Family and Individual Services" (FIS) and "Building Independence" (BI). However, fewer slots were created that funded congregate residential services.

The Independent Reviewer examined the Commonwealth's redesigned HCBS waiver program and determined that they provided an expanded and more flexible array of in- and out-of-home residential services. These included new supported, shared and independent living residential services being funded in the new waivers at a lower cost per person. For many individuals, these new residential services help achieve the goals of the Agreement: "to prevent the unnecessary institutionalization of individuals with ID/DD and to provide them opportunities to live in the most integrated settings appropriate to their needs consistent with their informed choice."

The Independent Reviewer concluded that, when considered together, the redesigned waivers and slot distribution fulfill the requirements of Section III.C.1. for Fiscal Year 2018. The Independent Reviewer also established minimum criteria for the Commonwealth to achieve future sustained compliance determinations. In each Fiscal Year remaining in the Agreement schedule, the Commonwealth must:

- create more waiver slots with the same funding appropriation;
- serve more individuals who are on the priority one waitlist;
- provide the services requested and needed by these individuals;
- ensure that needed slots are available to prevent the institutionalization, or continued institutionalization, of individuals in the target population; and
- achieve the goals of the Agreement more effectively and expeditiously.

Since the Commonwealth redesigned its waivers, during Fiscal Years 2018 – 2020, it has created 1,014 (+80.2%) more than the 1,265 required. Appendix A shows the number of additional waiver slots, including reserve slots for emergencies, that the Commonwealth has created compared to the number required by the Agreement between Fiscal Year 2012 and Fiscal Year 2020.

The Independent Reviewer has reviewed and confirmed that the Commonwealth has continued the meet the minimum criteria detailed above and has sustained compliance with III.C.1.a.-c. in Fiscal Years 2019 and 2020. The Independent Reviewer notes that the compliance indicators for III.D.1. incorporate his reasons for prior noncompliance findings with Section III.C.1.b. and c. The Parties agreed to address concerns about transitioning individuals with DD under twenty-two years of age from institutions other than the Training Centers (i.e., ICF/IIDs and Nursing Facilities) to the community in compliance indicators for III.D.1. The Parties and the Independent Reviewer agree that the Commonwealth will be in noncompliance with the III.D.1. until it achieves the compliance indicators.

Waitlists

The Independent Reviewer's ISR studies have consistently found that waiver slots provide individuals and their families with critical supports that significantly improve their quality of life and prevent institutionalization. Many families have been "on a waitlist" for years before their family members were awarded a slot. Since Fiscal Year 2012, the Commonwealth has created 5,769 new slots and the census of the Training Centers has declined from 1,084 to 78 as of April 3, 2020. However, the number of individuals who are eligible for the waivers, but who are on waitlists, has significantly and steadily increased. In July 2011, there were 5,783 names on the waitlist; as of April 3, 2020, this had grown steadily to 13,051. The widely publicized increase in the incidence of children with Autism Spectrum Disorders has been, and will continue to be, a significant contributing factor to this increase. DBHDS believes that the regulatory eligibility requirement of being placed on the waitlist to be able to receive Individual and Family Support Program funding is an additional factor.

During the four Fiscal Years 2013-2017 the waitlist increased by more than 1,000 individuals each year. During Fiscal Years 2018-2020 however, the Commonwealth created 2,279 new waiver slots, 1,014 more than the Agreement required, and the rate of increase in the waitlist slowed to fewer than 300 per year. It remains vitally important to the 13,051 individuals still on the waitlist and to their families that the General Assembly continue to recognize, and Virginia's agency staff continue to find creative ways to expand services to address this growing need.

Conclusion

The Commonwealth has again achieved compliance with Section III.C.1.a..i-ix., III.C.1.b i.-ix., and III.C.1.c i-ix.

2. Individual and Family Support Program, Peer-to-Peer and Family Mentoring, and Guidelines for Families

For this review period, the Independent Reviewer retained the same independent consultant who, over the past five years, completed four studies of Virginia's progress toward achieving the following interrelated provisions: the Individual and Family Support Program (IFSP) (II.D. and III.C.2.a.-f.), Family-to-Family and Peer Mentoring (IV.B.2. and III.D.5.), and Guidelines for Families (III.C.8.b.).

Annually, since Fiscal Year 2013, the Commonwealth had met the pertinent *quantitative* IFSP requirements in III.C.2. of providing annual monetary grants. Initially, this was to at least 700 individuals and/or families, and since Fiscal Year 2014, it increased to 1,000. However, the

Independent Reviewer has not yet determined that the Commonwealth has met the *qualitative* requirements for the IFSP, i.e., " … 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."

The consultant's last study in the fall of 2019 documented that DBHDS had developed the IFSP Strategic Plan and, subsequent to its development, had created an IFSP Community Coordination Program. DBHDS had also organized IFSP State and Regional Councils as forums for informing stakeholders about the IFSP and obtaining their input, and had undertaken an initiative to create the family-to-family and peer-to-peer mentoring program required by the Agreement.

In previous studies of these interrelated IFSP provisions, this consultant utilized thirteen criteria to guide the analysis of the Commonwealth's progress toward compliance. For this latest study, the compliance indicators agreed to by the parties in January 2020 guided the analysis. In addition, in April 2019, the Court directed the Commonwealth to develop a library of documents that would show the source of Virginia's authority for its actions and the organizational elements that it utilized to achieve compliance. The elements that it utilized to fulfill different provisions vary, yet they generally include policies, organizational structure, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, and quarterly reports. As part of the Settlement, the Commonwealth also committed to maintain and provide for verification sufficient records to document its performance, progress and compliance with the Agreement's requirements.

For these interrelated IFSP provisions, the parties agreed that compliance would be determined by meeting three sets of compliance indicators, which include a total of thirteen requirements with twenty distinct measures. This latest study reviewed and confirm the availability of the required documentation and reported on progress toward achieving each measure.

The study found that DBHDS has continued to make progress across most of these indicators. In some areas, however, the development and/or implementation of the strategies intended to achieve the compliance indicators had not yet been finalized, and the many elements of the required documentation were not available for review. Although further work, documentation and performance reports are needed to achieve many of the compliance indicator measures, there are three major areas that continue to need significant progress. These are:

- Identifying the performance and outcome measures of the IFSP, including the development of capacity for the collection and analysis of the needed data;
- Defining who would be considered "most at risk for institutionalization" for the purposes of the individual and family support program; and
- Finalizing the eligibility criteria for case management options available to individuals on the waitlist.

These areas of needed progress were also identified in the Independent Reviewer's June 2019 Report to the Court. Since that time, DBHDS records indicate significant effort and some progress. That fundamental decisions have not been finalized, however, appears to reflect significant process and policy challenges.

In other areas, this study found that DBHDS had taken some important steps forward toward implementing the requirements outlined in the compliance indicators (e.g., providing eligible individuals and families with IFSP funding availability announcements), but the documentation of authority provided were narrative documents without formal provenance. DBHDS still needed to translate these informal narratives into established documents (e.g., policies, procedures, departmental instructions, and reporting) that demonstrate the source of its authority. (See Appendix C for the consultant's study and its Attachment B for a Table of the Commonwealth's current status with each compliance indicator.)

IFSP Performance and Outcomes Measures

The description of DBHDS's conceptualization of the IFSP remains the same as in the consultant's 2019 study: the IFSP will emphasize family engagement across four primary domains, including the three sets of compliance indicators. These domains are the IFSP Funding Program, the IFSP Community Coordination Program, family-to-family and peer-to-peer programs, and the My Life, My Community (MLMC) website. (See Appendix C, page ninety-two for an informative visual presentation that shows how these four domains interact.)

The IFSP Funding Program is the element that involves DBHDS's annual distribution of IFSP funding to eligible individuals and families. As of March 31, 2020, DBHDS had approved approximately $2.3 million to 2,291 applicants from a total planned distribution of $2.5 million throughout Fiscal Year 2020. This already exceeds the requirements of the compliance indicator.

DBHDS has worked each year to improve the application, software, and distribution processes for the funding program. It has also developed various tools to support users.

As for all provisions and compliance indicators, the IFSP indicators will have been met when sufficient documentation is provided of its authority to operate IFSP, the policy that defines the criteria for "most at risk for institutionalization," the application and screening procedures and criteria; and, if other organizational entities are involved, documentation of the agreements that outline responsibilities. Reports of IFSP performance will also be required; these are not yet available. For example, the IFSP State Plan compliance indicators require reports regarding accomplishment of program outcomes, including stakeholder participation during the development process, and the IFSP Communication Plan compliance indicator requires reports regarding the dissemination of information to all families about program changes.

Most At Risk For Institutionalization

The study found that the IFSP staff have explored options and strategies with the IFSP State Council for operationalizing a prioritization approach to determining "most at risk." Although final policy and procedure decisions have not yet occurred, the IFSP staff have outlined a timeline that projects implementing program modifications during the eighteenth review period, i.e., the second quarter of Fiscal Year 2021. Once the new approach is implemented, DBHDS must gather and maintain the expected performance data reports and documentation that are sufficient to meet the Section III.C.2.a-f compliance indicators.

Waitlist Case Management

This study found that DBHDS staff had updated some documents that provide guidance to families regarding the eligibility for case management services. However, fundamental clarifications are needed.

The Commonwealth has cited various documents as providing the needed guidance. These include the CSB regulations (i.e., 12VAC30-50-455), the DBHDS Office of Licensing regulations (12VAC35-105-1250), the DBHDS Performance Contract requirements, and the DMAS regulations for Targeted Case Management (TCM) (12VAC30-50-440 and 12VAC30-50-450). On review, however, none of these documents specifically refer to eligibility or related criteria for waitlist case management.

It appears the Commonwealth does not currently have a clear regulatory basis for the provision of case management to individuals on the waitlist. DBHDS staff also provided two versions of a document entitled *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist,* dated February 25, 2020 and April 22, 2020, respectively. Neither appeared to be a formal policy or departmental instruction. Both included vague language that was open to a range of interpretations, i.e., that individuals on the waitlist "might be eligible" for case management due

to a "special service need." When this consultant found similar language in her 2019 study, DBHDS decided then not to issue this guidance. At that time, the Independent Reviewer recommended in his fourteenth Report to the Court that DBHDS should ensure that needed clarifications, policies and procedures be made before dissemination occurs. An updated document, *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019* was provided for the consultant's latest study. It referenced the now-expired DMAS regulatory language, which needs updating when new regulations are finalized. The guide did not provide any substantive additional information for individuals and families with regard to eligibility criteria for TCM while on the waitlist.

For this period's study, the consultant completed a thorough review of all the documents provided without finding any clear guidance regarding when an individual on a waitlist is eligible for case management services. The applicable compliance indicator states that "individuals are informed of their eligibility for IFSP funding and case management upon being placed on a waiver wait list and annually thereafter." Given the history of vague words that invite a wide range of possible interpretations, achieving the related compliance indicator will require the Commonwealth to provide its:

- Policy on case management options for individuals on the waitlist, including TCM for Medicaid-eligible individuals and other options for non-Medicaid-eligible individuals.
- Policy/instruction defining "DD or ID active support coordination/case management service criteria" and "special service need," and any associated protocol to be used by CSBs both for making determinations of eligibility and for terminating services.
- Guidelines for individuals on the waitlist and families regarding case management options and how to apply for them.
- Instructions/protocols for dissemination and notification to individuals on the waitlist and all other impacted entities.
- Evidence of dissemination and notification.

Peer-to-Peer and Family Mentoring

The Settlement Agreement required the Commonwealth to develop family-to-family and peer-to-peer programs to facilitate opportunities for families and individuals considering congregate care to receive information about options for community placements, services, and supports. For the sixteenth Review Period, DBHDS provided an updated addendum to the MOA with the Virginia Commonwealth University (VCU) Partnership for People with Disabilities to engage with individuals and families on behalf of the Department across a platform of programs. The

addendum, dated June 10, 2019, showed continuation of their collaboration related to the family-to-family program. It indicated the purpose of the collaboration and the involvement of the Family to Family Network of Virginia and Family Navigators, which has been in existence for fifteen years and is well-established.

The addendum included a clear description of the Family Mentoring program. However, a statement about peer-to-peer services, along the lines of the family-to-family description, was not provided. Although there was evidence of exploring options for the peer-to-peer program, it appeared that DBHDS had not defined the parameters of the peer mentoring program and there was no documentation available to show the authority, policies, and other items.

Compliance indicators for Section III.D.5. require the Commonwealth to report that at least 86% of individuals on the waiver waitlist, as of December 2019, have received information on accessing Family-to-Family and Peer Mentoring resources. Virginia must also report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and peer-to-peer supports have contact and the number who receive the service. DBHDS did not provide this specific data.

DBHDS did share the *Virginia Informed Choice Form*, which had been modified to include a checkbox that the case manager can mark to indicate that the individual/Authorized Representative was provided opportunities to speak with peers receiving waiver services who live and work successfully in the community. However, this form does not adequately communicate information on accessing Family-to-Family and Peer Mentoring resources, nor does it specifically address the Peer Mentoring aspect at all. Also, when the *Virginia Informed Choice Form* is signed by the individual/Authorized Representative, there is no accompanying statement on the form that the signatory is acknowledging they have received information on accessing Family-to-Family and Peer Mentoring resources.

The Independent Reviewer has identified many examples in the Commonwealth's community services documentation of checkboxes being unreliable indicators. Without accompanying notes, checkboxes offer insufficient records that the purported activity has been completed.

Documentation that this compliance measure has been met requires a clear protocol for the use of the *Virginia Informed Choice Form*. This protocol should specify the expectations that case manager will inform individuals and families of Family-to-Family and Peer Mentoring and any other appropriate resources, together with a note that this occurred. Once DBHDS staff can confirm

consistent application of the expectations, this would allow more reliable use of the aggregate data, and then to track and report as required.

With the exception of copies of the MOA with VCU, DBHDS did not provide any finalized or draft policy, procedures, tools or protocols related to the family-to-family and peer programs; any data collected regarding individuals and families who have participated in the family-to-family and peer programs, and any related analyses completed; any data collected regarding programmatic outcomes of the family-to-family and peer programs, and any related analysis completed; or, any draft or finalized versions of indicators, tools, processes and/or any quality improvement strategies to be used to assess programmatic outcomes as they related to family-to-family and peer programs. Documentation of the authority, policy and processes as well as reports of performance are necessary to demonstrate that the requirements of this Agreement are being properly implemented.

Guidelines for Families

In August 2019, DBHDS in collaboration with Senior Navigator formally launched the My Life, My Community (MLMC) website. It includes a variety of information for families seeking developmental disabilities services on how and where to apply for and obtain these services.

Senior Navigator made regular quarterly reports to DBHDS about activity on the website including, but not limited to, data for the number of sessions, number of users, number of page views, number of returning and new visitors and average duration users spent on the site. In addition, they reported on the volume of calls to their call center seeking technical assistance or additional information, including data about frequently asked questions and topics. Finally, the reports provided narrative updates about new materials and functionalities added since the previous report. It was impressive that, in interview, Senior Navigator staff reported significant increases in site usage, which is a reasonable proxy for overall public awareness. For example, when comparing usage between the first quarter of 2019 (i.e., January 1, 2019 – March 31, 2019) to that of the first quarter of 2020 (i.e., January 1, 2020 – March 31, 2020), the number of sessions increased by 398%, the number of users increased by 408%, and the number of page views increased by 661%.

In response to the document request for this study, IFSP staff reported they had identified a list of organizations and entities with whom to share information about the MLMC website, and stated that their goal was to work on the distribution of this resource once the IFSP's new marketing specialist was on board during the next (seventeenth) review period.

Some improvements still need to be made to the MLMC website's content and functionality. This is expected whenever a complex system is developed. The IFSP should prioritize making these improvements during their annual quality improvement initiatives, as they have with the new materials and functionalities added to the reports of website activity.

It appears that the Commonwealth has functionally achieved one of the two compliance indicators and two of three measures related to Guidelines for Families. The second indicator and third measure will be met when the website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families. A compliance determination rating for the provision can be awarded when documentation includes Virginia's authority for this compliance indicator and its related policies, procedures, and implementation protocols.

When provisions of the Agreement are achieved with an external partner agency, the contract should be provided; in this instance, the original contract between DBHDS and Senior Navigator, dated September 27, 2017, as well as the contract renewal addendum, dated August 15, 2019. The original contract provided a detailed and thorough description of the tasks and activities Senior Navigator would perform on the behalf of DBHDS. Where DBHDS relies on contractual arrangements as evidence of achieving a compliance measure, and does not have related internal policies, procedures, implementation protocols, instructions/guidelines, and other processes, DBHDS staff should stipulate that the dated contractual detail is a complete statement of their commitments and obligations, and will form the basis for ensuring their ongoing compliance. If any future renewals eliminate or otherwise limit any of the original commitments and obligations, the information in the Library would be modified and the parties notified in accordance with instructions from the Court.

Conclusion

DBHDS again in Fiscal Year 2020 provided funding to 1,000 individuals and/or families who are not receiving waiver-funded services. Therefore, it has sustained compliance with the quantitative requirement of III.C.2.a.-g.

It has made progress on many of its IFSP initiatives, but has not yet met many of the compliance indicators for, or achieved compliance with Sections III.C.2., III.C.8.b. or III.D.5.

3. Case Management Services

The Independent Reviewer retained the same independent consultants for this review period to conduct a follow-up study to their April 2019 review of the Agreement's Case Management provisions. That review had found that the DBHDS Case Management Steering Committee (CMSC) had initiatives underway to improve specific areas of previously identified inconsistent and inadequate case management performance. Also in April 2019, the Parties informed the Court of their agreement to a list of measurable indicators which must be achieved for the Independent Reviewer's future determinations of compliance.

The latest study included a review of the Commonwealth's methodology for system-wide gathering, reporting and documenting of progress toward achieving the case management compliance indicators. In addition, to inform their understanding of progress on the individual level in relationship to ten of the indicators, the consultants completed a qualitative review of a small sample of thirty-five Individual Support Plans (ISPs). These qualitative reviews included telephone interviews with case managers and individuals, caregivers, guardians or other authorized representatives. These reviews also included a discrepancy analysis to determine whether gaps existed between each individual's assessed needs and ISP goals, and the services and supports that were actually being provided.

There are four sets of compliance indicators involving case management. Sections III.C.5.b.i., III.C.5.d., and V.F.2.-5. focus on case management functions and monitoring. Section III.C.7.a.-b. includes aspects of case management functioning related to service planning and provision of integrated day opportunities and supported employment. (See Appendix D for the consultants' study report and its Attachment A for these indicators.)

Case Management Monitoring

To determine the Commonwealth's future compliance with the case management monitoring provisions, the Parties established sixteen indicators. DBHDS provided documentation to the consultants, including data that aligned with these sixteen indicators. Although the Independent Reviewer has not yet verified the data submitted by the Commonwealth, these data did show achievement across six of the sixteen indicators, all of which must be met for a compliance determination. The documentation demonstrated that DBHDS has begun work to achieve most of the remaining case management monitoring indicators, however some are not yet available or developed.

The case management monitoring indicators include measures related to the effective functioning of the DBHDS Case Management Steering Committee (CMSC) and the Support Coordination

Quarterly Review (SCQR). The consultants' review found that DBHDS had restructured to align this committee and review processes with the performance requirements of the indicators.

The charter of the CMSC had been updated and enhanced to reflect the DBHDS quality improvement philosophy, to formalize a semi-annual case management report to the Quality Improvement Committee (QIC), to authorize the CMSC to directly initiate technical assistance to underperforming CSBs, and to empower the CMSC to directly recommend enforcement actions to the Commissioner for CSB Performance Contract underperformance.

The SCQRs were overhauled to align operations with ten case management indicators. DBHDS reports that these revised SCQRs were initiated in Fiscal Year 2020. A planned late-summer 2020 look-behind review by the Community Quality Improvement (CQI) team will select a sample of individuals with at least two per CSB and a proportionate distribution across the HCBS waivers. These periodic, electronic reviews submitted by CSB case management supervisors have been supplemented with a manual (*Support Coordination Quality Review Survey Instrument & Technical Guidance*). This manual provides guidance to assure that supervisors are evaluating the work of case managers similarly across the Commonwealth. Further enhancing the impact of SCQRs is the linkage of the Quality Management Division's look-behind process to establish an assurance of reliability at the CSB level, and to facilitate providing technical assistance during the process of reliability checking.

Case Management Functions

The compliance indicators include ten measures identified in Section III.C.5.b.1. For review of these indicators, the consultants focused on:

- Twenty-six individuals who were listed as receiving Enhanced Case Management (ECM) in ten CSBs representative of the five DBHDS Regions; and
- Ten individuals, one in each of the ten CSBs who were identified as fourteen through seventeen years old.

The consultants' discrepancy audits of thirty-five individuals included telephone interviews with the current case manager and the individual and/or guardian/Authorized Representative/provider agency caregiver. In advance of the interviews, the consultants reviewed ISP documentation, recent case manager progress notes and any CHRIS incident reports from the past year, in order to determine what gaps existed between the individual's assessed needs, ISP goals and services, and the services and supports actually being provided.

The study found that, in general, case managers knew the individuals on their caseloads well. However, the median length of time that they had supporting the individual was about twelve months, which is six months less than the eighteen months that a similar study found in 2019. The average caseload size was 1:31, which is an improvement over the 2019 sample's average of 1:33. The large majority of this sample lived with their family or in their own home; fourteen individuals lived in provider settings: twelve (85.7%) in settings of one to four persons, and only two (14.3%) lived in settings of five or more.

The consultants' study included twelve individuals whose ISPs identified behavior support needs. Based on consultants' interviews with the case managers and caregivers, as well as a review of case notes, eight (sixty-seven percent) of the twelve individual's caregivers had been probed by their respective case managers regarding the effectiveness of the behavioral supports; this appears to be an improvement over prior Individual Services Review (ISR) studies. In four (thirty-three percent) of the twelve cases, the team had discontinued or determined a BSP was not needed. In three (twenty-five percent) of the twelve cases, BSPs were in process or were operated by another entity, such as public schools.

The consultants' findings again suggest that the case managers for the selected sample do not write specific and measurable outcomes in the ISPs and do not modify ISPs in response to changes or major events in the individual's life. The consultants determined that the DBHDS training materials included examples of outcome statements that were specific and measurable. Both of these qualities are essential. Without specific and measurable outcomes, progress cannot be objectively determined, e.g. regarding increased independence, self-sufficiency, and integration, which are overall goals of the Agreement and the ISP process. Without modifying the ISP as needed, the services provided to individuals are not adjusted to accommodate changes in status or the lack of appropriate implementation. Service modifications that are made without the case manager convening the ISP team do not benefit from the combined expertise of the professional and non-professional members of the individual's support team.

Continuing to find outcome statements in ISPs that are general and not of the quality included in DBHDS trainings suggests that CSB case management supervisors are not ensuring adherence to good outcome writing practices. The Independent Reviewer's studies have found the exact same poorly written outcome statements in an individual's ISP repeated year after year. This reflects the substandard, but common, practice of case managers cutting and pasting the exact same goal statements from one year to the next.

The compliance indicators include two regarding case managers' use of conflict resolution strategies. The interviewed case managers were generally not aware of formal CSB instructions or resources regarding conflict management. However, when asked by the consultants, two of every three case managers who had experienced conflict within the team reported following logical problem resolution strategies to get to closure.

The consultants also found that most ISP teams consist of persons important to or for the individual. However, the teams for school-age individuals often did not involve school representatives in the service planning meetings.

Case Management: Integrated Day Opportunities and Supported Employment

The Parties agreed to thirteen measures of case management performance related to integrated day opportunities and supported employment services. Although not yet independently verified, the Commonwealth's relevant data reports indicate that DBHDS has achieved seven compliance indicators. Since the findings from the consultants' qualitative study are based on a small sample, they cannot be generalized with significant confidence to a large cohort of the target population, and consequently cannot serve as the basis for determinations of compliance or noncompliance. However, the study's findings are largely consistent with progress that the Commonwealth reports. The DBHDS data reports and findings are detailed in Tables 3 and 4 in the consultants' report (see Appendix D).

DBHDS reports that its data gathering related to these indicators is a "work in progress," i.e., it is not yet gathering the required data in several areas that will be necessary to demonstrate that the compliance indicators have been achieved.

The integrated day opportunities and employment indicators require case managers to complete on-line training modules and to review the case management manual. DBHDS documentation in this review period shows that it has begun work on almost all the indicators, but again documentation that demonstrates the extent the indicators are met is not always available. (See Appendix D, Tables III and IV which recap the findings of the study.)

Regarding the indicator (1.d. for III.C.7.a.) "goals related to employment," the consultants determined that for a small sample of nineteen individuals the ISP teams appropriately documented for seventeen of them (ninety percent) the rationale for not including ISP goals related to employment (retirement age, refusal to work, etc.). One team (five percent) included a goal for employment, and another team (five percent) neglected to include a goal for employment after a discussion that suggested it was warranted and wanted by the individual.

Finally, the consultants' study sample for the discrepancy analysis included ten fourteen-seventeen year-olds regarding the indicator 2.f., for III.C.7.a. (I.e., "Was there discussion or documentation in the ISP of how Waiver services could support interest in employment?") All ten (100%) ISPs reflected this discussion and/or parents-guardians indicated that the discussion occurred. This suggests that the need for early transition planning related to future employment is well established in the minds of most case managers.

Conclusion

The consultants' study found that DBHDS documentation is frequently available and aligns with the indicators, and often appears to show achievement of the indicators. However, there are also many required reports and documentation that are not yet available.

The Commonwealth remains in noncompliance with Section III.C.5.b.i.-iii.; III.C.5.d.; and V.F.2., 4., and 5.

4. Crisis Services

For the sixteenth review period, the Independent Reviewer again retained the same independent consultant to complete the eighth annual study of the Commonwealth's statewide crisis services system. As in the past, this study included a review and analysis of facts regarding the status of the Commonwealth's accomplishments in implementing and fulfilling the Agreement's provisions as described and measured by the compliance indicators. New to this study, the consultant evaluated the status of documentation that DBHDS maintains to demonstrate its progress toward achieving the Agreement's twenty-one crisis services provisions and their twenty-nine associated compliance indicators. Overall, the crisis services provisions require the Commonwealth to:

- Develop and maintain a statewide crisis system for individuals with IDD;
- Provide timely and accessible supports to individuals who are experiencing a crisis;
- Provide services focused on crisis prevention and proactive planning to avoid crises;
- Provide mobile response, in-home and community-based crisis services to resolve crises and to prevent the individual's removal from his or her home, whenever practical; and
- Provide out-of-home crisis stabilization services for children and out-of-home transition homes for adults with co-occurring conditions.

To more fully inform its findings, this study also included a qualitative review of crisis supports and related community services for sixty individuals, twenty-one children and thirty-nine adults, who were referred for crisis services to the Regional Educational Assessment Crisis Response and Habilitation (REACH) programs during November 2019. As with this consultant's previous qualitative studies, the overarching goal was to determine whether the Commonwealth's community service capacity is sufficient and deployed adequately to assist individuals with IDD, who have behavioral and/or mental health co-occurring conditions, to remain in their homes with appropriate ongoing services. This goal is to reduce unnecessary hospitalizations and, if individuals are admitted, their lengths of stay.

To present her findings, the independent consultant organized and compared the Commonwealth's statewide crisis system performance data into five full-year periods, from April 1, 2015, through March 31, 2020. These five years correspond with the ten most recent review periods. For example, Year Five (April 1, 2019, through March 31, 2020) includes both the fifteenth and sixteenth review periods.

The attached Appendix E contains the consultant's report with tables that show REACH performance data for Year One through Year Five. The report's Attachment A consists of two tables that display the summary of findings from the qualitative review of the sixty individuals. Attachment B provides findings that include the private health information of these individuals and is therefore provided to DBHDS under seal. The consultant's analysis of the status of the Commonwealth's documentation related to the crisis services compliance indicators can be found in Attachment C.

The study presents more detailed analysis related to the provisions previously rated as non-compliant. This allows readers to focus their review and attention on areas of non-compliance, for which there are now compliance indicators. The study also includes updates on the Commonwealth's status regarding the provisions previously rated in compliance. Overall, the study found both positive outcomes and areas of concern. It also found that the Commonwealth provided documentation that aligned with the requirements of twenty-four of the thirty-two associated compliance indicators.

Several positive indications were found in the Commonwealth's reports. Despite more than double the number of crisis calls in Year Five (1,349) than in Year Two (617), REACH staff continued to respond onsite within the required average response times in all five Regions.

Fewer children were admitted to psychiatric hospitals statewide at the completion of using REACH mobile support services in Year Five (eighteen) than in Year Two (forty-two). The children and adults admitted to state psychiatric facilities had decreased average lengths of stay (LOS) during the fifteen and sixteenth review periods. The LOS for children decreased from twelve to ten days through Fiscal Year 2019 and to nine days through the end of December 2019 (i.e., through the first half of Fiscal Year 2020). The average LOS for adults decreased significantly from sixty-one days in Fiscal Year 2017 to thirty-two days in Fiscal Year 2019 and then to twenty-two days through December 2019.

In Year Five, a higher percentage of children were directly referred to REACH by case managers and families (forty-two percent). Such direct referrals present more opportunities for crises to be addressed at the home or school before the children are removed from their homes during crises to receive assessments at hospitals and CSB offices. Overall, Year Five data show that REACH's children's programs are becoming more widely known throughout their communities as important sources of information and support as well as for ongoing crisis prevention services.

As mentioned above, the study also found areas of concern. Even though REACH's onsite responses were timely, there is nonetheless significant increased pressure on REACH teams due to the continuing and substantial increase in the number of individuals with IDD in crisis. For these individuals, there has been:

- A steady increase in the number and percentage who have received crisis assessments out of their homes;
- A significant decrease in the percentage who use the crisis stabilization programs, which DBHDS calls Crisis Therapeutic Homes (CTHs); and
- A substantial increase in the number admitted to psychiatric hospitals.

In addition, the Commonwealth's psychiatric hospital discharge reports indicate that many individuals with IDD remain hospitalized after they are ready for discharge because there is "no willing provider."

All of these areas of concern relate directly or indirectly to CSB Emergency Services (ES) teams who are continuing a pre-Agreement and noncompliant process of conducting out-of-home crisis assessments.

Conducting assessments in the homes of individuals in crisis is the fundamental element of the statewide crisis services required by the Agreement. Not doing this is not in compliance with the

Agreement, and undermines the effectiveness of REACH teams. The root cause of this continuing failure is the CSB ES "Single Point of Entry" process. Instead of the in-home crisis assessment process required by the Agreement's provisions and the related compliance indicator, CSB ES teams continue to utilize pre-Settlement practices, even though they are widely recognized as contributing to significant increases in unnecessary admissions of individuals with IDD to psychiatric hospitals. The compliance indicator (2. for IIIC.6.a.i-iii) requires that eighty-six percent of children and adults who are known to the system should receive REACH crisis assessments at home, or the residential setting or other community setting (i.e., a non-hospital/CSB location). During the sixteenth period, the Commonwealth reported that only thirty percent of children and thirty-three percent of adults received the assessments in their homes or one of these other community settings.

For children, this thirty percent figure in Year Five was a slight improvement compared with twenty-seven percent in Year Four, yet still far below the eighty-six percent required by the relevant indicator. As reported previously, when these mobile crisis teams arrive timely at the homes of individuals in crisis, REACH teams have demonstrated the ability to de-escalate crises, to put in place short-term supports, to plan and implement in-home prevention strategies, and to offer a last resort option of staying in a crisis stabilization programs as an alternative to being admitted to an institution or hospital.

Both the qualitative crisis services and the Individual Services Retrospective Review (ISRR) studies during the sixteenth period included findings that there are not yet enough behavioral support service providers available to meet the needs of individuals and their families. There are also not enough residential and day service providers with the relevant experience and expertise.
Both studies also found multiple examples of a day and residential provider practice that harms individuals with intense behavioral needs and their families. For example, after individuals exhibit negative behaviors that the provider knew were to be expected, the provider terminated the individual's services. The root cause of this avoidable harm is the combination of residential and day service providers who have available program openings, but who have limited capacity in terms of behavioral experience and expertise.

Planning and Identifying Strategies for Preventing Future Crises

Effective crisis services are designed to provide short-term interventions and crisis prevention planning and training. The availability and quality of ongoing behavioral supports that provide mid- and long-term services are essential to sustaining long-term stability and to reducing the incidence of future crises.

During the past three years, the lack of available and qualified providers with behavioral experience, expertise and capacity appears to be a significant contributing factor to longer stays than needed for individuals in CTHs and in psychiatric hospitals.

As already mentioned, it is not uncommon throughout the Commonwealth for individuals with intense behavioral support needs to have their residential or day services terminated following a behavioral crisis. Not only are they not allowed to return to their former residence, if they have been placed in a hospital or CTH, but frequently, they are unable to find another willing and qualified provider. The Commonwealth's discharge data from its state-operated psychiatric hospitals indicate that "no willing provider" is the most common obstacle to discharge and transition to a community setting.

As mentioned above, both the qualitative review of sixty individuals who received crisis services and the ISRR found gaps in Virginia's capacity to meet behavioral support needs. The crisis services qualitative review documented that few of either the adults or children who could benefit from a behaviorist had one: twenty-five percent of the adults in this latest study, compared with thirty-three percent in the last qualitative review. For children, there was an improvement: thirty-seven percent in this latest study, compared with fifteen percent a year ago. Despite this improvement for children, the overall percentage is lower than in the last review: seventy-one percent of adults or children who need a behaviorist currently do not have access to one, compared with fifty-eight percent in the previous qualitative study. The ISRR found that still nine (thirty-three percent) of the twenty-seven individuals studied were not receiving needed behavioral support services.

The conclusion of the qualitative study underscores the compelling need for greater availability of behavioral support services to provide timely and ongoing services: "behavioral support services continues to be the least available and most needed support to assist individuals and families who have co-occurring conditions and present behavioral challenges."

During this review period, DBHDS issued its first *Behavioral Supports Report*. It shows that, from Fiscal Year 2016 through the third quarter of Fiscal Year 2020, the number of behavioral specialists that are reported to be working in its service system increased from 821 to 1,493 (an eighty-two percent increase). The Commonwealth's increased count of behaviorists includes Positive Behavior Support Facilitators (PBSFs), Board-Certified Behavior Analysts/Licensed Behavior Analysts (BCBA/LBAs), and Licensed Assistant Behavior Analysts (LABAs).

Virginia's documentation shows that it has achieved and exceeded one of the three requirements for a compliance indicator for III.C.6.a.i-iii., i.e., a thirty percent increase in the number of behavior specialists. However, the Commonwealth has not yet met the other two requirements of the indicator, namely, it has not yet conducted a gap analysis and set targets, nor has it provided documentation that eighty-six percent of individuals whose ISPs indicate a need have been referred to an identified provider within thirty days.

To document its progress, DBHDS plans to begin collecting data for individuals whose ISPs in July, August and September 2020 indicate a need for behavioral supports, and the time it takes for them to be referred to identified behavior specialists.

In April 2019, the Parties agreed to twenty-seven metrics across ten compliance indicators related to the behavioral support services required by the Agreement's provisions III.C.6.a.i-iii. As of March 31, 2020, the consultant reported that the Commonwealth's documentation indicated that one of the twenty-seven metrics had been met, and four had reports that aligned with the indicators but additional progress or documentation is needed. For the remaining twenty-two metrics, the Commonwealth did not provide documentation that aligns with the indicators.

Crisis Stabilization Programs

Each Region has a crisis stabilization program or CTH for adults. Each of these homes has no more than six beds and offers short-term alternatives to institutionalization or hospitalization. These CTH programs have provided an effective "last option" alternative to admission to a psychiatric hospital, and, for those admitted, a step-down option to shorten lengths of stay.

The Agreement also required crisis stabilization programs to be established by July 1, 2012 for children, as well as adults. At that time, the Commonwealth decided correctly that it was not appropriate for these homes to serve both adults and children, so it established adult-only CTHs and then set out to develop alternatives for children. After multiple delays over eight years, in January 2020, the Commonwealth finally opened two statewide CTHs dedicated solely to serving children, with each of these homes expected to provide up to six beds. However, at the end of the sixteenth review period, one CTH was fully operating, yet the other had achieved a license to serve just two individuals.

The Commonwealth also developed two statewide Transition Homes for adults that began operations during the sixteenth period.

Even though the second CTH for children is not at full capacity, the Commonwealth has met two of the three compliance indicator requirements for III.C.6.b.iii.G. by establishing and operating two Transition Homes for adults and two CHTs for children. The third requirement that is not yet met is to implement out-of-home crisis therapeutic prevention host-home like services for children connected to the REACH system.

During Year Five (both the fifteenth and sixteenth periods), DBHDS's changed criteria for admission to a CTH resulted in a significant reduction in the percentage of individuals to whom a CTH stay was offered as an alternative to being admitted to or remaining in psychiatric hospitals longer than needed.

Statewide Crisis Services: System Elements Previously Rated in Compliance

The crisis services system's "Point of Entry" is the CSB ES "hot lines." These operate twenty-four hours, seven days a week. They are able to assess crises and assist the caller in connecting with local resources. Together, these meet the requirement for the associated provision.

REACH mobile crisis teams then respond onsite within the times required by the Agreement's provisions: one hour in urban-designated areas, and two hours in rural-designated areas. These mobile teams often arrive at CSB offices or local hospitals, where the individuals are frequently transported to be assessed. When individuals have not already been removed from their homes, mobile crisis team members are adequately trained to address crises and provide in-home supports. Mobile crisis teams also identify and implement prevention strategies and provide in-home support for up to three days or more for individuals who receive mobile crisis supports.

REACH teams have continued to provide training to more than 600 law enforcement personnel in each of the past five years and continue to work with law enforcement who frequently accompany Emergency Services ambulances responding to 911 calls made during crises.

The Commonwealth did not add a second mobile crisis team to each Region in 2013, as the Agreement's provision specified. Instead, after consulting with the Independent Reviewer and DOJ, DBHDS added staff to increase Regions' capacity at that time to provide adequate resources to respond onsite and to deliver the crisis de-escalation, supports, services and treatment without removing individuals from their home. The extra staff also offer crisis prevention strategy and planning, short-term support capacity in the home, and the crisis stabilization "last resort" alternative to hospitalization.

The Commonwealth developed a crisis stabilization program in each Region. These CTHs offer a short-term alternative to institutionalization and are used as a last resort.

Conclusion

The Commonwealth's documentation indicates that it has met seven of the thirty-three crisis services compliance indicators. Additionally, it has reports with data related to eighteen indicators, but more progress or documentation is needed. For the remaining eight indicators, Virginia does not yet have, or has not provided, reports with the information required.

The Independent Reviewer has determined that the Commonwealth remains in compliance with Sections III.C.6.b.i.A. and B.; III.C.6.b.ii.C., D., E., and H.; III.C.6.b.iii.A. and III.C.6.b.iii.F. It remains in noncompliance 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.

5. Integrated Settings

The unnecessary institutionalization of Virginians with IDD was what initially led to the Agreement, following an investigation and finding by DOJ. At the time, the Commonwealth had insufficient capacity to provide integrated community-based services. Many children with complex medical and behavioral needs lived in large, congregate institutional settings with shift-based care. The in-home support services that allow individuals to live with their biological families or in small, personalized long-term foster homes were not generally available or sufficiently dependable. Children did not have the opportunity to bond with a single, long-term caregiver, something that research has confirmed is best for personal development.

When it negotiated the Agreement, Virginia did not admit to the validity of the DOJ finding that it was not in compliance with the Americans with Disabilities Act (which identified unjustified 'segregation' of persons with disabilities as a form of discrimination) and the Civil Rights of Institutionalized Persons, nor with the integration mandate of the U.S. Supreme Court's Olmstead decision. However, the Commonwealth and DOJ reached an Agreement with provisions intended to achieve the goals of community integration, self-determination, and quality services. The provisions also specify that the severity of an individual's disability shall not prevent access to the integrated settings and quality services that promote self-determination. Fulfilling these provisions will create the capacity and organizational structure needed to ensure that individuals with IDD have opportunities to live in integrated community-based settings.

Compliance Indicators

The integrated settings provisions of the Agreement became more specific and measurable with the Parties' recent agreement to the associated compliance indicators (see Attachment A of Appendix F). These indicators, which are comprised of fifteen distinct categories and twenty-nine specific measures (see Table 1 of Appendix F), require the Commonwealth to:

- Increase the percentage of individuals with IDD being served in integrated settings;
- Identify opportunities for providers to develop integrated residential service models;
- Engage individuals, families, and providers in identifying barriers to developing such services;
- Track individuals seeking such services;
- Complete periodic reviews measuring the promptness and ongoing delivery of in-home nursing services;
- Screen children prior to their admission to institutions other than Training Centers, i.e., Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and Nursing Homes;
- Track children who are admitted to ICF/IIDs and Nursing Homes;
- Provide a Community Transition Guide for Families of children living in ICF/IIDs and Nursing Homes;
- Provide information regarding the availability of community-based services and supports for families via the "My Life, My Community" website;
- Prioritize children who are ten years old and under for and with a waiver slot to facilitate discharge; and
- Ensure that CSBs are aware of children with IDD who are seeking admission to a nursing home from their community-based services.

