REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

SETTLEMENT AGREEMENT

UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

April 7, 2015 – October 6, 2015

Respectfully Submitted By



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Independent Reviewer
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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's seventh report on the status of compliance with the Settlement Agreement (Agreement) between the parties to the Agreement: the Commonwealth of Virginia (the Commonwealth or Virginia) and the United States (U.S.), represented by the Department of Justice (DOJ). This report documents and discusses the Commonwealth's efforts and the status of its progress during the review period April 7, 2015 – October 6, 2015. This report also provides information regarding Virginia's progress in relationship to the Agreement's ten-year implementation schedule and how its Home and Community Based Services waiver programs and regulations impede compliance.

The review period for this Report approximates the first half of the fourth year since the Court temporarily approved the Agreement on March 6, 2012, and approved it on August 23, 2012. The Court's temporary approval allowed the Commonwealth to plan the implementation of the Agreement's provisions. With the Court's August 23, 2012, order approving and adopting the Agreement as a consent decree, the Commonwealth became obligated to implement its provisions. The Agreement's provisions include a ten-year implementation schedule: July 1, 2011- June 30, 2021. The Agreement's implementation schedule begins more than a year before the Agreement was approved. Five and a half years of the ten-year implementation schedule remain as of the date of this Report.

The Independent Reviewer began monitoring the planning and implementation of the Agreement after the Court temporarily approved the Agreement on March 6, 2012. At the end of the first monitoring period, October 6, 2012, the Independent Reviewer reported that the Commonwealth made significant progress during the first fifteen months of the ten-year implementation schedule, including before the settlement was signed. The Reviewer also identified that the pay rates and structure of the Commonwealth's Home- and Community-Based Services (HCBS) wavier programs create incentives that promote congregation, are inadequate to serve those with complex needs and impede progress toward compliance.

The U.S. Center for Medicare and Medicaid Services (CMS) created the Home- and Community-Based Services (HCBS) 1915(c) waiver program in 1981. It authorized states to request the option of providing home- and community-based alternatives to institutional care. Virginia requested this option in 1990. States must propose and CMS must approve all HCBS 1915(c) waiver programs. These programs include eligibility criteria, service definitions, payment rates, service limits, and cost caps; they must specify a limit on the number of individuals who receive benefits. These numerical limits are commonly referred to as waiver slots. All states' waiver programs require the provision of case management and include a plan for the assessment of quality. All individuals who receive waiver slots must have a significant intellectual or developmental disability and a level of need that makes them eligible for institutional care.

The rules and payment rates of each state's HCBS 1915(c) waiver programs create pressures to structure settings and services in particular ways to allow service providers to survive financially. Over time, if payment rates are not increased with inflation, the financial pressures increase and the particular ways services and settings are organized become intensified. The Commonwealth's current HCBS 1915(c) waiver programs target groups of individuals based on diagnosis rather than needs. Individuals with ID are in one program. Individuals with DD, other than ID, are in

another. Virginia's waiver programs create financial pressure to develop larger congregate settings rather than smaller more integrated ones. This result conflicts with the goal of the Agreement to provide services "in the most integrated setting appropriate to meet their needs".

The Independent Reviewer's first Report to the Court, submitted December 6, 2012, identified the impediments inherent in the design and financial incentives of the Commonwealth's HCBS waiver programs. The statements below continue to be true:

> *"The bifurcated ID/DD systems contribute to the confusion of families" and to "service providers struggling to provide efficient services for people with similar needs operating with two different sets of rules, regulations and monitoring systems."*
>
> *"The current community service system is comprised of mostly large group homes and day support centers. Developing this physical infrastructure has led to most staff being trained and oriented to work in congregate settings."*

The Commonwealth has long identified the redesign of its HCBS waiver programs as its primary strategy to reform the service system to come into compliance with many provisions of the Agreement. The Independent Reviewer's sixth Report to the Court included the following statement that also continues to be true:

> *"During this review period, the Commonwealth has not been able to put its redesigned waivers into effect. The Commonwealth continues, therefore, not to be in compliance with many provisions. Furthermore, the Commonwealth will remain in non-compliance until it puts into effect, and effectively implements, a restructuring of its system that accomplishes the changes needed to meet these requirements. The Commonwealth's proposed redesign of its HCBS waiver programs include reforms necessary to provide essential community-based services for individuals with complex medical and behavioral needs, and to offer integrated day and independent living options, as required."*

The Independent Reviewer has repeatedly reported that the Commonwealth's regulations impede its ability to comply with many provisions of the Agreement. The Independent Reviewer's second Report included the following statement that continues to be true:

> The Commonwealth's *"regulations are reported to set low standards, to be broadly written, to be too vague to be effectively enforced, and to have not kept up with changes in the field of practice."*

The Commonwealth is experiencing a rapidly growing need for services to support individuals with ID/DD and their families. Since July 1, 2011, the Commonwealth has exceeded its obligations by creating 2455 waiver slots, 400 more than the Agreement requires. The Commonwealth created these slots to enable individuals to transition from institutions to live in the community. Most waiver slots, however, were created to support individuals on urgent wait lists to continue to live in their communities and avoid admission to institutions. Between July 1, 2011 and October 23, 2015, while the Commonwealth created 2,455 new waiver slots, 6,356 individuals with ID/DD have been added to the waitlists. The Commonwealth's wait lists hav grown to 10,240 children and adults, an increase of seventy-seven percent (Table 1, page 35). The widely reported and dramatic increase in the number of children with autism spectrum disorders has contributed to the increased number of individuals with ID/DD. The Commonwealth expects that the redesigned waiver programs will have a positive impact on the wait lists.