For this sixteenth review period, the Independent Reviewer retained an independent consultant to study the status of the Commonwealth's progress toward documenting the achievement of the III.D.1. provision and the associated compliance indicators regarding serving individuals in integrated settings consistent with their informed choice and needs. The consultant reviewed whether DBHDS documentation had been developed, was present, and included data regarding the achievement of the indicator. This review determined whether information included in the documentation aligns with all the requirements in the associated indicators. The review did not verify the performance-related data included in the DBHDS documentation.

The documentation that DBHDS provided demonstrates that it has made a concerted effort to promote the use of integrated settings and to achieve the compliance indicators for III.D.1. The Commonwealth's redesign of its HCBS waivers created new service models, service definitions, and payment rates to promote services in more integrated settings. Furthermore, it has created more waivers that fund the provision of residential service in more integrated settings. The ISR studies have confirmed, and the DBHDS data reports show, an overall statewide increase in the percentage of individuals who receive services in most integrated settings. It is clearly evident that the Commonwealth has made progress toward achieving many of the indicators by creating reports, assessing and screening children seeking admission to nursing facilities and ICFs, tracking children who are admitted, prioritizing children for transition to community-based settings, and providing information and outreach to families. The status details of the Commonwealth's documentation related to these and other integrated settings indicators are available in Table 1 of Appendix F.

One category of concern from the consultant's study is the number of children who continue to be admitted to, and remain living for many of their childhood years in institutions with shift-based care. For example, of the original baseline of fifty children with DD who were living in Nursing Facilities (NFs) in March 2016, twenty-five (fifty percent) were still living in NFs in March 2020, resulting in a minimum length of stay of more than four years. Also, during the twelve-month period, February 2019 through January 2020, eleven children were referred for admission to NFs. Of this cohort, nine were admitted and two were diverted to community-based settings; two of the nine admitted have subsequently been discharged, yet seven remain in NFs with lengths of stays longer than six months.

In addition, DBHDS has identified another forty-seven children with IDD who were not included in the Commonwealth's baseline listing of fifty children in March 2016. Twenty-four of these children continued to live in an NF as of September 30, 2019. These children are also not recorded in the Preadmission Screening and Resident Review (PASRR) list that compliance indicator number eight for III.D.1. requires for all children who have an indicator of a DD diagnosis and are seeking admission to an NF. This could mean that these forty-seven children were admitted into an NF without getting the required PASRR evaluation. Or, it could mean that they have been in an NF since before the PASRR process began to be enforced in 2015, but were missed when the Commonwealth established its baseline in March 2016.

Of significant interest to resolving one aspect of this concern is the compliance indicator requirement (15.b. for III.D.1.) for children living in ICFs and NFs. Specifically, DBHDS must

establish and implement accountability measures to ensure that CSBs are actively involved in the transition planning and discharge of these children.

This study renews another concern previously expressed (see Appendix D of the Independent Reviewer's twelfth Report to the Court, June 13, 2018) regarding "the fifth facility," the Children's Hospital of the King's Daughters. This facility provides pediatric care as a long-term care hospital, and functions as a pipeline directly into a large private institution (i.e., ICF/IID), St Mary's. Six infants with DD indicators were admitted directly to St. Mary's from this fifth facility in 2019.

Families who have a newborn with medical challenges appear to be persuaded by this hospital's clinicians that their babies are beyond their families' level of care. This subverts the intent and design of the Agreement provisions and specifically, the Commonwealth's single portal strategy, required by the relevant compliance indicator (9. and 10. for provision III.D.1.) These indicators require the Commonwealth to offer an array of options from which informed families can choose, before deciding the future living arrangements for their infants with medical challenges. This pipeline, without parents having an informed choice, increases the likelihood that these infants will spend their childhoods living in an institution with shift-based rather than home-based care. This outcome is the opposite of the Agreement's goals that the Commonwealth committed to achieve. An intervention to present alternatives at this very sensitive time in a newborn's life is missing.

Conclusion

For Section III.D.1., DBHDS's documentation indicates that the Commonwealth has met seven of the associated fifteen compliance indicators, and that it has reports that align with seventeen of the twenty-nine specific measures. (Please note that the Independent Reviewer has not verified the performance information in this documentation.) The Commonwealth may be working on, but did not provide reports that align with the remaining twelve of these measures. Table 1 of Appendix F recaps the status determinations for the twenty-nine measures.

In terms of implementation of the twenty-nine measures, the Commonwealth has not yet gathered the data and reports that meet fifteen of these measures. Until Virginia can demonstrate these fifteen requirements and performance measures have been properly implemented, it is in noncompliance with Section III.D.1.

6. Serving Individuals with Complex Behavioral Needs

For this period, the Independent Reviewer initiated an Individual Services Retrospective Review (ISRR) of individuals whose service outcomes were the subject of Individual Services Review (ISR) studies during one of the previous four years.

The purpose of the ISRR was to determine:

- Whether effective follow-up occurred regarding the concerns identified during the previous study, and
- Whether Virginia's community-based service system capacity was in place and available to meet the needs of individuals with intense behavioral needs who were previously found to have experienced gaps in service.

This ISRR study was conducted by the Independent Reviewer and four independent consultants. All have contributed to fifteen biannual ISR studies in Virginia since 2012, including the prior ISRs of these same individuals. This time, these five reviewers formed various two-person teams, identical to the teams who completed ISRs of the individuals in the selected sample for the current ISRR.

The process for each previous ISR study involved the review team, one of whom was always a registered nurse, completing a *Monitoring Questionnaire*. This was based on an onsite visit that included interviews with the individual and caregivers, observations of the individual being supported, their environment, and any personal adaptive equipment, as well as a review of the on-site daily records, such as medication records, daily health and safety protocol documentation, and daily logs. After the onsite visit, as well as a review of service documentation, and answering fact-based questions that are mapped to the provisions of the Agreement and Virginia's rules and regulations, the ISR review teams made several informed judgments in response to these questions:

- Based on documentation reviewed and interview(s) conducted, is there any discernible evidence of actual or potential harm, including neglect?
- In your professional judgment, does this individual require further review?
- Are there needed (health care) assessments that were not recommended?

If the ISR reviewers believed that for any individual there was a threat of imminent harm, the Independent Reviewer notified DBHDS, which responded with a written plan within forty-eight hours to resolve the risk. The completed ISR *Monitoring Questionnaire* for each individual culminated in

a list of concerns that required follow-up, including specifics that explained any "yes" answers to the judgment questions listed above. DBHDS reported back to the Independent Reviewer within ninety days of the *Monitoring Questionnaire* being submitted. They described the case manager's review of any issues listed, any actions initiated by the case manager including discussions with the AR and ISP team, and any resolutions relevant to the listed concerns.

From a cohort of forty-three individuals with intense behavioral needs, twenty-seven were randomly selected for the ISRR, allowing the study's findings to generalize to the cohort with a ninety percent confidence factor. The entire cohort were individuals whose Service Intensity Scale evaluation indicated level seven, i.e., "intense behavioral support needs." These individuals:

- Lived anywhere in Virginia,
- Received HCBS waiver-funded services,
- Had an annual Individual Support Plan (ISP) meeting between May 1, 2019, and December 31, 2019, and
- Had an issue of concern listed in the previous ISR *Monitoring Questionnaire*.

The ISRR included a review of the case manager's follow-up response to issues identified during the previous ISR review, a review of the individual's current ISP and service documentation, a phone interview with the caregivers who know most about the services and health care the individual is receiving, and related service outcomes. The ISRR did not include the onsite visit component of the ISR study.

ISRR Themes

The ISRR study found two overarching patterns:

1. Specific systemic shortcomings continue in the Commonwealth's community-based service system. Already identified in previous ISR studies, these are:

- The lack of available behaviorists to provide needed services;
- The inadequacy of the structured behavioral services;
- The limited capacity of residential and day service providers for individuals with intense behavioral needs; and
- The lack of needed dental care.

2. For most of the individuals studied, the issues of concern listed in previous ISRs remain. However, there were some slight to moderate service outcome improvements. Concerns had been reviewed, many were at least addressed, and some were fully resolved. Specifically, these are:

- When individuals did receive structured behavioral supports, the generally accepted elements of written behavioral plans were present more often;
- ISPs showed slight improvements in employment goals being discussed;
- There was an increase in receipt of day services and dental supports; and
- Documentation was present at the individual's residence across three areas: written informed consent, the intended effects and side effects of the medication, and monitoring as indicated for the potential development of tardive dyskinesia.

(See aggregate data from the ISRR and comparisons with the aggregate ISR data for these same individuals in Appendix B.)

The ISRR *Monitoring Questionnaires* completed for each individual were given to the Commonwealth under seal as they included private contact and health information. By September 30, 2020, DBHDS will provide written responses to any concerns listed in the *Monitoring Questionnaires* that the review teams identified.

The ISRR finding that individuals had slight to moderate improved service outcomes in areas of concern identified in earlier ISR reviews is to be expected, given that a team of independent reviewers completed a careful study, provided a list of issues related to needed improvement, and DBHDS responded.

It is positive that some concerns identified in previous ISRs – those that can be addressed by case manager or residential provider initiatives – frequently showed improvement once they had been pointed out as a result of an external review. On the other hand, specific systemic shortcomings persist, even after they have been repeatedly pointed out in the wake of external reviews. These are proving much more intractable.

This conclusion is strengthened by findings from the Independent Reviewer's studies across other topics that were conducted by different consultants during this sixteenth and earlier review periods.

Of the twenty-seven individuals studied, nine (33.3%) needed but did not have access to a needed behavioral specialist, and another two (7.4%) wanted to replace their behaviorist with a new one, but

could not locate someone to better meet their needs. Although the ISRR found that more of the structured behavioral supports that were in place included the elements of generally accepted practices, almost all remain below acceptable levels.

It is important to note that most of the case managers had reviewed the concerns listed in the completed *Monitoring Questionnaires* from previous ISR studies, discussed them with the ARs, followed up on many of them, and some had been resolved. However, between the previous ISR and this ISRR, several residential and day service providers had terminated their services, some even without notice, to several of the individuals studied, typically after behavioral episodes. These terminations appear to be fairly common, but represent a practice that the Independent Reviewer finds egregious and unacceptable. The practice has major negative consequences for the individuals, yet no significant negative consequences for the providers who admitted these individuals to their program fully aware that such behaviors were exhibited previously and should be expected.

The ISRR identified additional positive outcomes and areas of concern outlined below.

Additional Positive Outcomes

More individuals lived in more integrated settings. Of the twenty-one individuals who lived in a home licensed by DBHDS, eighteen (85.7%) lived in more integrated community-based settings of four or fewer individuals than the last time their circumstances were reviewed.

For virtually all the individuals studied, there were many positive healthcare process outcomes. All twenty-seven individuals (100%) had undergone a physical exam within the last year. Of the twenty-three who received recommendations from their primary care physicians (PCPs), recommendations for twenty-two (95.7%) were implemented within the prescribed time frame. Of the twenty-three who received recommendations from their medical specialists, again, recommendations for twenty-two (95.7%) were implemented within the prescribed time frame. All twenty-four individuals whose PCPs had ordered lab work, had that lab work completed within the recommended time frame.

There was evidence of stability in sixteen (72.7%) of the twenty-two residential placements reviewed, even where the client had demonstrated or continued to demonstrate undesirable behaviors. In every instance of this stability, progress had been noted although the degree of progress varied.

Additional Areas of Concern

Individuals with complex behavioral challenges need more extensive consultation and resources from outside of the residential provider agency. The reviewers concluded that the providers, for the most part, were trying to implement constructive behavioral interventions. However, the complex behavioral needs of these individuals exceeded the current knowledge of the providers and case managers. Nine of the individuals who need and lack behavioral support consultation services had this same issue identified in the previous ISR study.

The Agreement's required case management face-to-face assessments of risks and the appropriate implementation of behavioral services were not occurring. DBHDS has not provided guidance or instructions for assessment requirements, nor standards for implementation of behavioral services.

Integrated day opportunities were not available for several individuals in the study, other than activities operated out of their residences. Although new Community Engagement (CE) services were being arranged for two of these individuals, CE services for four individuals were involuntarily terminated. There were too few CE providers available, especially for individuals with intense behavioral needs.

For many of the individuals studied, the case managers did not fulfill certain requirements of the Agreement:

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

Conclusion

The ISRR provided additional direct evidence and confirmed findings of other studies conducted during the sixteenth and previous periods that result in the Independent Reviewer's determinations of compliance with III.C.5.a. and V.F.1., and determinations of non-compliance with III.C.5.b.ii. and iii., III.C.6.b.iii.B., D., and G., III.C.7.a. and b., and V.F.2.

7. Training Center Discharge and Transition Planning

The Agreement's Section IV is large and broad, including nearly fifty Training Center Discharge and Transition Planning provisions. These were developed to ensure fulfillment of the Commonwealth's long-standing goal and policy. Residents transitioning from an institutional model of care would be offered a community-based system designed to meet the needs of all individuals with ID/DD, allowing them to live in the most integrated settings appropriate to their needs, including those with the most complex needs.

To help fund achievement of this goal, the Commonwealth committed to an annual schedule of creating a total minimum of 805 waiver slots over ten years. These slots would enable individuals living in Training Centers to transition to a waiver-funded services system. The Court recognized when it approved the Agreement that the decision whether to close any Training Center lies not with DBHDS or a negotiated Agreement but with the Commonwealth's General Assembly.

Since July 1, 2011, the beginning of the Agreement's ten-year schedule, the Commonwealth has implemented new policies and procedures to benefit those living in Training Centers. These spell out how Virginia ensures that individuals are served in the integrated community-based settings appropriate to their needs and informed choice. Specifically, the Commonwealth committed to develop and implement a range of processes at all Training Centers that include:

- Discharge and transition plans for all residents;
- Active transition planning participation for the individuals and their Authorized Representatives;
- 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;
- Personalized goals that promote the individual's growth, well-being and independence;
- Individualized support plans to transition into the most integrated setting consistent with informed individual choice and needs;
- Choice among services providers that can provide the needed supports;
- Community Integration Managers at all Centers to provide oversight, guidance, and technical assistance to address or overcome barriers to discharge;
- Regional Support Teams, each coordinated by the CIM, to identify and address obstacles to transition to most integrated setting of four or fewer individuals;
- Family-to-family and peer-to-peer programs to facilitate conversations and meetings with individuals currently living in the community and their families;

- Restrictions on transfers to a congregate settings with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options;
- Active transition participation of the selected provider;
- Essential supports are in place at the individual's community placement prior to discharge; and
- Post Move Monitoring in each Region to proactively identify and address gaps in care.

This created a thorough and effective organizational structure and process that has been utilized over the last eight years in closing most of the existing Training Centers. During the sixteenth review period, the Commonwealth ceased residential operations at the fourth of the five Training Centers that it was operating when the Agreement was approved by the Court.

The following Table shows the steady decline since 2011 in the number of individuals residing in Virginia's Training Centers.

Virginia Training Center Census June 30, 2011 – April 30, 2020										
Training Center	**June 30, 2011**	June 30, 2012	June 30, 2013	June 30, 2014	June 30, 2015	June 30, 2016	June 30, 2017	June 30, 2018	June 30, 2019	**April 30, 2020**
SVTC	**242**	197	114	0	0	0	0	0	0	**0**
CVTC	**381**	342	301	288	233	192	144	86	45	**0**
NVTC	**157**	153	135	106	57	0	0	0	0	**0**
SEVTC	**123**	104	84	75	69	65	72	73	71	**78**
SWVTC	**181**	173	156	144	124	98	70	17	0	**0**
TOTALS	**1084**	**969**	**790**	**613**	**483**	**355**	**286**	**176**	**116**	**78**

At the South Eastern Virginia Training Center (SEVTC), the only facility still operational, the discharge and transition policies and processes remain in place.

During the sixteenth review period, the Parties informed the Court, with minor exceptions, they had agreed with all the Independent Reviewer's compliance determinations in his fifteenth (December 2019) Report. Then in January 2020, the Parties agreed to measurable compliance indicators for the three provisions that the Independent Reviewer had not yet rated as in compliance for Section IV. These three provisions all include a single area of non-compliance: the lack of integrated day opportunities and supported employment. The Parties agreed that a future determination of compliance for these three provisions would occur when compliance is achieved with Section III.C.7., Integrated Day Opportunities and Supported Employment.

Conclusion

Based on the Independent Reviewer's interviews with Commonwealth officials, and review of guidance documents and performance reports that include individual discharge records and plans, the Commonwealth has achieved and maintained Sustained Compliance with Sections IV. IV.B.3,5,7; B.9.a.-c., B.11.a.-b., and B.15; IV.C.1.-7.; and IV.D.1.-4.

The Independent Reviewer will focus future monitoring of the Training Center Discharge Planning and Transition provisions on whether SEVTC continues to comply with the provisions of Section IV, and whether the Commonwealth fulfills the integrated day opportunity and supported employment provisions outlined in Section III throughout its community service system.

IV. CONCLUSION

During the sixteenth review period, the Commonwealth, through its lead agencies DBHDS and DMAS, and their sister agencies, continued to achieve compliance with the provisions of the Agreement that it had previously accomplished. It also made progress toward meeting the requirements of provisions previously rated as noncompliant, but the Independent Reviewer has not determined any new ratings of compliance.

The Commonwealth fulfilled its policy goals of ceasing residential operations at the fourth of its five Training Centers – the CVTC – and of transitioning most of the residents there to community-based settings. By achieving these goals, the Commonwealth was able to successfully expand its community-based services to serve thousands more individuals with IDD.

The Commonwealth furthered initiatives toward fulfilling more of the Agreement's provisions. It provided more integrated settings, sustained health care services to individuals with complex medical needs, developed more independent housing opportunities, established and began operations at its first two CTHs for children and two statewide Transition Homes for adults, and selected and planned the transition to a new vendor for redesigning and completing the QSRs required by the Agreement.

Many previously reported systemic obstacles, however, continue to delay progress in other areas. The CSB ES assessments still occur most often at hospitals or CSB offices and undermine the REACH teams' effectiveness in avoiding the unnecessary institutionalization of individuals with IDD. Children and adults continue to be unnecessarily admitted to, or to remain for longer than needed in private institutions, receiving shift-based care, rather than home- and community-based care. This is caused, in part, by the lack of quality behavioral support and in-home nursing services,

as well as insufficient capacity of residential and day service providers with the expertise and experience needed to keep individuals with intense behavioral needs stable.

Once approved and fully implemented, other initiatives are expected to help the Commonwealth address these issues. These include final approval of the Commonwealth's new HCBS waiver regulations, rate increases and other improvements for in-home nursing services, new terms in DBHDS's performance contracts with CSBs; and full implementation of the DBHDS Licensing regulations, quality improvement programs for all services, and the QSRs and other remaining requirements of its quality and risk management system.

A critical development during this sixteenth period was the Parties' agreement and the Court's approval of precise compliance indicators for all the Agreement's provisions with which the Commonwealth remains in noncompliance. With clear measures established, the Commonwealth's managers now know exactly what must be achieved for compliance. However, there are now many more measures, which bring new challenges in collecting the required data and reliably documenting progress.

The DBHDS Commissioner is fully cognizant of the breadth and depth of the challenges that remain for the Commonwealth to sufficiently address before the end of the Agreement in 2021. To accomplish what is needed, DBHDS has designed, developed and implemented a well-organized project management plan. All of DBHDS's senior managers, subject matter experts and support staff are now intensely focused on resolving obstacles to essential progress during the forthcoming seventeenth and eighteenth review periods.

The Commonwealth's leaders have continued to meet regularly, to communicate effectively and positively with the Independent Reviewer and with DOJ, and to collaborate with stakeholders. They also continue to express strong commitment to fully implement the Agreement's provisions, the promises made to all the citizens of Virginia, especially to those with IDD and their families.

V. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the twelve actions listed in the provision categories below, and provide a report that addresses these recommendations and their status of implementation by September 30, 2020, unless otherwise noted. The Commonwealth should also consider the additional recommendations and suggestions in the consultants' reports, which are included in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the eighteenth review period (October 1, 2020 – March 31, 2021).

Crisis Services

1. Analyze the root causes of the failure of the CSB-ES "Crisis Point of Entry" process to function as required by the Agreement. Once completed, provide a plan that ensures mobile crisis teams respond to the home or other community setting where the individual's crisis occurred.

2. Provide the following information to the Independent Reviewer for the periods July 1, 2020, through September 30, 2020, and October 1, 2020, through March 31, 2021:

    - The number of individuals with IDD who were diverted to stay at a CTH instead of an admission to a psychiatric hospital;
    - The number of individuals with IDD who were not diverted to a CTH when a CTH stay would have been appropriate, and were instead admitted to a psychiatric hospital;
    - The number of individuals with IDD who were discharged by their residential services provider around the same general time of their crises and were either admitted to a CTH or to a psychiatric hospital;
    - The number of individuals with IDD in State hospitals who were ready for discharge, but remained designated reasons, including "no willing provider" and "other".
    - The lengths of stays of individuals with IDD in State hospitals who were ready for discharge but who had "no willing provider;" and
    - The utilization data and analysis being maintained by DBHDS for "forever" homes.

3. Provide the following information to the Independent Reviewer for the periods July 1, 2020, through September 30, 2020, and October 1, 2020, through March 31, 2021:

- The number of hours of service that behaviorists billed the Commonwealth for providing therapeutic consultation to individuals with IDD on the HCBS waiver and CCC+;
- The number of behavior plans (e.g.. BSPs and BCBAs) these behaviorists wrote and oversaw; and
- The number of individuals with IDD were admitted to psychiatric hospitals after the creation of the behavior plan.

Integrated Settings

4. Conduct a process study of the Assistive Technology, Environmental Modifications, and self-directed supports payment systems to ensure that steps are eliminated that do not add value to authorization approval and timely payments. The inclusion of self-advocates and family representatives should be considered in the study's design. Provide study results to the Independent Reviewer by December 31, 2020.

Case Management

5. Clarify and emphasize to CSBs that school personnel should be included or invited to participate in the ISP process, and that school programs are an appropriate community site for the case managers' face-to-face visits that alternate with individuals' residences.

6. Modify the ISP procedure so that ISPs can be more easily changed. The revisions need to ensure a paper trail to the logic behind and background to the change, and that ISP team members, appropriate professionals and caregivers are all included in the change process.

7. Make improvements to:

- The *Guidance* document relative to ISP measurable/observable outcomes, to ensure supervisors ask the question, "If I go into the individual's file, can I find a record of occurrences or activities toward the outcome statements that will demonstrate progress toward the outcome?" and
- The supervisor training on measurable/observable outcomes.

8. Add a specialized SC/CM training module regarding ISP measurable/observable outcomes for delivery during the SCQR technical assistance process.

9. Encourage a peer review process at CSBs for the production of the annual ISPs. Reviewers frequently find errors including gender pronouns, duplicative statements, wrong individuals' names, checklist boxes not checked where needed, and other mistakes that appear attributable to cutting and pasting erroneous information.
10. Establish a clear policy, procedure or protocol with regard to the expectations for the *Virginia Informed Choice Form*.

IFSP

11. Define and inform individuals on the waitlist and their families about:

- Case management options. This should include the policy and procedure that establishes minimum standards for CSB eligibility determination process with regard to a "special service need;" and
- Once individuals have been determined eligible for a case manager, describe the expectations related 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.

12. Provide documentation that shows:

- A finalized set of indicators that adequately assess performance and outcomes related to access, comprehensiveness and coordination of individual and family supports;
- The methodology for collecting and analyzing data on the finalized indicators; and
- Selected key measures to incorporate into DBHDS's overall Quality and Risk Management Framework.
- Revisions to the MOA with VCU that include keeping and reporting specific data on families and individuals.

I. APPENDICES

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APPENDIX A.

CREATION OF WAIVER SLOTS

by:
Donald Fletcher

Waiver Slot Allocation Summary
Fiscal Years 2012 - 2020
Settlement Agreement: required / actually created

Fiscal Year	***2012 ******	***2013 ******	***2014 ******	***2015 ******	***2016 ******	***2017 ******	***2018 (****)***	***2019 (****)***	***2020 (****)***	***Total***
Community Living Waiver (formerly ID) Training Centers	*60/ 90*	*160/ 160*	*160/ 160*	*90/ 90*	*85/ 85*	*90/ 90*	*90/ 100*	*35/*	*35/*	***805/ 775***
Community Living Waiver (formerly ID)	*275/ 495*	*225/ 300 (**25)*	*225/ 575 (**25)*	*250/ 25 (**25)*	*275/ 325 (**25)*	*300/ 315*	*325/ 80*	*325/ 214*	*355/ 220*	***2555/ 2549***
Family and Individual Support Waiver (formerly IFDD)	*150/ 180*	*25/ 50 (**15)*	*25/ 130 (**15)*	*25/ 15* (**15)*	*25/ 40 (**25)*	*25/ 365 (**10)*	*25/ 344 (**10)*	*25/ 414*	*50/ 807*	***375/ 2345***
Building Independence Waiver							*60*	*0*	*40*	***0/ 100***
Total	***485/ 765***	***410/ 510***	***410/ 865***	***365/ 130***	***385 /450***	***415/ 770***	***440/ 584***	***385/ 628***	***440/ 1067***	***3735/ 5769***
Additional Slots	***+15***	***+100***	***+455***	***(-235)***	***+265***	***+315***	***+144***	***+243***	***+627***	***+2,034***
	+1020 additional slots created in six years with previous HCBS waivers						***+1,014 additional slots created in three years with current HCBS waivers***			

* From reserves,

** Prioritized for children in NF/ICFs

*** *Previous* HCBS Waivers: Community Living (CL) – Training Center (TC) and Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFS-DD)

(****) *Current* HCBS Waivers: Community Living (CL) - Intellectual and Developmental Disability (IDD), Family and Individual Support-IDD (FIS), Building Independence-IDD (BI)

APPENDIX B.

INDIVIDUAL SERVICES RETROSPECTIVE REVIEW
Individuals with Complex Behavioral Needs

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

Individual Services Retrospective Review
Individuals with Complex Behavioral Needs
Sixteenth Review Period

Demographic Information

Sex	n	%
Male	16	59.3%
Female	11	40.7%

Age ranges	n	%
Under 21	3	11.1%
21 to 30	8	29.6%
31 to 40	5	18.5%
41 to 50	6	22.2%
51 to 60	2	7.4%
61 to 70	3	11.1%
71 to 80	0	0.0%
Over 80	0	0.0%

Levels of Mobility	n	%
Ambulatory without support	21	77.8%
Ambulatory with support	4	14.8%
Total assistance with walking	1	3.7%
Uses wheelchair	1	3.7%

Type of Residence	n	%
ICF-ID	0	0.0%
Group home	14	51.9%
Sponsored home	6	22.2%
Family/Own home	10	22.2%
Crisis Therapeutic Home	1	3.7%

Behavioral Needs and Supports

Behavioral Needs Items				
Item	***n***	***Y***	***N***	***CND***
Has there been police contact?	27	22.2%	77.8%	0.0%
Has the individual been admitted to a jail or prison	27	14.8%	85.2%	0.0%
Has there been a psychiatric hospitalization?	27	7.4%	92.6%	0.0%
Has there been the use of physical, chemical, or mechanical restraint?	27	14.8%	85.2%	0.0%
Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others?	27	85.2%	14.6%	0.0%
Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment?	27	81.5%	18.5%	0.0%
Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)?	27	70.4%	29.6%	0.0%
Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills?	27	55.6%	44.4%	0.0%
a. Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence?	27	92.6%	7.4%	0.0%

Behavioral Programming Items				
Item	***n***	***Y***	***N***	***CND***
If the individual engages in behaviors that negatively impact his/her quality of life and greater independence:				
Is there a functional behavior assessment in the current setting?	24	20.8%	79.2%	0.0%
Is there a written plan to address the behavior?	23	60.9%	39.1%	0.0%
If there is a written plan to address the behavior:				
Are there target behaviors for decrease?	15	93.3%	6.7%	0.0%
Are there functionally equivalent replacement behaviors/new adaptive skills targeted for increase?	15	64.3%	35.7%	0.0%
Does the plan specify the data to be collected, summarized and reviewed to determine whether planned interventions are working?	15	53.8%	46.2%	0.0%
Have the data been collected, summarized and reviewed by a qualified behavior clinician?	15	33.3%	66.7%	0.0%

Individual Support Plan

Individual Support Plan Items – positive outcomes				
Item	***n***	***Y***	***N***	***CND***
Is the individual's support plan current?	27	96.3%	3.7%	0.0%
Is there evidence of person-centered planning?	27	96.3%	3.7%	0.0%
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her individual support plan?	27	96.3%	3.7%	0.0%
Are all essential supports listed?	27	85.2%	14.8%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	27	100.0%	0.0%	0.0%
Medical	27	100.0%	0.0%	0.0%
Recreation	27	100.0%	0.0%	0.0%
Mental Health (psychiatry)	23	91.3%	8.7%	0.0%
Transportation	27	100.0%	0.0%	0.0%

Individual Support Plan Items – areas of concern				
Item	***n***	***Y***	***N***	***CND***
Has the individual's support plan been modified as necessary in response to a major event for the person, if one has occurred?	10	80.0%	20.0%	0.0%
If applicable, were employment goals and supports developed and discussed?	24	20.8%	79.2%	0.0%
If the individual's support plan did not include goals toward supported employment, were integrated day opportunities offered?	25	28.0%	72%	0.0%
Does typical day include regular integrated activities?	25	20.0%	70.0%	4.0%
Does the Individual's Support Plan address barriers that may limit the achievement?	27	77.8%	22.2%	0.0%
Does the individual's support plan have specific and measurable outcomes and support activities that lead to skill development or other meaningful outcomes?	27	3.7%	96.3%	0.0%
Is the individual receiving supports identified in his/her Individual's Support Plan/Plan of Care?				
Dental	26	84.6%	15.4%	0.0%
Mental Health (behavioral supports)	25	48.0%	52.0%	0.0%
Communication/assistive technology, if needed	6	83.3%	16.7%	0.0%

Healthcare

Healthcare Items - positive outcomes				
Item	***n***	***Y***	***N***	***CND***
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	27	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?	22	95.5%	4.5%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	22	95.5%	4.5%	0.0%
Is lab work completed as ordered by the physician?	24	100.0%	0.0%	0.0%
If applicable per the physician's orders, Does the provider monitor fluid intake?	7	85.7%%	14.3%	0.0%
Does the provider monitor food intake?	9	88.9%	11.1%	0.0%
Does the provider monitor weight fluctuations?	12	100.0%	0.0%	0.0%
Does the provider monitor seizures?	3	100.0%	0.0%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	*15*	*93.%*	*6.7%*	*0.0%*
If the individual receives psychotropic medication:				
Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	22	86.4%	9.1%	4.5%
Is there any evidence of administering excessive or unnecessary medication(s) (including psychotropic medication?	*27*	*0.0%*	*85.2.*	*14.8%*

Healthcare

Healthcare Items – areas of concern				
Item	***n***	***Y***	***N***	***CND***
If ordered by a physician, was there a current psychological assessment?	6	83.3%	16.7%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	26	73.1%	16.9%	0.0%
Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	12	75.0%	25.0%	0.0%
Are there needed assessments that were not recommended?	25	40.0%	60.0%	0.0%

Healthcare

Psychotropic Medications - areas of concern				
Item	***n***	***Y***	***N***	***CND***
If the individual receives psychotropic medication:				
Is there documentation of the intended effects and side effects of the medication?	23	82.6%	17.4%	0.0%
Is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	24	70.8%	29.2%	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)?	21	76.2%	14.3%	9.5%
Is there any evidence of administering excessive or unnecessary medication(s) (including psychotropic medication?	27	11.1%	77.8%	11.1%

Integration

Integration Item - positive outcomes				
Item	***n***	***Y***	***N***	***CND***
Do you live in a home licensed for four or fewer individuals with disabilities and without other such homes clustered on the same setting?	21	85.7%%	14.3%	0.0%

Integration items – areas of concern				
Item	*n*	*Y*	*N*	*CND*
If applicable, were employment goals and supports developed and discussed? If no, were integrated day opportunities offered?	24 19	20.8% 26.3%	79.2% 73.7%	0.0% 0.0%
Does typical day include regular integrated activities?	25	20.0%	76.0%	4.0%

Improvements Found Between Previous Individual Service Review (ISR) 2016-2019 and Individual Services Retrospective Review (ISRR) 2020

ISRR - ISR

Behavioral Supports ***- modest improvement -***			
	Previous Study 2016-2019	***Retrospective Study*** *4/2020*	***Improvement***
If the individual engage in behaviors that negatively impact his/her quality of life and greater independence, is there a written plan to address the behavior?			
If there is a written plan to address the behavior?	40.9%	62.5%	21.6%
Are there target behaviors for decrease?	77.8%	93.3%	15.5%
Are there functionally equivalent replacement behaviors targeted for increase?	37.5%	60.0%	22.5%
Are there new adaptive skills identified to be learned?	57.1%	78.6%	21.5%
Does the plan specify the data to be collected, summarized and reviewed to determine whether planned interventions are working?	42.9%	53.3%	10.4%
Have the data been collected, summarized and reviewed by a qualified behavior clinician?	16.7%	33.3%	16.6%
Were necessary changes made, as appropriate?	20.0%	42.9%	22.9%

ISRR - ISR

Individual Support Plan ***-slight improvements-***			
	Previous Study 2016-2019	***Retrospective Study*** *4/2020*	***Improvement***
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her Individual's Support Plan?	92.6%	96.3%	3.7%
In the individual's support plan, are all essential supports listed?	85.2%	88.9%	3.7%
If applicable, were employment goals and supports developed and discussed?	24.0%	33.3%	9.3%
Is the individual receiving dental supports identified in his/her Individual Support Plan?	77.8%	84.6%	6.8%
Is the individual receiving day supports identified in his/her Individual Support Plan?	83.3%	95.7%	12.4%
Is the individual receiving psychiatry supports identified in his/her Individual Support Plan?	91.3%	95.7%	4.4%
Is the individual receiving behavioral supports identified in his/her Individual Support Plan?	44.0%	48.0%	4.0%

ISRR - ISR

Psychotropic Medications ***-slight improvements-***			
	Previous Study 2016-2019	***Retrospective Study*** *4/2020*	***Improvement***
If the individual receives psychotropic medication:			
Is there documentation of the intended effects and side effects of the medication?	69.6%	82.6%	+13.0%
Is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	58.3%	70.8%	+12.5%
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)?	57.1%	76.2%	19.1%
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.?	85.7%	86.4%	.7%

APPENDIX C.

INDIVIDUAL AND FAMILY SUPPORT PROGRAM
PEER-TO-PEER, FAMILY-TO-FAMILY
AND
GUIDELINES FOR FAMILIES

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

INDIVIDUAL AND FAMILY SUPPORTS

By

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Consortium on Innovative Practices

May 16, 2020

I. 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 related provisions 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 Independent Reviewer's sixth, eighth, twelfth and 14th Reports to the Court, dated June 6, 2015, and June 6, 2016, June 13, 2018 and June 13, 2019, respectively, found the Commonwealth had met the pertinent quantitative requirements by providing IFSP monetary grants to at least 1,000 individuals and/or families. These same Reports to the Court further found that the Commonwealth had not met the qualitative requirements for the IFSP, but noted steady progress, which had accelerated significantly in the 12th and 14th review periods following the development of the IFSP State Plan.

In addition to developing an IFSP Strategic Plan, DBHDS had created an IFSP Community Coordination Program; organized a IFSP State Council and Regional Councils as forums for informing stakeholders about the IFSP and obtaining their input; continued to develop enhancements to the IFSP Funding Program; and undertook an initiative for a family-to-family and peer-to-peer mentoring program. Some of these efforts were still in the preliminary planning or early implementation stages at that time, but had good potential for moving the Commonwealth toward compliance.

In the preceding IFSP studies, and in the absence of specific, measurable compliance indicators, the Independent Reviewer had relied upon a set of thirteen criteria to guide the analysis. However, since the previous review period, the Parties (i.e. the Commonwealth of Virginia and the U.S. represented by DOJ) jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia has not yet been found in compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. For the next Report to the Court, due in June 2020, the Independent Reviewer's monitoring priorities again include studying achievement with the qualitative aspects of the IFSP, and will use these new agreed-upon compliance indicators going forward.

In addition, in April 2019, the Court directed the Commonwealth to develop a library of documents that would show the Court the source of Virginia's authority (i.e., its organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.) needed to demonstrate compliance. Therefore, this study will attempt to identify a minimum set of finalized policies, procedures, instructions, protocols and/or tools that will be needed for the Independent Reviewer to formulate future compliance recommendations, and whether the Commonwealth has developed relevant documents. In addition, the Independent Reviewer has asked the consultant to analyze the Commonwealth's reliable and valid data, as well as the documents and the method of analysis the Commonwealth is using, or plans to use, to determine whether it is maintaining "sufficient records to document that the requirements of each provision are being properly implemented", as measured by the relevant compliance indicators. This encompasses required reporting commitments.

For each provision cited above, this 16th period study again found DBHDS continued to make progress, but in some instances had not yet finalized development and/or implementation of the strategies intended to achieve the compliance indicators and/or formalized the reporting and documentation requirements. DBHDS still needed to focus additional attention on several areas, including the following: the definition of who would be considered "most at risk for institutionalization" for the purposes of the individual and family support program; finalizing the eligibility criteria for case management options available to individuals on the waitlist; developing the peer-to-peer support program; and, identifying indicators to assess performance and outcomes of the IFSP, including the development of capacity for the collection and the analysis of the needed data.

In addition, in some instances, DBHDS had taken some important steps forward toward implementing the requirements outlined in the compliance indicators (e.g., providing eligible individuals and families IFSP funding availability announcements), but IFSP staff sometimes provided only narrative documents that did not have any formal provenance. DBHDS still needed to translate the processes described in those narrative documents into the formal operational expectations (e.g., policies, procedures, departmental instructions, reporting capabilities) that are needed to demonstrate the source of its authority. Attachment B to this study provides a chart of the Commonwealth's current status for each requirement.

II. STUDY METHODOLOGY

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 may be found in Attachment A. A full list of individuals interviewed is included in Attachment C.

In previous IFSP studies, and in the absence of specific, measurable compliance indicators, the Independent Reviewer had relied upon a set of thirteen criteria to guide the analysis. The Parties (i.e. the Commonwealth of Virginia and the U.S. represented by DOJ) have jointly submitted to the Federal Court a complete set of compliance indicators (attached) for all provisions with which Virginia has not yet been found in compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. For the next Report to the Court, due in June 2020, the Independent Reviewer's monitoring priorities again include studying compliance with the qualitative aspects of the IFSP, and will use these agreed-upon compliance indicators going forward. This study will attempt to identify a minimum set of finalized policies, procedures, instructions, protocols and/or tools that will be needed for the Independent Reviewer to formulate future compliance recommendations. In addition, the Independent Reviewer has asked the consultant to analyze the Commonwealth's reliable and valid data, as well as the documents and the method of analysis the Commonwealth is using, or plans to use, to determine whether it is maintaining "sufficient records to document that the requirements of each provision are being properly implemented," as measured by the relevant compliance indicators.

III. FINDINGS

Section III.C.2.a-h (II.D)

The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization….
… In State Fiscal Year 2020, a minimum of 1000 individuals supported.

(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 above. 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.

The Commonwealth will achieve compliance with this provision of the Settlement Agreement when:

1) The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following:
    - Funding resources;
    - A family and peer mentoring program; and,
    - Local community-based support through the IFSP Regional Councils.
2) The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.
3) The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program.
4) The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including:
    - The number of individuals on the waiver waitlist who are provided with outreach materials each year;
    - Participant satisfaction with the IFSP funding program;
    - Knowledge of the family and peer mentoring support programs; and
    - Utilization of the My Life, My Community website.
5) Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.
6) IFSP funding availability announcements are provided to individuals on the waiver waitlist.
7) Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website
8) Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding.

At the time of the 14th Review Period, the Independent Reviewer found DBHDS had made good progress toward the development and coordination of community resources for individuals and families, as well as toward ensuring stakeholder involvement. The findings below for this 16th Review Period provide a summary of continued efforts by DBHDS to develop a comprehensive and coordinated set of individual and family support strategies, but with a highlighted focus on the need to finalize criteria for two key topics: determining the applicants most at risk for institutionalization and the eligibility of individuals for waitlist case management.