The Commonwealth has not been able to make progress on the provisions of the Agreement related to providing smaller and more integrated day and congregate residential programs for individuals living in the community. The Commonwealth's Departmental staff and stakeholders, however, have engaged in concerted and collaborative efforts and made progress. They have planned and implemented initiatives and made important progress in several areas. During this review period, the Commonwealth provided rental subsidies to allow individuals to live in their own apartment with more independence. It brought on line a data warehouse, which is a foundation element in its quality and risk management system. The Commonwealth also collected reliable point-in-time data for all individuals with ID/DD in supported employment. These successes have not resulted in determinations of compliance, but they are accomplishments of key milestones. Significantly, between October 13, 2011 and October 26, 2015, the Commonwealth helped 477 individuals transition to live in the community from the Training Centers; where the census has declined to 455 residents.

Since the Court's temporary approval of the Agreement on March 6, 2012, the Independent Reviewer has monitored primarily whether the Commonwealth has funded, designed, and put the required service elements into place. These elements include case management, transportation, crisis services, an individual and family support program, and discharge and transition planning. The Independent Reviewer initially rated these provisions as in compliance because the Commonwealth achieved the quantitative aspects of the provisions. During this reporting period, however, the Independent Reviewer, with the assistance of his independent consultants with subject matter expertise, completed qualitative reviews of transportation services, crisis services for adults, and the Regional Support Teams. There has been sufficient time for these service system elements to implement quality improvement programs, to identify how programs are falling short of expectations, and to demonstrate the ability to address performance problems.

The Agreement requires quality improvement programs for all services and of all service providers. The development of effective quality improvement programs takes time. While the Agreement had due dates for about half of the specific provisions in the Quality and Risk Management Section, it does not include due dates for providers to have quality improvement programs in place. It is the Independent Reviewer's considered opinion that it is possible to achieve quality standards only after identifying the quality standards and employing a quality improvement mechanism to provide information about whether a program is accessible, available and effectively meeting individuals' needs.

In this Report, the Independent Reviewer has determined that the Commonwealth is in non-compliance with qualitative aspects of transportation and mobile crisis services. Both have experienced ongoing complaints from members of the target population, their families and other service providers. The Commonwealth has not identified concerns related to the quality of transportation services for individuals with ID/DD and has not taken steps to address them. The Commonwealth has identified and has taken initial steps to address concerns with mobile crisis services. Neither service entity has developed an ongoing quality improvement program to identify, address, and resolve concerns and to ensure that the services provided to the members of the target population are of good quality.

The Commonwealth's development of a fully operating quality and risk management system requires a methodical multi-step approach. To date, the Department of Behavioral Health and Developmental Services (DBHDS) has made significant progress in some areas. In several areas, however, progress has been impeded by existing regulations. The regulatory requirements that exist do not align with the requirements of the Agreement. DBHDS reports that it is not able to make further progress in several key areas until its regulations are revised. Some examples include:

- DBHDS cannot require providers to report information regarding "risk triggers";
- DBHDS cannot utilize sanctions against providers that consistently do not meet standards;
- residential providers discharge individuals who do not have a home;
- DBHDS cannot establish minimum qualifications for required provider investigations;
- providers do not have access to records about whether job applicants have had one or more substantiated acts of abuse, neglect, or exploitation against a vulnerable adult.

Below is an overview of the provisions with which the Independent Reviewer has rated to be in compliance, substantial compliance or non-compliance. The Independent Reviewer determines substantial compliance when four of five Regions are clearly in compliance and when the fifth region has the required program in place and is implementing a plan to come into full compliance. During the seventh review period, the Commonwealth:

Maintained Ratings of Compliance with provisions that include:

- the creation of HCBS waiver slots;
- increased case management and licensing oversight;
- discharge planning and transition services for individuals residing in Training Centers;
- elements of a statewide crisis services system for adults with intellectual disabilities (ID);
- development of Virginia's Plan to Increase Independent Living; and
- offering choice of service providers.

Gained Ratings of Compliance due to achieving the quantitative measures of compliance

- mobile crisis on-site response times

Lost Ratings of Compliance with provisions due to qualitative and data concerns that include:

- transportation services;
- a statewide crisis services system for adults with developmental disabilities (DD);
- mobile crisis support services; and
- Regional Quality Councils' review of employment data.

Retained Ratings in Non-Compliance with provisions that were due by this time that include:

- opportunities for individuals with ID/DD to live in most integrated settings;
- transition of children to community homes from nursing facilities and large ICFs;
- crisis services for children and adolescents;
- integrated day activities and supported employment;
- subsidized community living options; and
- an individual support planning process focused on helping individuals to learn new skills in order to become more self-sufficient.