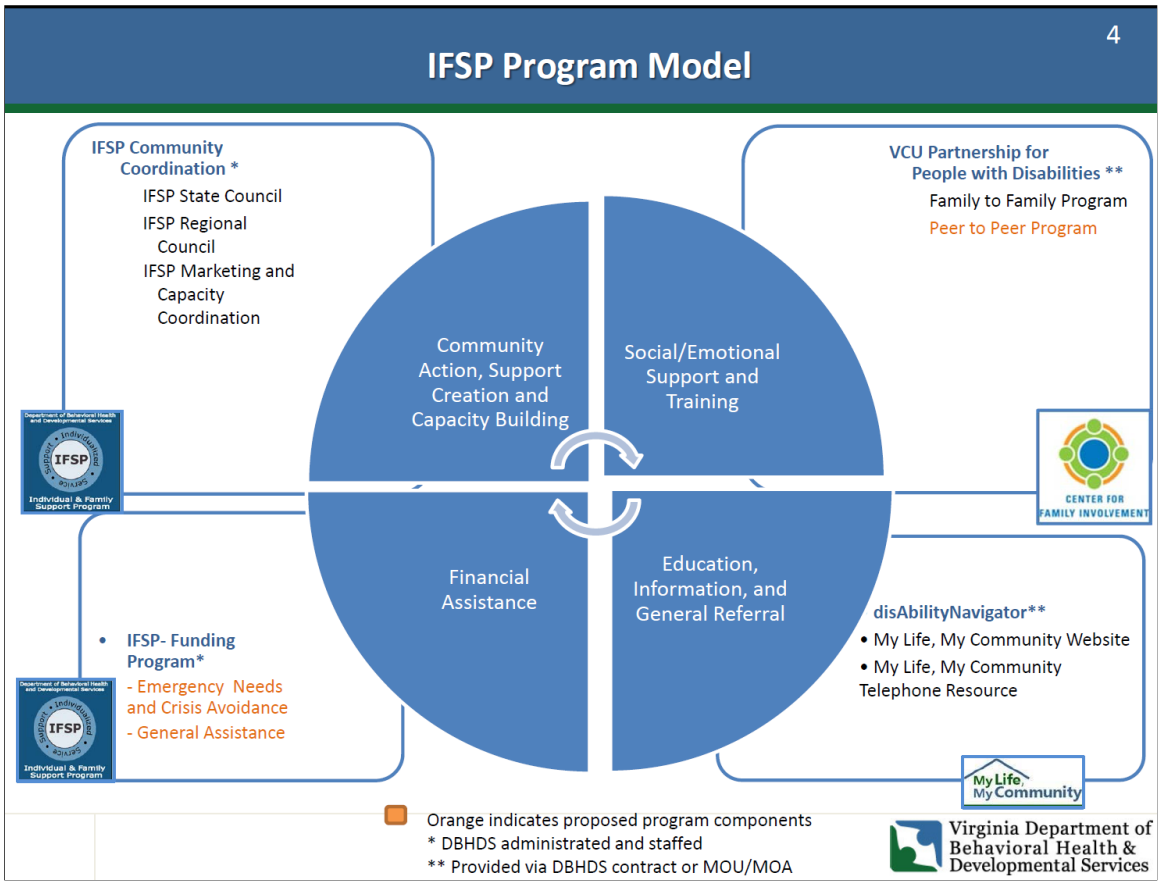
1) **The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP**

State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following:

- **Funding resources;**
- **A family and peer mentoring program; and,**
- **Local community-based support through the IFSP Regional Councils.**

As described at the time of the 14th Review Period, the conceptualization of what the IFSP will encompass continued to evolve and broaden in scope, with an emphasis on family engagement across four primary domain, including the three requirements of this compliance indicator: the IFSP Funding Program, the IFSP Community Coordination Program, family-to-family and peer-to-peer programs My Life, My Community (MLMC) website.

For the 16th Review Period, these domains remained the essential components of the IFSP as a whole, as depicted in the following graphic:



Source: Individual and Family Support Program State Council Meeting April 20,2020

The IFSP State Plan, as last updated in February 2019, included goals and objectives with regard to funding resources, family and peer mentoring programs and local community-based support through the IFSP Regional Councils. The following paragraphs provide a summary of implementation efforts for each of these three topics.

Funding Resources: As described in more detail throughout this section, DBHDS continued to implement and refine its IFSP Funding Program infrastructure. Briefly, for implementation, this infrastructure relies on the Individual & Family Support Program Application Portal, which is currently hosted on the DBHDS website. It can also be accessed via a link on the MLMC website. IFSP staff have developed various tools to support users in accessing and using the portal, including the *Individual & Family Support Program Application Portal User Guide FY 2020*, the *Individual and Family Support Program Guidelines, updated February 2020,* and a document entitled *Maximizing Your IFSP Funds: A detailed guide of allowable items, low to no-cost resources for commonly requested items and other possible services or supports available in the community, Ver. 12.10.19*. In addition, as described further below, IFSP staff had worked with other DBHDS staff to develop a robust capacity for providing all individuals on the waitlist with time-sensitive notifications of funding availability. The funding portal experienced significant issues during the most recent (FY20) funding period, which appeared to be a result of a sharp increase in applications after all members of the waitlist had been notified of the opportunity. DBHDS was working to make the necessary modifications to its software and processes, although IFSP staff indicated that the FY21 funding period might be delayed for a few months to ensure the system's readiness. Additional details with regard to prioritization criteria for funding, and potential related modifications to the overall Funding Program infrastructure, are provided below under compliance indicator 2 in this section.

A Family and Peer Mentoring Program: The Settlement Agreement required the Commonwealth to develop family-to-family and peer programs to facilitate opportunities for families and individuals considering congregate care receive information about options for community placements, services, and supports. As reported at the time of the 14th Review Period, DBHDS continued to collaborate and invest resources with the Virginia Commonwealth University (VCU) Partnership for People with Disabilities to engage with individuals and families on behalf of the Department across a platform of programs. These efforts included the implementation of a family-to-family network to provide one-to-one emotional, informational and systems navigational support to families and development of peer-to-peer networks. However, at that time, the Independent Reviewer found the Memorandum of Agreement (MOA) between DBHDS and VCU were broadly stated 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. In addition, at the time of the 14th Review Period, with the exception of copies of the MOA with VCU, DBHDS did not provide documentation of any finalized or draft policy, procedures, tools or protocols related to the family-to-family and peer programs; any data collected regarding individuals and families who have participated in the family-to-family and peer programs, and any related analyses completed; any data collected or analyses completed regarding programmatic outcomes of the family-to-family and peer programs, or any draft or finalized versions of indicators, tools, processes and/or any quality improvement strategies to be used to assess programmatic outcomes as they relate to family-to-family and peer programs.

For the 16th Review Period, DBHDS provided an updated addendum to the MOA, dated 6/10/19, to show continuation of the family-to-family program. It indicated the purpose of the collaboration

was to 1) provide direct family to family support to families of children and adults with ID/DD (particularly those receiving crisis services) in order to promote community based services and resources and to 2) develop programs that offer a continuum of peer-to-peer supports for people with ID/DD. According to the brochure for the Family to Family Network of Virginia, its intent is to support families of children and adults with disabilities and special health care needs. Through the program, Family Navigators provide support and information, and discuss options with families so they can make the best choices for their family member with a disability. Family Navigators are a parent or primary caregiver who is or has supported a child or adult family member with disabilities or special health care needs, who has been trained to support other families in accessing supports and services for their child and family and are knowledgeable about local and state resources and disability service systems. This program had been in existence for 15 years and is well-established.

On the other hand, the shape of the peer mentoring program was still evolving. The aforementioned MOA addendum indicated the goal of the collaboration was to develop feasible continuum of evidence-informed peer to peer supports for people ID/DD receiving or waiting to receive home and community-based services. Objectives included participating in DBHDS facilitated conversations to develop the continuum of peer supports, maintaining information on individuals with ID/DD who received peer to peer support, and working with DBHDS to recruit individuals with ID/DD to serve as a representative for the State IFSP Council and/or the IFSP Regional Councils. However, there was not a clear program statement about the peer services would be provided. along the lines of the family-to-family description. IFSP staff had also begun initial conversations with the Arc of Virginia to explore how a peer advocacy grant from the Virginia Board for People with Disabilities might support the creation and expansion of peer supports throughout the State. DBHDS also provided funds for the initial grant planning work by providing funds for a peer workshop, training, and a planning session at the July 2019 Arc Conference. Overall, though, DBHDS still needed to define the parameters of the peer mentoring program and provide the documentation to show the authority, policies, etc. needed to demonstrate compliance and to inform the Independent Reviewer's future determinations as well as to populate the Library.

Local community-based support through the IFSP Regional Councils: At the time of the 14th Review Period, the study described the Community Coordination program as the hub for family engagement. The primary role of that program was to support IFSP State and Regional Councils comprised of families of individuals on the waitlist. While the purpose of the State Council was to provide guidance to DBHDS reflecting the needs and desires of individuals and families across Virginia, the five IFSP Regional Councils were envisioned as the primary means of providing local community-based support (e.g., identifying and/or developing local resources and sharing those with their communities.) While state IFSP staff provided a good deal of support and technical assistance to the Regional Councils, DBHDS had also begun to tap resources at the VCU Partnership for People with Disabilities to provide some technical assistance and support to the Regional Councils.

For this 16th Review Period, IFSP staff at DBHDS reported that, during the past year, they had focused on enhancing the role of the Regional IFSP Councils. These efforts have included increasing the staffing resources dedicated to supporting the Regional Councils by converting a

contract position into a full-time salaried position to provide community support. In addition, DBHDS had expanded its utilization of VCU's Regional Navigator Coordinators (RNCs,) through the MOA cited above, to provide overall guidance, coordination and support to the Regional Councils. Based on the 6/12/19 workplan attached to the MOA, the agreement called for VCU's Center for Family Involvement (CFI) to support the IFSP Regional Councils, including meeting regularly with IFSP staff to support the goals of Virginia's IFSP State Plan related to Regional Councils; to use CFI personnel's extensive knowledge of local resources and connections to families in the community; to assist the IFSP Regional Councils to plan for and meet goals, to recruit members, and to identify resources for the MLMC website. Overall, Regional Council members interviewed for this study found this assistance to be invaluable, particularly as they continued to struggle with sustaining membership. IFSP staff and Council members alike agreed that the RNCs' extensive knowledge of local networks had helped the Regional Councils increase outreach and support at the community level, and that their assistance with planning meetings and regional activities had been invaluable. As described further below, IFSP staff and IFSP State Council members were also discussing the role of the Regional Councils in operationalizing a proposed plan to prioritize the receipt of IFSP Funding (i.e., a plan to prioritize "most at risk for institutionalization.") DBHDS had not yet fleshed out this strategy in any document or in its presentation to the IFSP State Council and it was unclear whether the Regional Councils had the resources to take on additional tasks. It was also not yet clear whether this might entail additional assistance from VCU and therefore require an amendment to the MOA

Overall, this relationship between VCU and the IFSP Regional Councils was an evolving one, and clear procedures were not always present. Where DBHDS relies on such contractual arrangements as evidence of compliance and does not have related internal policies, implementation protocols, instructions/guidelines, etc., DBHDS staff should stipulate that the dated contractual detail is a complete statement of their commitments and obligations, and will form the basis for ensuring their ongoing compliance. Future contract renewals that eliminate or otherwise limit any of the original commitments and obligations would be included in future reporting to the Library following protocols to be established by the Court.

2) **The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.**

At the time of the 14th period review, the Independent Reviewer found 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 IFSP. In interviews at that time, DBHDS staff reported they were in the early stages of considering a plan for integrating the current first come-first served requirements with the waiver waitlist priority status through a system of triaging applications and blending financial assistance with other available supports. As conceptualized, this plan would rely on screening IFSP applications on a first come-first served basis, and then prioritizing the urgency of needs and channeling requests accordingly. This plan would also leverage and integrate other ongoing crisis intervention strategies to address most critical needs. Overall, the plan appeared to hold some promise, but still required considerable fleshing out. For example, this proposed process would likely require additional IFSP staffing resources to expand the review of applications in order to weigh the urgency of need, determine the amount of funding dollars for each request and/or where to channel those requests and, for those referred elsewhere, follow-up

to ensure the supports had been received. DBHDS reported they had not yet fully evaluated how this conceptualized approach would play out. In addition, IFSP staff had not yet discussed these strategies with stakeholders, but were planning to soon engage the IFSP State Council.

For this 16th review period, DBHDS had not yet determined how to address the "most at risk" criteria, and thus the IFSP State Plan did not yet include such criteria. IFSP staff provided documentation that they had introduced the basic premises described at the time of the 14th review period to IFSP State Council members in May 2019, and discussed them further at a subsequent meeting in April 2020. The relevant meeting summaries documented a continued evolution and refinement of the conceptual approach, as described further below.

The May 2019 presentation to the IFSP State Council indicated DBHDS envisioned moving from general cash assistance only toward an application process that would triage applicants to cash assistance and/or social emotional support based on pre-defined priorities. Specifically, the presentation proposed that DBHDS would maintain three separate priority pools of funds, including 1) Crisis Assistance with a funding threshold set at a higher level and social emotional support provided by the Virginia Commonwealth University (VCU) Family-to-Family Program; 2) Emergency Needs and Crisis Avoidance with a flexible funding threshold and social emotional, also supported by the VCU Family-to-Family Program; and, (3 General Assistance to fund need specific requests at a lower funding threshold, with social emotional support provided by the IFSP Regional Councils.

The May 2019 meeting summary further indicated that the State Council members discussed several strategies for operationalizing this prioritization approach included the following:

- Working with the State Council to establish emergency categories and assist with establishing typologies for those most at risk for crisis assistance;
- Developing a typology of most-at-risk based on characteristics of those identified by a data review process as having the characteristics that will make them more likely to be referred for crisis in the next 12 months;
- Conducting initial screening and assessment for other sources of assistance and making referrals for information and referral to Senior Navigator as needed. If families need additional support and wanted to be matched with a family mentor, RNC's would conduct initial screenings and assessment for assistance to identify other sources of assistance and make referrals for information. RNCs would also match Family-to-Family program Family Navigators (FN's) as appropriate and provide oversight and monitoring

By the time of the April 2020 State Council meeting, DBHDS had not implemented this set of prioritization criteria. According to the meeting summary and materials provided, it appeared they had continued to tweak the proposed process. The presentation to the State Council members indicated that the IFSP Funding Program would maintain two separate priority pools of funds: 1) Emergency Needs and Crisis Avoidance with a flexible funding threshold and emphasis on referral for social emotional support by the VCU Family-to-Family Program, and 2) General Assistance to fund need specific requests at a lower funding threshold with social emotional support provided by the IFSP Regional Councils. The proposed timelines for implementation were as follows:

- By June 2020, IFSP staff would present the IFSP State Council with FY21 Funding Program priorities and timelines.
- By Summer 2020, IFSP staff would develop and formalize partnerships needed to execute the design, finalize the programming needed to support the new model and work with the Regional Councils to share information on the program design.
- By Late Fall/ Early Winter 2020, IFSP staff would implement the changes into the FY21 Funding Program structure and work with partners to assess their capacity to assist with and evaluate the model.

State Council members suggested that DBHDS should survey the public with regard to this proposed approach and discuss the results at the beginning of next meeting. They also stated a need to develop a strong communication plan to explain this to families, with infographics, as well as a solid plan and accompanying deadlines. Given the lack of specific detail in the presentation about the operational details, these were excellent recommendations. Following the IFSP State Council meeting, IFSP staff indicated that DBHDS planned to move forward with these recommendations, beginning with presenting a final draft of the model, along with some marketing materials, at the June State Council meeting; a plan to survey the public in June and August 2020, in concert with the satisfaction survey process and through virtual town hall meetings; and, to implement the funding prioritization in the FY 21 funding cycle. Given the short timeframes, they were also considering a later application date than usual for that FY21 funding cycle, which would allow them more time to educate the public and to ensure the Regional Councils had sufficient capacity to serve in their projected roles.

As pending improvements are approved and made, DBHDS continued to need to provide the following minimum set of documentation, once finalized:

- Policy defining criteria for "most at risk for institutionalization."
- Policy and/or instruction describing or otherwise illustrating all components of the screening process, including any associated protocol and/or criteria used.
- As other entities are involved in the implementation of this process, the agreements outlining the various responsibilities and any associated protocol.
- Evidence of stakeholder participation in the development of and/or approval of these policies, procedures and protocol.
- Evidence of dissemination to all impacted Parties as part of the on-going communication plan.

The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program.

At the time of the 14th Review Period, the study continued a previous recommendation that DBHDS needed to finalize and implement a process by which all individuals on the waitlist and their families receive timely announcements and information about the IFSP Funding Program and other available supports. DBHDS staff were aware of the continuing challenge to ensuring that all individuals and families on the waitlist had access to information about accessing services. IFSP personnel reported they were planning to align notifications of IFSP funds with communications to families upon their entry to the waiver waitlist and annually as a part of the waiver waitlist attestation process.

At the time of the 16th Review Period, IFSP staff reported they had worked with the Office of Integrated Supports Services to revise the language in the annual waiver waiting list attestation letter to include information about the MLMC website and general information on peer supports offered through VCU. The purpose of the letter was to operationalize the requirement to contact individuals on the waiting list every year to make sure they still desired to remain on it. Based on review of the letter template, it also informed recipients that individuals on the waitlist were eligible for supports offered through the IFSP through the following statement: "To learn more about IFSP and related resources/supports that may be available to you, go to My Life My Community on the web at http://www.mylifemycommunityvirginia.org/ or call 844-603-9248 to speak with a live operator by phone."

In addition, IFSP staff reported some other new or pending enhancements to their overall communication strategies. For example, in January 2020, they had begun providing families with a periodic news digest highlighting resources, events and trainings that might be of interest to self-advocates and families. IFSP staff also reported having received approval to add a Marketing Specialist position who would be responsible for creating and implementing an overall communication plan. However, this had been delayed due to the COVID-19 public health emergency.

3) **The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including:**
    - **The number of individuals on the waiver waitlist who are provided with outreach materials each year;**
    - **Participant satisfaction with the IFSP funding program;**
    - **Knowledge of the family and peer mentoring support programs; and**
    - **Utilization of the My Life, My Community website.**

At the time of the 16th review period, DBHDS had not updated the IFSP State Plan (revision date February 6, 2019) since the time of the previous review. The study's findings for the 14th Review Period therefore continued to be applicable. At that time, the study noted that the IFSP State Plan identified a set of outcome targets for each of its short-term goals, which thoughtfully addressed some of the recommended measure (e.g., access, as measured by individual and family levels of

awareness of the IFSP, and individual and family satisfaction.) Examples of outcome targets for access included that 80% of individuals on the waiver waiting list who were Priority One had been outreached for assistance, and that 90% of people on the waiver waiting list indicated awareness of IFSP and supports. Other identified targets focused on performance measures that appeared to address underlying desired outcomes. It was positive that IFSP staff had developed a data collection matrix of its current efforts at data collection, which included both quantitative and qualitative measures and identified the data collection schedule (i.e., quarterly or annually.) Generally, this set of data measured system outputs, such as the number of trained family navigators and the number and types of events where IFSP materials were presented, rather than outcomes, such as increased awareness or other results for individuals/families.

However, one notable effort to measure outcomes was the ongoing annual satisfaction survey, as it related to individual and family satisfaction with the IFSP Funding Program. For the past three years, IFSP staff had issued a survey to all individuals who had received IFSP funding during each particular year. As reported for this 16th Review Period, for FY19, they reported sending out 2,752 surveys, and receiving 815 responses. Overall, respondents reported favorable experiences across a number of indicators. Many of these measured satisfaction with the processes, although one did ask respondents to rate how much they agreed with a statement that the funding had a positive impact on their lives.

However, this approach to measuring satisfaction was limited, in that it only measured the satisfaction of those who were awarded funding (i.e., were successful in getting their applications in before the funds were exhausted.) In other words, this likely did not provide the full picture of the satisfaction of all eligible individuals and families who sought funding. Instead, it focused only on those who would be most likely to report satisfaction with the process and the IFSP Funding Program as a whole. Measuring the satisfaction of this latter group as a subset might provide some valuable data with regard to how the receipt of funding impacted individual outcomes. However, for purposes of program improvement, it would also be essential to survey those whose applications were not approved to identify and understand the problems or challenges those applicants experienced. In addition, DBHDS should be cautious about reporting the current dataset to the public as representing overall funding program satisfaction without significant caveats.

DBHDS staff had not yet issued the FY20 satisfaction survey, but the IFSP Funding Program was beset with significant issues during this funding period. Based on interview with IFSP staff, the system was not prepared for a much higher rate of applications, likely due to the positive effort of DBHDS staff to notify all individuals on the waitlist, and the software could not handle the greater influx. As a result, the funding portal shut down within minutes of opening, so that many people could not submit applications. For those who were able to submit applications, some experienced a compromise of their personal data, including their Social Security numbers. DBHDS had taken immediate and ongoing action to remedy these issues, which was positive. However, for full transparency, as well as an opportunity for lessons learned, DBHDS staff should consider measuring the satisfaction of the entire applicable population rather than only those who received funding.

As reported previously, going forward, DBHDS will also want to consider additional measures to assess impact on risk of institutionalization, the comprehensiveness of the IFSP, as it reflects the expressed needs of those it is designed to serve, and the degree and adequacy of coordination, both on a systemic and individual basis. This should include a measure to assess the evenness and consistency of the implementation of waitlist case management. DBHDS will also need to consider how it will integrate key IFSP measures into its overall departmental Quality Improvement/Risk Management Framework.

5) Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.

For both components of this compliance indicator (i.e., eligibility for IFSP funding and for waitlist case management), DBHDS had continued to develop new processes and/or to update relevant information. However, as described below, DBHDS still needed to finalize and publicize the criteria upon which eligibility for IFSP funding (i.e., "most at risk for institutionalization") and waitlist case management would be based

Eligibility for IFSP Funding: For the 14th Review Period, DBHDS had continued some outreach efforts to those on the waiting list regarding the IFSP Funding Program. However, based om interviews completed 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**.**

For the 16th Review Period, DBHDS had undertaken an effort to inform individual and families, upon being placed on the waiver waitlist and annually thereafter, of their eligibility for IFSP supports. As described above, DBHDS had implemented an annual waiver eligibility attestation process in which every individual on the waitlist received a letter on or around the anniversary date of the initial determination. As provided for review, this letter included the following statement: *"Individuals on the DD Waiver Waiting List are eligible for supports offered through the Individual and Family Support Program (IFSP). To learn more about IFSP and related resources/supports that may be available to you, go to My Life My Community on the web at http://www.mylifemycommunityvirginia.org/ or call 844-603-9248 to speak with a live operator by phone."* While the letter did not provide specific notification that the supports in question could include funding, it was very positive that DBHDS had undertaken this significant effort to notify all individuals on the waitlist about the IFSP program and how to obtain more information.

However, as described above with regard to compliance indicator 2, this effort was compromised by the continuing lack of clear criteria defining "most at risk for institutionalization" and how that would impact eligibility. In other words, informing individuals of their eligibility for IFSP Funding in a meaningful way requires that clear eligibility criteria exist.

Waitlist Case Management: At the time of the 14h Review Period, this reviewer found that DBHDS protocols did not provide clear guidance with regard to individuals' eligibility to receive case management (or support coordination, as it is also known) while on the waiver waitlist. For example, various regulatory guidance documents (e.g., the 2016 Medicaid State Plan Amendment for targeted case management and emergency regulations, etc.) indicated that individuals with developmental disabilities "may" receive time-limited case management when a "special service need" existed. However, none of the documents provided any criteria for what could constitute a "special service need," and neither stakeholders or case managers interviewed at that time had a clear understanding of the meaning of that term. The 14th Review Period study recommended that DBHDS needed to clearly define expectations for case management options available to individuals on the waitlist, as those 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. This included defining specific policy and procedure that would standardize the eligibility determination process across all CSBs. Further, DBHDS still needed to ensure individuals on the waitlist and their families were informed about these options.

For this 16th review period, DBHDS staff had made some updates to various guidance documents, but additional clarifications were still needed. The following paragraphs outline the updates as well as the outstanding concerns:

- At the time of the 14th period review, DBHDS had issued emergency regulations in conjunction with the roll-out of its re-designed waivers, which indicated individuals on the waiting list could receive, or be eligible for, individual case management services from the Community Services Boards (CSBs). However, those regulations (i.e., 12VAC30-50-455) did not clearly define expectations for case management options available to individuals on the waitlist. Instead, regulatory language included the following: "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." The regulations did not provide specificity about the circumstances under which individuals on the waiting list "may" receive case management services or provide guidance about how eligibility decisions would be made.

  At the time of this 16th period review, DBHDS staff reported the above-referenced emergency regulations had expired and permanent regulations had not yet been adopted. Instead, DBHDS staff provided another document, *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist*, 4/22/20, that referenced specific regulatory standards for support coordination/case management services across the Commonwealth. These included the following: DBHDS Office of Licensure regulations (12VAC35-105-1250), DBHDS Performance Contract requirements (http://dbhds.virginia.gov/office-of-management-services) and DMAS regulations for Targeted Case Management (12VAC30-50-440, 12VAC30-50-450). However, upon review, none of these documents specifically referenced eligibility, or related criteria, for waitlist case management. Therefore, at this time, it appeared the Commonwealth did not have a

clear regulatory basis for the provision of case management to individuals on the waitlist.

- At the time of the 14th review IFSP staff provided a working document entitled *Case Management Options for Individuals on the DD Waivers Waitlist Guidance Document for Development for Family Marketing on Case Management Eligibility, Ver. 4/2019*, that included information with regard to case management for individuals on the waitlist. It stated that individuals with developmental disabilities, other than intellectual disability, who are on the waiting list generally do not receive routine support coordination/case management services unless there is a "documented special service need." It went on to define a "special service need" as one that requires linkage to and temporary monitoring of those supports and services identified in the ISP to address an individual's mental health, behavioral, or medical needs, or provide assistance related to an acute need that coincides with support coordination/case management allowable activities. Further, it indicated that "(i)f a special service need is identified, an ISP, in compliance with DBHDS Licensure Regulations, is developed to address the special service need."

For the 16th review period, DBHDS provided two versions of the above-referenced *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist*, dated 2/25/20 and 4/22/20 respectively. While the most recent version had a DBHDS logo in the header, it did not appear to be in the form of a formal policy or departmental instruction. The two documents contained virtually identical language with regard to waitlist options, except that the 4/22/20 version referenced the specific regulatory standards for support coordination/case management services, as cited under the previous bullet. Both contained the same language as the version from 4/2019 with regard to a "special service need," with no further definition of the criteria to be applied or the process for determination of eligibility. This language continued to be vague and open to various interpretations from one CSB to another; indeed, from one case manager to another. For example, many individuals on the waitlist might be expected to have needs that required linkage to supports and services to address an individual's mental health, behavioral, or medical needs, so it was not clear what might make such a need "special." The language was also somewhat circular in nature with regard to that determination, indicating that, on the one hand, the "special service need" is one that is identified in an ISP, but on the other, that the case management agency would develop an ISP if a "special service need" was identified.

At the time of the 14th Review Period, DBHDS had not yet been disseminated this information directly to individuals on the waitlist or their families and DBHDS staff indicated that it anticipated the primary methods for such dissemination would be on the MLMC website and included in an annual attestation process for waitlisted individuals (described further below.) The Independent Reviewer then recommended that DBHDS should ensure the needed clarifications, policies and procedures are made before dissemination occurs. For this 16th Review Period, this recommendation stands.

- At the time of the 14th review period, the study found that 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 services, noting that there was the option for case management/support coordination that was not connected to waiver-funded services. It further indicated 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. However, DBHDS had not promulgated any related standardized procedures for making such eligibility determinations, such as specific criteria or a uniform screening This continued to be the case for this review period.

  For this 16th review period, DBHDS had updated the aforementioned publication, *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019*. It referenced the now-expired regulatory language, which will need to be updated when new regulations are finalized. The guide also included a related question and answer (below), but it did not provide any substantive additional guidance to individuals and families with regard to eligibility criteria for TCM while on the waiting list. In fact, without additional clarifying language, families might construe this answer to mean their family member could not receive case management services unless they paid for them.

  > *Q: While my family member is on the DD Waiver Statewide Waiting List, do I have to pay for Support Coordination services?*
  > *A: All individuals on the waiting list are not required to receive Support Coordination services; however, the Support Coordinator should contact you and your family member annually to determine if anything has changed that affects your position on the waiting list. Some individuals on the waiting list are not financially eligible for Medicaid at the time of application, but will be eligible when they are approved for the DD Waiver. If you feel that your family member needs Support Coordination services and he/she is not currently Medicaid-eligible, the CSB may provide the services on a sliding fee scale.*

- As reported at the time of the 14th review period, on April 12, 2019, DBHDS had implemented a web-based Development Disabilities Support Coordination Manual (https://sccmtraining.partnership.vcu.edu/supportcoordination/), which included information about case management for individuals on the waitlist. This information stated that TCM services are services furnished to assist individuals, eligible under the Medicaid State Plan, which could include, among other individuals, a "person with a developmental disability on the waiting list for the DD Waiver who is eligible for Medicaid AND has a short term special need…" However, the manual did not provide any guidance for case managers or CSBs about what could qualify as a "short-term special need."

For the 16th review period, this study found the language remained the same and did not reveal any additional or clarifying information on the topic of case management for individuals on the waitlist. The material also still referenced the expired emergency regulations, which DBHDS should update as applicable.

As a result of these continuing issues, this 16th Review Period study continues to recommend that DBHDS should provide the following minimum set of documentation to inform the Independent Reviewer's future analysis of compliance:

- Policy on case management options for individuals on the waitlist, including TCM for Medicaid eligible-individuals and other options for non-Medicaid eligible individuals.
- Policy/instruction defining "DD or ID active support coordination/case management service criteria" and "special service need" and any associated protocol to be used by CSBs both for making determinations of eligibility and for terminating services.
- Guidelines for individuals on the waitlist and families regarding case management options and how to apply for them.
- Instructions/protocols for dissemination and notification to individuals on the waitlist and all other impacted entities.
- Evidence of dissemination and notification.

6) **IFSP funding availability announcements are provided to individuals on the waiver waitlist.**

At the time of the 14th Review Period, DBHDS did not have a methodology in place to ensure that all individuals on the waitlist received timely notifications of IFSP funding availability.

For this 16th Review Period, it was positive that IFSP staff undertook an initiative in June and July of 2019 to ensure that every individual on the waitlist would receive a timely notification about the upcoming IFSP funding period, either by email or by postal service. This required an intensive effort by multiple staff to ensure complete coverage, and was to be applauded. IFSP staff provided a document describing the steps they had taken to achieve this goal, which also included sending funding period announcements out through various listservs. This was a robust and thorough process. It was good to see that the notification also provided information about some other services for which individuals and families of the waitlist might be eligible, such as IFSP Regional Councils, CSBs, the VCU Family-to-Family program. However, the information did not specifically reference case management options For purposes of identifying the basis for programmatic authority and continuity, DBHDS should develop a formal expectation (e.g., a policy, procedure, departmental instruction, etc.) that, going forward, all individuals on the waitlist will receive direct timely notifications from DBHDS of upcoming funding periods.

7) **Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website.**

At the time of the 14th Review Period, DBHDS had not yet launched the MLMC website, but IFSP staff reported they intended to post eligibility guidelines on the site once it became operational.

At the time of the 16th Review Period, the website was operational and DBHDS had posted various eligibility guidelines for IFSP resources and other supports and services on the MLMC website. The following provides examples of key documents and information found on the website in April 2020 and May 2020, and identifies some continuing issues with regard to their adequacy and utility. These concerns are also discussed elsewhere throughout this report.

- The *Individual and Family Support Program Guidelines, updated February 2020*. As the Independent Reviewer has previously reported, these guidelines were mostly thorough and clearly written, and served as a valuable resource for individual and families seeking funding assistance through the IFSP. However, they did not yet provide a clear description of how the program would serve those who were "most at risk for institutionalization."
- The *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019,* which was also a valuable resource, but which will require updating to reflect new regulations, upon their adoption, and a clear and consistent description of case management options for individuals on the waitlist.
- The MLMC website has a search capacity that allows users to search for specific services in their desired locations. Based on interviews with stakeholders and this reviewer's own experience, users sometimes found the system was often not intuitive enough for a layperson to use and could be difficult to navigate. It was positive to note that at the IFSP State Council meeting on 4/20/20, members made some good observations and recommendations with regard to the website's functionality and even offered to do user testing. In interview with Senior Navigator staff, they were very open to further improvements and looked forward to the possibility of user testing by State Council members.
- In May 2020, the MLMC website posted the *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist*, dated 4/22/20. However, as described above, this document did not provide clear guidelines for individuals and families with regard to the types of needs that would be considered as a "special service need" or describe the expectations for CSBs to apply those with consistency.

8) **Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding.**

DBHDS continued annual distribution of IFSP funding to eligible individuals and families. For the last full Fiscal Year, (FY19), the number of individuals served exceeded the required 1,000, with a distribution of $2,998,243 to 3,028 individuals and families. For FY 20, year to date, DBHDS has approved funding for approximately 2,291 applications and distributed approximately $2.3 million, which already exceeds the requirements of this compliance indicator. IFSP staff reported they anticipate distributing a total of $2.5 million for FY20.

Section III.C.8.b.

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

The Commonwealth will achieve compliance with this provision of the Settlement Agreement when:

1) DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website.
2) Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families.

The following describes the current status, including progress made since the previous review, with regard to these indicators.

1) **DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website.**

At the time of the 14th Review Period, DBHDS had continued to collaborate with Senior Navigator to re-brand and expand upon the My Life My Community (MLMC) website to provide a centralized on-line portal for individuals and families to access relevant information about availability of community supports and services. The on-line informational website had its "soft launch" at the end of March 2019 and was expected to be officially launched at the time of its review by the IFSP Councils in May 2019, with content continuing to expand over time.

For this 16th Review Period, and as described earlier in this report, in August 2019, DBHDS and Senior Navigator had formally launched the MLMC website. It included various forms of information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. However, some improvements were still needed in content and functionality, as described above.

Senior Navigator made regular quarterly reports to DBHDS about activity on the website including, but not limited to, data for the number of sessions, number of users, number of page views, number of returning and new visitors and average duration users spend on the site. In addition, they reported on the volume of calls to their call center seeking technical assistance or additional information, including data about frequently asked questions and topics. Finally, the reports provided narrative updates about new materials and functionalities added since the previous report. It was impressive that, in interview, Senior Navigator staff reported significant increases in site usage, which may be construed as an indicator of overall public awareness. For example, when comparing usage between the first quarter of 2019 (i.e., 1/1/19- 3/31/19) to that of the first quarter of 2020 (i.e., 1/1/20- 3/31/20), the number of sessions increased by 398%, the number of users increased by 408% and the number of page views increased by 661%.

With regard to other documentation needed that will be provided in the library, the Commonwealth should identify the source of Virginia's authority for this compliance indicator, and should provide the original contract between DBHDS and Senior Navigator, dated 9/27/17, as well as the contract renewal addendum, dated 8/15/19. The original contract provided a detailed and thorough description of the tasks and activities Senior Navigator would perform on the behalf of DBHDS. As previously indicated, where DBHDS relies on contractual arrangements as evidence of compliance and does not have related internal policies, implementation protocols, instructions/guidelines, etc., DBHDS staff should stipulate that the dated contractual detail is a complete statement of their commitments and obligations, and will form the basis for ensuring their ongoing compliance. If any future renewals eliminate or otherwise limit any of the original commitments and obligations, the information in the Library would be modified and the Parties notified in accordance with instructions from the Court.

2) **Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families.**

In response to the document request for this study, IFSP staff reported they had identified a list of organizations and entities with whom to share information about the MLMC website, and stated that their goal was to work on the distribution of the resources once they had on-boarded the new marketing specialist, as described earlier with regard to the IFSP communication plan. DBHDS expects that this will occur during the seventeenth review period.

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.

*(**IV.B.9:** PSTs and the CSB case manager shall coordinate with the specific type of 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 Representative 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 and peer programs to facilitate these opportunities.)*

The Commonwealth will achieve compliance with this provision of the Settlement Agreement when:

1) At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources.
2) The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested.
3) The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to- family and the peer-to-peer supports have contact and the number who receive the service.

At the time of the 12th and 14th Review Periods, the Independent Reviewer found the proposed Memorandum of Agreement (MOA) between VCU Center for Family Involvement (CFI) were broadly stated and did not specify how the proposed Family-to-Family and Peer Mentoring 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. For individuals on the waitlist, the continuing lack of clarity regarding this interface is similar to and may derive in part from the continuing lack of criteria for case management eligibility. With the exception of copies of the MOA with VCU, DBHDS did not provide any finalized or draft policy, procedures, tools or protocols related to the family-to-family and peer programs; any data collected regarding individuals and families who have participated in the family-to-family and peer programs, and any related analyses completed; any data collected regarding programmatic outcomes of the family-to-family and peer programs, and any related analysis completed; or, any draft or finalized versions of indicators, tools, processes and/or any quality improvement strategies to be used to assess programmatic outcomes as they related to family-to-family and peer programs. Documentation of the authority, policy and processes as well as reports of performance are necessary to demonstrate that the requirements of this Agreement are being properly implemented.

The following provides a summary of the status of these indicators for the 16th Review Period.

1) **At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources.**

DBHDS did not provide specific data to show that at least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources. The Informed Choice Form had been modified to include a section for the Support Coordinator to check whether or not he or she provided the individual opportunities to speak with other individuals receiving waiver services who live and work successfully in the community. On its own, this would not seem to be sufficient to show that individuals had received information on the other Family-to-Family and Peer Mentoring resources available through the VCU CFI, as described earlier in this report. In addition, the Independent Reviewer has identified many examples of check boxes without accompanying notes are not reliable indicators that the activity has been completed. However, as described below, the Informed Choice Form also indicated that the individual could contact the VCU CFI Family-to-Family network, and provided email and telephone contact information. It was not clear that, by signing the Informed Choice Form, individuals were acknowledging that they had received specific information. DBHDS should provide a clear protocol for the use of the Informed Choice Form, and the expectations that Support Coordinators will inform individuals of the various resources. Once DBHDS staff can then confirm consistent application of the expectations, this would presumably allow them to reliably use the aggregate data from the form to show that this indicator has been achieved.

Beyond the Support Coordinator checkbox to indicate if an individual had been provided with opportunities to talk to other individuals living and working successfully in the community, the Virginia Informed Choice Form did not specifically address "Peer Mentoring" resources. As described earlier in this report, peer mentoring resources had not been fully developed.

2) **The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested**.

For the 16th Review Period, a review of the Informed Choice Form indicated the Support Coordinator should complete it at initially and annually, as stated in the compliance indicator, but also in other circumstances that might indicate a change in status (e.g., upon requests for new services or a change in providers.) This was positive. When questioned about the other documents that would show the Court the source of Virginia's authority in this area, DBHDS Provider Development staff indicated uncertainty with regard to the policy, procedure or protocols that might be included in that Library. He noted these requirements were woven throughout case management expectations, but also further noted the expiration of the emergency regulations that formalized those requirements. DBHDS will need to determine the documentation that will allow for the Independent Reviewer's future analysis of achievement for the indicators in the focus area.

In addition to the above, IFSP staff reported they had worked with Provider Development staff to ensure references for Family-to-Family and Peer Mentoring were incorporated into the Virginia Informed Choice Form. In interview, Provider Development staff indicated the Informed Choice Form included information for the Family-to-Family program, but not specifically for peer mentoring. A review of the Informed Choice Form confirmed this latter report.

3) **The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to- family and the peer-to-peer supports have contact and the number who receive the service.**

The VCU-CFI provided regular reports to DBHDS with regard to family-to-family supports, including the number of individuals who receive various categories of services. However, based on review of the most recent data report provided, for the date range of 7/01/19 through 12/19/19, it continued to be unclear how, or if, these data reflected any results from the initial or annual ISP informed choice processes. The data provided did not specifically address whether the individuals were receiving DD waiver services, nor did the data fields indicate that this specific topic had been addressed for any of the families served. While it was positive that the CFI kept these valuable data with regard to family needs, they could not be used to substantiate achievement with these indicators. Once DBHDS issues a clear policy, procedure or protocol with regard to the expectations for the Informed Choice Form, DBHDS staff may want to revise the MOA with VCU to keep and report specific data on this topic.

The VCU-CFI data reports did not include specific data with regard to peer-to-peer mentoring.

IV. CONCLUSIONS AND RECOMMENDATIONS

For this 16th Review Period, DBHDS had continued to make some progress in each of these areas, as described above, but work was still needed for many, also as described above. Recommendations for continued progress included the following:

1. DBHDS should provide documentation as recommended throughout this report show the Court the source of Virginia's authority (i.e., its organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.) needed to demonstrate that each indicator of compliance have been achieved.

2. In addition, where DBHDS relies on contractual arrangements as evidence of compliance, policies, implementation protocols, instructions/guidelines, etc., are required whether they are produced by DBHDS or VCU. DBHDS staff should stipulate that the dated contractual detail is a complete statement of their commitments and obligations, and will form the basis for ensuring their ongoing compliance. Any future renewals that eliminate or otherwise limit any of the original commitments and obligations would be included in future reporting to the Library and to the Parties.

3. DBHDS still needed to define the parameters of the peer mentoring program and provide the documentation to show the source of Virginia's authority needed to demonstrate that the indicators of compliance have been achieved.

4. DBHDS should finalize and formalize the definition of "most at risk for institutionalization" as it impacts eligibility requirements and program structure for the IFSP Funding Program, beyond the existing first-come, first-served approach. As recommended previously, this process should be undertaken in a fully transparent communication process with stakeholders.

5. DBHDS should clearly define expectations for case management options available to individuals on the waitlist, as those relate to facilitating access to the IFSP Funding Program and to the broader array of individual and family supports for which they might be eligible. This would include defining specific policy and procedure that would establish minimum standards for the eligibility determination process, with regard to a "special service need," across all CSBs. Further, DBHDS should ensure individuals on the waitlist and their families are informed about these options.

6. DBHDS should finalize a set of 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. For purposes of sustainability, DBHDS should select and incorporate key measures into its overall Quality and Risk Management Framework as that is further developed.

7. With regard to IFSP Funding, for full transparency, as well as an opportunity for lessons learned, DBHDS staff should consider measuring the satisfaction of the entire applicable population rather than only those who received funding.

8. In its MOU with VCU, DBHDS should clearly specify the proposed interfaces between the VCU family to family and peer mentoring programs and the annual individual service planning and informed choice processes.

9. Once DBHDS issues a clear policy, procedure or protocol with regard to the expectations for the Informed Choice Form, DBHDS staff should revise the MOA with VCU to include keeping and reporting specific data on families and individuals for whom they provided family and peer mentoring services for the purposes of the Settlement Agreement requirements.

ATTACHMENT A: DOCUMENTS/DATA REVIEWED

1. Annotated Responses to Study Questions
2. Virginia's Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities, Updated 2/16/19
3. Individual and Family Support Program Guidelines, Updated February 2020
4. Allowable Expenses
5. Maximizing Your IFSP Funds, Version. 12/10/19
6. IFSP Data FY 2013 through FY 2019
7. IFSP Flyer
8. FY 2019 IFSP Funding Data-Summary, 8/28/19
9. FY20 User Guide Wave 3
10. FY19 Satisfaction Survey
11. FY 2019 IFSP Funding Satisfaction Survey Results
12. IFSP Digest, Jan 2020, Feb 2020
13. Cumulative Council Membership, April 2020
14. DBHDS IFSP State Council Meeting Summary, Sept. 27, 2019
15. IFSP September 2019- Council Presentation
16. September 2019 State Council Meeting and Notes
17. IFSP State and Region Council Conference Meeting Agenda, 5/3/19
18. Regional Council in a Box
19. 2020 IFSP Council Calendar Planning Worksheet
20. IFSP Support Specialist- Community Coordination Job Description
21. Program Administration Community Support Marketing Specialist Contract Temp (IFSP Marketing Specialist, 5/20/19
22. Navigating the DD Waivers Updated, 6/18/19
23. Individual and Family Support Merged Charters, 1/29/20
24. MyLifeMyCommunityVirginia.org Webpage and Call Center Stats, 1stQuarter FY20
25. MyLifeMyCommunityVirginia.org Webpage and Call Center Stats, 2ndQuarter FY20
26. Target Organizations for Outreach and Information
27. Virginia's Family Engagement Model: Shifting Virginia's Individual and Family Support Program Revised: April 2019
28. Framework for Council Prioritization Model, 5/1/19
29. Framework for Council Prioritization Model, 4/16/20
30. Getting to 100 percent Contact for Individuals on the WWL (7/11/19)
31. Notification of DD Waitlist Eligibility, 7/31/19
32. Annual Attestation Cover Letter, English and Spanish
33. CMS-Approved Virginia Medicaid State Plan Case Management 16-010
34. IFSP Update Summary CDR, 3/31/20
35. Case Management Options for Individuals on the DD Waivers Waitlist Guidance Document for Development for Family Marketing on Case Management Eligibility, Ver. 4/2019
36. Case Management Options for Individuals on the DD Waivers Waitlist 5/5/20
37. Case Management Options for Individuals on the DD Waivers Waitlist, 2/25/20
    IFSP State Council Meeting Agenda, with Minutes, 4.20
38. Development Disabilities Support Coordination Manual (https://sccmtraining.partnership.vcu.edu/supportcoordination/
39. DBHDS Office of Licensure regulations (12VAC35-105-1250)
40. DBHDS Performance Contract requirements (http://dbhds.virginia.gov/office-of-management-services)
41. DMAS regulations for Targeted Case Management (12VAC30-50-440, 12VAC30-50-450)
42. Expired emergency regulations (12VAC30-50-455)
43. Virginia Application Individual and Family Support Community of Practice, 3/5/19
44. Virginia Navigator Contract, 9/27/19

45. 720-4632, Contract Renewal with Virginia Navigator, 8/31/19
46. MLMC webpages, accessed 4/20/20-4/22/20
47. 720-4671 MOA Partnership for People-revised, 5/30/18
48. DBHDS F2F, P2P, LEAP Workplan FY2020 with Addenda Version Date: 6/10/2019 and Version Date: 11/1/2019
49. Family-to-Family-Network-of-VA-Brochure-2018
50. Virginia Informed Choice Form, 6/5/19
51. CFI and F2F Description
52. F2F-CFI Description
53. CFI Referral Process and Form
54. DBHDS F2F and P2P Report July 2019 to Dec 2019
55. CFI Data Report July to Dec 2019
56. CFI Data Report Oct Dec 2019
57. Arc Self Advocacy Proposal VA Board

ATTACHMENT B The status of DBHDS development of Documentation that aligns with the Compliance Indicators		
Provision text	**Indicator**	Status
III.C.2.a-f **(II.D)** The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization…. … In State Fiscal Year 2019, a minimum of 1000 individuals supported. (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 above. 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.	1) The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following: • Funding resources • A family and peer mentoring program • Local community-based support through the IFSP Regional Councils	IFSP State Plan, version issued February 16, 2019. Requires updating every three years. No overall report for plan goals and objectives. Some, but not all, are reported elsewhere, as identified below. Peer mentoring not fully implemented, no data reports provided.
	2) The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.	Pending, projected for Fall/Winter 2019
	3) The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program.	Documentation confirmed
	4) The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including: • The number of individuals on the waiver waitlist who are provided with outreach materials each year • Participant satisfaction with the IFSP funding program • Knowledge of the family and peer mentoring support programs • Utilization of the My Life, My Community website	Pending, DBHDS does not yet issue an overall annual report with regard to all measurable program outcomes. DBHDS provided annual data reports that addressed participant

		satisfaction with the IFSP funding program. DBHDS did not provide an annual report for the number of individuals on the waiver waitlist who are provided with outreach materials each year; however, they had provided outreach information to "all individuals" on the waitlist just prior to the opening of the 2020 funding period. DBHDS receives some data reports from VCU-CFI on the implementation family mentoring, but these did not fully measure overall knowledge of the family and peer mentoring support programs
	5) Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.	Information provided at time of enrollment and at annual attestation incomplete. Pending final resolution of eligibility criteria ("most at risk") and case management

		criteria ("special service need.")
	6) IFSP funding availability announcements are provided to individuals on the waiver waitlist.	Documentation confirmed
	7) Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website	Pending above
	8) Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding.	Documentation confirmed
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.	1) DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website.	Documentation confirmed
	2) Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families.	Pending, anticipated by 9/2020
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. (IV.B.9.b: PSTs and the CSB case manager shall coordinate with the specific type of 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	1) At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources.	Unknown
	2) The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested.	Form updated for Family-to-Family program; no data reports provided.
	3) The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver	VCU-CFI provides some data for

Representative 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 and peer programs to facilitate these opportunities.)	services with whom family-to- family and the peer-to-peer supports have contact and the number who receive the service.	individuals receiving family-to- family supports, but does not specifically report on the number of individuals receiving DD waiver services who access the program. Reporting also does not include specific data with regard to peer-to-peer supports.

ATTACHMENT C: INTERVIEWS & STAKEHOLDER INPUT

1. Beverly Rollins, DBHDS Director of Administrative and Community Operations
2. Erika Jones-Haskins, DBHDS IFSP Community Coordinator
3. Jenni Schodt, Settlement Agreement Coordinator
4. Eric Williams, DBHDS Director of Provider Development
5. Dana Yarbrough, Director, Center for Family Involvement, Virginia Commonwealth University Partnership for People with Disabilities
6. Tonya Miling, Executive Director, Arc of Virginia
7. Katie Benghauser, Senior Navigator
8. Kim Tarantino, Senior Navigator
9. Teri Morgan, Executive Director, Virginia Board for People with Disabilities
10. Sean Campbell, IFSP Council Member
11. Jennifer Krajewski, IFSP Council Member
12. Stephanie Thull, IFSP Council Member
13. Barbara Barrett, IFSP Council Member
14. Elizabeth Noriega, IFSP Council Member
15. IFSP State Council on-line meeting, 4/20/20

APPENDIX D.

CASE MANAGEMENT SERVICES

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

Case Management Requirements

By

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

Consortium on Innovative Practices

April 22, 2020

Executive Summary

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a follow-up to our 2019 review of the Case Management requirements of the Agreement. This review was based on a review of a) documentation of case management compliance indicators agreed to by the Parties, and b) ISP reviews based on ten (10) "elements" for a sample of thirty-five (35) individuals, including telephone interviews with case managers and individuals, caregivers, guardians or authorized representatives. These elements align closely but not precisely with the compliance indicators and the sample of thirty-five reviewed is small compared to the universe of well over 10,000 individuals with IDD who receive case management services. This findings from this review provides an overall picture of Virginia's status documenting and achieving the compliance indicators, it does not provide sufficient findings from a large enough sample to generalize findings to the target population.

There are three sets of compliance indicators involving case management: Sections III.C.5.b.i, III.C.5.d, and V.F.2-5, cover case management functions and its monitoring and Section III.C.7.a-b, cover integrated day supports and supported employment (see Attachment A). For the monitoring indicators there are sixteen (16) metrics and for the integrated day supports and supported employment indicators there are thirteen (13) metrics. DBHDS provided documentation that showed that it achieved six (6) of the (16) compliance indicators and seven (7) of the thirteen (13) compliance indicators. In both sets, the Commonwealth reports that gathering the required data to demonstrate proper implementation for the remaining indicators, are 'works in progress'.

For the case management functions indicators there are ten (10) "elements" or metrics identified at Section III.C.5.b.1 For this review of those indicators we focused on thirty-five (35) individuals. This group included a) twenty-six (26) individuals, who were listed as receiving Enhanced Case Management (ECM) in ten CSB's representative of the five DBHDS Regions and b) a subgroup of ten (10) individuals , one in each of the 10 CSBs who were identified as age 14-17; five of these teenagers were also ECM . Each review included: a) a content review of the ISP, recent case manager progress notes, and any CHRIS reports from the past year, b) case manager telephone interviews, and c) a follow-up assessment of the individual's well-being via telephone interviews with the individual, caregivers and/or guardians/Authorized Representatives (ARs). We then conducted a discrepancy analysis using our Review Tool (see Attachment B) to determine if gaps existed between the individual's assessed needs and ISP goals (as documented in the case management system reports and documents) and the services and supports that were actually being provided.

Our discrepancy analysis suggested that the most frequent systemic shortcoming in the individual service plans for this sample continues to be: ISP has specific and measurable outcomes and Modifying the ISP as needed. Without specific and measurable outcomes, progress cannot be objectively determined regarding increased independence, self-sufficiency, and integration, which are overall goals of the Settlement Agreement and the ISP process. Without Modifying the ISP as needed, the services provided to individual because of a changes in status or inappropriate implementation benefit from the combined expertise of the professional and non-professional members of the individual's support team.

This study was adjusted from its original planned approach due to the onset of COVID-19 restrictions. Face to face interviews, which were planned for mid-March, are often more robust and informative than telephone interviews. The substitution of telephone interviews for the face to face interviews, therefore, resulted in an assessment that was not based on the ideal methodology.

Methodology for this Report

- Conducted discrepancy analyses of thirty-five (35) individuals (10 stratified for age) in ten CSBs representative across all five regions;
- Reviewed thirty-five (35) ISPs, interviewed case managers, and interviewed individuals, caregivers and/or Authorized Representatives (ARs) as appropriate; reviewed past three months of recent progress notes and past years CHRIS reports;
- Reviewed SCQR reports, 7.3.19, 4.1.20;
- Reviewed revised CMSC charter and FY19 semi-annual reports to QIC;
- Reviewed *Support Coordination Quality Reviews, Retrospective Reviews, and Inter-rater Reviews, 2019*; *Support Coordination Quality Review Survey Instrument & Technical Guidance*, *FY20*;
- Reviewed CMSC corrective action follow-up with CSBs;
- Reviewed QID 2019 reports of technical assistance to CSBs;
- Reviewed reliability checks among QID team members;
- Reviewed online case management training module, case management policy manual;
- Telephone interviewed DBHDS leadership.

Performance Monitoring

The compliance indicators involving case management monitoring are at III.C.5.d and V.F.2-5 (see Attachment A). Table 1 below recaps the findings of this study as to the monitoring of case management performance. For the monitoring indicators there are sixteen (16) metrics and six (6) appear to have been achieved. Documentation which was reviewed in this cycle suggest that DBHDS has begun work to come into compliance with and to maintain documentation to demonstrate proper implementation as measured by almost all the indicators. Paper trails that document compliance, however, are not yet available for a number of the indicators. For the purposes of Table 1 item status is described as *Documentation confirmed* (appears compliant), *Pending Date (*is aligned with the compliance indicators but additional progress or documentation is necessary), and *Pending* (no evidence provided to substantiate achievement) .

The charter of the CMSC (Case Management Steering Committee) was updated and enhanced to reflect DBHDS quality improvement philosophy, to formalize a semi-annual case management report to the QIC (Quality Improvement Committee), to authorize the CMSC to directly initiate technical assistance to underperforming CSBs, and to empower the CMSC to directly recommend enforcement actions to the Commissioner for CSB Performance Contract shortcomings.

Also noteworthy was the overhaul of the Support Coordination Quarterly Review (SCQR) to reflect the ten (10) elements. DBHDS reports that these revised reviews were initiated beginning FY20 A planned late summer 2020 look behind review from the CQI (Community Quality Improvement) team of samples of individuals with at least two per CSB and a proportionate distribution across waivers. These periodic, electronic reviews submitted by CSB case management supervisors have been supplemented with a manual (*Support Coordination Quality Review Survey Instrument & Technical Guidance*). This manual provides guidance to assure that supervisors are evaluating the work of case managers similarly across the Commonwealth. Further enhancing the impact of this review is the linkage of the Quality Management Division's look-behinds of SCQRs to establish an assurance of reliability at the CSB level and to enable regularized technical assistance during the process of reliability checking. However, the CMSC timetable suggests that it will be September 2020 before

inter-rater reliability figures are available, which leaves little time for additional follow-up and technical assistance to underperforming CSBs.

Table 1
Performance Monitoring Documentation

		Documentation available:
1	*The Case Management Steering Committee will analyze the Case Management Quality Review data submitted to DBHDS that reports on CSB case management performance each quarter.* ***(III.C.5.b.i)***	Documentation confirmed
2	*In this analysis 86% of the records reviewed across the state will be in compliance with a minimum of 9 of the elements assessed in the review.* ***(III.C.5.b.i)***	Documentation confirmed
3	*In this analysis any individual CSB that has 2 or more records that do not meet 86% compliance with Case Management Quality Review for two consecutive quarters will receive additional technical assistance provided by DBHDS.* ***(III.C.5.b.i)***	Pending for 2020
4	*If, after receiving technical assistance, a CSB does not demonstrate improvement, the Case Management Steering Committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.* ***(III.C.5.b.i)***	Pending for 2020
5	*DBHDS, through the Case Management Steering Committee, will ensure that the CSBs receive their case management performance data semi-annually at a minimum.* ***III.C.5.b.i)***	Documentation confirmed
6	*All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-compliance will be tracked to ensure remediation.* ***(III.C.5.b.i)***	Pending
7	*The Case Management Steering Committee will review and analyze the Case Management data submitted to DBHDS and report on CSB case management performance related to the ten elements and also at the aggregate level to determine the CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families). .* ***(III.C.5.d)***	Documentation confirmed
8	*The Case Management Steering Committee will produce a semi-annual report to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement.*	Documentation confirmed
9	*The Case Management Steering Committee's report will include an analysis of findings and recommendations based on review of ….data from the oversight of the Office of Licensing, DMAS Quality Management Reviews, CSB Case Management Supervisors Quarterly Reviews, DBHDS Quality Management Division quality improvement review processes including the Supervisory retrospective review, Quality Service Reviews, and Performance Contract Indicator data. .* ***(III.C.5.d)***	Pending
10	*The Case Management Steering Committee will also make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings.* ***(III.C.5.d)***	Pending
11	*Members of the DBHDS central office Quality Improvement Division will conduct annual retrospective reviews to validate the findings of the CSB case management supervisory reviews and to provide technical assistance to the case managers and supervisors for any needed improvements. A random subsample of the original sample will be drawn each year for this retrospective review…..* ***(III.C.5.d)***	Pending for 2020
12	*The DBHDS central office Quality Improvement Division's reviewers will visit each CSB in person and review case management records for the individuals in the sub-sample. They will then complete an electronic form so that agreement between the CSB Case Management Quality Review and the DBHDS Quality Improvement Division record reviews can be measured quantitatively……* ***(III.C.5.d)***	Pending for 2020

13	*There will be an ongoing inter-rater reliability process for staff of the DBHDS Quality Improvement Division conducting the retrospective reviews. .* ***(III.C.5.d)***	Documentation confirmed
14	The actions to achieve compliance listed in Section **III.C.5.b.i** will also achieve compliance with this provision of the Settlement Agreement. **(V.F.2)**	See above #2-6
15	The Commonwealth tracks the number, type and frequency of case management contacts. DBHDS will establish a process to review a sample of data each quarter to determine reliability and provide technical assistance to CSBs as needed……The data regarding the number, type, and frequency of case management contacts will be included in the Case Management Steering Committee data review. Recommendations to address non-compliance issues with respect to case manager contacts will be provided to the Quality Improvement Committee for consideration of appropriate systemic improvements and to the Commissioner for review of contract performance issues. **(V.F.4)**	Pending for 2020
16	The Case Management Steering Committee will establish two indicators in each of the areas of health and safety and community integration associated with selected domains in V.D.3 and based on its review of the data submitted from case management monitoring processes. Data indicates 86% compliance with the four indicators**. (V.F.5)**	Pending

ISP Reviews

Methods:

We conducted discrepancy audits of thirty-five (35) individuals over a two week period in March 2020. From among these individuals 2-5 individuals, who were listed as receiving Enhanced Case Management (ECM) with an ISP date of November 2019 or later, were randomly selected from each of ten CSBs drawn from across the five planning regions. At least one 14-17 year old was randomly selected from each CSB. The questions from the Case Management Review Tool that we used are reflected in Attachment B.

Telephone interviews were conducted with the current Case Manager and the individual and/or Guardian/Authorized Representative/Agency caregiver. In advance, we reviewed ISP documentation, recent Case Manager progress notes and any CHRIS reports from the past year, in order to determine what gaps exist between the individual's assessed needs, ISP goals and services, and the services and supports actually being provided. We defined a discrepancy as *a difference between 'what is' based on the case manager record review and interview and 'what should be' based on our assessment of the individual, their situation and 'what should be' based on the Settlement Agreement.*

Findings:

Of the thirty-five (35) cases reviewed, twenty-four (24) were male and eleven (11) were female. The individuals ranged in age from 10-73 years, with an average of 34.5 yrs. The sample group included ten 14-17 year-olds. Nine of the thirty-five individuals were not or were no longer ECM.

Case Managers were positive and cooperative during the interview process, particularly in light of the switch to telephone interviews and 'stay at home' instructions. In general, the Case Managers knew the individuals on their caseloads well. The median length of time supporting the individual was about 12 months, which is 6 months less than our 2019 sample's median time of eighteen (18) months. The average caseload size was 1:31, which is an improvement over our 2019 sample's average of 1:33. The large majority of this sample lived with their family or in their own home, twelve (12) lived in provider settings of 1-4 persons, and only two (2) lived in settings of five (5) or more.

Table II recaps the findings for the ten case management indicators. Our discrepancy analysis again suggested that the challenges faced by case managers for this sample were ISP has specific and measurable outcomes - #4 a (e.g., a poor Desired Outcome: "John lives in a clean environment") and modifying the ISP in response to changes or major events in the person's life -#6 (e.g., the omission of discussion of the emergence of the problem of gallstones, the family decision not to pursue surgery, and any necessary pain relief). These latter challenges persist from previous reviews. The Independent Reviewer and DBHDS continue efforts to clarify the interpretation of the language, "Change of status or needs."

Regarding outcomes, when we asked the question broadly, "If I go into the individual's file, could I locate occurrences or activities toward the outcome statements and their progress?" we still often found that many outcomes were not measurable or observable but rather general and "squishy". Without specific and measurable outcomes, progress or achievement cannot be objectively determined. DBHDS training materials include as examples: "Max is employed at or above minimum wage for six months" is the outcome statement and "Max will locate, apply for, secure and learn a new job" are the activities (February 2018) and "Mary looks pretty" is the outcome

statement and "When Mary purchases 5 outfits and goes to the beauty salon once each month" are the activities (April 2015) . We did not consistently see outcome statements of this quality.

Of the three items in the Parties' compliance indicators which we had not previously queried (#1, #9 and #10), the two regarding conflict resolution suggest that while most case managers are not aware of formal CSB instructions on conflict resolution, two of every three case managers who had experienced conflict within the team followed logical problem resolution strategies to get closure.

Further, most teams consist of persons important to or for the individual. We note that where teams were not inclusive, they appear among school age individuals (3), when school representatives were not involved in the discussion or did not participate in the person centered planning. We also noted a tendency for service planning meetings not to include the individual as a participant; it was not always clear in the ISP that these exceptions were due to the presence of a Planning Partner who provided the individual's perspective or substitute decision maker, who represented the individual due to difficulties participating in the discussion.

Table II
Compliance Indicators Discrepancy Rate
Across 35 Case Managers

		Findings from sample of 35 case managers
1	*The ISP was developed with professionals and non-professionals who provide individualized supports and included the individual and others important to the individual. (III.C.5.b.i)*	86%
2	*Is it documented that the individual was offered choice among case managers, in the last annual ISP meeting? (III.C.b.5.c)*	100%
3	*Is it documented that the individual was offered choice among providers, in the last annual ISP meeting? (III.C.b.5.c)*	
4	*Does the ISP have specific and measurable outcomes? (III.C.5.b.i)*	69%
5	*Has the CM visited the individual as required during the past 3 months* and made notes on assessment of ISP implementation? (III.C.5.b.iii)*	97%
6	*If needed, has the CM modified the individual's ISP during the past year in response to major events or changes in the person's life? (III.C.5.b.iii)*	56%
7	*Are all the essential supports and services, which are needed to achieve outcomes, listed in the ISP? (III.C.5.b.i)*	91%
8	*The CM is continuously assessing risk and ensuring that risk mitigation strategies are included in the ISP? (III.C.5.b.ii)*	100%
9	*Are the ISP's supports and services consistent with the individual's identified risks, needs, and preferences? (III.C.5.b.ii)*	94%
10	*The CSB has in place policies, procedures, protocols or instructions on solving conflict or disagreement within the team about developing and/or revising ISPs, including addressing changes in the individual status. (III.C.5.b.i)*	40%
	The CM has used the strategies in #10 when needed to resolve conflict. (III.C.5.b.i)	68%

We also further queried twelve (12) ISPs, which included behavior support needs, as to what type of monitoring was conducted by the case manager. Based on our interviews with the case managers and caregivers and a review of case notes, eight (8) of the twelve (12 case managers regularly probed with caregivers the effectiveness of their behavioral supports. In four (4) of the twelve (12) cases the team had discontinued or determined a BSP was not needed. In three (3) of the twelve (12) cases BSPs were in process or were operated by another entity, such as public schools. In any case, if the ISP suggested behavior support needs we expected case managers to be monitoring and reporting on behavioral issues.

Family members, caregivers and/or the individual were for the most part satisfied with services. Issues were raised, however, with the complexities, which were at times obstacles to getting individuals' needs met timely. These included: a) the service approval and denial process, b) the authorization process for Assistive Technology and Environmental Modifications, c) transportation, and d) parental billing and payment processes under self-direction programs.

In summary, we reviewed case management services for thirty-five (35) individuals against the ten elements. The Parties agreed that *"86% of the records reviewed ….will be in compliance with a minimum of 9 elements"* and, further, that *"Any individual CSB that has 2 or more records that do not meet 86% compliance with Support Coordination Quality Reviews for two consecutive quarters will receive additional technical*

assistance…." The approach reported here does not directly duplicate the SCQR process, which DBHDS will ultimately utilize to determine the findings of achievement with the ten elements, but it is similar enough to serve as a fidelity check on that process. For our sample, no CSB hit the 86% mark and of the 35 cases, only eight (8) met the nine (9) minimum (23%). However, in the latest SCQR cycle (4.1.20) DBHDS identified 28 of 40 CSBs whose records were in achievement of the ten elements or 191 individual records of 238 records (80%) that had met the indicator. We may be analyzing these results differently than the SCQR process report, and the SCQR results have not yet been subjected to the look behind/reliability check process DBHDS plans for this summer. This discrepancy between our independent review of the ten elements and the supervisors' review of the ten elements underlines the urgency of the reliability checks and follow-up technical assistance. In previous studies, we have expressed concern that reporting by case manager supervisors is likely to include bias. It is, therefore, critical that the inter-rater reliability process identify and effective actions are taken to reshape the reporting process to minimize bias.

Integrated Day Services and Supported Employment

Table III and IV below recap the findings of this study as to the orientation of case management toward integrated day services and employment. In this area there are thirteen (13) distinct Compliance Indicators, which were agreed to by the Parties last year. The DBHDS documentation in this cycle suggests that DBHDS has begun work on almost all the indicators, but paper trails that demonstrate achievement is not always available.

Table III
Compliance Indicators: Integrated Day Services and Supported Employment

All case managers are required to take the on line case management training modules and review the case management manual. Information contained includes:		
		Documentation available:
1	*The Employment First Policy with an emphasis on the long term benefits of employment to people and their families and practical knowledge about the relationship of employment to continued Medicaid benefits; III.C.7.a*	Documentation confirmed
2	*Skills to work with individuals and families to build their interest and confidence in employment; III.C.7.a*	Documentation confirmed
3	*The importance of discussing employment with all individuals, including those with intense medical or behavioral support needs and their families; III.C.7.a*	Documentation confirmed
4	*The importance of starting the discussion about employment with individuals and families as early as the age of 14 (when transition begins under IDEA) with goals that lead to employment (e.g., experiences in the community, making purchases, doing chores, volunteering); III.C.7.a*	Documentation confirmed
5	*The value of attending a student's IEP meeting starting at age 14 to encourage a path to employment during the school years and to explore how DD services can support the effort; III.C.7.a*	Documentation confirmed
6	*Developing goals for individuals utilizing Community Engagement Services that can lead to employment (e.g., volunteer experiences, adult learning). III.C.7.a*	Documentation confirmed

7	*Making a determination during their monitoring activities as to whether the person is receiving support as described in the person's plan and that the experience is consistent with the standards for the service. III.C.7.a*	

The data reported in Table IV below was included in our discrepancy analysis discussed above under the ISP Review section. These six measures, and the assessment of case manager training and their familiarity with the online manual, were queried in addition to the ten elements tied directly to case management functioning (see Attachment B).

Regarding the indicator (III.C.7.a. indicator 1.d.) "goals related to employment", we determined that for seventeen (17) individuals the team appropriately documented the rationale for no goals related to employment (retirement age, refused to work, etc.). One team included a goal for employment and one team neglected to include a goal for employment after a discussion that suggested it was warranted and wanted by the individual.

Table IV
Compliance Indicators: Integrated Day Services and Supported Employment Measures

The Commonwealth will achieve compliance with this provision of the Settlement Agreement when:		
11	*At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process. III.C.7.a.*	100% (19/19)
12	*At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment. III.C.7.a.*	50% (1/2)
13	*At least 86% of individuals who are receiving waiver services and have employment services authorized in their ISP will have a provider and begin services within 60 days. III.C.7.a.*	100% (1/1)
14	*At least 86% of individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process. III.C.7.a*	100% (18/18)
15	*At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. III.C.7.a*	74% (25/34)
16	*At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. III.C.7.a*	100% (10/10)
	All case managers are required to take the on line case management training modules…	91% (32/35)
	All case managers are required to review the case management manual….	91% (32/35)

Finally, the sample drawn for the discrepancy analysis included ten 14-17 year olds in order to probe the compliance indicator at III.C.7.a.2.f – "Was their discussion or documentation in the ISP of how Waiver services could support interest in employment?" All ten ISPs reflected this discussion and/or parents-guardians indicated the discussion occurred. This suggests that the need for early transition planning is well established in the minds of most case managers. However, considering the failure of

a few case managers to involve schools in the individual's person centered planning (see discussion at p.6 above regarding school involvement in teams) and some comments that interaction with school personnel was not desired or sanctioned by some CSBs at the local level, the importance of close partnerships with school personnel may need continuing emphasis by DBHDS.

Suggestions for Departmental Consideration

DBHDS consider a process study of the Assistive Technology, Environmental Modifications and self-directed supports payment systems, in order to ensure that steps are eliminated that do not add value to authorization approval and timely payments. The inclusion of self-advocates and family representatives should be considered in the design of the study.

DBHDS should consider clarifying and emphasizing to CSBs that school personnel should be included or invited to participate in the ISP process and that school programs are an appropriate site for alternating face to face visits of the case manager.

DBHDS should consider modifying the ISP procedure for changing the ISP to be a more flexible process that ensures a paper trail to the logic and background to the change, while also ensuring that ISP Team members, appropriate professional and caregiving staff are included so that the individual benefits through their combined expertise and involvement.

Relative to Measurable/Observable Outcomes, DBHDS should consider enhancing the *Guidance* document to ensure supervisors ask the question, "If I go into the individual's file, can I find a record of occurrences or activities toward the outcome statements that will demonstrate progress toward the outcome?". Further supervisor training on measurable or observable objectives may be warranted given the lack of progress in this area, perhaps as a specialized module delivered during the SCQR technical assistance process.

DBHDS should consider front-end sub-studies of inter-rater reliability with multiple, smaller sample of CSBs, in order to accelerate acceptance of the SCQR process an acceptable measure of case management achievement of the indicators and simultaneous implementation of technical assistance which can be refined during the second cycle. This approach may allow increased levels of compliance by the end of the originally estimated 10-year schedule (6.30.21) for the Settlement Agreement, and still allow for technical assistance in future cycles.

DBHDS should clarify with the SCQR process managers that (per the indicator statement) only records achieving 9 of all 10 elements are to be considered to meet the indicator.

DBHDS should consider encouraging a peer review process at CSBs for the production of the annual ISPs. We found frequent errors including gender pronouns, duplicative statements, checklist boxes not checked where needed, etc. Many appear attributable to the strategy of cut-and-pasting.

Attachment A
Settlement Compliance Indicators

III.C.5.b.i

The following indicators to achieve compliance listed in this provision will also achieve compliance with other provisions associated with case management (III.C.5.b.ii, III.C.5.b.iii, III.C.5.c, and V.F.2). Relevant elements of person-centered planning, as set out in CMS waiver regulations (42 C.F.R. § 441.301(c)), are captured in these indicators.

In consultation with the Independent Reviewer, DBHDS shall define and implement in its policies, requirements, and guidelines, "change of status or needs" and the elements of "appropriately implemented services."

DBHDS will perform a quality review of case management services through CSB case management supervisors/QI specialists, who will conduct a Case Management Quality Review that reviews the bulleted elements listed below. DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB. Each quarter, the CSB case management supervisor and/or QI specialist will complete the number of Case Management Quality Review as determined by DBHDS by reviewing the records of individuals in the sample. The data captured by the Case Management Quality Review will be provided to DBHDS quarterly through a secure software portal that enables analysis of the data in the aggregate. DBHDS analysis of the data submitted will allow for review on a statewide and individual CSB level. The Case Management Quality Review will include review of whether the following ten elements are met:

•The CSB has offered each person the choice of case manager. (III.C.5.c)
• The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. (III.C.5.b.ii; V.F.2)
• The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (III.C.5.b.iii; V.F.2)
• The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences. (III.C.5.b.ii; V.F.2)
• The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. (III.C.5.b.i; III.C.7.b)
• The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served. (III.C.5.b.i; III.C.5.b.ii)
• The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary. (III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)
• Individuals have been offered choice of providers for each service. (III.C.5.c)
• The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences. (III.C.5.b.iii; V.F.2)
• The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individuals' needs. (III.C.5.b.iii; V.F.2)

The Case Management Steering Committee will analyze the Case Management Quality Review data submitted to DBHDS that reports on CSB case management performance each quarter. 86% of the records reviewed across the state will be in compliance with a minimum of 9 of the elements assessed in the review. Any individual CSB that has 2 or more records that do not meet 86% compliance with Case Management Quality Review for two consecutive quarters will receive additional technical assistance provided by DBHDS. If, after receiving technical assistance, a CSB does not demonstrate improvement, the Case Management Steering Committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.

DBHDS, through the Case Management Steering Committee, will ensure that the CSBs receive their case management performance data semi-annually at a minimum.
All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-compliance will be tracked to ensure remediation.

III.C.5.d

The Case Management Steering Committee will review and analyze the Case Management data submitted to DBHDS and report on CSB case management performance related to the ten elements and also at the aggregate level to determine the CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families). The Case Management Steering Committee will produce a semi-annual report to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The Case Management Steering Committee's report will include an analysis of findings and recommendations based on review of the information from case management monitoring/oversight processes including: data from the oversight of the Office of Licensing, DMAS Quality Management Reviews, CSB Case Management Supervisors Quarterly Reviews, DBHDS Quality Management Division quality improvement review processes including the Supervisory retrospective review, Quality Service Reviews, and Performance Contract Indicator data. The Case Management Steering Committee will also make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings.

Members of the DBHDS central office Quality Improvement Division will conduct annual retrospective reviews to validate the findings of the CSB case management supervisory reviews and to provide technical assistance to the case managers and supervisors for any needed improvements. A

random subsample of the original sample will be drawn each year for this retrospective review. The sample will be stratified so that each CSB is included in the sample. The DBHDS central office Quality Improvement Division's reviewers will visit each CSB in person and review case management records for the individuals in the sub-sample. They will then complete an electronic form so that agreement between the CSB Case Management Quality Review and the DBHDS Quality Improvement Division record reviews can be measured quantitatively, in addition to providing feedback to the CSB case management supervisors to increase the reliability of future reviews. There will be an ongoing inter-rater reliability process for staff of the DBHDS Quality Improvement Division conducting the retrospective reviews.

III.C.7.a. and III.C.7.b.

1. All case managers are required to take the on line case management training modules and review the case management manual. Information contained includes:
a. The Employment First Policy with an emphasis on the long term benefits of employment to people and their families and practical knowledge about the relationship of employment to continued Medicaid benefits;
b. Skills to work with individuals and families to build their interest and confidence in employment;
c. The importance of discussing employment with all individuals, including those with intense medical or behavioral support needs and their families;
d. The importance of starting the discussion about employment with individuals and families as early as the age of 14 (when transition begins under IDEA) with goals that lead to employment (e.g., experiences in the community, making purchases, doing chores, volunteering);
e. The value of attending a student's IEP meeting starting at age 14 to encourage a path to employment during the school years and to explore how DD services can support the effort;
f. Developing goals for individuals utilizing Community Engagement Services that can lead to employment (e.g., volunteer experiences, adult learning).
g. Making a determination during their monitoring activities as to whether the person is receiving support as described in the person's plan and that the experience is consistent with the standards for the service

2. The Commonwealth will achieve compliance with this provision of the Settlement Agreement when:
a. At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process.
b. At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment.
c. At least 86% of individuals who are receiving waiver services and have employment services authorized in their ISP will have a provider and begin services within 60 days.
d. At least 86% of individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process.
e. At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP.
f. At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.

V.F.2-5

2. The actions to achieve compliance listed in Section III.C.5.b.i will also achieve compliance with this provision of the Settlement Agreement.

4. The Commonwealth tracks the number, type and frequency of case management contacts. DBHDS will establish a process to review a sample of data each quarter to determine reliability and provide technical assistance to CSBs as needed.
The data regarding the number, type, and frequency of case management contacts will be included in the Case Management Steering Committee data review. Recommendations to address non-compliance issues with respect to case manager contacts will be provided to the Quality Improvement Committee for consideration of appropriate systemic improvements and to the Commissioner for review of contract performance issues.

5. The Case Management Steering Committee will establish two indicators in each of the areas of health and safety and community integration associated with selected domains in V.D.3 and based on its review of the data submitted from case management monitoring processes. Data indicates 86% compliance with the four indicators.

Attachment B
Review Tool

a. CM's length of time supporting this individual**:**
b. CM's caseload size:
c. Number of recipients living at this location:

1	The ISP was developed with professionals and non-professionals who provide individualized supports and included the individual and others important to the individual. (III.C.5.b.i)
2	Is it documented that the individual was offered choice among providers, including case managers, in the last annual ISP meeting? (III.C.b.5.c)
3	Does the ISP have specific and measurable outcomes? (III.C.5.b.i) *(DBHDS expects measurable statements to be included in the ISP template section, "I will no longer want/need supports when…". These should tie back as steps to get to the Outcome Statement, which should be an achievement)*
4	Has the CM visited the individual as required during the past 3 months* and made notes on assessment of ISP implementation? (III.C.5.b.iii) *(*Every 30 days if enhanced CM, including every other visit in their home; every 90 days if not enhanced. Explore and note how CM assessed implementation.*)
5	If needed, has the CM modified the individual's ISP during the past year in response to major events or changes in the person's life? (III.C.5.b.iii)
6	If applicable, have the CM observed/made notes on the implementation of behavior support plans? (DF*) (Explore and note how CM assessed bsp implementation.*)
7	Are all the essential supports and services, which are needed to achieve outcomes, listed in the ISP? (III.C.5.b.i)
8	The CM is continuously assessing risk and ensuring that risk mitigation strategies are included in the ISP? (III.C.5.b.ii)
9	Are the ISP's supports and services consistent with the individual's identified risks, needs, and preferences? (III.C.5.b.ii)
10	Was supported employment <u>discussed and/or documented</u> in the last annual ISP? (III.C.7.a) *(NA=discussed but determined to not be appropriate)*
11	Were supported employment goals included in the ISP? (III.C.7.a)
12	If supported goals are in the ISP and supported employment services authorized, is a provider in place or within 60 days of ISP? (III.C.7.a)
13	Were community engagement services discussed <u>and/or documented</u> in the last annual ISP? (III.C.7.a)
14	Were community engagement services goals included in the ISP? (III.C.7.a)
15	For those Age 14-17 was their discussion or documentation in the ISP of how Waiver services could support interest in employment?(III.C.7.a)
16	Did the CM take the online case management training modules? (III.C.7.a)
17	Can the CM locate a copy of the case management manual? (III.C.7.a)
18	The CSB has in place policies, procedures, protocols or instructions on solving conflict or disagreement within the team about developing and/or revising ISPs, including addressing changes in the individual status. (III.C.5.b.i)
19	The CM has used the strategies in #18 when needed to resolve conflict. (III.C.5.b.i)

APPENDIX E.

CRISIS SERVICES

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 8, 2020

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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 10/1/19-3/31/20, the sixteenth review period. It includes a qualitative study of 60 individuals who were referred to REACH during this review period. This review will analyze the Commonwealth of Virginia's status toward implementing the following requirements and related compliance indicators agreed to by the Parties: The Commonwealth shall:

- develop a statewide crisis system for individuals with ID and DD (IDD),
- 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

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 (SA). This study will review the status of the Commonwealth's progress toward fulfilling the provisions that are detailed in Section III.C.6.a-b. of the SA, which includes the subset III.C. b. ii. A and B, as well as III.C.6.iii.A, D, E, and G., and the compliance indicators for these provisions as agreed to by the Parties.

Additionally, it will include a qualitative review of the crisis supports and other needed and related community services for 60 individuals, 21 children, and 39 adults, who were referred to REACH during the second quarter (Q2) of Fiscal Year (FY) 2020 during November 2019. The focus of the qualitative study is to determine the effectiveness of REACH programs and community behavioral, psychiatric, and psychological supports to: de-escalate and prevent crises; to stabilize individuals who experience crises that 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 at the time of the crisis or post hospitalization. The study's 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 thereby minimize hospitalizations and, if admitted, the lengths-of-stay.

The foci of this review will be:

- The status of the REACH programs' functioning to respond to crises in children and adults' homes.
- The Commonwealth's ability to provide crisis prevention and intervention services that include timely assessments, services and supports to de-escalate crises without removing individuals from their homes.
- REACH programs' effectiveness planning and identifying strategies for preventing future crises.
- REACH programs' provision of short-term crisis supports in the home and use of the CTH to stabilize crises.

The review will also track the progress of the Commonwealth's development of out-of-home crisis stabilization services for children and out-of-home transition homes for adults with co-occurring conditions.

SECTION 3: REVIEW PROCESS

The Expert Reviewer reviewed relevant documents and interviewed key DBHDS administrative staff, REACH administrators, REACH staff and Case Managers 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 crisis services requirements of the Agreement. The documents reviewed included those provided by the Commonwealth that it determined were sufficient to demonstrate its progress toward properly implementing the requirements of the Agreement.