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

In summary, the Commonwealth remains in compliance with many provisions of the Agreement; and it has made progress with others. Based on concerns about quality, during this review period, the Independent Reviewer rated the Commonwealth in non-compliance in areas in which it was previously rated as in compliance based on quantitative measures. Furthermore, the Commonwealth's progress toward compliance with many provisions of the Agreement is largely on hold. The Commonwealth will remain in non-compliance until it approves and effectively implements its primary compliance strategy--the redesigned HCBS 1915 (c) waiver programs. The Commonwealth will not come into compliance with other provisions until it revises its regulations to align with the requirements of the Agreement.

During the next review period, the Independent Reviewer will prioritize monitoring the status of the Commonwealth's compliance with the requirements of the Agreement in the following areas: Crisis Services for Children; Case Management and Individual Service Planning; Individual and Family Support Program, Guidelines for Individuals and Families Seeking Services, Integrated Day Opportunities and Supported Employment, and plans to revise regulations to align with the Agreement. The Individual Services Review study will focus on children: those who live in and those are diverted and transitioned from nursing facilities and large ICFs.

Throughout the recent review period, the Commonwealth's staff have been accessible, forthright, and responsive. Attorneys from the Department of Justice have gathered information that will be helpful to effective implementation of this Agreement; they continue to work collaboratively with the Commonwealth. Overall, the willingness of both Parties to openly and regularly discuss implementation issues and any concerns about progress towards shared goals has been important and productive. The involvement and contributions of the stakeholders have been vitally important to the progress that the Commonwealth has made to date; their meaningful participation will continue to be critically necessary. The Independent Reviewer greatly appreciates the assistance generously given by the individuals at the center of this Agreement and their families, their case managers and their service providers who produced documents, helped to arrange interviews with staff and family members and facilitated site visits to homes and programs.