Documents Reviewed:

1. Children's REACH Quarterly Reports: FY19 Q4, FY20 Q1, FY20 Q2, FY20 Q3
2. Adult REACH Quarterly Reports: FY19 Q4, FY20 Q1, FY20 Q2, FY20 Q3
3. DBHDS Quarterly Qualitative Reviews of Children's and Adults REACH Programs for FY19 Q4, FY20 Q1, FY20 Q2, FY20 Q3
4. Behavioral Supports Report FY20 Q3
5. Therapeutic Consultation Description of Services
6. REACH Staffing Report
7. Status Report: Children's CTH and Adult Transition Homes
8. REACH and CSB records of the 21 children and 39 adults selected for the qualitative study
9. Supplemental Crisis Report: FY20 Q3
10. Crisis Risk Assessment Draft

Interviews with DBHDS and REACH staff: I interviewed Heather Norton, Director, Acting Deputy Commissioner; 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; Larissa Terwilliger Children's REACH Program Director for Region I; Liv O'Neill, Children's REACH Program Director for Region IV; Brandon Rodgers, REACH Program Director for Region V; numerous staff from the REACH teams in Regions I, II and V; and CSB Case Managers. The REACH staff and Case Managers were all interviewed as part of the qualitative study of the sixty individuals who received REACH services during this, the sixteenth, reporting period. I 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. This review came at a difficult time for all staff who were interviewed. Case Managers and REACH staff continue to provide ongoing and necessary supports to individuals with IDD during the COVID-19 pandemic. It was very inspiring to hear of the creativity, dedication and perseverance of staff and teams to make sure individuals are as safe, healthy and stable as possible now.

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 to compare data and trends over 12-month periods of time. This report is based on data for five years that is 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)
Year 4: FY18 Q4 - FY19 Q3 (thirteenth and fourteenth periods)
Year 5: FY19 Q4 - FY20 Q3 (fifteenth and sixteenth periods)

The year periods do not match fiscal years or calendar years because review periods do not align with either fiscal or calendar years. The review periods are the six-month periods: April through September and October through March. These time periods are reflected in the definition of Years 1, 2, 3, 4 and 5 above. It must be noted that the children's REACH program did not begin reporting until the third quarter (Q3) of FY16. Therefore, Year 1 for the children's data includes only six, rather than 12 months of information.

The Commonwealth has achieved consistent compliance with some of the SA provisions for crisis services. These indicators will be identified in the sections below but I will only note continued compliance and data from this year rather than continue to draw comparisons with previous years so the readers can focus their review and attention on those areas of non-compliance.

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

The information provided below includes information from the four Children's REACH Quarterly Reports that DBHDS provided for Fiscal Year (FY) 2019 Quarter 4 and FY20, Quarters 1, 2 and 3. These four quarterly reports cover the one-year time period April 1, 2019 – March 31, 2020; these data are reflected as the data for Year 5.

REACH Referrals - The number of children who were referred to the Children's REACH crisis services programs continues to increase. This includes children newly referred or referred again after being previously discharged from REACH. There were 205 children referred in Year 1 (partial year); 854 referred in Year 2; 1,269 referred in Year 3; 1,410 referred in Year 4; and 1644 referred in Year 5. There was a significant 17% increase in overall referrals in Year 5 compared with Year 4.

The number of crisis referrals (i.e. those that occur when an individual is in crisis) has dramatically increased from 108 during six months in Year 1; 464 in Year 2; 672 in Year 3; 752 Year 4; and 922 in Year 5. Non-crisis referrals also increased each year from only 97 in Year 1; to 390 in Year 2; 597 in Year 3; 658 calls in Year 4; and 722 in Year 5. The previous percentage of crisis versus non-crisis referrals was consistently 53% of the total number of referrals, statewide. However, crisis referrals reflect 56% of all referrals in Year 5. However, there is wide variation across the Regions in the number and percentage of crisis referrals. For example, in Years 4 and 5 Region II received the fewest of any of the five Regions; whereas, Region V received 405 crisis referrals, which was the most received by any Region. This is a significant 58% increase in crisis referrals than Region V received in Year 4 which totaled 257. In that same year, of all referrals received, crisis referrals were 36% in Region II compared with 77% in Region V.

The REACH Children's programs are becoming more known throughout their communities. They are a source of information and support for families during crises as well as for prevention services. It will be important that the Commonwealth maintains a sufficient number of staff to effectively respond to the number of calls received, especially those that result from crises, recognizing Regions have differential caseloads of crisis calls that require on-site responses. As an example, Region II has 20 REACH Coordinator positions, of

which 12 are filled. Region V has only a total of 12 full time Coordinators yet had 438 crisis calls compared to 168 crisis calls in Region II in Year 5.

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. ES continued as the primary referral source in Year 4 declining to 35% of the referrals. The ES made 601, or 37% of the crisis referrals in Year 5. Hospitals consistently referred 11% of children for crisis services during Years 1, 2 and 3, and accounted for 10% of the referrals in Years 4 and 5. Direct referrals for families accounted for 25% of the children referred during each of the first three years but increased to 30% of the referrals in Year 4 and represented 31% of the crisis calls in Year 5. Families continue to account for a higher percentage of the referrals in Regions II and V, and a consistently lower percentage in Regions I and III. Overall in Year 5, Case Managers (CM) referred 11% of the children to REACH, but CM referrals represented a higher percentage of referrals in Region I and III at 31% and 19% respectively. Together families and CMs accounted for 42% of the referrals in Year 5, similar to the percentage in Year 4. A higher percentage of children being referred to REACH directly by CM's and families indicates more children being referred for crisis intervention before becoming involved with pre-screenings (i.e. assessments) at hospitals and CSB offices. Such direct referrals present more opportunities for crises to be addressed at the home or school before the children are removed from their homes.

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. Regions individually remain consistent in their referral sources.

*Table 1 s*ummarizes the number of referrals for Years 1, 2, 3, 4, and 5

Table 1: Total Children's Referrals			
Year	***Crisis***	***Non-crisis***	***Total***
Year 1	108	97	205
Year 2	464	390	854
Year 3	672	597	1,269
Year 4	752	658	1,410
Year 5	922	722	1,644

Time of Referral - The REACH programs track the time and dates of referral calls. The calls that were received during weekdays have increased steadily, from 72% of the calls in Year 1 to 81%, 85%, 86%, and 84% of the calls in Years 2, 3, 4, and 5 respectively.

REACH programs do not report whether the time of the day during which calls are received is different on weekdays versus weekend days. Previously DBHDS reported when calls were received in four time periods. DBHDS reduced reporting 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-8PM. In Years 3, 4 and 5, 93% of the calls were received between 7 AM-11PM; the remaining calls were received between 11PM-7AM. The overall number of calls, however, has increased. The number of calls received between 11PM-7AM totaled 113 in Year 5.

Conclusion: It is evident that the REACH on-call system remains 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 only. 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 five years, the percentage of children referred:

- with an ID only diagnosis, ranged from 10%-20%;
- with both ID and DD, ranged from 12%- 28%; and
- with a diagnosis of DD, only ranged from 52%-72%.

There was a marked increase in DD-only referrals, from 52% in Years 1 and 2 to 65% in Year 3, and to 72% in Years 4 and 5. This increase in the actual number of children referred with DD-only from 451 in Year 2, to 830 (+84%) in Year 3, to 1,010 (+22%) in Year 4, and to 1,191(18%) is very significant. The increase is evidence of this REACH programs' outreach and usefulness to this population. The number and percentage of referrals for children with ID-only, and ID and DD continue to decrease. In Year 3, 195 children with ID only were referred to REACH. This number declined to 167 children with ID-only in Year 4, and to 165 in Year 5. The decline in the number of children with both an ID and DD diagnosis declined steadily since Year 2 from 243 to 186 in Year 3 and 170 in Year 4 but increased to 198 of the referrals in Year 5.

The number and percentage of individuals referred with DD-only continues to increase. This pattern may indicate that there are a higher number of children with autism or mental health diagnoses than there are 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.

Conclusion: The REACH Children's Program continues to receive an increased number of referrals and of crisis referrals in each reporting period. The number increased by 208 (50%) between Year 2 and Year 3, another 80 in Year 4, and 170 in Year 5. These increases demonstrate that the programs' outreach efforts are connecting children in need with the statewide children's crisis services. The significant increase of crisis calls in Year 5 may have resource implications for the REACH teams. The Commonwealth's outreach efforts are reaching individuals with diagnoses that are across the spectrum of intellectual and developmental disabilities. It is noteworthy, however, that for children with ID only diagnoses continue to decline. The REACH programs may need to focus attention and

outreach to stakeholders representing this disability group to make sure they are aware of the REACH services.

Calls Received by REACH - The Children's REACH programs track all calls received in addition to new referrals during each quarter. These calls are defined as crisis, non-crisis and information calls. There are far more calls received by REACH each year than new referrals. The REACH teams respond to all crisis calls. These have increased from 134 in Year 1 to 1,349 in Year 5, which is a 28% increase over the number of crisis calls in Year 4. Non-crisis calls have increased exponentially from 304 calls in Year 1 to 5,442 calls in Year 5, which is an increase of 36% over the number of non-crisis calls in Year 4. Only the number of informational calls decreased between Year 4 and Year 5. Regions have increased the number of staff positions assigned to the REACH programs in the past four years. However, the number of additional positions has not kept pace with the increase in crisis calls or referrals, and the REACH programs have a number of vacant positions. These are described later in this report. As the number of referrals and crisis calls to the REACH programs increase, it is critical that each REACH Children's Program has sufficient staffing resources to answer these calls and to respond on-site as required to meet the crisis intervention needs of these children and their families. *Table 2* depicts the change in the number of all calls between Year 1 and Year 5. The number of crisis calls has continued to increase and increased exponentially in Year 5 to 1,349 from 970 the previous year. The overall number of calls increased by 1,442 between Years 4 and 5. *Table 2* below depicts this data.

Table 2: REACH Calls				
	Crisis Calls	***Non-Crisis Calls***	***Info Calls***	***Total***
Year 1	134	304	401	839
Year 2	617	2,449	854	3,920
Year 3	929	6,027	1,183	8,139
Year 4	970	3,469	2,612	7,051
Year 5	1,349	5,442	1,702	8,493

Response Time - In all five Regions throughout Year 5, the REACH staff responded onsite within the required **average** response times. The Regions designated as rural Regions, with the exception of the rural area of Region II, respond on average in 68 minutes or less. The averages in response time across the four quarters for rural Regions range from 50-68 minutes. The average response times for the rural section of Region II averages between 75 and 88 minutes, which are still under the required 120 minutes to respond on time. The average response times for the two urban Regions range from 42-53 minutes across the four quarters of Year 5.

DBHDS has designated Regions I, III and V, as rural. This designation requires these Regions to respond onsite to crisis calls within two hours. In Year 5, these three Regions, responded on-time 98%, 97%, and 99% of the time, respectively. Region IV, an urban region, which is expected to respond onsite within one hour, met this expectation 92% of the time during Year 5. Region II continues to have the most significant difficulty

responding to calls within the one hour expected timeframe in its urban area. Region II improved from a percentage of 62% in Year 1 and 60% in Year 2, to 79% of on-time responses in Year 3. However, its percentage of on-time response in Year 4 dropped to 70% in Year 4. Region II's on-time response improved in Year 5 during which 77% of its crisis calls were responded to within one hour. In 2017 DBHDS added to Region II, CSBs in a rural area, which was formerly part of Region I. Its on-time responses for this part of the Region were met 98% of the time for 39 crisis calls responded to in less than two hours. The reasons for untimely responses were not provided in the REACH Children's Quarterly Reports. However, DBHDS reported that the reasons are similar to the reasons discussed in the Adult Section: traffic, distance and multiple calls. For the individuals in the qualitative study the Regions responded to 100% of the calls and were on time for 98% of these calls.

Over the past five reporting 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 are 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 sufficient 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 19% of the calls; within 31-60 minutes for 53%; within 61-90 minutes for 19%; and within 91-120 minutes for 8%. The remaining calls (1%) 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 30 minutes is that the crisis may not have been stabilized at that location and the child in crisis may have been removed and be in route to a hospital to be screened by the CSB ES staff.

Overall, the Commonwealth's timely onsite response rate was 94% with 1,265 of the 1,341 calls responded to within the expected one-hour or two-hour timeframes in Year 5. This compares positively to Year 1, 2, 3 and 4 when 87%, 86%, 90% and 92% of the calls respectively, were responded to on-time. This is particularly noteworthy because 215 more calls required a face-to-face on-site response during Year 5 than during Year 4. However, there were 1,349 calls reported, 1,341 total calls responded to face-to-face, and 1,344 assessments completed. This difference is explained by the changes in conducting face-to-face assessments during the COVID pandemic. It appears three individuals had assessments that were not face-to-face when REACH staff participated by telephone, and five individuals were not assessed by REACH staff.

All Regions' REACH Teams continue to respond onsite to the vast majority of crisis calls. The number of crisis calls responded to is higher than the number of new crisis referrals during the review period. This is the result of a number of crisis calls from individuals who had already been involved with REACH and were not counted as a new referral. In this 16th reporting period eight crisis calls were not responded to face-to-face. Seven of these calls occurred in Region V and one in Region II. These all occurred in FY20 Q3. The teams responded by telephone because of the COVID precautions.

Involvement of Law Enforcement -DBHDS reports the number of crisis responses that involve police officers. This percentage was 45% in Year 5; 44% for both Years 3 and 4, compared to 22% when DBHDS began reporting this data in Year 2. During this past year,

Law Enforcement was involved in the highest percentage (66%) of the crisis calls in Regions II. Law Enforcement was involved in the smallest percentage of the calls (39%) in Region III. Region I experienced police involvement in 47% of the crisis calls and Regions IV and V experienced police involvement in 43% of the crisis calls. 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 children with autism spectrum disorders.

Mobile Crisis Assessments - The number of mobile crisis assessments that were completed during Year 5 was 1,344 compared to 968 in Year 4, compared to 926 in Year 3. There were 631 assessments conducted during Year 2. Only 104 crisis assessments were conducted in Year 1, which included only a six-month period of time. Between Year 4 and 5 the Children's Teams completed 39% more crisis assessments.

The locations where mobile assessments occur are also included in the data provided. Hospitals, where 675 (50%) of the 1,344 assessments occurred, remained the most frequent assessment setting in Years 2, 3, 4 and 5. Only 25% of the assessments in Year 1 occurred at hospitals. When hospitals are combined with the ES CSB office locations, there had been a steady increase in the percentage of assessments that occur in these out-of-home locations through Year 4. In Year 5 the Commonwealth realized a reduction in the percentage of crisis assessments conducted out-of-home. The percentages of these out-of-home assessments are 53%, 61%, 67%, and 67%, and 60%, respectively for the five years. 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 Years 3 and 4, showing a slight increase to 30% in Year 5. Although not based on a significant sample, the percentage of screenings that occurred in the child's home or other community setting was 40% for the children in the qualitative study compared to 20% in the previous study.

Conclusion: The number of REACH crisis assessments in Year 5 is a 39% increase compared with Year 4. This is a startlingly high increase in the number of assessments and therefore the workload required of REACH staff. Providing linkages and ongoing prevention services may be critical to deter future crises for children with IDD. Hopefully the availability of the Children's Crisis Therapeutic Homes (CTHs) will mitigate future crises as well. The fact that the number and percentage (60%) of assessments are conducted in out-of-home settings, in either hospital or the ES/CSB locations, is evidence that the Commonwealth's crisis service system is not being implemented by the CSBs to comply with the specific requirements or the goal of the SA that crisis services respond onsite to prevent the individual from being removed from the home. The fact that individuals who receive their initial assessments at these out-of-home locations are much more likely to be hospitalized is additional evidence that the crisis system is not preventing the individual from being removed from his or her home/current placement. Not preventing the removal of the individual from his or her home, also eliminates the possibility of fulfilling the Agreement's requirement that, "services, supports and treatment to de-escalate crisis without removing individuals from their homes, whenever possible".

It is positive that the percentage of assessments completed at family homes increased and the percentage completed in the hospital or ES decreased from 67% of the crisis assessments in Year 4 to 60% of these assessments in Year 5.

DBHDS data 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 significant increase in both referrals and requests for mobile crisis assessments. These numbers seemed to be leveling in Year 4 but have significantly increase once again in Year 5. REACH is being informed of possible psychiatric admissions for a higher number and higher percentage of individuals now that the program is more established and the Commonwealth's outreach efforts have continued. The number of non-crisis calls also increased exponentially between Year 4 and Year 5, from 3,469 to 5,442 calls. This is an increase of 57% of the calls. Information-only calls decreased in Year 5. The high number of non-crisis calls is a positive indication of the value families and community providers place on REACH, but significantly increases the workload across the REACH children's programs.

Mobile Crisis Support Services - In Year 1 there were only 123 children who received mobile supports (MS) over the six-month period. The number of children receiving MS in Years 2 and 3 is remarkably consistent: 601 and 602, respectively. However, the number of children receiving MS in Year 4 decreased significantly from 602 in Year 3 to 278 in Year 4. In Year 5 there is a slight increase of 11 more children who receive MS. The Regions vary considerably in terms of how many individuals receive mobile crisis supports over the five years. Regions I and II continue to decrease MS resulting in the fewest children served in these two Regions in all five years. Regions III, IV and V increased the number of children served in Year 5. However, only Region III has surpassed the number served in Year 2 by Year 5. The number of children served by Region is depicted in *Table 3* below.

Table 3: Children Receiving Mobile Supports

Region	*Year 2 Total*	*Year 3 Total*	*Year 4 Total*	*Year 5 Total*
RI	163	238	46	26
RII	177	190	30	29
RIII	30	34	33	52
RIV	85	96	69	83
RV	146	44	80	99
Total	**601**	**602**	**278**	**289**

The number of crisis calls is so much higher in Year 5 which makes it more surprising that there is only a 4% increase in the number of individuals receiving mobile crisis supports. With an increase in the number of crisis calls and in referrals for crisis services, the minimal increase in the provision of mobile crisis services does not appear to result from either fewer individuals in crisis or those in crisis having substantially fewer needs. Rather, resource limitations, either too few staff or funding, may have led to a reduction in services. The staffing of the Regions' programs is discussed in the Summary section of the report.

The number of children receiving mobile crisis supports counts both new individuals and readmissions. Readmission is defined as children who are receiving mobile supports for a subsequent time. The percentage of readmissions is under 14% for all five 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, or families may be using prevention services.

The numbers of the children who receive mobile crisis supports, as detailed in *Table 3* above, is lower than the number of children who were reported to have used REACH as a result of a crisis assessment, as described in *Table 4* 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. The higher number receiving crisis support at the time of the crisis assessment can only be explained by the creation of a safety plan, crisis stabilization plan, or the use of prevention services. It is an indication that a number of children identified as returning home after the crisis assessment with REACH support (340) are not using mobile support since only 289 children in total used MS. This is somewhat validated by the qualitative study data for the children. Only 16 of the 21 children in the qualitative study used MS which is 76% of those who accepted REACH services at the time of their referral in November. Also, of interest is that no children could be included in the qualitative study from Region I. There were five referrals in Region I for children in November 2019 but three did not accept services and two were ineligible.

DBHDS does report separately on the number of prevention hours provided for children. The total number of hours for Year 5 is 10,141 hours, compared to 2,136 hours of MS. Prevention services are similar to MS but are not offered at the time of the crisis. Prevention is offered later after the family situation has been stabilized, or if MS was either not sufficient or the family rejected MS at the time of the crisis but requested services at a later point. This is a significant amount of support and accounts for 83% of the in-home support offered to families, compared to 17% of the total in-home support that is mobile support. The amount of prevention varies considerably across the Regions. Region I reports' providing 742 prevention hours of service in Year 5 compared to Region IV that reports 3,554 prevention hours in Year 5. There is much less variation in the number of MS hours which ranges from 187 hours in Region I to 535 hours on Region IV. DBHDS began reporting on the number of individuals who receive prevention services in FY20 Q1. It is not possible to compare this information to previous years, but it is useful to have at this juncture. Prevention services were delivered by the REACH teams to 396 children in FY20 Q1; 513 in FY20 Q2; and 496 children in FY20 Q3. Many more children are receiving prevention services then the number receiving MS. Children on average received six hours of prevention services in FY20 through Quarter 3. It may be possible in the future to determine the contribution of prevention services to keep children home and not in need of hospitalizations.

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 and 4 when 928 and 968 children had crisis assessments,

respectively. In Year 5, 1,344 individuals 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 significantly higher number and percentage of the children are being hospitalized. The number increased by 178 children between Years 2 and 3, which represented 36% versus 25% of the total number of children who were assessed for a crisis. The percentage of hospitalizations remained steady between Years 3 and 4 with 340 children hospitalized. Significantly even more children were hospitalized in Year 5 with a total of 467, which is 35% of all of the children screened for a crisis. This is also an increase of 27 (37%) of children hospitalized instead of being stabilized at home, comparing the numbers in Year 4 and Year 5.

Unfortunately, the maturing of the REACH crisis service for children has not significantly reduced the percentage of children who were hospitalized at the time of the crisis assessment as the percentage has remained around 35% for Years 3,4, and 5. The number of children referred for crisis assessment and support in Years 3 and 4 is very similar. However, far fewer children and families are benefitting from mobile crisis supports in Years 4 and 5 than have previously. In Year 5, 828 (62%) of the 1,344 children assessed for a crisis returned home. However only 340 (25%) were afforded crisis mobile supports. In Year 4, 603 (62%) of the 968 children assessed for a crisis returned home. However only 184 (19%) were afforded crisis mobile supports. In Year 3, 583 of the 928 children who were assessed remained at home and 304 (33%) of them used mobile support. This is a significant increase in the number of families benefitting from mobile crisis supports between Years 4 and 5 which is very positive. However, the percentage of those children who received mobile supports from REACH in Year 5 is 25% compared to 19% in Year 4 compared to 33% in Year 3. The decline in the percentage of total referrals who receive mobile support while better in Year 5 than in Year 4 has not returned to the percentage achieved in Year 3. This is concerning at a time when the number of children hospitalized is increasing significantly. DBHDS must monitor this growing need and response from REACH and take needed steps to ensure that the programs have adequate resources to provide needed supports.

DBHDS should carefully study the increase the number of hospitalizations for children at the time of the crisis 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. REACH responds to crises at the family home whenever possible, but REACH staff needs to be accompanied by CSB ES staff for a change to occur in where crisis response and assessment are conducted.

It is also evident that it is critical to have crisis stabilization (Crisis Therapeutic Home-CTH) settings for children that are available as an alternative to hospitalization. Only seven children in Year 5 benefitted from crisis stabilization programs offered by community providers. The Commonwealth opened the Children's CTHs during this reporting period. The CTH is Region II is only licensed at this point for two visitors. The CTH in Region IV is licensed for six visitors. 17 children were able to use the Region IV CTH in FY20 Q3 for crisis stabilization, with two children readmitted. This is included in the Table below under

the Other category. It is extremely positive that both CTHs are operational at a time of increasing crisis assessments and subsequent hospitalizations. Children in the qualitative study experienced 15 hospitalizations out of 48 screenings. This consultant determined that five (31%) of these hospitalizations could have been diverted if there was a CTH option.

Table 4 below illustrates the disposition at the time of assessment in Years 1, 2, 3, and 5.

Table 4: 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	13	5	0	28	10	**56**
2	152	11	7	168	275	**613**
3	330	8	7	304	279	**928**
4	340	11	14	184	419	**968**
5	467	42	7	340	488	**1,344**

The REACH reports include data regarding the disposition for individuals at the completion of mobile crisis supports. For the first time REACH reports on dispositions after the use of the Children's CTH. The data demonstrate that the vast majority of children are able to continue to live at home. The number who stay home represent 90% of the children who used REACH in Years 4 and 5. This includes a small number of children and families who continue to receive mobile supports. The continuation of MS was the highest in Year 3 when it was only provided to 30 of the 604 children. In Year 4 only 18 (6%) continued to use REACH mobile supports, and this decreased to two families using MS in Year 5.

The percentage of children who were hospitalized after using mobile crisis supports dropped from 14% of the children who received mobile supports in Year 3, to 8% in Year 4 which is a similar percentage to Years 1 and 2. This percentage further decreased to 6% of the children who were hospitalized after receiving REACH services in Year 5. The fewest number of children were hospitalized after using REACH crisis mobile supports in Year 5 compared to all previous years. This is a demonstration of the success of crisis mobile supports in assisting children and families to stabilize after a crisis, and possibly the addition of the CTH as another alternative to hospitalization.

The decrease in hospitalizations after REACH programs have been involved is the outcome that was expected and desired by the creation of the REACH teams. REACH is proving to be successful in stabilizing children's living situations when it can offer its community-based supports.

Table 5 below depicts this data.

Table 5: 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	0	101	7	**119**
2	42	7	6	458	12	**525**
3	82	1	30	489	2	**604**
4	21	3	18	234	2	**278**
5	18	3	2	260	9	**289**

Number of Days of Mobile Support - REACH is expected to provide up to three days of mobile crisis support on average for children and adolescents. Every Region provided at least an average of three days of mobile support in Year 5 with the exception of Region V that was under three days average in all quarters except FY20 Q3. The days ranged from 1-15 across the Regions. Region III continues to provide the highest number of days of MS, providing up to 15 days of mobile supports every Quarter and the highest number of average days in three Quarters in Year 5.

The mobile crisis support service includes comprehensive evaluation; crisis education prevention plan (CEPP); consultation; and family/provider training. The evaluation, CEPP and consultation are required elements of service for all REACH participants. However, a child may have had a CEPP competed during an earlier interaction with REACH and therefore the finalization of the CEPP would not be included in these data. However, there should be an evaluation and consultation for each individual at the time of MS. 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 6* portrays this information below.

Table 6: Children Receiving Mobile Supports and CEPP					
Year	***Mobile Support***	***Evaluation***	***CEPP***	***Consultation***	***Provider Training***
1	123	58	66	84	84
2	601	472	430	400	375
3	602	568	539	568	487
4	278	284	262	270	264
5	289	306	305	252	248

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 were 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 Region II in Year 5 reflect achievement of this requirement. Region III evaluated everyone who received mobile supports and provided all but one with consultation. The data from Region V indicates much greater achievement in Year 5 compared to Year 4. Evaluations appear over-reported in Region I for the total number of individuals receiving mobile supports. Region I reports' completing the evaluation for 46 children but only reports providing mobile supports to 26 children. The other service elements are over-reported as well. DBHDS explained that this was the result of a reporting error in FY19Q4 that has since been corrected.

***Conclusion**:* Of the number of children served in Year 5:

- *95% received the evaluation and consultation that DBHDS requires*
- *87% received a CEPP*
- *86 % received provider training*

Provider training in the crisis plans continues to increase to providers. This training should enhance the families and providers skills and improve the chances of successfully avoiding future crises.

CEPPs were written for 43% and finalized on-time for 29% of the twenty-one children in the qualitative study. The findings in the qualitative study for children include children served by the REACH program in Regions II and V. In Region II overall 95% of the CEPPs were done and 75% were finalized on time. Region V has percentages of 38% for the initial CEPP being completed and 30% for CEPPs finalized within thirty days of the initial CEPP. In many cases Region V did not provide the CEPPs for the consultants to review. They were not consistently downloaded with other documents at the beginning of the study. Region V staff said they would share them after the interviews the consultants conducted with the team but did not produce them for our review.

Training - Only Region I has a separate Children's REACH program. The training conducted by the other Regions is portrayed in the Training Table under the Adult REACH section. The staff of the Region I Children's REACH Program continues to provide training to stakeholder groups. During Year 5 the Children's Team trained 558 individuals in Region I. CIT Officers, Case Managers, ES staff, Residential Providers, and Families were trained.

Crisis Stabilization Programs (aka Crisis Therapeutic Homes – CTH) - The Children's REACH programs were expected to open crisis stabilization homes for children by June 2012. DBHDS now calls these settings Crisis Therapeutic Homes (CTH). Two homes opened in January 2020. Each will have the capacity to serve six children. Currently the CTH in Region IV is licensed for six children but the CTH in Region II is licensed for only two until staffing can be increased which has been problematic because of the COVID restrictions. 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 require time out of their family homes to stabilize and for mobile supports to be put in place, if needed. The home in Region II will serve children from Regions I and II. The home in Region IV will serve children from Regions III, IV and V. Region IV reported serving 17 visitors during FY20 Q3 who needed crisis stabilization. The average Length of Stay (LOS) was under three days which is an extreme variation from the LOS at the CTHs for adults.

DBHDS reports planning to execute contracts for the out-of-home therapeutic prevention host homes by July 2020. DBHDS expects that two providers will be involved in providing this service. These providers have host homes located in Regions III, IV and V, which will offer access to children from all Regions. This option is a critically important alternative to hospitalization for children who need time away from the family setting.

Psychiatric Admissions - DBHDS reported that 454 children with IDD in Year 5 compared to 390 children with IDD in Year 4 were admitted to psychiatric hospitals. This is the highest number of children hospitalized in any year since the review of children's services began, occurring after a decrease in hospitalizations in Year 4 compared to Year 3. This is an increase of 16% in children's hospitalizations in the past year. It is promising that the consistent percentage in both Years 3 and 4 of children admitted to hospitals who were active with REACH prior to the crisis, has reduced in Year 5. The children who were hospitalized who had previously received assistance from REACH, represented 37% of all admissions in Years 1 and 2, which decreased to 30% of the hospital admissions in Years 3 and 4, and to 29% of children admitted to psychiatric hospitals. This indicates the benefit of first providing REACH mobile supports, when they can be offered and provided, to prevent first time admissions or readmissions to hospitals. *Table 7* summarizes this data regarding hospital admissions.

Table 7: Children's Admission to Hospitals			
Year	***Referrals***	***Active Cases***	***Total***
1	42	25	**67**
2	149	88	**237**
3	314	133	**447**
4	268	122	**390**
5	323	131	**454**

The Hospital Addendum to the Children's Quarterly Reports data includes data about the known dispositions at the end of each Quarter for the children who have been discharged from a hospital. Of the individuals 313 (68%) have retained their home setting or are living with another family member; 29 (6%) transitioned to an alternate residential provider; 70 (15%) are reported as Other; and 51 (11%) remain hospitalized. REACH was involved with the majority of these families. It is not reported in the Hospital Addendum but DBHDS sent confirming data to this reviewer. It is positive that 76% either retained their home setting or moved to a setting that can hopefully afford the children stability. This is a greater total number of hospitalizations than was reported in the total number of active cases and

referrals in *Table 7* above. The data totals of 463 versus 454 in *Table 7* indicate multiple hospitalizations for some children.

Conclusion: There is a steady increase in the number of children being assessed for crises and the subsequent hospitalization of many of them. REACH can finally offer CTHs (crisis stabilization homes) as a diversion or stepdown from hospitalization. Therapeutic host homes as diversions from hospital admissions for children are not as yet available. Until the CTHs are more available and there are host homes 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 the number of children who were hospitalized increased in Year 5, and there were 454 hospitalizations when children were not offered or provided community-based alternatives to divert them from hospitalization.

One factor that needs to be addressed and is discussed in more detail in the summary of the qualitative study is the fact that 60% of screenings for hospitalization were conducted at the ES office or, more frequently, a hospital Emergency Room (ER). This pre-Settlement Agreement systemic approach consistently results in children being removed from their homes without being stabilized and many more being hospitalized than being provided REACH services to de-escalate the crisis and stabilize the home situation or being offered an alternative as a diversion from being hospitalized. This continuing systemic approach to provide initial assessment after an individual has been removed from and outside the individuals' homes is the opposite of what is required by the Agreement and it clearly leads to the opposite and undesirable result than what the Commonwealth agreed was desired or expected outcome from the creation of the REACH teams. Clearly an additional contributing factor to the number of children with IDD who are hospitalized is insufficient diversion opportunities without any CTH programs available for children until FY20 Q3. Hopefully both CTH settings will be fully operational in FY21 and their availability will reduce the number of hospitalizations being experienced by children.

B. Reach Services for Adults

New *REACH Referrals* - the number of referrals to the Adult Region REACH Programs continues to increase. Regions received 2,424 referrals of adults with IDD in Year 5, as compared to 2,258, 1,677, 1,247 and 705 referrals in Years 4, 3, 2 and 1, respectively. The number of referrals received in Year 5 is only a 7% increase from the previous year. However, this is because there were actually fewer non-crisis referrals in Year 5 compared to Year 4. It is significant to note an increase of 563 crisis referrals which results in a 66% increase in crisis referrals. This has impact on the REACH staffing resources since the program's focus is to respond to crisis calls.

A comparison of the number of referrals across all of the Regions illustrates a dramatic difference in Region V, which is consistent to the reporting across the regions in Year 4. Region V experienced 1,007 of the total referrals accounting for 42% of the 2,424 referrals. The referrals in the other four regions ranged from 232-423. The number of crisis calls in Region V was 382 compared to the range across the other regions of 60-114 crisis calls.

Region V's percentage of crisis calls is 72%, which is much higher than any other region. DBHDS reports that Region V has significantly more new referrals because of the location of military bases and a commensurate number and turnover of a portion of the military families in this Region. This has implications for the staffing needs in Region V in particular.

Table 8: Adult Referrals to REACH			
Year	***Crisis***	***Non-Crisis***	***Total***
1	Not reported	Not reported	**705**
2	647	600	**1,247**
3	888	789	**1,677**
4	857	1,401	**2,258**
5	1,420	1,004	**2,424**

DBHDS reports that a total of 840 individuals received REACH mobile or CTH services in Year 4. This includes 584 individuals who used mobile supports and 256 who used the CTH. This remains a significant decline in the total of 1,024 adults that DBHDS reported received REACH services in Year 3 but an increase from the number using these services in Year 4 when a total of 785 used either MS or the CTH. This overall increase in Year 5 over the previous year is the result of an increase in MS use from 487 individuals in Year 4 to 584 individuals in Year 5. There was a slight decrease from the individuals reported as using the CTH in Year 4, which was 298 adults. The number of individuals who used the CTHs in year 5 is significantly fewer than in any previous year. The decreased utilization of the CTHs is inconsistent with the increase in the number of referrals, of both a crisis and non-crisis nature, and an increase in the number of hospitalizations. The decrease in the amount of crisis stabilization services since Year 3 continues to indicate that there are insufficient staff and other resources to meet the crisis needs of the increased number of referral and individuals being served by the REACH programs.

The decreased utilization of both of these crisis services will be described in greater detail later in this report and is described in Tables 15 and 16. The above numbers are not an unduplicated count of individuals because they include both admissions and readmissions, and some individuals use both mobile supports and the CTH program. Overall 14% of the calls to the Adult REACH Programs were of a crisis nature in Year 5, which is similar to Year 4 (16%) but dissimilar to Years 2 and 3 when crisis calls accounted for over 50% of the calls. The total of calls is very skewed by the number of non-crisis calls received by Region V that totaled 6,924. However, with the exception of Region IV all of the Regions continue to receive far more non-crisis calls than crisis calls. This may be an indication of REACH's success serving many individuals over the past years who continue to use REACH as a crisis prevention service.

Table 9 depicts the number of calls and the nature of the call.

Table 9: Total Adult Calls			
Year	***Crisis***	***Non-crisis***	***Total Calls*** *Including Information-Only Calls*
1	1,380	2,052	**4,525**
2	1,159	2,690	**5,101**
3	1,906	6,584	**11,528**
4	2,229	11,702	**16,813**
5	2,663	12,445	**18,876**

Calls to REACH are reported separately from referrals.

The number of calls the REACH programs receive continues to increase each year, including 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, or when any individual calls REACH multiple times for a non-crisis or an informational need. The call numbers across all call types in Year 5 note a steady increase.

In Year 5, CSB Emergency Services continued to make the majority of the referrals (38%) to REACH. ES and hospitals together made 47% of all referrals, which is consistent with the percentage of referrals made in Year 4. This indicates that the requirements on these providers to notify REACH of any prescreening for hospitalization is being implemented. 26 referrals were made by law enforcement in Year 5 compared to 12 in Year 4. This is the third consecutive year referrals have been made by police officers, who made six referrals in Year 3. This seems to demonstrate that police view REACH as a resource when they are called to a crisis in the community involving an individual with IDD.

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

Involvement of Law Enforcement - DBHDS reports the number of crisis responses that involve police officers. This percentage is 45% for Year 5 which is the same as the percentage in Year 4. DBHDS reports a total of 4,001 calls in Year 5, compared to 1,874 calls in Year 4, and that Police were involved in 1,899 of these crisis responses in Year 5. During this past year, law enforcement was involved in the highest percentage of the crisis calls in Region II, with an average of 66% response for both children and adults. Regions III and IV had the lowest percentage of calls involving the police with 41% and 44% respectively; Region I experienced police involvement in 50% of the adult crisis calls and Region V experienced police involvement in 52% of the crisis calls. This pattern is similar for the REACH crisis responses for children in Year 5, with the exception of Region V where police responded to 43% of the calls involving children. 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. There are many instances when police officers and REACH staff are able to stabilize the crisis and divert a hospitalization from occurring. 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 children with autism spectrum disorders. It should be noted that the overall number of calls as well as those responded to by police doubled between Year 4 and Year 5.

Disposition at the Time of the Crisis - 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 10 provides the disposition after the individuals' initial assessments by REACH.

At the time of disposition, a majority of the individuals served by REACH continued to retain the residential setting where they lived at the time of the initial assessment. In Year 5, this was 1,545 (58%) compared to 1,236 (56%) in Year 4; 1,135 (60%) in Year 3; 869 (56%) in Year 2; and 736 (69%) in Year 1. This illustrates the continued increase in the number of individuals referred to REACH, and the lack of meaningful increase in the percentage of individuals who retained their homes. 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 for Years 1, 2, and 3, this percentage increased from 13% to 18% in Year 4, and to 25% in Year 5. The actual number of individuals who used such services also continues to increase. This is a significant increase but is primarily attributable to Region V, which accounts for 346 of the 661 individuals who retained their setting with REACH assistance. Region V accounted for the higher number using REACH after a crisis in Year 4 also. It is interesting to compare the differences across the Regions of the percentage of individuals who retain their setting with REACH support compared to those who return home and do not need to use REACH after the crisis. Only 13% of individuals in Region I and 16% in Region IV use REACH to retain their home setting after a crisis compared to 50% in Region II; 64% in Region III; and 62% in Region V. These differences have implications for the demand on staff to provide MS after a crisis screening being substantially different across the Regions. In Year 5, Regions III and V together provided MS to 75% of the individuals who needed this support to retain their home settings.

While REACH has experienced an increase in both the number of crisis calls and the number of referrals, there has also been a significant increase in the number of individuals who are hospitalized at the time of the crisis assessment from 210 in Year 1 to 885 in Year 5. The increase in hospitalizations was 77 between Year 4 and Year 5, so the trend of a greater number of hospitalizations continues. The percentage that were hospitalized at the time of assessment also increased substantially, from 20% in Year 1 to 36% in Year 4. However, in Year 5 the percentage of individuals who were hospitalized dropped to 33% of the individuals who had a crisis screening. The data from the qualitative study that is portrayed later in this report indicates that DBHDS could provide alternative community-based options and thereby divert more hospital admissions, if the required crisis stabilization beds (CTH beds) were available.

In Year 1, the percent of individuals who used crisis stabilization services was 25% of the number screened for crises; whereas, in Year 5 29% of the individuals screened for a crisis used one of REACH's crisis stabilization services, compared to 21% using crisis stabilization of the individuals screened in Year 4. This is the result of a significant increase in the number of individuals using MS in Year 5: 661 compared to 352 in Year 4. However, this number cannot be directly compared to the numbers receiving MS in previous years because it now includes individuals who receive prevention services after a crisis. The more accurate comparison of the use of MS in Year 5 compared to other years is found in *Table 15*.

The use of the CTH program or other crisis stabilization units increased by only ten from 112 in Year 4 to 122 in Year 5. The use of these crisis stabilization beds remains lower than in Years 2 and 3. Since Year 2, the decline in the use of the crisis stabilization alternative to hospitalization at the time of the crisis assessment, when the number of individuals in crisis has steadily increased, is clear and compelling evidence that the Commonwealth continues to have inadequate crisis stabilization bed capacity. The Commonwealth is not fulfilling the requirements to offer this "last resort option" as an alternative to institutionalization, nor has it developed a second crisis stabilization program in each Region. The use of the CTH at the time of the crisis assessment has declined steadily since Year 2, from 8.6% to 4.6%.

REACH provides critical crisis supports that do reduce the number of hospitalizations when such supports are made available at the time of the crisis assessment. In Year 1 the percentage of individuals who were not hospitalized because they used REACH MS or CTH was 25% of the total number of individuals who experienced a crisis assessment. This percentage dropped to 21%, 19% and 21% of everyone who had a crisis assessment in Years 2, 3, and 4 respectively. There was a dramatic increase in both the number (783) and the percentage (29%) of all adults who were screened for a crisis in Year 5 who received either MS or CTH services from REACH. It is significant that REACH has increased its ability to offer MS or CTH at the time of the crisis assessment. *Table 10* illustrates the disposition at the time of assessment across Years 1, 2, 3, 4, and 5.

Table 10: Disposition for Adults 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	**1,063**
2	515	200	669	136	1	53	**1,574**
3	595	243	892	128	0	46	**1,904**
4	808	352	884	112	0	66	**2,222**
5	885	661	884	122	0	103	**2,655**

* *The CTH column includes alternative CSU beds in each year of 7, 33, 27, 36, and 41 respectively*

Disposition After Receiving REACH Services - *Table 11* lists the disposition after the individuals received either mobile or crisis stabilization/CTH services from REACH. This table shows where the adult REACH participants are residing after either mobile crisis supports or use of the CTH has ended. Three out of four of the individuals in Years 1-4 retained their home settings after receiving REACH crisis supports. The total number who retained their home setting increased in Year 5 from 607 to 639 individuals. However, the percentage who retained their setting dropped from 74% in Year 4 to 67% of the individuals who retained their residential setting after receiving REACH services in Year 5.

In Year 5, a higher percent (33%) of individuals were hospitalized at the time of assessment compared with the 8% who were hospitalized after receiving REACH mobile crisis support services and the 13% who were hospitalized after using the CTH program. These percentages of individuals hospitalized after REACH services have increased slightly since Year 4.

94 individuals either continued to use the CTH's past this reporting period (78) or after receiving mobile supports (16), compared to those who continued to use the CTH in previous years: 73 in Year 4; 81 individuals in Year 3, 61 individuals in Year 2, and 102 adults in Year 1. This increase in number (since Year 2), continuing to use the CTH or using it after MS may indicate it is allowing more individuals to not be hospitalized or it may be an indication of a lack of suitable alternative residences when they are needed.

The number of individuals who used REACH services increased by 133 between Years 4 and 5. As reported above, more individuals retained their setting and more used the CTH. Unfortunately, there was a significant increase of 35 individuals who were hospitalized, which increased the percentage of those hospitalized after receiving REACH services from 7% in Year 4 to 10% in Year 5.

Table 11 also depicts that the use of alternative residential option represents a similar percentage compared to the number of individuals who retained their home settings across all five years with the number increasing in Year 5:

- *84 (8%) in Year 1*
- *77 (10%) in Year 2*
- *74 (10%) in Year 3*
- *64 (10%) in Year 4*
- *81(11%) in Year 5*

This lack of availability of new long-term residential options with quality behavioral support services for individuals who experience a crisis appears to be a significant contributing factor to longer stays at the CTH or to the psychiatric hospitalization of individuals after providing REACH mobile crisis supports. Many of the adults in the qualitative study did not have a provider who met their needs, and many had transitioned more than once during the reporting period. Only 15 (38%) of the 39 adults in the study had a provider who met their needs and only 26 (67%) of these adults kept their original

provider. This data indicates the need for more providers with the expertise and competencies to address the needs of individuals with IDD and co-occurring conditions.

Table 11 below illustrates the disposition at the end of REACH services (mobile crisis supports or CTH) for Years 1, 2, 3, 4 and 5. 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 11: Disposition for Adults at the Completion of REACH Services							
Year	***Psychiatric Admission***	***Alternative Residence***	***Retain Setting***	***CTH***	***Jail***	***Other***	***Total***
1	79	84	994	102	0	35	**1,294**
2	66	77	760	61	5	29	**988**
3	48	74	754	81	3	29	**989**
4	58	64	607	73	1	17	**820**
5	93	81	639	94	9	38	**953**

Conclusion: *Table 10* shows the outcome for individuals who have received REACH services after their crisis assessments. *Table 11* shows the outcomes for individuals after REACH has completed MS and CTH services. 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 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. REACH has increased its availability of supports in Year 5.

Overall the number of adults who were hospitalized increased again in Year 5. The increase between Year 4 and Year 5 is 112 adults, including those hospitalized at the time of the crisis assessment (+77) and after receiving REACH services (+35). 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 quantity and quality of diversionary services. The CTH Crisis Stabilization programs are not consistently available to be offered as a "last resort" to divert individuals from hospitalization when they are first screened in response to a crisis or after receiving REACH services, if these services have not sufficiently stabilized the individual.

DBHDS provides an addendum to its quarterly crisis services reports. The addenda report additional data on the outcomes for individuals who were 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 to their previous home setting or whether an alternative residential placement needed to be, and was, located. In *Tables 10 and 11*, the total number of **dispositions for** individuals who had contact with REACH and who were

admitted to psychiatric hospitals was 978, 885 occurred at the time of the crisis assessment and 93 after REACH services were provided.

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, 832, 833, and 918 individuals with ID/DD hospitalized in Years 1, 2, 3, 4, and 5, respectively. This number is based on the number of new referrals and active cases DBHDS reports. In Year 5 these 918 individuals experienced 971 admissions of which REACH was made aware. DBHDS has always reported that the number of hospitalizations in the addenda will be a higher number than the total of hospitalizations at the time of crisis assessment plus the number of hospitalizations after REACH services. This variation is 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 Department notes that these data in the addenda do not reflect, and that the Department does not know, the total number of individuals with IDD who are admitted to private psychiatric institutions.

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 112 individuals between Years 4 and 5. Based on the data from *Tables 10 and 11* in this report, this equates to a 13 % increase in the adults with IDD who were hospitalized as the result of a crisis.

The percentage of active participants who received REACH services and were hospitalized had been decreasing each year through Year 4, while the number of individuals who were newly referred and were hospitalized at the time of the crisis had increased. This difference was seen as an indication of the value of receiving REACH services, and the effectiveness of the linkages provided by REACH, to reduce the need for hospitalization. From Year 4 to Year 5 however, the actual number, as well as the percentage, of active participants in REACH services, who were hospitalized, also increased, from 351 to 399 individuals, and represented 43% of the overall hospitalizations. This one-year reversal of a positive trend over the previous four years is a concern.

The number of active REACH participants was actually higher than for new referral in Region IV in Year 5 (87 active cases and 68 new referrals) and represents a high percentage (47%) of all of the hospitalizations in Region II. We will need to analyze this in future reporting periods to see which direction the trend will take. The percentages of individuals known to REACH who are hospitalized compared to new referrals is still lowest in Years 4 and 5 compared to Years 1, 2, and 3.

The almost 250% increase in the number of all new referrals from Years 1-5 is very significant. The increase in the number of crisis referrals from Year 2 (647), when crisis referrals were first reported separately, to Year 5 (1,420) represents a 120% increase. 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. In such circumstances, REACH has no existing relationship with the family or provider and has no knowledge of the individuals' needs, behaviors or medical conditions. This lack of information impacts the programs' ability to intervene, especially if REACH is contacted after the individual is in route to the ES office or hospital. In these situations, REACH staff cannot help to de-escalate and stabilize the situation at the individual's home, which is their central purpose. The tremendous increase in crisis referrals also has implications for staff resource needs. *Table 12* below depicts these data.

Table 12: Number of Hospitalizations for Active REACH Adult 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**
4	482 (58%)	351 (42%)	**833**
5	519 (57%)	399 (43%)	**918**

DBHDS reports that the difference in the two data sources is that the Addendum of Psychiatric Admissions includes all involuntary and known voluntary admissions. Heather Norton explained that the CSB ES is not involved in screenings for individuals who are seeking voluntary admission, and that the public hospitals do not always notify REACH of these admissions. A family member may inform REACH during or subsequent to the hospitalization. The Independent and Expert Reviewers have recommended in the past that DBHDS and these Regions' REACH teams work with hospitals to ensure their awareness of the importance of, and requirement to inform REACH of these admissions so that REACH staff can be involved in proactive discharge planning**.** It appears from the data for Year 4 and Year 5 that this outreach is occurring and has been effective in ensuring that REACH staff knows about all admissions to publicly operated psychiatric hospitals.

Conclusion: The CSB ES staff and/or hospital are 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 alternatives 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.

DBHDS does report on how many different individuals with IDD have been admitted to psychiatric hospitals and how many hospitalizations occurred during the reporting period. Some individuals may have had multiple hospitalizations. There were many individuals in the qualitative study who experienced between 2-8 hospitalizations. It is necessary to have DBHDS be able to report specifically on the actual number of:

- Individuals with multiple hospitalizations, and
- The number of hospitalizations for each individual with multiple admissions

The number of hospitalizations, as reported in this section of the DBHDS report, continues to increase, more than doubling since Year 1 and increasing by 10% between Years 4 and 5, compared to a 19% increase between Years 3 and 4. The pattern of dispositions changed in Year 5 following Year 4, and outcomes were less positive regarding continued hospitalization. An increased number of individuals have remained hospitalized each year, reaching 192 in Year 5 and ranged from 14%-20% of all individuals hospitalized over the five years. The individuals who used the CTH after a hospitalization ranged from 8%-12% through Year 4. The use of the CTH post hospitalization increased significantly from 71 in Year 4 to 102 in Year 5. This is positive and may indicate that individuals were able to step down once ready for discharge more frequently.

The percentage of individuals who retain their home setting without REACH supports dropped to 35% in Year 5 from 51% in Year 4. But this is the first year in which a significant number of individuals retained their home setting with MS as noted earlier in this report. This totals 197 (20%) of the population hospitalized. This brings the total percentage of individuals who retain their home setting to 55% which is more comparable to the previous years. (In the qualitative study 67% of the 30 adults retained their residence.) *Table 13* below depicts these data.

Table 13: Disposition for Adults Hospitalized*

Year	*Remain in Hospital*	*Home with Mobile Supports*	*Home without Mobile Supports (% of Total)*	*CTH*	*New Provider*	*Other*	*Total*
1	56	2	244 (61%)	46	24	25	**397**
2	105	3	402 (59%)	54	52	68*	**684**
3	133	1	437 (59%)	77	53	46*	**747**
4	174	18	458 (51%)	71	74	100*	**887**
5	192	197 (20%)	340 (35%)	10	81	151*	**971**

** 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 provider, residence, crisis stabilization bed, or other needed community supports. However, the continuing trend is of an increasing number and percentage of individuals remaining hospitalized each year. 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 by utilizing the transition homes that opened in FY20 Q3. Currently there are only two individuals using each of these transition homes, in part due to the COVID pandemic. The impact of these homes cannot be determined until the next reporting period, at the earliest. When the Commonwealth

reduces the number of stays that exceed the 30-day maximum established by the Agreement, 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. This will be discussed in detail later in this report.

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.

When an individual with IDD is screened for admission, the revised REACH standards require REACH staff to:

- join with the ES staff for every admission screening and
- stay involved with everyone who is hospitalized as a result of the screening.

If an individual is hospitalized, REACH standards require REACH staff to:

- participate in the admission,
- attend commitment hearings,
- attend treatment team meetings, and
- participate 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 IDD and unless the screenings occur at the individual's home, whenever possible. However, for the adults in the qualitative study, the Regions' REACH Teams' provided hospital support for 87% of the 15 adults who were hospitalized, who accepted REACH support. A smaller percentage of adults in the qualitative study received supports while they were in the hospital. Hospital support was provided by REACH for 28 (60%) of the 47 hospitalizations. Region V reports that the state hospital in its area does not always respond to the outreach by the REACH team's hospital liaison.

Training - The REACH quarterly reports document that the REACH Adult Programs continued to provide extensive training to a range of stakeholders. The five Regional REACH programs trained 7,055 individuals during Year 5. The Commonwealth continues to meet this expectation. This is summarized in *Table 14* below:

Table 14: Training by REACH Program Staff								
Year	***CIT/Police***	***CSB***	***ES***	***Providers***	***Hospital***	***Family***	***Other***	***Total***
1	727	967	153	307	250	0	1,054	**3,458**
2	659	1,061	347	885	101	27	862	**3,942**
3	743	712	189	584	437	1,524	558	**4,747**
4	734	961	297	1,534	250	453	2,045	**6,274**
5	**828**	**1,377**	**338**	**1,485**	**219**	**670**	**2,138**	**7,055**

***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 - During Year 5, the REACH programs continue to serve an increased number of individuals with DD, other that ID, than has been reported during earlier review periods. REACH served 711 individuals with DD only, which was 29% of the total referred. This represented a 21% increase over the 585 individuals with DD only who were referred in Year 4.

Conclusion: Outreach to the DD community has resulted in REACH serving more, and an increased percentage, of individuals diagnosed with DD only. These increases may also result from CSBs now being responsible for providing, or arranging 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 the findings and conclusions of this study with a qualitative analysis of the supports and services that have been provided to individuals. This qualitative analysis makes the findings of this study more robust because it focuses on the outcomes in the lives of members or the target population, and not solely on a review of documents, data and reports developed by REACH and DBHDS. The consultant, from a targeted cohort of those served by REACH during the review period, randomly selected the names of the individuals in the qualitative study.

The qualitative study that was conducted during the sixteenth review period includes 21 children and 39 adults. The focus of the study 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 may result in hospitalization; and to provide successful in and out-of-home supports that assist the individuals to retain their community residential settings at the time of the crisis or post-hospitalization. The study, its results and conclusions are presented in Appendix 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 2,424 calls during Year 5 compared to 2.258 in Year 4. In Year 5, 19% of the 2,424 calls were received on weekends or holidays. In Year 5, 118 (10%) of the calls were received between 11PM-7AM, and 43% between 3PM-11PM. The remainder of the calls was received from 7AM-3PM (47%). These data do not specify the calls that were received after 5PM because the calls are reported by the three REACH program shift hours.

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 5 all five Regions provided training to CSB ES staff. The total ES staff trained during this review period was 338, compared to 297 trained in Year 4.

Conclusion: It remains difficult to draw a conclusion from the data provided 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.

REACH leaders in Regions III, IV, and V developed a training program to provide similar training for their staff that is used by all five of the Regions' REACH teams. DBHDS has reviewed and approved the curriculum for use across the three Regions, as reported previously. The DBHDS standards for the REACH programs require comprehensive staff training consistent with set expectations for the topics, which is to be provided within 30, 60, and 120 days of hire. REACH 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. DBHDS lead staff conduct semi-annual reviews of the REACH programs. One of the topics reviewed is the training of both new and tenured REACH staff. The review team also confirms that all staff who are required to be licensed or certified have maintained their licenses and certifications. The results of the Qualitative REACH evaluations are shared with this independent consultant. All REACH programs fully meet the training requirements established by DBHDS in Year 5 as evaluated through the Quality Reviews DBHDS conducts semi-annually.

REACH staff is involved in a growing number of responses to crisis calls. REACH staff responded to 1,063 crisis calls in Year 1; 1,574 crisis calls in Year 2; 1,904 crisis calls in Year 3; and 2,222 crisis calls in Year 4, and 2,663 crisis calls in Year 5. 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. These data are depicted in Table 15.

Of individuals who receive REACH mobile crisis services, approximately three out of four are maintained in their home settings. This information, which is detailed in Table 10 In Year 5, as was true in Year 4, 79% maintained their residential setting. Only 2% in Year 5, compared to 7% in Year 4, moved to a new appropriate community setting. It is unfortunate that the availability of new residential alternatives is decreasing. In the qualitative study only 15 (38%) of the 39 adults were in residential settings that could meet their needs.

While the information above is positive, a relatively small percentage of the individuals who were screened returned home with mobile crisis support or were diverted to a crisis stabilization home (i.e. CTH). 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, 16% in Year 4, and increased to 25% in Year 5. The percentages of the adults using the CTH at the time of the crisis was 9% in Years 1 and 2, reduced to 7% in Year 3, reduced to 5% in Year 4, and further reduced to 3% in Year 5. In Year 1, 25% of the individuals screened for a crisis used either mobile crisis supports or the CTH, while only 21% on the individuals screened in Year 4 used either or both of these REACH services. This percentage has increased to 25% in Year 5, which is positive and a result of the increased use of mobile support. At the same time the number of adults who were hospitalized at the time of the crisis assessment increased dramatically from 210 in Year 1; to 515 in Year 2; to 595 in Year 3; to 808 in Year 4, and significantly again in Year 5 when 885 individuals were hospitalized at the time of the crisis assessment. This continued increase in the number of hospitalizations over five annual review periods is deeply concerning. In light of this steady increase in the number of hospitalizations, it is more concerning that the CTH in particular appears to be underutilized as a diversion for hospitalizations.

Response Time - In all five Regions in Year 5, the REACH staff responded onsite within the required **average** response times. In fact, all Regions except Region I and the rural section of Region II have an average response time of 68 minutes or less in all quarters of Year 5. Both of the urban Regions (II and IV) have average response times ranging from 42

minutes to 53 minutes. Region I responds, on average, between 67-85 minutes and in the rural portion of Region II, the mobile teams responded onsite between 75-88 minutes across the four quarters in Year 5.

DBHDS has designated Regions I, III and V, as rural. A section of Region II was designated rural two years ago when the regional boundaries changed. The "rural" designation requires these Regions to respond onsite to crisis calls within two hours. In Year 5, all of the regions with a rural designation responded on-time between 94% and 98% of the time, as was true in Year 4. Region IV, an urban region, which is expected to respond onsite within one hour, met this expectation only 85% of the time during Year 5 compared to 93% in Year 4. Region II continued to have the most significant difficulty responding to calls within the one-hour expected timeframe in its urban area, dropping from 77% in Year 4 to an on-time percentage of 76%. DBHDS reports the reasons for delays as traffic, weather conditions, distance and multiple calls. This is the first year multiple calls have been listed as a reason and it was across various quarterly reports. This is another indication of a staffing shortage as there are not sufficient REACH staff to respond to multiple crises in all of the Regions at all times.

Starting in Year 3, DBHDS has reported response time broken down into 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 sufficient for REACH staff to respond on site in time to participate fully in the crisis screening or to ensure the screening is conducted at the individual's home.

During this review period REACH staff responded onsite to crisis calls within 30 minutes for 20% of the calls; within 31-60 minutes for 47% of the calls; within 61-90 minutes for 22% of the calls; and within 91-120 minutes for 10% of the calls. 31 calls (1%) were not responded to within the required two-hour timeframe. REACH responded to 67% of the calls within one hour. When responding to a crisis in a family's home, the consequence of responding in more than 30 minutes is that the crisis may not have been stabilized there and the individual may be in route to the hospital to be screened by the CSB ES staff.

Overall, the Commonwealth's timely onsite response rate was 92% with 2,423 of the 2,639 calls responded to within the expected one- or two-hour timeframes. This compares consistently to Years 1, 2, 3, and 4. This achievement is particularly noteworthy because 410 more calls required a face-to-face on-site response during Year 5 compared to Year 4. The need for onsite crisis response has more than doubled since Year 1 when 1001 individuals required a face-to-face assessment.

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, 243, 352, to 661 adults in Years 1, 2, 3, 4 and 5 respectively. There was also an increase in the percentage of individuals who were screened and who retained their settings with mobile crisis support, which was up to 25% in Year 5 compared to Year 4. Mobile crisis support seems effective when it can be provided, but, if available, it could be beneficial to more individuals. Its availability and use have not reduced the number of

individuals who were hospitalized. All Regions meet the training requirements for the REACH staff, as established by DBHDS. Screenings occur on time 92% of the time with 67% occurring within one hour in this reporting period compared to 61% in Year 4. However only 34% of the crisis assessments occur in the individual's home or day program location. This percentage is consistent with the percentage of crisis responses in a community setting for adults in the qualitative study in which 32% of the crisis assessments occurred in the individual's home or day program.

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. This number has reduced significantly in Year 4 when 785 adults used either Mobile Crisis Supports or the CTH. However, use of both programs has increased to 840 adults in Year 5. Note that these totals are not an "unduplicated count". Each individual is counted twice if they receive both mobile crisis supports and crisis stabilization services. They are also counted again when they use one service a second time. 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) had declined through Year 3 and remained at that same number in Year 4. Positively there is a significant increase in the use of MS in Year 5, from 487 to 584 adults (20%). However, the number of individuals who use the CTH continues to decline to a low of 256 adults in Year 5. The decrease in Year 5 of the use of the CTH is 14% compared to the utilization in Year 4. This is depicted in Table 15. It is concerning that far more individuals are screened and that the number of hospitalizations for adults continues to increase yet the number who have the opportunity to use the CTH has declined. Fortunately, more individual are utilizing MS.

Table 15: Number of Adults Using Mobile 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**
4	487	298	**785**
5	584	256	**840**

REACH Programs also provide prevention services after an individual completes Mobile Crisis Supports, is discharged from the CTH, or initially if prevention support is more appropriate.

Prevention consists of regular check-ins with the individuals and their families, recommendations for linkages, and refreshers on the components of the Crisis Education and Prevention Plan (CEPP). DBHDS presents data that summarizes the number of hours of both Mobile Crisis Supports and Prevention each REACH Program provides. Mobile Crisis Support hours increased dramatically between Years 1 and 2 but have dropped significantly in both Years 3, 4 and 5 to fewer hours than the number of hours provided in Year 1. Prevention hours are the highest number of hours provided since Year 1. The total hours of both mobile support and prevention have decreased since Year 1 but increased significantly (9%) in Year 5 compared to Year 4.

Table 16 depicts these data.

Table 16: Number of Hours of Mobile Support and Crisis Prevention Support

Year	*Mobile Crisis Supports*	*Crisis Prevention*	*Total*
1	6,477	22.297	**28,774**
2	11,573	13,908	**25,481**
3	4,844	22,803	**27,647**
4	4.907	20,780	**25,687**
5	4,902	23,258	**28,160**

DBHDS began reporting the number of adult's who used prevention services starting in the first quarter of FY20. There was a total of 2,920 adults who received prevention as a support during FY20 Q1-Q3. Each adult who received prevention visits averaged six hours of this REACH service.

Conclusion: The use of the three types of crisis supports that REACH provides has declined between Years 1 and 4, but prevention increased in Year 5. However, during the same time period the number of crisis calls, number of referrals, and the number of crisis assessments all increased significantly. The number of assessments completed increased from 1001 in Year 1 to 2655 in Year 5, an increase of 165% and the number of adults with co-occurring conditions who are admitted for a psychiatric hospitalization has increased from 397 in Year 1 to 971 in Year 5, an increase of 145%.

Service Elements of REACH - 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), if they do not 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 achievement his area in any review period. DBHDS reported the following rates of adherence to its requirements during Year 4: 90% of evaluations were completed; 75% of CEPPs; 100% of consultations; and 76% 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 17* summarizes this information over the three years below:

Table 17: 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
4	929	838	697	929	706
5	840	795	657	898	615

Conclusion: The Adult REACH Programs continue to complete the service elements and to provide consultation for 100% of the adults. In this reporting period there were actually more consultations reported than the number of individuals receiving either MS or CTH. Region V reports consultations for 103 individuals in the CTH for stepdown but only reports 32 using it for this purpose out of a total of 50 CTH visitors. However, overall the Regions achieved a higher percentage of completed evaluations, and CEPPs Year 5 compared to Year 4. The percentage of provider training dropped from 76% in Year 4 to 73% in Year 5. Completion of these service elements was 100% for Regions II and IV for completing evaluations and providing the consultation, which is the follow-up service. Individuals may already have a CEPP at the time of receiving services during a reporting year so may not need a CEPP completed.

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 5, REACH teams trained a total of 828 police officers compared to 734 officers trained in Year 4,743 officers trained in Year 3, 659 police officers trained in Year 2 and 727 officers trained in the Year 1. This training for law enforcement was provided in all Regions. Regions II and IV provided the training to the highest number of officers accounting for 57% of the law enforcement personnel trained by REACH staff in

Year 5. Region I had not trained any police officers n Year 4 but trained 137 in Year 5, which was 20% of all of the police trained in Year 5.
Conclusion: REACH staff continues to train law enforcement personnel. The Commonwealth's continued implementation of its plan to enhance training for law enforcement personnel is essential. Police officers respond to many of the crises involving individuals with IDD 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 2,655 mobile crisis assessments completed in Year 4 compared to 2,222 mobile assessments completed in Year 4, 1,904 mobile assessments completed in Year 3, which is a significant increase compared to the 1,574 assessments conducted in Year 2, and the 1,063 mobile assessments performed during Year 1. During Year 5 REACH staff responded onsite to the vast majority of crisis calls that they received. Each year REACH responds to 400-500 more crises than the previous year.

The location where the crisis assessment occurs is critically important. The SA established the expectation that Commonwealth's crisis system should be available to conduct crises assessments in the individual's home, day program or other community location. During Year 5, 2,655 crisis assessments were conducted involving REACH staff. Only 895 (34%) were conducted in the individual's home or day program, whereas the CSB ES staff conducted total of 1,605 (66%) assessments at out -of-home locations, i.e. the CSB office or hospital. In Year 5 we see both the highest number and highest percentage of assessments being conducted at the hospital or CSB/ES. The percentage of assessments conducted in the family home, residence or day program was highest in Year 1 at 44% of all assessments. It has decreased to 34% in Year 4. It is positive that the hospital screeners are more routinely informing REACH of hospital screenings, but it is very concerning that the CSB's have not implemented the requirements of the SA, and instead have maintained their pre-Settlement Agreement approach to conducting assessments after individuals are removed from their homes to the CSB ES or hospital.

In Year 5, 34% of the of the crisis assessments were conducted in the individuals' homes, day programs, or other community locations, which is comparable to the previous three years. The percentage is significantly less than the 48% of assessments that were conducted in these settings in Year 1. The high percentage of crisis screenings at out-of-home locations for the initial assessments is an indication that CSB 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 opportunities to de-escalate and 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 out-of-home assessments and hospital admissions over the five years is concerning. Removing individuals from their homes to conduct crisis assessments is contrary to the requirements of the Agreement and doing so

contributes to an increase in the number of individuals with IDD admitted to psychiatric facilities.

In Year 3, and for the first time, more individuals were assessed at provider locations than at family homes. This trend continued in Year 4 and again in Year 5. REACH responded to 509 crisis calls at either residential or day provider locations and 386 crisis calls at family homes in Year 5 and to 443 at either a residential or day location and 287 at the family of individual's home in Year 4. This is an indication of the value that the providers place on the REACH programs to assist their staff when crises occur. However, it may also be an indication of the provider community's lack of clinical and behavioral expertise to address significant behavioral challenges that some adults present. 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. *Table 18* compares the location of crisis assessments across the four years.

Table 18: Location of Crisis Assessment

Year	*Home*	*Residential*	*Day*	*Hospital*	*CSB/ES*	*Other*	*Total*
1	222	219	37	385	43	48	**1,006**
2	235	280	44	826	107	51	**1,568**
3	285	364	57	946	195	62	**1,909**
4	287	401	42	1245	180	67	**2,222**
5	386	459	50	1407	192	161	**2,655**

The trend of referrals being made primarily during normal business hours continues. REACH received a total of 2424 in Year 4. 470 (219%) of these calls were received on weekends or holidays, which is comparable to the percentage of calls on these days in Year 4. The Regions received 1,053 calls (43%) between 3PM-11PM and 253 calls (10%) between 11PM-7AM. 47% (1,118) 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 day. However, fewer crisis calls were responded to in community settings in Year 5 as was true in Year 4 compared to the three previous years.

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

DBHDS collects and reports data on the amount of time that REACH devotes to a particular individual. REACH is expected to provide up to three days of mobile crisis support on average for adults. With the exception of Region V every Region did provide at least an average of three days of mobile support in Year 5. The days ranged from 1-18 days. Region III continues to average the most days throughout the year. Region V averaged between 1.4-2.2 days or each of the four quarters in Year 5, never meeting the expectation of averaging three days of MS.

Conclusion: REACH is providing the amount of mobile crisis support required in four of the Regions, many times exceeding the average requirement. Region V is not meeting this requirement.

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 2,639 (99%) of the 2,663 crisis calls in Year 5, missing 24 calls compared to missing seven calls in Year 4. 16 of these calls were in Region V, 11 of which were in FY20 Q3. The Region reports participated in some screenings by telephone as a result of COVID precautions. Regions I and II missed a total of three screenings, also in FY20 Q3. REACH responded to 2,423 of the 2,639 (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). The on-time percentages have been either 93% or 92% for all four years.

***Conclusion*:** The REACH programs overall have maintained an on-time response rate of 92% in Year 5, out of the 99% of the calls responded to face-to-face. It is understood that some calls were not responded to in-person as a result of the pandemic. 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 six 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 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 four years. Utilization in Year 5 increased slightly from 298 visits in Year 4 to 318 visits. This is currently substantially less than the 660 visits in Year 1. The number of individuals using the CTH is relatively the same in Year 5 (303) as in Year 4 (298). DBHDS began reporting on individuals who have prolonged stays of greater than 30 days in FY20 Q1. This is helpful information to have to better understand why the CTH programs are not more readily available. This total included 62 individuals; 30 were using the CTH for step-down from a hospital, 26 for crisis stabilization, and six for prevention. The lengths of their stays are discussed later in this section. This number of longer stays in the CTHs is a contributing to fewer individuals having the opportunity to use the CTHs.

DBHDS includes data about the capacity and utilization of the CTH beds for all of the Regions. None of the Regions were at full capacity in any quarter of Year 4. Overall capacity was reported to be 91%. The ranges of bed capacity used across the five Regions for Year 5 are:

Region 1: 80-88%
Region II: 70-95%
Region III: 92-97%
Region IV: 77-92%
Region V: 81-82%

DBHDS also reports the number of days the REACH CTHs were at full capacity in each quarter. As an example, this ranges from a low of 33% in Region V to a high of 84% in Region III during FY20 Q2. The number of days at full capacity are lower in FY20 Q3 but this may be caused by COVID precautions. It is concerning that there are so many days when there are openings at the CTHs, but they are not being used for prevention or other types of support. It is surprising that DBHDS reports no waiting lists for the CTH programs in three of the four quarters, and only reports a few individuals on the waiting list n FY19 Q4. This is the first year when no waiting list is reported for the majority of the quarters. This is not at all congruous with reports from CMs regarding the desperate need some individuals have for the CTHs or the number of adults we found in the qualitative study who could have been diverted from hospitalizations but were not. Why none of these individuals are not on a waiting list is not explained by the quarterly reports.

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 have been used by fewer individuals as well as a smaller percentage of all individuals using the CTHs for stabilization after a crisis. The numbers of visits to the CTHs for stabilization dropped from 321 in Year 1, to 173 in Year 3, a number slightly higher than the 145 visits to the CTHs for crisis stabilization in Year 2. Only 109 visits in Year 4 were for stabilization and this increased to 146 visits in Year 5. 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 visits by individuals who left hospitals for the CTHs, which represented 24% of the visits to the CTH. In Year 4, 119 visits to the CTH were for step-down, but this number represents 40% of the visits to the CTH. However, this number increased to 132 (41%) in Year 5 as the overall number of visits decreased by two.

The use of the CTH for prevention has dropped from 303 visits in Year 1 to only 25 visits in Year 5. No evidence was found that this decline resulted from those in crisis having fewer needs for crisis stabilization or prevention. It is unknown whether this decline is because of fewer requests, and if so whether fewer requests occur because of longer stays for those admitted to the CTHs and unavailability of beds, or fewer available staff. Regardless, it appears that these programs are not being offered or provided as intended and as practiced by REACH in previous years. This conclusion is supported by the reports from many CMs who were interviewed for the qualitative study. All of them report wishing they had greater access to the CTH in their region for the individuals they support because it is such a valuable resource. *Table 19* describes the various uses of the Crisis Stabilization Programs **(**CTH's) over the past five years.

Table 19: 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	145 (36%)	149 (37%)	84 (21%)	20 (5%)	398	**378**
3	173 (32%)	181 (34%)	129 (24%)	55 (10%)	538	**483**
4	109(37%)	48 (16%)	119 (40%)	22 (7%)	320	**298**
5	146(46%)	25(8%)	132(41%)	15(5%)	318	**303**

The decline in the use of CTH is clearly not the result of declining needs. More frequent use of the CTHs as a resource for stabilization and step-down is needed as a last option to psychiatric hospitalizations and to shorten hospitalizations for individuals who are ready to be discharged but do not have a community residence identified. 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, during the subsequent years, 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. In Year 5 the fewest individuals used the CTH as a crisis prevention. It is not as available for planned prevention when there are so many lengthy stays at the CTH for individuals placed after a crisis.

Table 20, Utilization of the CTH in Average Day Ranges, depicts the average lengths-of-stay (LOS) 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 SA requirement, of the REACH CTH program is that no stays are for longer than 30 days.

The Crisis Stabilization Programs (CTHs) were designed to offer short-term alternatives to institutionalization with stays greater than 30 days not being allowed. The premise of capping the LOS 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. The average LOS is over 30 days in Region III for crisis stabilization and for stepdown in Regions II and III.

Maintaining shorter stays of no more than 30 consecutive days is helpful to REACH participants as a whole. When the number of days particular individuals stay exceeds the 30 days that are allowed, other individuals are precluded from using the CTH for crisis stabilization or prevention.

Table 20 depicts this data

Table 20: Utilization of Crisis Stabilization Programs (CTH) Average Day Ranges

Type of Use	***Year 1***	***Year 2***	***Year 3***	***Year 4***	***Year 5***
Stabilization	12-21	14-42	19-35	19-37	16-35
Prevention	4-11.5	4.5-12	5-26	3.5-14	1-17
Step-down	N/A	19-39	16-36	21.5-67	18-38

DBHDS is reporting on the number of stays longer than 30 days and the duration of these visits as of FY20 Q1. These extended stays are expected to occur far less frequently once the DBHDS transition homes are opened and fully operational. There is a total of 45 individuals who have stayed at the CTHs for more than 30 days this fiscal year as reported through FY20 Q3. There were:

- *19 adults in FY20 Q1 with a range of 32-179 days, with two of the individuals staying more than 100 days;*
- *21 adults in FYQ2 with a range of 32-472 days, with four individual staying over 100 days; and*
- *22 adults in FYQ3 with a range of 37-595 days, with seven staying over 100 days*

The CTHs will be more readily available for more individuals if the programs are able to achieve lengths-of-stay in accordance with the 30-day maximum stay established in the Settlement Agreement. DBHDS opened the two transition homes for adults that it had planned. One is serving individuals in Regions I and II, and the other serves individuals in Regions III, IV, and V. Currently, in part due to COVID there are only two individuals in

each of the transition homes. These settings will add to the Commonwealth's capacity to respond by providing therapeutic alternative residences that can support individuals who need stays of more than 30-days for crisis stabilization to make a positive transition to a new permanent residence.

***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). Significant and consistent evidence supports this conclusion including information found in the qualitative study completed for the 30 selected adults who were referred for crisis services in this review period. 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. We found that 13 (28%) of the 47 hospitalizations of adults could have been diverted if a CTH bed had been available.

It is evident from these data that the Crisis Stabilization Programs (CTHs) are not improving their ability to be a source of short-term crisis stabilization, intervention and prevention as required by the SA as evidenced by longer average stays and fewer individuals having the opportunity to use the CTH Program. Fewer individuals were able to use the CTH for crisis prevention. 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. It is important that its use for prevention and for re-admission returns to a more substantial number of adults. It is concerning that fewer adults overall were able to use the CTH in Years 3, 4, and 5 than were able to use the CTH option in Year 1. There were many more individuals in crisis and admitted to, and discharged from, psychiatric facilities. The lack of available CTH capacity appears to be a significant contributing factor to the increase in the number of psychiatric hospitalizations.
In summary several facts provide substantive evidence that the Commonwealth has substantially reduced, and for some members of the target population, eliminated the availability of this crisis service. These facts are that: the need for the CTHs have increased, while fewer individuals have been offered the CTH as a last option to hospitalizations, and the number of individuals on Waiting Lists for the CTH has decreased substantially. Clearly the waiting list is not an accurate measure of those waiting or needing the crisis stabilization service.

DBHDS has opened and licensed the two transition homes for adults who require extended stays. However, these homes were not fully operational during the 16th review r period. 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 opened these homes in mid-year FY20. 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 resource 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 and available, when individuals are not removed from their homes for assessment during crises. Timely mobile crisis support was provided to 584 Adults in Year 5 compared to 487 adults in Year 4, 486 individuals in Year 3, 543 individuals during Year 2, and to 641 individuals in Year 1. It is heartening to see an increase in the MS that was provided in this review period although it is still less than in Year 1 when there were far fewer crisis referrals. This fact supports the conclusion that limited resources for more individuals have resulted in more individuals' needs for crisis supports not being met.

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. 41 individuals were supported in the Mental Health Crisis Stabilization program, compared to 36, 27, 33, and 7 respectively in the previous four 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 SA requires DBHDS to determine if individuals in the target population require additional crisis stabilization programs. DBHDS hopes and is planning that the addition of transition homes will help it meet 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 more as designed, intended and required. 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. It is not yet clear however that two transition homes will be sufficient. Utilization data and evidence that individuals' needs for a last option are being met will provide the answer.

SECTION 6: SUMMARY

The Commonwealth of Virginia continues to make progress in some areas to implement a statewide crisis system for individuals with I/DD. There has been no progress in providing assessments before individuals are removed from their homes. During Year 5 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 children but increasing the number of adults who receive MS. The CTH program is used increasingly for step-down and crisis stabilization but its use for prevention continues to decline. This is related to the extended stays of many adults in the CTHs. REACH meets the expectations for offering 24/7 crisis response and responding to all crisis calls and doing so for the vast majority in a timely manner. 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 trained varies across regions.

The Children's REACH program is fulfilling many requirements, and during the latter portion of the 16th review period began to offer out-of-home crisis stabilization programs for use as a last alternative to children being admitted to institutions, including psychiatric hospitals.

The decrease in the use of mobile crisis supports for children in Years 4 and 5 compared to previous years, and the reduced access to the CTH for adults is concerning. DBHDS reports that in previous years two of the Regions included prevention services in the reports of Mobile Supports that inflated those numbers, but it is not known by how much this data impacted the total numbers for Years 1-3. However, the facts of significant increases in referrals and in hospitalizations clearly indicate that the needs of members of the target population for crisis support services are not being met due in part to insufficient crisis staff and the limited number of CTH beds. This concern is similar to the concern expressed in Years 3 and 4. DBHDS provided a staffing summary for the REACH community services of the adult and children programs for FY20. The REACH programs for adults have now been combined with the programs for children in all Regions, except Region I. REACH employs clinicians for leadership responsibilities; coordinators; in-home crisis workers; and CTH staff. The number of positions assigned to the CTH programs all include the CTH Managers. The data below does not include PRN positions which are staff called in on a per diem basis. All Regions except Region V uses some PRN positions. It also does not include the positions assigned to the children's CTH programs since they are in two Regions only so would skew the comparison across the Regions. The two programs each employ thirteen staff. Each program has a few vacancies.

Table 21 below portrays the total number of REACH staff positions in each Region:

Table 21: REACH Program Staff Positions					
Region	***Clinical***	***Coordinator***	***In-Home***	***CTH***	***Total***
I	*12*	*12*	*15*	*13*	***52***
II	*13*	*20*	*8*	*17*	***58***
III	*18*	*9*	*7*	*28*	***62***
IV	*19*	*17*	*12*	*15*	***63***
V	*11*	*12*	*14*	*20*	***57***
Total	***73***	***70***	***56***	***93***	***292***
Average	*15*	*14*	*11*	*19*	***58***

The significant staffing variations between Region raise questions regarding prioritizing the allocation of resources to meet some crisis needs but not others. The number of staff positions assigned to the CTH vary from a low of thirteen in Region I (down from 23 in Year 4) to a high of twenty-eight positions in Region III (up from 27 in Year 4) while each CTHs has the same six bed capacity. Region V has by far the highest number of calls and referrals; yet, this Region has an overall below average number of Coordinators. However, Region V increased its in-home crisis staff from 10 in Year 4 to 14 in Year 5. While Region V now has more in-home crisis staff than the average, it does not have the highest number of any Region. Region I has fifteen in-home crisis staff, adding eight positions since Year 4.

While struggling to meet the needs of a significant increase in the need for various crisis services, at the time of this study, every Region had a number of staff vacancies in each category. This was true in Year 3 as well, when there was a 25% vacancy rate. In Year 4 the vacancy rate dropped to 20%. Overall, the REACH programs are operating with forty-seven out of 292 REACH staff positions vacant, a statewide vacancy rate of 16%. It is positive that the Regions are maintaining more filled positions overall. However, the 16% is deceptive to some degree. The fewest vacancies occur among the clinical/leadership group which has eleven out of sixty-two (18%) positions statewide. Meanwhile, there are thirteen of fifty-seven (23%) vacancies for Coordinators, eleven out of forty-five (24%) vacancies for in-home crisis workers. and fifteen out of 108 (14%) vacancies in the adult CTH programs. Overall, thirty-nine (18%) of the positions that provide direct crisis support were vacant at the time the data were reported.

The vacancies in each Region are as follows:

Region I: 6 (17%)
Region II: 14 (24%)
Region III: 13 (21%)
Region IV: 7 (11%)
Region V: 7 (12%)

Functioning effectively with vacancy rates of 16-20% depending on job category 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. The vacancy rates are particularly high in Regions II (24%) and Region III (21%). It is reasonable to conclude that the high number of staff vacancies is a significant contributing factor to the REACH programs continued decrease in the number of individuals for whom CTH services were provided, and, therefore to the increase in hospitalization. Mobile supports increased in this reporting period for children and adults. Regions IV and V have the highest number of mobile support workers and receive a high number of referrals.