II. SUMMARY OF COMPLIANCE:

Settlement Agreement Reference	Provision	Rating	Comments
III	**Serving Individuals with Developmental Disabilities In the Most Integrated Setting**	**Compliance ratings for the fifth, sixth, and seventh review periods are presented as:** (5th period) 6th period **7th period**	**Comments include examples to explain the ratings and status. The Findings Section and attached consultant reports include additional explanatory information.**
III.C.1.a.i-v.	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community …	(Compliance) Compliance **Compliance**	The Commonwealth created 555 waiver slots during FY 2012 -2016, the minimum number required.
III.C.1.b.i-v	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities)… v. In State Fiscal Year 2016, 275 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth created 1500 waiver slots between FY 2012 and FY 2016, 250 more than the1250 required. It created 325 slots in FY 2016, 50 more than required. It met the quantitative requirements of this provision. It expects to initiate its plan to transition individuals under 22 years of age living in nursing facilities in March 2016.
III.C.1.c.i-v.	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities)… v. In State Fiscal Year 2016, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth created 400 waiver slots between FY 2012 and FY 2016 for individuals with DD, other than ID, 150 more than the 250 required. It met the quantitative requirements of this provision. It has not implemented its plan to transition individuals under 22 years of age. It has prioritized diverting children to alternative home- and community-based services.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.2.a-b	The Commonwealth shall create an individual and family support program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2015, a minimum of 1000 individuals supported.	(Compliance) Non Compliance **Non Compliance**	The Commonwealth met the quantitative requirement by supporting 1,201 individuals in FY 2015. In FY 2016, $600K has been distributed to 625 individuals/families. The current IFSP does not include a comprehensive and coordinated set of strategies.
III.C.5.a	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	(Compliance) Compliance **Compliance**	□ 24 (100%) of the individuals studied were receiving case management. □ 24 (100%) also had current Individual Support Plans.
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.i.	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	(Non Compliance) Non Compliance **Non Compliance**	DBHDS is making substantive changes to the ISP process and DD case management. It is providing training to ID case managers. The Commonwealth expects that improvements become evident in the next (eighth) review periods.
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 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 re: III.C.5.b.i.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.5.c	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	(Non Compliance) Compliance **Compliance**	The IR did not find evidence that case managers provided direct services, other than case management. The required term is included in the "FY 2016 CSB Performance Contract".
III.C.5.d	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	(Non Compliance) Non Compliance **Non Compliance**	The DBHDS regulations and licensing monitoring protocols do not align with the Agreement's requirements. DBHDS has implemented additional monitoring processes.
III.C.6.a.i-iii	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth has developed the required elements of a statewide crisis system for adults with ID. DBHDS is putting in place the elements of a statewide children's crisis system. Additional appropriated funds were provided as of 7/1/2015. DBHDS cannot assure that it is reaching individuals with DD who need the crisis system.
III.C.6.b.i.A	The Commonwealth shall utilize existing CSB Emergency Service, 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 for adults with ID. CSB hotlines are operated 24 hours per day, 7 days per week.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.6.b.i.B	By June 30, 2012, the Commonwealth shall train CSB Emergency Services 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 programs continue to train CSB Emergency Services (ES) staff and to report quarterly. DBHDS has developed a standardized curriculum. All new CSB ES staff and case managers are required to be trained.
III.C.6.b.ii.A.	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	(Compliance) Compliance **Non Compliance**	The Commonwealth has developed and implemented a training program and a process to reinforce learning. The training it provided has not been adequate for team members to respond with, effective or timely assessments, or good quality in-home supports and treatment, in many cases.
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) Compliance **Non Compliance**	REACH teams provide crisis response, crisis intervention, and crisis planning. REACH programs did not provide effective prevention plans or strategies, or in-home supports. DBHDS now requires that crisis plans be completed for every individual referred to REACH.
III.C.6.b.ii.C	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with ID/DD comes into contact with law enforcement.	(Non Compliance) Compliance **Compliance**	During the review period REACH trained 332 police, an increase over the 224 law enforcement staff trained during the previous reporting period.
III.C.6.b.ii.D	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	(Non Compliance) Compliance **Compliance**	REACH Mobile crisis teams are available around the clock and respond at off-hours for adults with ID.
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**	Most regions provided adults with ID with more than an average of three days in-home support services.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.6.b.ii.G	By June 30, 2013, the Commonwealth shall have at least two mobile crisis teams in each Region that shall respond to on-site crises within two hours.	(Non Compliance) Non Compliance **Compliance**	The Commonwealth had not created new teams as required. REACH teams achieved responses within two hours for 434 (94.1%) of 461 calls. Late crisis calls were generally involved minor amounts of time.
III.C.6.b.ii.H	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond on site to crises as follows: in urban areas, within one hour, and in rural areas, within two hours, as measured by the average annual response time.	(Compliance) Non Compliance **Compliance**	The Commonwealth reported average response times of within one hour in urban areas and within two hours in rural areas.
III.C6.b.iii.A.	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services	(Compliance) Compliance **Compliance**	All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults with ID.
III.C.6.b.iii.B.	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	(Compliance) Compliance **Compliance**	For adults with ID admitted to the programs, crisis stabilization programs continue to be used as last resort. For these individuals, teams have attempted to resolve crises and avoid out-of home placements.
III.C.6.b.iii.D.	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	(Compliance) Compliance **Substantial Compliance**	Four Regions' programs have no more that six beds. Region III's program now has more than six beds. It reports that it has a plan to return to compliance.
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.	(Substantial Compliance) Substantial Compliance **Substantial Compliance**	Four Regions' stabilization programs are not located on institution grounds and are in compliance. Region IV has 'broken-ground' to build a crisis stabilization home and move its existing program.
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.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.6.b.iii.G.	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	(Compliance) Compliance **Non Compliance**	The Commonwealth has not made a determination of whether it is necessary to develop additional crisis stabilization programs for adults with ID. There appears to be compelling evidence that additional crisis stabilization capacity is needed to meet the needs of the target population.
III.C.7.a	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	(Non Compliance) Non Compliance **Non Compliance**	This is an overarching provision. Compliance will not be achieved until the sub-provisions of Integrated Day – Supported Employment are in compliance.
III.C.7.b	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy… (3) employment services and goals must be developed and discussed at least annually …	(Non Compliance) Non Compliance **Non Compliance**	CSBs are not fulfilling the term of their Performance Contracts that requires implementation of the Commonwealth's Employment First Policy. For 18 (90%) of 20 individuals studied, case managers did not *develop and discuss* employment goals and services. DBHDS expects improvements in the ISPs to begin in the next 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 rec. opportunities, and other integrated day activities.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth developed a plan for Supported Employment. It finalized an updated draft plan for integrated day opportunities after the Independent Reviewer was reviewing information for this Report.
III.C.7.b.i.A	Provide regional training on the Employment First policy and strategies through the Commonwealth.	(Compliance) Compliance **Compliance**	The Employment Services Coordinator provided numerous trainings, i.e., 10 trainings in 10 weeks were provided to a total of 303 staff in 4 of the Regions.

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 re:		The Commonwealth implemented an improved method of collecting data. Data reported includes only 86% return rate for group supported employment. The Commonwealth has not determined the number of individuals who are receiving supported employment, as defined in the Agreement, and cannot determine the number for meaningful increases in each year.
III.C.7.b.i. B.1.a.	The number of individuals who are receiving supported employment.	(Compliance) Non Compliance **Non Compliance**	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.b.	The length of time individuals maintain employment in integrated work settings.	(Non Compliance) Non Compliance **Non Compliance**	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.c.	Amount of earnings from supported employment;	(Non Compliance) Non Compliance **Non 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**	The Commonwealth provided the number of individuals.
III.C.7.b.i. B.1.e.	The length-of-time individuals remain in pre-vocational services.	(Compliance) Compliance **Compliance**	The Commonwealth provided the number who remain in such services.
III.C.7.b.i. B.2.a.	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year	(Compliance) Non Compliance **Non Compliance**	The Commonwealth has set the % to meaningfully increase. The data gathered are not complete and include individuals in supported employment that does not align with the Agreement.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.7.b.i.	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	(Compliance) **Non Compliance**	The Commonwealth has expanded the definition to include a higher number of individuals. The data gathered are not complete and include individuals who earn below minimum wage.
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.	(Non Compliance) Compliance **Non Compliance**	The RQCs met quarterly. The DBHDS Employment Coordinator, the liaison between the SELN (Supported Employment Leadership Network) and the RQCs, presented employment data to them. The RQCs' had only limited discussion of supported employment data.
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.	(Non Compliance) Compliance **Non Compliance**	Same as immediately above
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	(Compliance) Compliance **Non Compliance**	A review found that DMAS /Logisticare do not know whether transportation services for the target population are of good quality. Several sources indicate a higher level of complaints from this population.
III.C.8.b.	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth guidelines ("Just the Facts") do not include information regarding how and where to apply and how to obtain services for individuals / families who are on the waitlists or others seeking services who do not know how to apply to get on it.