The Commonwealth continues to have 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 5. REACH was involved with far more hospitalizations of individuals with IDD reported in Year 5.

DBHDS and REACH should analyze the increase in hospitalizations to determine and then to take corrective actions needed to achieve the planned, expected and desired outcomes for individuals from the creation of a statewide crisis services system. In my review, effective and sustainable linkages between hospitals, CSB ES programs and REACH crisis

services are essential to reducing hospital admissions and lengths-of-stay. In addition., however, the premise of good crisis assessment and intervention before individuals are removed from their homes is well accepted across Commonwealth officials and stakeholder groups as the most effective strategy to reduce hospitalizations of children and adults with IDD. It is extremely concerning that while conducting this study DBHDS reported that it does not have the resources and cannot reallocate or reorganize to achieve this critical building block during FY21.

The reduction in the overall provision of mobile supports to children and in the use of the CTH program for adults is very concerning especially in light of the simultaneous increases in crisis calls to REACH and in hospitalizations.

The qualitative review study of a randomly selected, but not a significant 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 successfully diverted from hospitalizations if the programs and resources called for in the Settlement were available. 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. This appears particularly problematic in Region III from data learned during both of the last two qualitative studies.

REACH staff develops and implements plans and provides families with links to community resources. 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. Both children and adults used mobile crisis supports in 67% of the sample of individual cases in the study which is a decrease from 74% who used MS in the previous study.

DBHDS reports having put significant effort into increasing the number of behavioral specialists. DBHDS issued its first Behavioral Supports Report for FY20 Q3. It demonstrates significant increases in the number of Behaviorists in the Commonwealth between FY16 and FY20. The Commonwealth reports an increase from 821 to 1,493 (82%). This is to include Positive Behavior Support Facilitators (PBSF) and Board-Certified Behavior Analysts/Licensed Behavior Analysts (BCBA/LBA). This 82% increase in the number of behaviorists far exceeds the compliance indicator of over 30% of the baseline in July 2015. However, the 82% may not be comparable as the number of behaviorists reported by the Commonwealth includes assistant level behavior analysts, which the compliance indicator does not include. DBHDS cannot yet report on the level of need for behaviorists nor whether there are gaps in the capacity of Behaviorists by geographic area. There are no data yet to indicate how many of these individuals are working with individuals on the waivers or the number of hours billed. Many BCBAs may be working directly in school systems benefitting children and adolescents, and still doing most of the same work they did when they were not counted by the Commonwealth in 2015. The only data that reflects need are the number of individuals with challenging behaviors who are referred to the RSTs. DBHDS reports that it will start to get enhanced data in July 2020 through the Waiver Management System. DBHDS reports that these data will include the number of individuals on the waiver who have or need a behavior plan. 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. Very few of either the children or adults who could benefit from a behaviorist had one: 25% of the adults compared to 33% in the last qualitative study, and 37% of the children compared to 15% in the last qualitative study were engaged with a behaviorist. Overall 71% of children and adults who need a behaviorist do not have access to one in this qualitative study compared to 58% in the previous qualitative study. However, it is notable that the number of children who have behaviorists in this qualitative study has increased significantly in the past year.

DBHDS's efforts to develop residential providers, which can support individuals with co-occurring conditions, have not yet been sufficient. This is evidenced by the number of individuals in the qualitative study who were not served by a provider who could continue to support them after a crisis. Developing a sufficient number of residential providers with the capacity and competence to support the number of individuals with intense behavioral needs will be critical to the system's success in reducing unnecessary hospitalizations. Increased provider capacity will also be critical to 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, milestones to fill identified gaps and the outcomes in future reporting periods. The outcome of the qualitative study evidences the work that is needed in this area. While 81% of the children in the qualitative study had providers that could meet their needs, only 38% of the adults had providers with the necessary expertise to address their mental health diagnoses or behavioral challenges. Overall, this reviewer's study concluded that 53% of the individuals in the sample had adequate support from providers which is fewer that the 62% determined in my previous study in 2019.

Attachment A: Summary of the Qualitative Study

Attachment B. Individual summary for each child and adult studied.

Attachment C. Overview of the status of the Commonwealths available document related to the compliance indicators.

Attachment A: Summary of the Qualitative Study of REACH Participants

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Section I Introduction

The status of the Commonwealth's progress was studied for the provisions that are detailed in Sections III.C.6.b. ii. B, and III.C.6.b. ii. E, of the Settlement Agreement for the sixteenth review period. The Expert Reviewer will review progress toward fulfilling the requirements of the provisions and some of the Crisis Services compliance indicators. Findings, conclusions, and any recommendations or suggestions will be reported to the Independent Reviewer to assist in his determination of compliance.

As part of the 16th period review, the Expert Reviewer conducted a qualitative study of the crisis services and behavioral supports for sixty individuals with I/DD who were randomly selected from those referred to REACH during the review period. The sixty individuals selected for this study live in Regions I, II or V. This qualitative study is to complement the review of the data reports submitted by DBHDS. The study will inform the determinations made by the Independent Reviewer regarding the Commonwealth's progress toward meeting the provisions of the SA related to developing and implementing crisis services for individuals with IDD and behavioral challenges or who have mental health diagnoses.

This study includes a review of the effectiveness of the REACH programs and community behavioral, psychiatric and psychological supports to de-escalate and prevent crises; to stabilize individuals who experience a crisis; and to provide successful in-home and out-of-home supports, including community linkages for ongoing services and supports, that assist individuals to retain their community residential settings.

Section II Methodology

The qualitative study includes a review the records of sixty children and adults who received REACH services during FY20Q2. DBHDS produced the list of all children and adults who received REACH services between 11/1/19 and 11/30/19. The study includes individuals from Regions I, II, and V who were psychiatrically hospitalized and others whose crises were managed with community support. To create a stratified sample for this study, I then randomly selected sixty children and adults with I/DD who were served by REACH in the three identified Regions who were referred to REACH in November 2019. The review also included interviews with REACH staff and the selected individuals' Case Managers.

There was a total of 107 individuals who were referred during the defined time period who accepted REACH services. Table A portrays the age groups and regional affiliation of these individuals. The selected sample included 78% of the individuals referred to REACH in Region I; 73% of the individuals referred to REACH in Region II; and 49% of the individuals referred to REACH in Region V, in the time period noted. The sample overall includes 58% of the adults who were referred, and 52% of the children referred in Regions II and V. Overall the sample included 56% of the total of children and adults referred in all three Regions between 11/1/19 and 11/30/19. We did not include any of the individuals referred during November 2019 who did not accept REACH services. This group included eight refusals and two ineligible adults in Region I. All five of the children referred to

Region I in November did not accept REACH services. It also included five refusals by children and seven refusals by adults in Regions II and V.

Table A: Individuals Receiving REACH Services 11/1/19 and 11/30/19 Sample Selection

Region	Adults Referred 11/1/19-11/30/19	Children Referred 11/1/19-11/30/19	Adults Selected	Children Selected	Total in Sample
I	9		7	0	7
II	12	10	8	8	16
V	46	30	24	13	37
Total	67	40	39	21	60

DBHDS was asked to produce the following documentation for each of the selected individuals:
REACH records; Individual Plans (IP) and behavioral support plans, if applicable; and the names and contact information of the Case Managers (CM) and REACH Coordinators

DBHDS produced all of the REACH records and all contact information. DBHDS shared ISPs for all individuals who had these plans. Very few individuals in the sample worked were receiving support services from a Behaviorist and no behavior plans were included in the documents provided.

All three REACH teams were interviewed. Regions II and V have each combined the children and adult services into one cross-trained team. Region I had only adults in the study, so the Adult Team was interviewed. We interviewed REACH team members using conference calls after we reviewed the records. All teams were very helpful, and we appreciate the time they gave to produce all of the needed records and to answer questions.

DBHDS provided the contact information for the CMs and we contacted them all. Those who responded were interviewed by telephone. In total, thirty CMs were interviewed, twenty-four for adults, and six for children. This is far more than were interviewed during the qualitative study this author conducted one year earlier, during the fourteenth review period. We greatly appreciate their time and insights about REACH and the service delivery system in Virginia for individuals with IDD and co-occurring conditions.

Section III Summary of Findings

This report is based on the review of the sixty individuals in the sample, including thirty-nine adults and twenty-one children. The purpose of the record review and the interviews was to analyze the Commonwealth's efforts to provide crisis intervention and prevention services to help avoid hospitalization and maintain the community settings for individuals who experienced a crisis; determine if REACH responds to crises in a timely way, completes required plans, and coordinates effectively with families, providers and CMs; and determine if the community system offers the necessary community supports these individuals need in addition to REACH services to stay in their residences.

The analysis included a review of REACH's crisis response; the timeliness and location of the crisis response; if hospitalization was avoided as a result; if diversion was possible but not attained due to a lack of community resources; the provision of in-home mobile supports; the use of the CTH; the development of the crisis plan; the development of community linkages for the individual; the availability of psychiatrists and behaviorists; the provider capacity; and whether the individual retained his provider.

Forty-five of the individuals lived with their families including all twenty-one of the children and twenty-four of the adults. Two of the adults lived independently. One adult lived in a nursing facility; three of the adults lived in Sponsor Homes and nine adults lived in Group Homes.

Nineteen of the thirty adults were on one of the HCBS Waivers. Many of the remaining adults were on a waiting list for waiver services. Only three children were on a waiver. Twenty-six of the individuals had a CM, including eighteen adults and eight children.

Individual Support Plans (ISP): ISPs were provided by DBHDS for twelve of the sixty (20%) individuals in the study. which is far fewer than were provided in the fourteenth review period qualitative study. Only Region I provided ISPs for all of its adults on a waiver. Some CM progress notes were provided for additional individuals, but not Individual Support Plans. The ISP gives a greater sense of the individual needs. However, it was telling that very few of the ISPs include specific information on the serious behaviors some of these individuals present, nor are the behaviors or mental health concerns addressed in the plans. Plans do not always reflect the input of providers or REACH. This is a similar finding to the finding in the fourteenth review period.

REACH Crisis Response: The vast majority of the initial calls in this review period were placed during an active crisis resulting from behavioral actions that involved physical aggression, property destruction, and/or extreme self-injurious behavior including suicide ideation or threats. The Police were involved with twenty-two (37%) of the sixty individuals, including nine children and thirteen adults. It is evident that the police and REACH staff work closely together on the scene of these crises. Many times, a hospitalization is diverted.

Where the pre-screening occurred: In this study the majority of individuals had more than one crisis screening during the review period. Thirty-seven (62%) of the adults and children had more than one crisis screen during the period with many experiencing several. This included twelve children and twenty-five adults. The highest percentage ad number of multiple screenings occurred in Region V for seventeen adults and eight children for an overall percentage of 68%. Region II had six adults and four children screened for more than one crisis for a total of 62%. Only in Region I were the majority of the seven adults (five)in the study screened only once for a crisis. Because there were so many screenings the ratings in Table B for location of screenings; REACH attendance at the screening; REACH's timely response; hospitalizations; diversion of hospitalization; possibility of diversions; and support during hospitalizations are all reported based on the number of times it occurred compared to the total number of screenings or hospitalizations.

Only (18%) of the individuals in the study experienced a crisis response ***only*** at their home or day program, including four adults and seven children. The other 49 individuals (82%) in the study had at least one screening at the hospital or the CSB ES, with the majority conducted at the hospital. The police were involved in numerous screenings but overall for twenty (51%) of the adults and thirteen (62%) of the children in the study. In many cases, REACH and/or the police were able to stabilize the situations at home without necessitating a hospital screening, which is significant. **Overall there were 164 crisis screenings** for the 60 individuals in the study. Sixty (37%) of the screenings were conducted at the person's home or day program location. This includes data from August 2019 through March 2020.

The crisis screenings conducted at the hospital or ES totaled 104, or 63% of all of the screenings. The Commonwealth, in establishing crisis intervention and prevention services, committed to implement a new approach, timely responses to crises would occur be at the home or relevant community setting to de-escalate the situation before individual are removed from their home. If individuals still needed to be removed, they would be offered an "last resort" option to avoid hospitalizations. A new indicator has been established by the Parties to have 85% of the screenings conducted at one's home or other community location. We know from past reports that this is not always possible as CSBs Emergency Services screeners have continued to utilize the pre- Settlement protocol. They do not respond to an individual at their home. Instead the individual in crisis is routinely removed from their homes and assessed at the hospital or CSB office. A substantially higher percent of these out-of-home assessments result in individuals being admitted to hospitals. REACH staff is not given the option to de-escalate the individual situation before the individual is removed and the individual is not offered a last option alternative to hospitalization. Often REACH is not contacted until the individual is in route to, or at the hospital. In all situations when REACH did respond to the home, and before the individual was removed, the crisis was stabilized there.

Although it is far more likely for an individual, especially an adult, to be hospitalized once he or she has been removed from the home setting, not all hospital screenings result in a hospitalization. In Region I, only one hospital screening led to a hospitalization. In Region II four individuals experienced screenings at the hospital but were not admitted, and eight

individuals who were screened at the hospital in Region V were never hospitalized in the reporting period.

The percentage of screenings conducted in a crisis setting rather than at home remains very constant across review periods. It is unlikely that the number of individuals for whom a crisis is fully responded to at home, and thereby the individual is stabilized there, will increase until CSB ES staff is mobile and they can and do respond with REACH staff at the home. The Commonwealth expects that this will occur after the DBHDS's FY21 performance contracts with the CSBs is modified to require an increase in the number of crises responded to in the home setting.

REACH response to the crisis: REACH responded directly to 159 of the164 crises screenings. REACH staff arrived on-time for 155 of the 159 in-person responses. The overall response rate is 97.5% and the staff were on time for 95% of the screenings. Of the five screenings without an onsite response, the Region II REACH team did not respond to four when they were either not notified or notified after the decision to hospitalize the individuals had been made.

Hospitalizations: Twenty-nine (48%) individuals in the study were never hospitalized. However, the other thirty-one (52%) individuals in the study, ten children and twenty-one adults, were hospitalized a total of sixty-two times. Six individuals including two children in Region II and nine individuals including two children in Region V had multiple hospitalizations ranging from 2-8 hospital admissions.

REACH provided hospital support for four (40%) of the ten children whose families accepted REACH services and for fourteen (67%) of the twenty-one adults who accepted REACH support, for an average of 58% who received REACH support while in the hospital who accepted REACH involvement. There was a total of sixty-two hospitalizations for thirty-one individuals. REACH provided hospital support in thirty-four (55%) of these hospital stays. Region I provided hospital support for 100% of the hospitalizations; Region II for 82% of the hospitalizations; and Region V for only 43% of the hospitalizations. Region V reports poor response from the hospitals to REACH's offers to involve their hospital liaison. When REACH is able to support individual in the hospitals the CMs report a high level of satisfaction among families.

Hospitalizations Avoided: Hospitalization was avoided for 29 individuals (48%) including eleven children and eighteen adults. It appears that hospitalizations could have been diverted for thirteen (42%) of the thirty-one individuals who were hospitalized. The length of hospital stays might have been shortened if an adult CTH bed was available or the children's CTHs were open. While a number of children in this study were hospitalized due to suicide or homicidal ideation, and therefore hospitalization was necessary, the REACH teams all report many hospitalizations for children generally served by REACH could be diverted with CTH capacity. In this study REACH identified five children and eight adults who could have been diverted, over a total of eighteen (29%) of the sixty-two hospitalizations that occurred during the reporting period for individuals in the sample.

Adults were not diverted because the adult CTH programs were at capacity at the time of these hospitalizations. REACH staff report this as the reason the CTH is not offered. CMs routinely speak about the value of the CTH program, lamenting how difficult it is to get someone accepted and the need for more beds. The widely acknowledged and demonstrated benefits of the CTH combined with the increased need for the CTH option clearly established that the Commonwealth has cut back on the availability of the CTHs for reasons other than the needs of the target population or the most effective approach to achieving the goals of the
Settlement.

Children did not have a CTH option until January 2020. It will be valuable to determine if there is a reduction in hospitalizations for children once the children's CTHs are in full operation, and if twelve beds are sufficient to divert children from unnecessary hospitalizations.

Accepted REACH: All of the sixty individuals and families in this study accepted REACH services at the time of the crisis assessment. REACH was always involved in the screening, developing a safety plan, and usually developing a crisis stabilization plan. In some instances, families did not follow through to schedule mobile supports (MS) or prevention services.

Utilization of Mobile Supports: REACH provided in-home mobile supports to forty (67%%) of the sixty who initially accepted services. These services provided to twenty-four adults and sixteen children. REACH also continued with many of the individuals and families, providing prevention services. In the majority of situations, the number of days of services provided exceeded the three days that are routinely planned after a crisis. The use of mobile supports has sustained many of these individuals. There are many instances where REACH offered MS and families did not follow through or end up wanting this service after the crisis was resolved. When MS is provided most CMs report it has been beneficial to the individual and has helped to stabilize the situation.

The number of mobile support days counted only include the actual face-to-face interventions by REACH staff with the individual. The number does not include the time of observation to develop the Crisis Stabilization Plans and Crisis Education and Prevention Plans (CEPP); time spent training parents or staff; phone consultation with the individual or family; or the time arranging linkages or consulting with the team. Much of the in-home mobile support is focused on activities to help stabilize the individual; build rapport and trust; identify triggers to behaviors; develop coping strategies; and build self-esteem.

REACH develops goals for individuals receiving mobile supports. Not all plans include measurable objectives or necessarily note progress toward achieving the outcomes. This documentation was excellent in Regions I and II, however, improvement is needed in Region V, where in some cases, there were no notes at all that summarized activities and outcomes for the entire period of time REACH was involved with the individual. Overall, while progress notes have become less therapeutic and more descriptive of the actual crisis service provided, it is still difficult to track what REACH staff review, when the review is done, what adjustments are made and how staff are measuring success or failure related to

in-home mobile supports. Frequently, the written plans still do not use measurable objectives, which makes it more difficult to track progress towards achieving outcomes. Region II's written documentation should be used as the model that best meets the expectations of the REACH guidelines.

CEPP: CEPP's were developed or updated for thirty-six of the individuals in the sample. CEPPs could were not done on-time for a few individuals in Regions I or II because the individuals had discontinued services before the CEPP could be completed, changed providers during REACH services, or remained hospitalized. Overall, CEPPs were completed for 60% of the sample for whom CEPPS could be done but only 33% were finalized within the time period set by the REACH standards, which is within thirty days of the provisional CEPP being completed.

The Regions vary in their ability to complete CEPPs. Region I completed 100% of provisional CEPPs and finalized five of seven (71%). Region II does well developing provisional CEPPs and finalizing them with 94% and 75% completed respectively. Region V wrote provisional CEPPs for only 38% of the individuals needing a CEPP and finalized them for only 30% on time. In Region V far more CEPPs are completed for adults (12 of 24) than for children (2 of 13). The data for Region V is consistent with the qualitative sample for the previous reporting period. Region V was informed during the interview which CEPPs were missing from the data uploaded for the reviewers, but the Region did not send any additional documentation. The percentages for completed CEPPs for individuals in the sample vary from those found in the REACH quarterly reports for CEPPs.

CTH: Only nine of the adults used the CTH, all but one successfully. One adult eloped from the CTH and was struck by a car. He was re-hospitalized. Six individuals used the CTH and were diverted from being hospitalized. Three others used the CTH as step down option which allow the individual to leave the hospital sooner. It appears another eighteen individuals could have avoided hospitalization if a CTH bed was available. There is extreme satisfaction expressed by CMs when they work with someone who is able to use the CTH program. Staff there work on therapeutic goals, communicate well with the CM and other team members, address medication management issues, and help with the transition for the individual back to his or her community setting. The CTH trains existing staff and make themselves available to new providers. However, CMs report it is very difficult to get someone accepted at the CTH because of limited bed capacity, high utilization and high demand. DBHDS does not usually report individuals on the CTH Waiting Lists. Consistently CMs complain about its unavailability across reporting periods. The CM's routine complaints about the lack of access is another reason to question the validity of the waiting list data. Knowing that the CTH will not be available may result in CMs not referring individuals who could benefit from the CTH.

Linkages: One of REACH's primary focuses is to help individuals, families, CMs, and teams establish linkages with community services that will more comprehensively help individuals to stabilize and maintain this stability; retain their residential and day providers; be assisted to find employment; and access the medical and clinical supports they need to live successfully in the community.

REACH recommended, and in some cases arranged, linkages for forty-seven (78%) of the fifty-eight individuals who needed community linkages. These included connection with CSBs and CMs; pursuing waiver eligibility; DARS for employment support; day programs; outpatient therapy; family counseling; mental health support; neurologists; psychiatrists; in-home intensive supports; and behavioral specialists. Two individuals did not need linkages when referred to REACH as they had all their needed community supports already in place.

The extent and quality of the Regions' work varies when provide linkages and connections to other services and supports that are needed. Region I recommended linkages for all individuals; Region II for all but one child; and Region V for only twenty-five of the thirty-seven individuals in the study sample. There was no evidence that linkages were recommended for five adults and seven children in Region V.

Psychiatry: Forty-nine individuals (84%) have a psychiatrist; psychiatric support was determined to be unnecessary for two adults. There were three adults and six are children who needed but did not have a psychiatrist. One person had a psychiatrist in the past but refuses treatment. In three other cases, CMs and REACH found new psychiatrists for individuals who had lost or discontinued their previous psychiatrist.

Behaviorist: This continues to be the least available and most needed support to assist individual and families who have co-occurring conditions and present behavioral challenges. Only fifteen individuals had a behaviorist: eight adults and seven children. A behaviorist is not recommended for nine individuals in the sample. Thirty-six (60%) of the sixty individuals in the sample cannot access a behaviorist but need this expertise. This remains a significant area of need in Virginia for individuals with I/DD and behavioral needs. This study again found extensive unmet need for behavioral support to an extent that was similar to past studies. There was no evidence found during this study of progress on the availability of behaviorist or structured behavioral support services

Case Manager: Thirty-seven individuals have a CM. One adult refuses case management. There were CMs identified for thirty-one adults and six children. We were able to interview six of the children's CMs and twenty-four of the adult's CMs. It is unfortunate and notable that seven of the CMs did not respond to a request to be interviewed. Each CM was asked about the individual's current status; how helpful REACH was; what training REACH provided; how REACH communicated with the CM and the family; and if the individual needed a behaviorist.

Four CMs for adults in Region I were interviewed. Three were very positive about REACH services and their interactions with the REACH staff. One individual had used the Region I CTH and found it to be an excellent resource. The CM found the CTH staff responsive and knowledgeable. The CTH staff provided significant training to the new GH staff and was in contact with the CM on a weekly basis. One CM had a mixed reaction to REACH. REACH was not as helpful with the person she supports and were not regularly communicating with her. She perceives that they are understaffed.

Nine CMs were interviewed in Region II. The three who support children all rate REACH high in its effectiveness, communication and response to emergencies. They commented on what a positive addition the Behavioral Specialist has been to address challenging behaviors and develop behavioral plans for children who do not have a community behaviorist. Six CMs serving adults were interviewed. Three of them found REACH's interventions to be very positive, especially the quality of therapeutic intervention at the CTH. The other three CMs had mixed views about REACH. Two reported somewhat positively about the actual services for the individual but complained about having to change coordinators because cases are not kept open, which leads to less continuity. One found REACH inflexible about scheduling insisting to see an older man at the end of his day when he was usually too tired to participate. She attributes the rigidity to staff shortages.

Seventeen CMs were interviewed in Region V. The three who support children all rate REACH poorly in terms of their response to emergencies and for their lack of communication to the CMs. All have developed their own linkages at hospitals for communication and rely on parents for information about REACH interventions. None of them have been invited to participate in CEPP development or been trained in the CEPP. None report positive supports for the individual despite these other concerns. Among the CMS serving adults who use REACH the concerns about poor communication and lack of coordination of training in the CEPPs was similar. Some complain REACH staff do not return phone calls or respond to emails. Some report parents discontinued REACH services because REACH staff fail to arrive at scheduled times or cancel with little notice. Two reported the interventions provided by REACH worsened the behaviors of the individuals. Two were positive about REACH services. One used both MS and the CTH and found both helped the individual to stabilize. The other used only MS but spoke very highly of the expertise and responsiveness of the REACH staff and reports the team seems to be stronger than in the past.

These concerns are similar to those previously reported about the shortcomings of the Region V REACH program. The REACH Director acknowledged there were complaints from CSBs regarding communication and coordination with CMs and the team was addressing these concerns. CMs continue to report better communication with the CTH team.

Provider Capacity: Table C that follows this narrative summary includes information about the number of individuals who have a provider who meets their needs and how many individuals retained their residential setting at the time of the crisis. Forty-three (72%) of the individuals retained their setting including seventeen children and twenty-six adults. Children who left home went to residential treatment facilities or group settings. One adult remains hospitalized but the other adults transitioned to group homes or sponsored homes that are better resourced to meet their needs. As in previous studies, a number of group homes or sponsored homes would not allow the adult to return after the crisis occurred.

Only thirty-two (53%) of the individuals had providers who could substantially meet their needs. This includes twelve children and twenty adults. This is rated based on the adequacy of the provider the individual had at the time of the crisis or crises. This was determined by the following factors: multiple hospitalizations; a lack of behavioral support that reduced crises; placement with a provider that discharged the individual due to behavioral challenges; and families and individuals who are not on the waiver so do not have the range of supports they or their families need to help them continue to be stable and experience a quality of life.

Not all providers were willing to accept training from REACH, followed the CEPP or accepted recommendations for linkages or improvements in the structure and expectations of the day programs. The competency of provider staff and the capacity to effectively support individuals with significant behaviors remains a challenge for the Commonwealth to successfully maintain in their communities individuals with I/DD and either behavioral or mental health challenges.

There are twenty-one children in this study. Eight of the children are served by Region II. All of these children were able to remain with their families although one has insufficient supports in place to stabilize the child. Thirteen of the children are served by Region V. Four of these children were transitioned to a residential program. Nine of the children remain with their families but only five (56%)of them have the supports they need to live successfully with their families.

REACH Program Impressions: Overall REACH is accomplishing the intended goals of stabilization when mobile supports and the CTH programs are used. The CTH was surprisingly underutilized in this sample which is concerning because the CTH has demonstrated its effectiveness when used. This is consistent with the finding in the qualitative study conducted in the fourteenth period and with the data in the Year 5 DBHDS reports. Hospitalization is not being diverted for all of the individuals who could have the crisis stabilized if stabilization beds were available. In other cases, individuals who may need stabilization in a hospital experience longer stays than are necessary because a step-down CTH bed is not available or due to limited provider capacity.

REACH responds to crises in a timely manner and provides extensive mobile in-home supports generally. REACH continues with its participants providing prevention support after mobile crisis support is no longer needed. REACH works effectively with CMs, generally. The feedback from CMs this reporting period continues to be less consistently positive about communication in Region V. The extensive cross systems work, necessary in a few of these cases, was exceptionally well done and had very positive results. Individuals in this sample experience multiple hospitalizations, even after receiving REACH in-home services which is troubling. It is apparent that the provider community cannot yet respond positively and consistently to the needs of individuals with behavioral challenges and mental health needs. There are many in this sample who experienced multiple moves in this reporting period. Behavioral supports remain insufficient to meet the need of Virginia citizens with behavioral challenges. Ten of the adults (26%) in the sample are not yet able to access waiver services which increases the likelihood that crises will continue in their

lives. Only five of the twenty-one children are enrolled in a waiver, but more non waiver-funded community supports exist for these children than for adults without a waiver.

The success of REACH could be more consistent with less recidivism for the individual served if a behaviorist were put in place for all who displayed that need. It is understood that the lack of resources in the profession is a national issue. Virginia reports that it is increasing the number of BCAs and BSPs. It is not yet clear whether and how much additional service capacity has resulted. It would be encouraging to track and document the actual increased availability of behavioral specialist with expertise and experience supporting individuals with IDD and co-occurring conditions.

Introduction to Attachment A: Tables B and C: The results of the study are presented in the following two tables. The tables are separated by the service indicators that are being measured rather than by age distinction of children and adults. Now that the Regions have integrated the children and adult services under one REACH program, with the exception of Region I, this distinction did not seem as critical. It is now possible to see overall each Region's performance across the indicators for everyone it serves regardless of age. The columns reflect the areas of REACH responsibilities to respond to crises and provide supports including the crisis plan; the number of hospitalizations; the availability of behaviorists and psychiatrists; and the adequacy of providers. Table B includes the indicators related to crisis screening, hospitalization, and REACH service support of MS and CTH. Table C includes the indicators related to the CEPP and the community services available to the individuals.

Attachment A: Summary of finding from the qualitative review of sixty individuals

Table B: Findings for Adults and Children Referred for REACH Services Hospitalizations, Screenings and REACH Supports: 11/1/19-11/30/19

IND	REACH @ Screen	Response On Time	Hospital Diverted	Could have been diverted w/R	Hospital	Hospital Support	Screening Location	Mobile Support	CTH
01 (I) A	1/1	1/1	1/1	N/A	0/1	N/A	HOSP	NO	NO
2 (I) A	1/1	1/1	1/1	N/A	0/1	N/A	HOSP	YES	NO
3 (I) A	2/2	2/2	2/2	N/A	0/2	N/A	HOSP1/ HOME1	NO	YES
4 (I) A	1/1	1/1	1/1	N/A	0/1	N/A	HOSP	YES	NO
5 (I) A	1/1	1/1	1/1	N/A	0/1	N/A	HOSP	YES	NO
6 (I)A	1/1	1/1	1/1	N/A	0/1	N/A	HOSP	YES	YES
7 (I)A	3/3	3/3	2/3	0/1	1/3	1/1	HOSP1/ HOME2	YES	NO
Total#/RI	**10/10**	**10/10**	**9/10**	**0**	**1/10**	**1/1**	**3/10**	**5/7**	**2/7**
% met/RI	**100%**	**100%**	**90%**	**0%**	**10%**	**100%**	**30%**	**71%**	**29%**
01 (II)A	3/3	3/3	1/3	2/2	2/3	2/2	HOSP2/ CTH1	YES	YES
02 (II)A	4/6	4/6	4/6	0/2	2/6	2/2	HOSP4/ HOME2	NO	NO
03 (II)A	3/3	3/3	3/3	N/A	0/3	N/A	HOSP1/ HOME2	YES	NO
04 (II)A	2/3	2/3	2/3	1/1	1/3	1/1	HOSP2/ HOME1	YES	YES
05(II)A	5/5	5/5	2/5	0/3	3/5	2/3	HOSP3/ HOME2	YES	NO
06(II)A	1/1	1/1	1/1	N/A	0/1	N/A	HOME1	NO	NO
07(II)A	1/1	1/1	1/1	N/A	0/1	N/A	HOSP1	NO	NO
08 (II)A	4/5	4/5	1/5	4/4	4/5	4/4	HOSP4/ HOME1	YES	YES
09(II)C	2/2	2/2	2/2	N/A	0/2	N/A	HOME1	YES	NO
10(II)C	2/2	2/2	0/2	0/2	2/2	2/2	HOSP1/ CSB1	YES	NO
11 (II)C	4/4	4/4	2/4	0/2	2/4	O/2	HOME1/ CSB2/ HOSP1	YES	NO
12(II)C	1/1	1/1	1/1	N/A	0/1	N/A	HOME1	YES	NO
13(II)C	4/4	4/4	4/4	N/A	0/4	N/A	HOME3/ HOSP1	NO	NO
14(II)C	1/1	1/1	1/1	N/A	0/1	N/A	HOME1	YES	NO
15(II)C	1/1	1/1	1/1	N/A	0/1	N/A	CSB1	YES	NO
16(II)C	3/3	3/3	2/3	1/1	1/3	1/1	CSB1/ HOME2	YES	NO
Total#/ RII	**41/45**	**41/45**	**28/45**	**8/17**	**17/45**	**14/17**	**19/45**	**12/16**	**3/16**
% met/ RII	**91%**	**91%**	**62%**	**47%**	**38%**	**82%**	**42%**	**75%**	**19%**

Table B (continued)

IND	REACH @ Screen	Response On Time	Hospital Diverted	Could have been diverted w/R	Hospital	Hospital Support	Screening Location	Mobile Support	CTH
01 (V)A	2/3	2/3	2/3	0/1	1/3	1/1	HOSP2/ HOME1	YES	NO
02 (V)A	8/8	8/8	6/8	1/2	2/8	2/2	HOSP6/ HOME2	YES	NO
03 (V)A	7/7	7/7	6/7	1/1	1/7	1/1	HOSP5/ HOME2	YES	NO
04 (V)A	2/2	2/2	2/2	N/A	0/2	N/A	HOSP1/ HOME1	YES	NO
05 (V)A	3/3	3/3	3/3	N/A	0/3	N/A	HOSP1/ HOME2	YES	YES
06 (V)A	1/1	1/1	1/1	N/A	0/1	N/A	HOSP1	YES	NO
07 (V)A	1/1	1/1	0/1	0/1	1/1	0/1	HOSP1	NO	NO
08 (V)A	2/2	1/2	1/2	0/1	1/2	1/1	CSB1/ HOME1	YES	NO
09 (V)A	6/6	6/6	3/6	0/3	3/6	0/3	HOSP6	NO	NO
10 (V)A	4/4	4/4	4/4	N/A	0/4	N/A	HOSP3/ HOME1	NO	NO
11 (V)A	1/1	1/1	1/1	N/A	0/1	N/A	HOME1	YES	NO
12 (V)A	1/1	0/1	0/1	1/1	1/1	0/1	HOSP1	YES	NO
13 (V)A	5/5	5/5	2/5	0/3	3/5	3/3	HOSP3/ HOME2	YES	YES
14 (V)A	2/2	2/2	0/2	0/2	2/2	0/2	HOSP2	NO	NO
15 (V)A	8/8	8/8	0/8	2/8	8/8	6/8	HOSP8	YES	YES
16 (V)A	7/7	7/7	2/7	1/5	5/7	2/5	HOSP7	NO	YES
17 (V)A	2/2	0/2	2/2	N/A	0/2	N/A	HOME2	YES	NO
18 (V)A	1/1	1/1	0/1	0/1	1/1	0/1	HOSP1	NO	NO
19 (V)A	2/2	2/2	0/2	0/2	2/2	0/2	HOSP2	NO	NO
20 (V)A	5/5	5/5	5/5	N/A	0/5	N/A	HOSP1/ HOME4	YES	NO
21 (V)A	2/2	2/2	2/2	N/A	0/2	N/A	HOME2	YES	NO
22 (V)A	2/2	2/2	0/2	0/2	2/2	0/2	HOSP2	NO	NO
23 (V)A	1/1	1/1	1/1	N/A	0/1	N/A	HOSP1	NO	NO
24 (V)A	1/1	1/1	0/1	0/1	1/1	0/1	HOSP1	NO	NO
25 (V)C	1/1	1/1	1/1	N/A	0/1	N/A	HOME1	YES	NO
26 (V)C	1/1	1/1	1/1	N/A	0/1	N/A	CSB1	YES	NO
27 (V)C	3/3	3/3	0/3	0/3	3/3	0/3	HOSP3	NO	NO
28 (V)C	1/1	1/1	1/1	N/A	0/1	N/A	HOME1	YES	NO
29 (V)C	3/3	3/3	3/3	N/A	0/1	N/A	HOME3	YES	NO
30 (V)C	2/2	2/2	0/2	0/2	2/2	2/2	HOSP2	YES	NO
31 (V)C	1/1	1/1	1/1	N/A	0/1	N/A	CSB1	NO	NO

Table B (continued)

32 (V)C	3/3	3/3	2/3	1/1	1/3	0/1	HOSP2/ HOME1	NO	NO
33 (V)C	1/1	1/1	0/1	1/1	1/1	0/1	CSB1	NO	NO
34 (V)C	3/3	2/3	2/3	1/1	1/3	0/1	HOSP1/ HOME2	YES	NO
35 (V)C	7/7	7/7	6/7	0/1	1/7	0/1	HOSP2/ HOME5	YES	NO
36 (V)C	4/4	4/4	4/4	N/A	0/4	N/A	HOME4	YES	NO
37 (V)C	2/2	2/2	1/2	1/1	1/2	1/1	HOSP2	YES	NO
Total#/ RV	**108/109**	**104/109**	**65/109**	**10/44**	**44/109**	**19/44**	**38/109**	**23/37**	**4/37**
%met/RV	**100%**	**95%**	**60%**	**23%**	**40%**	**43%**	**35%**	**62%**	**11%**
TOTAL #	**159/164**	**155/164**	102/164	18/62	62/164	34/62	60/164	40/60	9/60
% MET	**97.5%**	**94.5%**	**62%**	**29%**	**38%**	**55%**	**37%**	**67%**	**15%**

Table C: Findings for Adults & Children Referred for REACH Services
CEPP Development and Community Services: 11/1/19 – 11/30/19

IND	CEPP	CEPP/in 45 days	Linkages	Psychiatry	BSP	Provider Meets Need	Kept Provider	Residence	CM
01 (I)A	YES	NO	YES	N/A	N/A	NO	NO	FAMILY	YES
02 (I)A	YES	YES	YES	N/A	N/A	YES	YES	FAMILY	N/A
03 (I)A	YES	YES	YES	YES	N/A	NO	NO	FAMILY	YES
04 (I)A	YES	YES	YES	YES	N/A	YES	YES	IND	YES
05 (I)A	YES	YES	N/A	YES	YES	YES	YES	GH	YES
06 (I)A	YES	YES	YES	YES	NO	NO	NO	SPONSOR	YES
07 (I)A	YES	NO	YES	YES	NO	NO	NO	FAMILY	YES
Total# RI	**7/7**	**5/7**	**6/6**	**5/5**	**1/3**	**3/7**	**3/7**		**6/6**
%met RI	**100%**	**71%**	**100%**	**100%**	**33%**	**43%**	**43%**		**100%**
01 (II)A	YES	YES	YES	YES	NO	YES	YES	FAMILY	YES
02 (II)A	YES	YES	YES	YES	N/A	NO	NO	GH	YES
03 (II)A	YES	YES	YES	YES	NO	NO	NO	GH	YES
04 (II)A	YES	YES	YES	YES	NO	NO	NO	GH	YES
05 (II)A	YES	YES	YES	YES	YES	NO	NO	GH	YES
06 (II)A	YES	NO	YES	YES	NO	YES	YES	GH	YES
07 (II)A	YES	YES	N/A	NO	YES	YES	YES	IND	YES
08 (II)A	YES	YES	YES	YES	N/A	YES	YES	GH	YES
09 (II)C	YES	YES	YES	YES	N/A	YES	YES	FAMILY	NO
10 (II)C	YES	NO	YES	YES	YES	YES	YES	FAMILY	YES
11 (II)C	YES	NO	YES	YES	YES	YES	YES	FAMILY	YES
12 (II)C	YES	YES	YES	YES	YES	YES	YES	FAMILY	YES
13 (II)C	NO	NO	NO	YES	NO	NO	YES	FAMILY	NO
14 (II)C	YES	YES	YES	NO	YES	YES	YES	FAMILY	NO
15 (II)C	YES	YES	YES	NO	YES	YES	YES	FAMILY	NO
16 (II)C	YES	YES	YES	YES	NO	YES	YES	FAMILY	NO
Total# RII	**15/16**	**12/16**	**14/15**	**13/16**	**7/13**	**11/16**	**12/16**		**11/16**
%met RII	**94%**	**75%**	**93%**	**81%**	**54%**	**69%**	**75%**		**69%**

Table C (continued)

IND	CEPP	CEPP/in 45 days	Linkages	Psychiatry	BSP	Provider Meets Need	Kept Provider	Residence	CM
01 (V)A	YES	NO	YES	YES	NO	NO	UNK	FAMILY	YES
02 (V)A	YES	YES	YES	YES	YES	NO	YES	GH	YES
03 (V)A	YES	YES	YES	YES	YES	NO	NO	GH	YES
04 (V)A	YES	YES	YES	YES	YES	YES	YES	SPONSOR	YES
05 (V)A	YES	YES	YES	YES	NO	YES	YES	FAMILY	YES
06 (V)A	NO	NO	YES	YES	NO	YES	YES	FAMILY	YES
07 (V)A	NO	NO	YES	YES	NO	YES	YES	FAMILY	NO
08 (V)A	NO	NO	YES	YES	NO	YES	YES	FAMILY	YES
09 (V)A	NO	NO	YES	YES	NO	YES	YES	FAMILY	YES
10 (V)A	NO	NO	YES	YES	NO	NO	YES	NF	NO
11 (V)A	YES	YES	YES	YES	NO	YES	YES	FAMILY	NO
12 (V)A	YES	YES	NO	YES	NO	YES	YES	FAMILY	YES
13 (V)A	YES	YES	YES	YES	NO	NO	NO	FAMILY	YES
14 (V)A	NO	NO	NO	NO	NO	NO	YES	FAMILY	NO
15 (V)A	YES	YES	YES	YES	YES	YES	YES	FAMILY	YES
16 (V)A	NO	NO	YES	YES	YES	NO	NO	FAMILY	YES
17 (V)A	YES	YES	YES	YES	NO	YES	YES	FAMILY	YES
18 (V)A	NO	NO	YES	YES	NO	YES	YES	FAMILY	YES
19 (V)A	NO	NO	NO	YES	NO	NO	YES	FAMILY	NO
20 (V)A	YES	YES	YES	YES	NO	NO	NO	FAMILY	YES
21 (V)A	YES	NO	YES	YES	N/A	YES	YES	FAMILY	YES
22 (V)A	NO	NO	NO	YES	NO	NO	YES	FAMILY	NO
23 (V)A	NO	NO	NO	NO	NO	NO	YES	FAMILY	NO
24 (V)A	NO	NO	YES	YES	N/A	YES	YES	SPONSOR	YES
25 (V)C	NO	NO	YES	NO	YES	YES	YES	FAMILY	NO
26 (V)C	NO	NO	NO	YES	NO	YES	YES	FAMILY	NO
27 (V)C	NO	NO	NO	YES	NO	NO	NO	FAMILY	NO
28 (V)C	NO	NO	NO	NO	NO	NO	YES	FAMILY	NO
29 (V)C	NO	NO	NO	YES	NO	NO	NO	FAMILY	YES
30 (V)C	NO	NO	NO	NO	NO	NO	NO	FAMILY	NO
31 (V)C	NO	NO	YES	YES	NO	NO	NO	FAMILY	NO
32 (V)C	NO	NO	YES	YES	NO	YES	YES	FAMILY	NO
33 (V)C	NO	NO	NO	NO	NO	NO	YES	FAMILY	NO
34 (V)C	NO	NO	YES	YES	NO	YES	YES	FAMILY	YES
35 (V)C	YES	YES	YES	YES	YES	NO	YES	FAMILY	YES
36 (V)C	YES	NO	YES	YES	NO	YES	YES	FAMILY	NO
37 (V)C	NO	NO	NO	YES	NO	NO	YES	FAMILY	NO
Total#/ RV	**14/37**	**11/37**	**25/37**	**31/37**	**7/35**	**18/37**	**28/37**		**20/37**
%met/ RV	**38%**	**30%**	**68%**	**84%**	**20%**	**49%**	**76%**		**54%**
TOTAL #	**36/60**	**28/60**	**45/58**	**49/58**	**15/51**	**32/60**	**43/60**		**37/59**
% MET	**60%**	**47%**	**78%**	**84%**	**29%**	**53%**	**72%**		**63%**

Attachment B: Individual Summaries of the Children and Adults in the Qualitative Study

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Note: These summaries include private health information, and, therefore, were provided to the Department of Behavioral Health and Developmental Services under seal because they

Attachment C: Overview of the status of the Commonwealths available documentation related to the compliance indicators.