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 primarily offers individuals congregate settings. An increased percent of the individuals who transitioned from Training Centers have moved to settings with five or more residents or with multiple group homes on one setting. □44% in FY 2013, 62 of 141 □53% in FY 2014, 84 of 158 □58% in FY 2015, 62 of 107 □61% in FY 2016, 12 of 19
III.D.2.	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources…	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth began to facilitate individuals receiving waivers who would choose to live in their own home to do so. Further progress is needed in resolving systemic barriers, including providing necessary rental subsidies and in demonstrating sustained ability to achieve its Independent Living timeline and outcome targets in all Regions.
III.D.3.	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth developed a plan. It created strategies to improve access and provided rental subsidies to some individuals to live in their own apartments. It has taken positive steps toward compliance.
III.D.3.a.	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ...	(Compliance) Compliance **Compliance**	A DBHDS housing service coordinator developed the plan with these representatives and 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 through FY15. It revised its Housing Plan with new strategies and recommendations.
III.D.4	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing, from a one-time fund of $800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii.	(Compliance) Compliance **Compliance**	The Commonwealth has established the one-time fund and distributed funds. Fourteen individuals are now living in rental units with this rental assistance. Five limited time rental vouchers remain.
III.D.5	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	(Non Compliance) Non Compliance **Non Compliance**	Documents reviewed did not indicate that the family-to family and peer programs were active and creating pairings for individuals served in sponsored homes or congregate settings.
III.D.6	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	Compliance) Compliance **Non Compliance**	Individuals were placed in settings of five or more or to ICFs without the review of Regional Support Teams Referrals were not submitted or submitted so late that the RST did not have time to fulfill its responsibilities or to utilize its authority.
III.D.7	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home …	(Compliance) Compliance **Compliance**	The Commonwealth: included this term in the performance contracts, developed and provided training to case managers, and implemented ISP form with 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 CBSs 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 (CRC) are located in and are members of the Regional Support Team in each Region and are utilized for these functions.
III.E.2	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	(Non Compliance) Non Compliance **Non Compliance**	PSTs did not submit some referrals as required. Individuals moved to settings of five or more, or to ICFs, without the CRCs submitting referrals in time for the RSTs to fulfill their responsibilities or to utilize their authority.
III.E.3.a-d	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met)	(Compliance) Compliance **Compliance**	DBHDS established the RSTs, which meet monthly. The CRCs refer cases to the RSTs regularly.
IV	**Discharge Planning and Transition**	**Compliance ratings for the fifth, sixth, and seventh review periods are presented as:** (5th period) 6th period **7th period**	**For the Discharge provisions, the IR did not prioritize monitoring and did not provide compliance ratings during the sixth review period.**
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	(Compliance) **Compliance**	The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It made subsequent improvements re: concerns the IR identified.
IV.A	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	(Non Compliance) Non Compliance **Non Compliance**	The Commonwealth has not implemented its strategy to come into compliance. Most integrated residential and day options are often not available for individuals with intense needs.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.3.	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	(Compliance) **Compliance**	The IR's individual services review studies found that DBHDS has consistently complied with this provision. The discharge plans are well documented
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, well being, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	(Non Compliance) Non Compliance **Non Compliance**	Discharge plan goals did not include measurable outcomes that lead to skill development and increased self-sufficiency. The Commonwealth acknowledges its inability to provide integrated day services until it implements its redesigned waivers.
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 (developed within 30 days prior to discharge)	(Compliance) **Compliance**	The IR's individual services review studies found that DBHDS has consistently complied with this provision and that the discharge plans are well documented. DBHDS tracks and reports that all residents of Training Centers have discharge plans.
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	(Compliance) **Compliance**	The IR found that documentation of information provided was present in the discharge records □ for 75 (91.5%) of the 82 individuals studied during three review periods.
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	(Compliance) **Compliance**	The discharge plans included this information.
IV.B.5.c.	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	(Compliance) **Compliance**	□ for 50 (98.0%) of 51 individuals studied during the fifth and seventh review period, the discharge records included these assessments.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	(Compliance) **Compliance**	The PSTs select and list specific providers that can provide identified supports and services.
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	(Compliance) **Compliance**	The CIMs and Regional Support Team document barriers on the data collection sheet.
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	(Compliance) **Compliance**	The severity of the disability has not been a barrier in the discharge plans.
IV.B.5.e.ii.	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	(Compliance) **Compliance**	DBHDS has identified the factors that led to readmission and has implemented steps to support individuals with intensive needs.
IV.B.6	Discharge planning will be done by the individual's PST…Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	(Non Compliance) **Non Compliance**	The individual review study found that the discharge plans lacked recommendations for how individuals can be best served. They did not include skill development to increase self-sufficiency or integrated day opportunities. DBHDS is implementing improvements.
IV.B.7	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	(Compliance) **Compliance**	The Commonwealth's discharge plans indicate that individuals with complex needs can live in integrated settings..
IV.B.9.	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	(Compliance) **Compliance**	The individual reviews during the fifth and seventh review periods found that □ 52 (100%) individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST.
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	(Compliance) **Compliance**	Discharge records included evidence that the Commonwealth had offered a choice of providers.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the … community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	(Non Compliance) **Non Compliance**	The IR's reviews found that of the individuals studied ▫11 (45.8%) of 24 individuals and their ARs did not have an opportunity to speak with individuals currently living in their communities and their family members. DBHDS sent packets of information to ARs. Of 61 referrals at CVTC and NVTC one family and two peer mentor pairings occurred. DBHDS plans to contact each family to offer this opportunity
IV.B.9.c.	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	(Compliance) **Compliance**	PST's and case managers assisted individuals and their Authorized Representative. Providers were identified and engaged; and provider staff were trained in support plan protocols that were transferred to the community.
IV.B.11.	The Commonwealth shall ensure that Training Center PST's have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	(Compliance) **Compliance**	During the fifth and seventh review periods, the IR found that 48 (92.3%) of 52 individuals /Authorized Representatives who transitioned from Training Centers were provided with information regarding community options.
IV.B.11.a.	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	(Compliance) **Compliance**	The IR confirmed that training has been provided via regular orientation, monthly and ad hoc events at all Training Centers, and via ongoing information sharing.

Settlement Agreement Reference	Provision	Rating	Comments
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 meeting and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches … will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers	(Compliance) **Compliance**	The IR confirmed that staff receive required person-centered training during orientation and annual refresher training. All Training Centers have person-centered coaches. DBHDS reports that regularly scheduled conferences provide opportunities to meet with mentors. An extensive list of trainings was provided and attendance is well documented. These include "Core Retraining", after which is a comprehensive test.
IV.B.15	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	(Non Compliance) **Non 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**	The IR found that the residential provider staff for ▫ 51 (98.1%) of 52 individuals participated in the pre-move ISP meeting and were trained in the support plan protocols.
IV.C.2	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	(Compliance) **Compliance**	During the fifth and seventh period, the IR found that ▫ 49 (94.2%) of 52 individuals had moved within 6 weeks, or reasons were documented and new time frames developed.

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.	(Non Compliance) Compliance **Compliance**	The IR determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions. The IR found that for 52 (100%) individuals PMM visits had occurred and that the monitors had been trained and utilized monitoring checklists. During the sixth review period, the Commonwealth completed a look-behind process with a significant sample size. The look-behind process was maintained during the seventh period.
IV.C.4	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	(Compliance) **Compliance**	The IR review studies during the third, fifth and seventh review periods found that ▫ for 52 (96.3%) of 54 individuals, the Commonwealth updated discharge plans within 30 days prior to discharge.
IV.C.5	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge ...	(Non Compliance) **Non Compliance**	The IR review studies found that essential supports were not in place prior to discharge for 8 (28.6%) of 28 individuals in the fifth and for 3 (12.5%) of 24 individuals in the seventh review periods. For the fifty-two individuals in the two groups: □ 8 (15.4%) did not have out-of-home day opportunities identified or provided, □ 3 (5.8%) did not have behavioral or medical supports identified or provided.

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**	The discharge records reviewed in the third and fifth review periods indicated that individuals who moved to settings of five or more did so based on their informed choice after receiving options.
IV.C.7	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	(Compliance) **Compliance**	The IR confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans.
IV.D.1	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	(Compliance) **Compliance**	Community Integration Managers are working at each Training Center.
IV.D.2.a	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals;	(Compliance) **Compliance**	CIMs have reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals.
IV.D.3	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	(Non Compliance) **Non Compliance**	The Commonwealth has created five Regional Support Teams. All RSTs are operating and receiving referrals. The IR found, during the seventh period, that □ for 0 (0.0%) of 12 individuals referred to the RST, there was sufficient time to work with the PST and CIM to resolve identified barriers.

Settlement Agreement Reference	Provision	Rating	Comments
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed …	(Compliance) **Compliance**	The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.
V.	**Quality and Risk Management**	**Compliance ratings for the fifth, sixth, and seventh review periods are presented as:** (5th period) 6th period **7th period**	**For the Quality provisions without due dates, the IR did not prioritize monitoring and did not provide compliance ratings during the sixth review period.**
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	(Non Compliance) **Non Compliance**	This is an overarching provision of the Agreement. Compliance will not be achieved until the sub-provisions in the Quality and Risk Management Section are determined to be in compliance.
V.C.1	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	(Non Compliance) **Non Compliance**	The Commonwealth has improved its draft list of risk triggers by including risks of harm in addition to harm that has occurred. It has not completed or implemented the lists and draft annual risk assessment. It has not changed regulations to allow collection of required data.
V.C.2	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	(Non Compliance) **Non Compliance**	DBHDS implemented a web-based incident reporting system. Although improved, providers do not report within 24 hours. consistently. The reporting form is inadequately designed and does not produce reliable data.