Compliance Indicators-The Commonwealth and the US Department of Justice agreed to several indicators to more specifically measure the elements of compliance. The indicators were negotiated for all the provisions with which the Commonwealth had not achieved compliance as determined by the Independent Reviewer. Compliance indicators were agreed to on April 22, 2019 for many of the crisis service requirements of the SA. DBHDS prepared and issued a Supplemental Crisis Report for FY20 Q3. It includes data collected in and prior to FY20 Q3. The following is a summary of the data presented by the Commonwealth regarding the status of its achievement of many of these indicators. Please see Attachment C for a report of the Commonwealth's information regarding their status developing data gathering and Reports that will demonstrate proper implementation of the provisions of the Agreement as measured by the compliance indicators that the Parties agreed to in April 2019.

1. A compliance indicator target has been set of 86% of children and adults who are known to the system will receive REACH crisis assessments at home, the residential setting, or other community setting (non-hospital/CSB location).

Status: Overall, DBHDS Reports show that 46% of individuals received REACH crisis assessments in a community location. The percentages of crisis assessment completed in individuals' homes or other community locations varies by Region from 22% in Region I to 57% in Region 5 of all crisis assessments. This cannot be compared to the data in the Adult and Children's REACH Quarterly reports because the data in the supplemental crisis report pertains to only individuals that REACH categorizes as known to the system, meaning the CSB, at the time of the crisis screening. The DBHDS Reports include combined data that includes children and adults. This information shows that the Commonwealth has not achieved the measure in this indicator.

2. The indicator target regarding the hospitals responsibility to refer individuals with IDD to REACH is that 95% of children and adults admitted to state-operated and private psychiatric hospitals who are known to the CSB will be referred promptly (within 72 hours of admission) to REACH.

Status: DBHDS reports that during FY20 Q3 91% of adults and 95% of children were referred to REACH within 72 hours. The overall average of timely referrals to REACH is 92%. The current DBHDS report appears to align with the requirements of this indicator and to show that the 95% measure has not been met for the overall population of adults and children in FY20 Q3.

3. A compliance indicator surrounding hospitalization data requires that documentation indicates a decreasing trend in the total and percentage of total admissions as compared to population served and lengths of stay of individuals with DD who are admitted to state-operated hospitals and known by DBHDS to have been admitted to private psychiatric hospitals.

Status: DBHDS reports that it collects data relevant to this compliance indicator including the total number of individuals with IDD admitted to state psychiatric facilities in FY17, FY18, and FY19; and then displays the percentages of admissions of individuals with IDD to these facilities compared to the sum of all persons admitted to psychiatric facilities in the same time periods.

As DBHDS has consistently reported, the number of hospital admissions continues to increase. The total of 626 hospitalizations in state psychiatric facilities occurred FY17. There were 230 hospitalizations of children and 396 hospitalizations of adults. The percentage these admissions represent for IDD individuals compared to the whole population admitted to state psychiatric facilities varies for children and adults. The percentage for children has declined from 31% to 29% of total admissions from FY17 through FY19. The percentage of admissions for adults, compared to the whole population admitted to state psychiatric facilities has increased from 6% in FY17 to 10% in FY19. DBHDS did include the percentages of IDD admissions compared to all person hospitalized at these facilities for the first two quarters of FY20. There is a continued decline for children with IDD who are admitted to 26% of the total number of children admitted to state psychiatric facilities. The percentage for adults declines to 9% for FY20 Q1 and Q2. This is a lower percentage than the previous fiscal year but remains higher than the percentages of admissions in either FY17 or FY18. The percentages of admission when the groups of children and adults are combined also demonstrates an increase as a percentage of all individuals admitted to state psychiatric facilities between FY17 and FY19, from 9% in FY17 to 13% in FY19. This percentage decreases to 11% for FY20 Q1 and Q2.

DBHDS has less longitudinal data available for admissions to private psychiatric facilities. The Supplemental Crisis Report includes data for FY20 Q1 and Q2 regarding the percentage of individuals with IDD who were admitted compared to the total of involuntary admissions under a TDO. This percentage decreased from 15% to 13% of all children admitted under a TDO between the two quarters. The percentage of 3% for adults admitted and 4% of the overall admissions to private hospitals remained the same in both FY20 Q1 and FY20 Q2.

DBHDS includes data on the average and median lengths of stay (LOS) in state psychiatric facilities for FY17 through FY20 Q2. The average LOS for children decreases for twelve to ten days through FY19 and drops further to nine days in FY20 through Q2. The average LOS for adults decreases significantly from sixty-one days in FY17 to thirty-two days in FY19. There is a further decrease in average LOS for adults in FY20 through Q2 to twenty-two days.

DBHDS is just recently able to track this data for individuals hospitalized at private hospitals. In FY20 Q3 the average LOS for children was 8.5 days and was 8.6 days for adults. DBHDS has also included data from FY20 Q3 that compares the average and median LOS in private hospitals and the same data for FY20 Q1 and Q2 in state psychiatric hospitals for two groups. The groups are defined as those individuals accepting REACH services and those refusing REACH services. Data for state hospitals from FY20 Q3 could not be included because DBHDS first verifies all diagnosis of IDD.

In the private hospital there is little difference for either children or adults in the average or median LOS between those accepting REACH and those refusing REACH. This is also true of the children admitted to state hospitals who experienced no differences in either the average or median LOS. However, there is a more significant difference in the average LOS for adults. Those who accepted REACH services had average LOS of twenty-seven days and those who refused REACH stayed an average of thirty-three days. The median LOS for the adults was similar though across both groups of adults accepting REACH services and those adult refusing REACH services.

DBHDS's current report only includes information regarding known admissions to private psychiatric admissions for FY20 Q3. Data from previous reports does not align with the requirements of this indicator. The methodology used to count the number and for collecting the count of those "known by DBHDS" consistently has not been provided for review. This compliance indicator requirement does not appear to be met.

4. An indicator has been set outlining that 86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals will have a community residence identified within 30 days of admission**.**

Status: DBHDS provides data for FY20 Q3 only. In this period 87% of all children and adults admitted to the CTH or to a psychiatric hospital had a community residence identified within thirty days. This varied from a low of 80% of all individuals hospitalized or admitted to the CTH in Region III, to a high of 100% of all of these individuals in Region V. The data reported by DBHDS appears to align with the compliance indicator and shows that the indicator was met for the three-month period, FY20 Q3.

5. There is a related compliance indicator that outlines the following: DBHDS will increase the number of residential providers with the capacity and competencies to support people with co-occurring conditions using a person-centered/trauma-informed/positive behavioral practices approach to 1) prevent crises and hospitalizations, 2) to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals**.**

Status: DBHDS issued a Request for Proposal (RFP) in FY18 to target further development of residential providers that can support individuals with complex behavioral needs. Multiple vendors were selected to provide person-centered, trauma informed support for individuals experiencing psychiatric hospitalizations and lengthy stays at the CTHs. Four homes called "forever" homes, have opened and offer twenty-two beds to serve this population. The homes are located in the northern and western regions of Virgin. No data were presented in the report on the utilization of these residential settings. However, DBHDS was subsequently able to provide this information. These new residences now support:

- 9 individuals who transitioned from CVTC
- 5 individuals who were discharged from state hospitals
- 2 individuals who transitioned from REACH CTHs
- 3 individuals who transitioned from their family home
- 2 individuals who transitioned from another group home
- 1 bed is available

It is not yet possible to determine whether VA is gathering and reporting data or completing the required analysis regarding the prevention of crises and hospitalizations to demonstrate that it is implementing the provision properly to measure achievement of this indicator

6. DBHDS will utilize waiver capacity set aside for emergencies each year to meet the needs of individuals with long term stays in psychiatric hospitals or CTHs.

Status: During the current fiscal year to date, 23 out of 49 emergency waiver slots (47%) were provided to support the discharge of people from a psychiatric hospital, REACH CTH, or the Adult Transition Home. DBHDS's current report does not include the facts and analysis to demonstrate that individuals related "needs are met" and therefore that it is implementing the provision properly to measure achievement of this indicator.

7. A specific compliance indicator has been set which indicates that 86% of initial CEPPs are developed within 15 days of the assessment.

Status: DBHDS reports data on the percentage of CEPPs that were completed within fifteen days of enrollment in REACH for individuals enrolled in the program during the Quarter under review. It is noted this is different data than is reported in the Adult and Children's REACH Quarterly Reports that include more CEPPs than the number completed within fifteen days of the assessment. The overall percentage of children and adults for whom an initial CEPP was completed within fifteen days of enrollment in REACH was 84% in FY20 Q3. This percentage varies from a low of 62% in Region IV to a high of 100% in Region II. DBHDS further analyzes this data to discern the reasons the initial CEPP was not completed within fifteen days of enrollment. These reasons include scheduling conflicts with participants, families or providers; hospitalization; or a REACH error in completing the CEPP within the expected timeframe. DBHDS reports additional data for the number of CEPPS completed within the fifteen days, or longer with justifiable reason. When justifiable reasons for a late completion of the CEPP are factored, the percentage of completed initial CEPPs increased to 90% overall. Regions IV completed the initial CEPPs for 100% of their participants under this criteria and Region III increases its percentage from 62% to 79%. The requirement of 86% was not met until DBHDS factored in justifiable reasons increasing the percentage from 84% to 90% met. It appears that the DBHDS's only current report that includes the facts and analysis that aligns with the compliance indicator, is the overall report with the percentage of children and adults for whom an initial CEPP was completed within fifteen days of enrollment in REACH which showed 84% in FY20 Q3. The indicator that was agreed to does not include a category of justifiable reasons for CEPPs being completed in 15 days, only that 86% of the CEPPs are completed in the time period. DBHDS should restructure its related reports to align with the compliance indicator.

8. A specific target indicator has been established that 86% of REACH staff will meet training requirements.

Status: These data are a representation of employee training achieved during FY20 Q2 and FY20 Q3 and include both new and veteran REACH employees. During these two quarters 99% of the REACH staff are meeting the training requirements. The Report provided by the Commonwealth aligns with the requirements of the indicator and shows that the Commonwealth has achieved the measure in the indicator.

In summary DBHDS states: "*This is the first supplemental quarterly report on specific indicators agreed upon between the Commonwealth and the US Department of Justice surrounding crisis services for persons with developmental disabilities in the Commonwealth. The content of the report will be refined in additional quarters as processes are solidified and associated data become available surrounding additional compliance indicators on crisis services for the DD population. Data will continue to be utilized to guide decision making to meet the overarching goal of Virginians with a developmental disability that contact the crisis system receiving timely and effective services in the least restrictive setting possible."* The above statement by DBHDS indicates full awareness that the Commonwealth must develop new and refine previous reports, so they align with the requirements and measures of the compliance indicators. Future determinations of achievement will also review methods that were used to establish that the information in their reports are reliable and valid. The Commonwealth's current and previous reports will be relevant to future determinations that include the data elements that align with the indicator, to which the Parties have agreed.

The table below lists the Crisis Services Compliance Indicator and this reviewer's understanding of the status of each.

The status of DBHDS development of documentation that aligns with the Crisis Services Compliance Indicators

Definitions of Status

Documentation Confirmed*: Report aligns with and appears to achieve the indicator*
Pending with Date*: Report aligns with indicator, but additional progress and/or documentation is necessary to achieve the indicator. DBHDS expects next Report by the date specified*
Pending: *No Report was provided that aligns with the indicator or substantiates progress*
Unknown*: Report is not yet available to the system or is unknown to the Reviewer*

Provision text	Indicator	Status
The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental	**1. Early Identification; and 2. Assessment in Home** DBHDS will add a provision to the CSB Performance Contract requiring CSBs to identify children and adults who are at risk for crisis	Pending with Date:7/1/20

disabilities. The crisis system shall: i. Provide timely and accessible support to individuals with intellectual and developmental disabilities who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families ii. Provide services focused on crisis prevention and proactive planning to avoid potential crises; and iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable	through a screening at intake, and if the individual is identified as at risk for crisis needs, refer the individual to REACH to ensure that when needed the initial crisis assessments are conducted in the home.	
	DBHDS will add a provision to the CSB Performance Contract requiring, for individuals who receive ongoing case management, the CSB case manager to assess an individual's risk for crisis during face to face visits and refer to REACH when a need is identified.	Pending with Date:7/1/20
	DHBDS will establish criteria for use by CSBs to determine "risk of hospitalization" as the basis for making requests for crisis risk assessments.	Pending with Date:7/1/20
	DBHDS will ensure that all CSB Executive Directors, Developmental Disability Directors, case management supervisors, and case managers receive training on how to identify children and adults receiving active case management who are at risk for going into crisis. Training will also be made available to intake workers at CSBs on how to identify children and adults presenting for intake who are at risk for going into crisis and how to arrange for crisis risk assessments to occur in the home or link them to REACH crisis services. DBHDS will add a provision to the CSB Performance Contract requiring training on identifying risk of crisis for case managers and intake workers within 6 months of hire.	Pending with Date: 7/1/20
	DBHDS will implement a quality review process conducted initially at six months, and annually thereafter, that measures the performance of CSBs in identifying individuals who are at risk of crisis and in referring to REACH where indicated.	Pending with Date: 8/1/20
	86% of children and adults who are known to the system will receive REACH crisis assessments at home, the residential setting, or other community setting (non-hospital/CSB location).	Pending with Date: 9/30/20

	The Commonwealth will provide a directive and training to state-operated psychiatric hospitals to require notification of CSBs and case managers whenever there is a request for an admission for a person with a DD Diagnosis. Via the morning reporting process, the Director of Community Support Services or designee will notify the REACH Director or designee of admission for follow up. DBHDS will request and encourage private psychiatric hospitals to notify the emergency services staff of the CSB serving the jurisdiction where the individual resides of requests for admissions and admissions of individuals with a DD diagnosis.	Documentation confirmed for state hospitals Pending with Date for private hospitals Date:6/1/2020
	The Commonwealth will track admissions to state-operated psychiatric hospitals and those to private hospitals as it is made aware, to determine whether there has been a referral to REACH and will implement a review process to determine if improvement strategies are indicated.	Documentation confirmed for state hospitals Pending with date for private hospital admissions Date:6/1/20
	95% of children and adults admitted to state-operated and private psychiatric hospitals who are known to the CSB will be referred promptly (within 72 hours of admission) to REACH.	Documentation confirmed
	By June 2019, DBHDS will increase the number of Positive Behavior Support Facilitators and Licensed Behavior Analysts by 30% over the July 2015 baseline and reassess need by conducting a gap analysis and setting targets and dates to increase the number of consultants needed so that 86% of individuals whose Individualized Services Plan identify Therapeutic Consultation (behavioral support) service as a need are referred for the service (and a provider is identified) within 30 days that the need is identified.	Documentation confirmed for numbers of Behaviorists Pending for individuals being referred for behavioral support services
	The Commonwealth will provide practice guidelines for behavior consultants on the minimum elements that constitute an adequately designed behavioral program, the use of positive behavior support practices, trauma informed care, and person-centered practices.	Unknown

	The Commonwealth will provide the practice guidelines and a training program for case managers regarding the minimum elements that constitute an adequately designed behavioral program and what can be observed to determine whether the plan is appropriately implemented.	Unknown
	The permanent DD waiver regulations will include expectations for behavioral programming and the structure of behavioral plans.	Unknown
	Within one year of the effective date of the permanent DD Waiver regulations, 86% of those identified as in need of the Therapeutic Consultation service (behavioral supports) are referred for the service (and a provider is identified) within 30 days.	Unknown
	86% of individuals authorized for Therapeutic Consultation Services (behavioral supports) receive, in accordance with the time frames set forth in the DD Waiver Regulations, A) a functional behavior assessment; B) a plan for supports; C) training of family members and providers providing care to the individual in implementing the plan for supports; and D) monitoring of the plan for supports that includes data review and plan revision as necessary until the Personal Support Team determines that the Therapeutic Consultation Service is no longer needed.	Unknown
	DBHDS will implement a quality review and improvement process that tracks authorization for therapeutic consultation services provided by behavior consultants and assesses: 1) the number of children and adults with an identified need for Therapeutic Consultation (behavioral supports) in the ISP assessments as compared to the number of children and adults receiving the service; 2) from among known hospitalized children and adults, the number who have not received services to determine whether more of these individuals could have been diverted if the	Unknown

	appropriate community resources, including sufficient CTHs were available; 3) for those who received appropriate behavioral services and are also connected to REACH, determine the reason for hospitalization despite the services; 4) whether behavioral services are adhering to the practice guidelines issued by DBHDS; and 5) whether Case Managers are assessing whether behavioral programming is appropriately implemented.	
	1. DBHDS will implement a quality review process for children and adults with identified significant behavior support needs (Support Level 7) living at home with family that tracks the need for in-home and personal care services in their homes. DBHDS will track the following in its waiver management system (WaMS): a. The number of children and adults in Support Level 7 identified through their ISPs in need of in-home or personal care services; b. The number of children and adults in Support Level 7 receiving the in-home or personal care services identified in their ISPs; and c. A comparison of the hours identified as needed in ISPs to the hours authorized.	Pending with Date: 7/1/20
	2. Semi-annually, DBHDS will review a statistically significant sample of those children and adults with identified significant behavior support needs (Support Level 7) living at home with family. DBHDS will review the data collected in 1.a-c and directly contact the families of individuals in the sample to ascertain: a. If the individuals received the services authorized;	Unknown

	b. What reasons authorized services were not delivered; and c. If there are any unmet needs that are leading to safety risks.	
	Based on results of this review, DBHDS will make determinations to enhance and improve service delivery to children and adults with identified significant behavior support needs (Support Level 7) in need of in-home and personal care services.	Unknown
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.	DBHDS will, on a semi-annual basis, assess REACH teams for: 1) whether REACH team staff meet qualification and training requirements; 2) whether REACH has developed Crisis Education and Prevention Plans (CEPPs) for individuals, families, and group homes; and 3) whether families and providers are receiving training on implementing CEPPs.	Pending with Date: 12/31/20 Annual Reports must become Semiannual
	Based on findings, DBHDS will 1) determine the need for training related to mobile crisis; and 2) when necessary as determined by DBHDS, require a quality improvement plan through the Performance Contract from the CSB managing the REACH unit.	Documentation confirmed
	Outcomes to be achieved: 86% of REACH staff will meet training requirements 86% of initial CEPPs are developed within 15 days of the assessment 86% of families and providers will receive training in implementing CEPPs	Documentation confirmed for staff training families and providers training Pending with date for CEPP development Date: 9/30/20

	Documentation indicates a decreasing trend in the total and percentage of total admissions as compared to population served and lengths of stay of individuals with DD who are admitted to state-operated and known by DBHDS to have been admitted to private psychiatric hospitals**.**	Pending with Date: 9/30/20
	For individuals with DD who are admitted to state-operated psychiatric hospitals and those known by DBHDS to have been admitted to private psychiatric hospitals, DBHDS will track the lengths of stay in the following categories: • those previously known to the REACH system and those previously unknown; • admissions of adults and children with DD to psychiatric hospitals as a percentage of total admissions; and • median lengths of stay of adults and children with DD in psychiatric hospitals.	Pending with Date:9/30/20
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.	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 findings are redundant and covered in Indicators for **III.C.6. a. i-iii** and **III.C.6.b.ii.A.**
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	The Commonwealth will establish and have in operation by June 30, 2019 two Crisis Therapeutic Home (CTH) facilities for children and will provide training to those supporting the child to assist the child in returning to their placement as soon as possible.	Documentation confirmed
	DBHDS will utilize waiver capacity set aside for emergencies each year to meet the needs of individuals with long term stays in psychiatric hospitals or CTHs.	Pending with Date:9/30/20

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	DBHDS will increase the number of residential providers with the capacity and competencies to support people with co-occurring conditions using a person-centered/trauma-informed/positive behavioral practices approach to 1) prevent crises and hospitalizations, 2) to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals.	Pending with Date: 9/30/20
	86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals will have a community residence identified within 30 days of admission.	Documentation confirmed For FY20 Q3 only
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.	86% of individuals with a DD waiver and known to the REACH system admitted to CTH facilities will have a community residence identified within 30 days of admission. This indicator is also in **III.C.6.b.iii.B.**	Documentation confirmed For FY20 Q3 only
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	The indicator for this provision is covered in **III.C.6.b.iii.G**.	
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	The Commonwealth will establish and have in operation by June 30, 2019 two Crisis Therapeutic Home (CTH) facilities for children. This indicator is also in **III.C.6.b.iii.B.**	Documentation confirmed

target population in that Region		
	To address the CTH stays of adults beyond 60 days, DBHDS will establish and operate two transition homes by June 30, 2019.	Documentation confirmed
	The Commonwealth will implement out-of-home crisis therapeutic prevention host-home like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service through statewide access in order to prevent institutionalization of children due to behavioral or mental health crises	Pending 9/30/20

APPENDIX F.

INTEGRATED SETTINGS

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

Integrated Settings

By

Ric Zaharia, Ph.D.

Consortium on Innovative Practices

April 21, 2020

Executive Summary

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a review of the compliance indicators, which the Parties have finalized for Integrated Settings (III.D.1). These indicators were comprised of fifteen (15) distinct categories and twenty-nine (29) specific metrics.

DBHDS provided documentation that confirmed that it had achieved fourteen (14) metrics. Six (6) metrics require additional documentation to show achievement. And for nine (9) metrics documentation was not available to show achievement.

Methodology for this Report

- Reviewed FY19 dataset for nursing services to assess utilization rate for private duty nursing and skilled nursing;
- Reviewed most recent semi-annual "Provider Data Summary" report (11/19) and distribution;
- Reviewed most recent semi-annual "Integrated Residential Settings" report (9.30.17);
- Reviewed activities and minutes of a DBHDS focus group for the purposes of identifying barriers to more integrated services;
- Reviewed cases of children assessed by VIDES prior to admission to an ICF/IID and subsequent tracking during CY19;
- Reviewed cases of children reviewed by PASRR, who have an indicator of a DD diagnosis and have been admitted to a nursing home, and tracking, including discharges and transitions during CY19;
- Reviewed current "Community Transition Guide" and its semi-annual distribution list for CY19;
- Reviewed *My Life My Community* website and website activity data (Q1, FY20);
- Reviewed the DBHDS "*ICF Community Transition Protocol*" (2.19.20);
- Reviewed the activity summary for DBHDS "*Family Outreach Plan*" for families/guardians/ARs of individuals with DD under age 22 in ICF/IIDs and nursing facilities;
- Reviewed the current status of research into the use of host home models for children and the Commonwealth's activities to evaluate and to expand the availability of these options, including consideration of the Every Child Texas model;
- Reviewed DBHDS "awareness letters" and "action letters to CSBs regarding children considering ICF/IID admission or discharge, including related tracking of responses to the awareness and action letters, FY20.

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Integrated Settings Compliance Indicators

The Integrated Settings indicators are comprised of fifteen (15) distinct categories and twenty-nine (29) specific metrics. For the purposes of this review, findings are placed in three categories: "pending" is documentation requested but not provided; "documentation confirmed" is documentation requested, received, aligns with and shows achievement of the indicator; "pending with (date)" is documentation, which was provided, aligns with but requires additional progress or documentation to show achievement, and "pending" is the lack of or available documentation provided for review. DBHDS provided documentation that showed that it had achieved fourteen (14) metrics). Six (6) metrics show evidence but require additional progress or documentation to show achievement (Pending, with (date)). On nine (9) metrics documentation was not available to show progress toward achievement (pending). Table 1 below recaps the results for the twenty-nine (29) metrics.

Among the original 50 baseline children reviewed via PASRR (Pre-admission Screening and Resident Review) in NFs (nursing facilities) in March 2016, twenty-five (25 or 50%) remain in NFs. The average length of stay of the remaining baseline children is obviously over 48 months. Within the cohort of eleven (11) children referred for admission/PASRR during the twelve month period of 2/19 – 1/20, nine (9) were admitted and two (2) were diverted; two (2) of these nine (9) admissions have subsequently been discharged; seven (7) of those from this cohort who remain in NFs have length of stays longer than 6 months. .

Most complex among the compliance indicators was the establishment of baselines and a method of evaluating the delivery of community based nursing services (skilled, private duty, EPSDT - Early and Periodic Screening, Diagnosis and Treatment). The Independent Reviewer clarified the intent and interpretation of the four metrics involved.

DBHDS's early analysis of the claims data from DMAS which had to be combined with WaMS authorization data surfaced a number of questions about how to examine the dataset, including the formulas needed to respond to the indicators' benchmarks. Additional work has continued as this author shared with DBHDS the Independent Reviewer's assessment of this compliance indicator 's expectations. Hopefully, this improved mutual understanding will allow the dataset to be re-analyzed, in order to assess DBHDS's status against the benchmarks.

The remaining compliance indicators involve future cycles of activity documentation or contemporaneous reports of activities not yet available. DBHDS may be working on, but cannot yet, provide documents that demonstrate its status regarding the progress it has made or whether it has achieved the proper implementation of the remaining compliance indicators. Of most interest in future cycles is the requirement that DBHDS hold CSBs accountable for involvement in the discharge planning of children in ICF/IIDs or nursing facilities.

To that end this review renews a concern previously expressed (Appendix D, of the Independent Reviewer's 12th Report to the Court, June 13, 2018) that the 'fifth' facility, which provides pediatric care as a long-term care hospital, is a pipeline directly into an ICF/IID. Six (6) infants were admitted directly to St. Mary's ICF/IID from CHKD (Children's Hospital of the King's Daughters) in CY19. Families, who have a newborn with medical challenges, appear to be persuaded by hospital clinicians that their newborns are beyond their family's level of care. This subverts the intent and design of the VIDES, single portal strategy of offering an array of options

before they choose the direction their family will go. It also increases the likelihood that the infants will spend their childhoods living in an institution with shift-based rather than home-based care. This outcome is the opposite of the Settlement Agreement's goals that the Parties committed to achieve. An intervention to present alternatives at this very sensitive time in a newborn's life is missing. The single portal process was designed to ensure families have an informed choice among the options available to them.

Table 1
Integrated Settings

III.D.1	Documentation available to substantiate:
1. DBHDS service authorization data will continue to demonstrate an increase in the percentage of the DD Waiver population being served in the most integrated settings as defined in the Integrated Residential Settings Report.	Documentation confirmed
a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings	Pending 9.30.20 report
b. Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "support needs leel" of Levels 6 and 7, since FY 2016 are receiving services in the most integrated setting.	Pending
2. DBHDS continues to compile and distribute the Semi-annual Provider Data Summary ….	Documentation confirmed
The Data Summary indicates an increase in services available by locality over time.	Pending May 2020 Data Summary
3. DBHDS will establish a focus group with family members, individuals, and providers to identify potential barriers limiting the growth of sponsored residential, supported living, shared living, in-home supports, and respite for individuals with a "support needs level" of Level 6 or 7.,	Documentation confirmed
DBHDS will report on how many individuals who are medically and behaviorally complex (i.e., those with a "support needs level" of Level 6 or 7) are using the following DD Waiver services, by category: sponsored residential, supported living residential, shared living, in-home supports, and respite services.	Pending, respite data pending
Using this data and the focus groups DBHDS will prepare a plan to prioritize and address barriers within the scope of its authority and establish timelines for completion with demonstrated actions.	Pending
4. DBHDS tracks individuals seeking a service consistent with integrated living options as defined in the Integrated Residential Settings Report that is not available at the time of expressed interest as described in indicator # 13 of III.D.6. 86% of people with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option …have access to an option that meets their preferences within nine months.	Pending (verbal report of zero individuals for past quarter)
5. DBHDS establishes an ongoing periodic review process for measuring the promptness and on-going delivery of authorized service units for private duty and skilled nursing services, including those provided under the EPSDT benefit, in order to identify and remedy patterns of service delivery interruptions.	Pending
6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018 for FY 2018….	
Data will be tracked separately for EPSDT and waiver funded nursing.	Pending
Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.	Pending
7. DBHDS continues to screen children through a VIDES assessment prior to admission to an ICF/IID. During the screening, DBHDS collects information from the family regarding the reason ICF/IID placement is being sought.	Documentation confirmed
8. DBHDS continues to do Level II Preadmission Screening and Resident Reviews ("PASRR") on all children who have an indicator of a developmental disability diagnosis and are seeking nursing home services.	Documentation confirmed
All children who enter nursing facilities are limited to those who require	Documentation

medical rehabilitation, respite or hospice services.	confirmed
9. DBHDS tracks individuals under 22 who have received a PASRR screening for nursing facility entry or a VIDES assessment for ICF/IID entry and have been admitted. Children in ICFs receive annual Level of Care reviews and children in nursing facilities receive required resident reviews every 180 days at a minimum.	Documentation confirmed
10. DBHDS provides a Community Transition Guide to families of children in nursing facilities and ICFs/IID. For those seeking ICF/IID placement, the Guide is provided when a request for a VIDES assessment is made and every 6 months thereafter.	Documentation confirmed
The Guide is designed to provide practical information to children and their families who are preparing to make decisions related to the type of care that best suits their support needs or are preparing to transition from nursing facilities and ICFs/IID to homes in the community. The Guide assists families in preparing to move to a new home through an explanation of resources and services such as DD Waivers, CSBs, and the DBHDS Community Transition Team that can assist the family with the transition process.	Documentation confirmed
11. Information with respect to services and supports for children with DD is available to families on the My Life My Community website.	Documentation confirmed (website)
This information is disseminated consistent with the indicators in III.C.8.b.	Documentation confirmed (distribution, website activity)
12. DBHDS includes children aged 10 years and under as a priority group for discharge from ICF/IID settings per the ICF Community Transition Protocol, including prioritizing waiver slots to facilitate their discharge.	Pending (protocol omits waiver slot prioritization)
13. DBHDS implements a Family Outreach Plan that provides an avenue of communication with families/guardians/ARs of individuals with DD under 22 years of age receiving long term care services in nursing facilities and ICF/IIDs.	Pending
Contact with parents/guardians/ARs is initially made by mail with follow up phone calls. All families are provided with the Community Transition Guide as described in indicator #10 above. Families/Guardians/ARs interested and open to discussion of available community services are contacted not less than semi-annually. All families receive an annual contact unless there is a request for no contact. Contact through the Family Outreach Plan will also involve individualized information in a manner that accommodates their cognitive disabilities, addresses past experiences of living in community settings and concerns and preferences about community settings, and includes facilitating visits and direct experiences with the most integrated community settings that can meet the individual's identified needs and preferences. DBHDS facilitates with families a contact by a family-to-family peer support facilitator who shall contact families of children on at least a semi-annual basis for children aged 10 years and under, and on an annual basis for children aged 11 to 21 years, unless the family refuses contact.	Pending (pending dates of contact with 2 peer support families)
14. DBHDS will collaborate with sister agencies and private providers to explore augmenting current Medicaid funded host home service models for children that incorporate core elements of the Every Child Texas model focusing on children coming out of institutional settings.	Documentation confirmed
15. DBHDS ensures that all CSBs are aware of children with DD seeking admission to a nursing facility from their catchment area and of children considering ICF/IID admission or discharge whose families are interested in community-based services through an awareness letter.	Documentation confirmed

When a child is identified as being in active discharge status from a nursing facility or ICF/IID, DBHDS sends an action letter to CSBs that enumerates the actions needed from the CSB and ensures funds are available for up to 120 days of Case Management Services for discharge planning.	Documentation confirmed
a. 90% of those children known to be in active discharge status at a nursing facility or ICF/IID have an action letter sent to their home CSB.	Documentation confirmed NFs – 7/7 (2.19 to 2.20) :ICFs – 3/3 (2.20-3.20)
b. DBHDS establishes and implements accountability measures for those CSBs not actively involved in a child's discharge planning from a nursing facility or ICF/IID within 30 days of receiving an action letter.	Pending

Recommendations:
DBHDS should consider the implementation of a parents training program for newborns at CHKD, the pediatric long term care hospital, similar to one in place at VCU Children's Hospital.

DBHDS should compile and analyze semi-annual data sets to establish nursing utilization rates as it approaches the end of the 10-year schedule (6.30.21) for the Settlement Agreement.

Suggestions for DBHDS Consideration

DBHDS should consider convening a users group to give feedback at the next update of the *Community Transition Guide* to make needed modifications to address concerns regarding accessibility and user-friendly issues.

DBHDS should consider convening a user's group to give feedback at the next update of the *MyLifeMyCommunity* website to make needed modifications to address concerns regarding accessibility and user-friendly issues are addressed.

The Commonwealth should consider conducting a DBHDS executive level briefing on "augmenting current Medicaid funded host home service models for children that incorporate core elements of the Every Child Texas model focusing on children coming out of institutional settings."

Attachment A
Settlement Compliance Indicators

III.D.1

1. DBHDS service authorization data will continue to demonstrate an increase in the percentage of the DD Waiver population being served in the most integrated settings as defined in the Integrated Residential Settings Report.

a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings

b. Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "support needs level" of Levels 6 and 7, since FY 2016 are receiving services in the most integrated setting.

2. DBHDS continues to compile and distribute the Semi-annual Provider Data Summary to identify potential market opportunities for the development of integrated residential service options. The Data Summary indicates an increase in services available by locality over time.

3. DBHDS will establish a focus group with family members, individuals, and providers to identify potential barriers limiting the growth of sponsored residential, supported living, shared living, in-home supports, and respite for individuals with a "support needs level" of Level 6 or 7. DBHDS will report on how many individuals who are medically and behaviorally complex (i.e., those with a "support needs level" of Level 6 or 7) are using the following DD Waiver services, by category: sponsored residential, supported living residential, shared living, in-home supports, and respite services. Using this data and the focus groups, DBHDS will prepare a plan to prioritize and address barriers within the scope of its authority and establish timelines for completion with demonstrated actions.

4. DBHDS tracks individuals seeking a service consistent with integrated living options as defined in the Integrated Residential Settings Report that is not available at the time of expressed interest as described in indicator # 13 of III.D.6. 86% of people with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in-home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months.

5. DBHDS establishes an ongoing periodic review process for measuring the promptness and on-going delivery of authorized service units for private duty and skilled nursing services, including those provided under the EPSDT benefit, in order to identify and remedy patterns of service delivery interruptions.

6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018 for FY 2018. The utilization rate is defined by whether the hours for the service are identified as a need in an individual's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.

7. DBHDS continues to screen children through a VIDES assessment prior to admission to an ICF/IID. During the screening, DBHDS collects information from the family regarding the reason ICF/IID placement is being sought.

8. DBHDS continues to do Level II Preadmission Screening and Resident Reviews ("PASRR") on all children who have an indicator of a developmental disability diagnosis and are seeking nursing home services. All children who enter nursing facilities are limited to those who require medical rehabilitation, respite or hospice services.

9. DBHDS tracks individuals under 22 who have received a PASRR screening for nursing facility entry or a VIDES assessment for ICF/IID entry and have been admitted. Children in ICFs receive annual Level of Care reviews and children in nursing facilities receive required resident reviews every 180 days at a minimum.

10. DBHDS provides a Community Transition Guide to families of children in nursing facilities and ICFs/IID. For those seeking ICF/IID placement, the Guide is provided when a request for a VIDES assessment is made and every 6 months thereafter. The Guide is designed to provide practical information to children and their families who are preparing to make decisions related to the type of care that best suits their support needs or are preparing to transition from nursing facilities and ICFs/IID to homes in the community. The Guide assists families in preparing to move to a new home through an explanation of resources and services such as DD Waivers, CSBs, and the DBHDS Community Transition Team that can assist the family with the transition process.

11. Information with respect to services and supports for children with DD is available to families on the My Life My Community website. This information is disseminated consistent with the indicators in III.C.8.b.

12. DBHDS includes children aged 10 years and under as a priority group for discharge from ICF/IID settings per the ICF Community Transition Protocol, including prioritizing waiver slots to facilitate their discha13. DBHDS implements a Family Outreach Plan that provides an avenue of communication with families/guardians/ARs of individuals with DD under 22 years of age receiving long term care services in nursing facilities and ICF/IIDs. Contact with parents/guardians/ARs is initially made by mail with follow up phone calls. All families are provided with the Community Transition Guide as described in indicator #10 above. Families/Guardians/ARs interested and open to discussion of available community services are contacted not less than semi-annually. All families receive an annual contact unless there is a request for no contact. Contact through the Family Outreach Plan will also involve individualized information in a manner that accommodates their cognitive disabilities, addresses past experiences of living in community settings and concerns and preferences about community settings, and includes facilitating visits and direct experiences with the most integrated community settings that can meet the individual's identified needs and preferences. DBHDS facilitates with families a contact by a family-to-family peer support facilitator who shall contact families of children on at least a semi-annual basis for children aged 10 years and under, and on an annual basis for children aged 11 to 21 years, unless the family refuses contact.

14. DBHDS will collaborate with sister agencies and private providers to explore augmenting current Medicaid funded host home service models for children that incorporate core elements of the Every Child Texas model focusing on children coming out of institutional settings.

15. DBHDS ensures that all CSBs are aware of children with DD seeking admission to a nursing facility from their community-based services through an awareness letter. When a child is identified as being in active discharge status from a nursing facility or ICF/IID, DBHDS sends an action letter to CSBs that enumerates the actions needed from the CSB and ensures funds are available for up to 120 days of Case Management Services for discharge planning.

a. 90% of those children known to be in active discharge status at a nursing facility or ICF/IID have an action letter sent to their home CSB.

b. DBHDS establishes and implements accountability measures for those CSBs not actively involved in a child's discharge planning from a nursing facility or ICF/IID within 30 days of receiving an action letter.

APPENDIX G.

LIST OF ACRONYMS

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

HPR	Health Planning Region
HR/OHR	Office of Human Rights
HSN	Health Services Network
IADL	Individual Activities of Daily Living
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports ("DD" waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
ISR	Individual Services Review
LIHTC	Low Income Housing Tax Credit
MLMC	My Life My Community (website)
MOU	Memorandum of Understanding
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OSIG	Office of the State Inspector General
PASSR	Preadmission Screening and Resident Review
PCR	Person Centered Review
PCP	Primary Care Physician
PHA	Public Housing Authority
POC	Plan of Care
PMM	Post-Move Monitoring
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
QMD	Quality Management Division
QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Service Reviews
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RFP	Request For Proposals
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group

SEVTC	Southeastern Virginia Training Center
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
START	Systemic Therapeutic Assessment Respite and Treatment
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
VCU	Virginia Commonwealth University
VHDA	Virginia Housing and Development Agency