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

Settlement Agreement Reference	Provision	Rating	Comments
V.C.6	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider.	(Non Compliance) **Non Compliance**	DBHDS cannot effectively use available mechanisms to sanction providers, beyond use of Corrective Action Plans. DBHDS reports that, provisional licenses being issued for repeat offenders.
V.D.1	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers, … Review of data shall occur at the local and state levels by the CSBs and DMAS/DBHDS, respectively.	(Non Compliance) **Non Compliance**	This is an overarching provision requiring effective quality improvement processes at the local and state levels. Compliance will not be achieved until the quality improvement sub-provisions are in compliance. The lack of consistently collected, and complete and reliable, data has not allowed effective review at the local and state levels. Only limited analysis occurred.
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**	The Commonwealth has taken steps to improve collection and use of data, to develop reports, and to share data among staff and divisions. Implementation of the Data Warehouse is an important accomplishment. Significant work remains to increase and organize the data and to ensure its reliability.
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 is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	(Non Compliance) **Non Compliance**	The Commonwealth began collecting and analyzing information in FY 2012. Data collection for some measures began June 30, 2014. For other measures, it has not begun. Case management and ISP data are not complete or reliable. Data about individuals with DD services and private ICFs are not included.

Settlement Agreement Reference	Provision	Rating	Comments
V.D.4	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	(Non Compliance) **Non Compliance**	This is an overarching provision. It will be in non-compliance until reliable data are provided from all the sources listed and cited by reference in V.C. and in V.E-G.
V.D.5	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	(Non Compliance) **Non Compliance**	The RQCs had limited and unreliable data. The RQCs completed limited analysis and discussion of trends or recommendations
V.D.5.a	The councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	(Non Compliance) Compliance **Compliance**	The five Regional Quality Councils now include all the required members.
V.D.5.b	Each council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	(Non Compliance) **Non Compliance**	The RQCs met quarterly and had limited discussion of trends. The data available were not complete or reliable. The DBHDS Quality Improvement Council directed their work.
V.D.6	At least annually, the Commonwealth shall report publically, through new or existing mechanisms, on the availability … and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	(Non Compliance) **Non Compliance**	The Commonwealth has begun to compile and has posted on its website: information toward creating and publicly 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**	The Commonwealth has surveyed all CSBs and will survey a sample of providers to ascertain a baseline regarding existing quality improvement practices. It has targeted 12/31/2015 to set clear expectations about QI processes for providers.

Settlement Agreement Reference	Provision	Rating	Comments
V.E.2	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	(Non Compliance) **Non Compliance**	The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS plans to require reporting through the risk management and provider QI programs as described in V.E.1. above.
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 began to implement the QSR process. It plans to use the results to improve quality of services on the provider, CSB, and system wide levels and to provide technical assistance. It has not finalized the data it will collect to assess provider quality improvement strategies.
V.F.1	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	(Compliance) Compliance **Compliance**	The IR found that 79 (100%) individuals studied were receiving case management services. The IR will complete a qualitative review after the Commonwealth implements its current initiative to improve ISPs and case management.
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**	DBHDS is making substantive changes to the ISP process, ISP monitoring, the training provided to ID case managers, and the changes related to the DD case management through the HCBS waiver restructure. The Commonwealth expects that meaningful changes in the ISP will be evident at the end of the next review period.

Settlement Agreement Reference	Provision	Rating	Comments
V.F.3.a-f	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	(Compliance) **Compliance**	The IR found that □ 23 (95.8%) of 24 individuals who met the eligibility criteria for enhanced case management received monthly face-to-face meetings as required.
V.F.4	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	(Non Compliance) **Non Compliance**	DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to assess CSB compliance with their performance standards relative to case manager contacts.
V.F.5	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	(Non Compliance) Non Compliance **Non Compliance**	The IR determined during the sixth period that the key indicators developed by DBHDS do not address specific elements of the case manager's face-to-face visit observation and assessments. For example, there continues to be no plans to address the halo effect of case managers skewing reports to the positive.
V.F.6	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	(Compliance) Compliance **Compliance**	The Commonwealth developed the curriculum with training modules that include the principles of self-determination.
V.G.1	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	(Compliance) **Compliance**	DBHDS completed 434 unannounced licensing inspection visits between 4/1/15 and 9/30/15.
V.G.2.a-f	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Compliance) **Compliance**	DBHDS has maintained a licensing inspection process with more frequent inspections.

Settlement Agreement Reference	Provision	Rating	Comments
V.G.3	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	(Non-Compliance) **Non Compliance**	The DBHDS Licensing regulations and protocol do not align with the Agreement's requirements. Licensing is undergoing a thorough review to determine system requirements.
V.H.1	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self –determination awareness, and required elements of service training.	(Non-Compliance) **Non Compliance**	The Commonwealth is offering some training to DSPs, their supervisors and case managers. It has not created a plan to: develop the curriculum to train staff in the required elements of service for the individuals, or determine the competencies required or the methods and frequency of determining competency.
V.H.2	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	(Non-Compliance) **Non Compliance**	Same as V.E.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**	The Commonwealth has worked steadily to modify the Quality Service Review process to meet the requirements of the Agreement. The selected contractor recently began conducting reviews. Compliance will be achieved when results are used to improve quality.
V.I.2	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives …	(Non Compliance) **Non Compliance**	Same comment as V.I.1. immediately above.

Settlement Agreement Reference	Provision	Rating	Comments
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 comment as V.I.1.
V.I.4	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	(Non Compliance) **Non Compliance**	Same comment as V.I.1.
VI	**Independent Reviewer**		
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 Parties … shared with Intervenor's counsel.	(Compliance) Compliance **Compliance**	The DHBDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his Report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.
IX	**Implementation of the Agreement**		
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 IR has determined that the Commonwealth did not maintain sufficient records to document proper implementation of the provisions including: web-based incident reporting, case management, crisis services, employment, and licensing.

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

III. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology:

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

- by reviewing data and documentation produced by the Commonwealth in response to requests by the Independent Reviewer and the Department of Justice (DOJ);
- by discussing progress and challenges in regularly scheduled Parties' meetings and in work sessions with Commonwealth officials;
- by examining and evaluating documentation of supports provided to individuals and their families;
- by interviewing individuals and/or their families, providers, and other stakeholders; and
- by visiting sites, including individuals' homes, community-based residential, day and other programs.

During this seventh review period, the Independent Reviewer prioritized the following areas review and evaluation. Seven independent consultants were retained to complete studies of:

- Individual Services Review: Discharge and Transition from Training Centers
- Crisis Services for Adults
- Crisis Services for Children
- Transportation Services
- Regional Support Teams
- Quality and Risk Management
- Mortality Review

For the seventh time, the Independent Reviewer utilized his Individual Services Review study process and Monitoring Questionnaire to evaluate the status of services for a sample of individuals. By utilizing the same questions over several review periods, for different subgroups and in different geographic areas, the Independent Reviewer identified findings that include positive outcomes, areas of concern and trends. By reviewing these findings, the Independent Reviewer has identified and reported themes. For this report, the Individual Services Review study was focused on the services for individuals who transitioned from Virginia's Training Centers. Twenty-four individuals were selected randomly from the forty-two individuals who transitioned to live in community homes located in either Region I (northwestern/central Virginia) or Region II (northern Virginia) during Fiscal Year 2015. The random selection of this sample size provides 90% confidence that the findings of the study can be generalized to the group of forty-two.

The studies completed by the Independent Reviewer's consultants for this report each involved reviewing the status of the Commonwealth's compliance with specific prioritized provisions that were targeted for review and evaluation. The Independent Reviewer utilized a process to ensure that information would be gathered that indicates the Commonwealth's achievements in establishing the requisite staff, policy, program and process elements. The Independent Reviewer shared the planned scope, methodology, site visits, document review, and interviews with the Commonwealth and requested its suggested refinements. The Independent Reviewer also asked the Commonwealth to provide the measurable outcomes that it has established and to identify the records that it maintains to demonstrate proper implementation of the provisions that are the focus of each study.

The Independent Reviewer's consultants then reviewed the status of program development to ascertain whether the Commonwealth's initiatives had been implemented sufficiently for measurable results to be evident. The consultants conducted interviews with selected officials, staff at the state and local levels, workgroup members, providers, families of individuals served and other stakeholders. The primary focus of previous studies, and the Independent Reviewer's subsequent determinations of compliance ratings,, has been whether the Commonwealth has complied with the quantitative measures of compliance. During this review period, however, the studies of *Crisis Services For Adults* and *Transportation Services* focused on whether the qualitative measures of compliance have been achieved. To determine the ratings of compliance, the Independent Reviewer considered information provided prior to November 1, 2015. This included the findings and conclusions from the consultant's topical studies, the Individual Services Review study, and many other services. The Independent Reviewer's compliance ratings are best understood by reviewing the comments in the Summary of Compliance table, the Findings section of this report, and the consultant reports included in the Appendix.

The provisions in the Discharge Planning and Transition and the Quality and Risk Management sections of the Agreement were closely studied during the fifth reporting period. The compliance ratings for many provisions in these sections were not expected to change substantially during the sixth review period so the Independent Reviewer did not study or rate them. They have been studied and are rated in this report.

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

B. Compliance Findings

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

The U.S. Center for Medicaid Services operates the Home and Community-Based 1915(c) waiver program. The funding from the Home and Community-Based Services (HCBS) waiver provides support services in the community as an alternative to receiving services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Individuals with ID/DD may receive HCBS waiver funded services once they are awarded a waiver slot.

Since Fiscal Year 2012, the first year the Commonwealth provided funding to implement the provisions of the Settlement Agreement, a total of 2455 new waiver slots have been created under the Agreement; 400 more than were required. The Commonwealth created 450 waiver slots in FY 2016, sixty-five more than the minimum required. It created these waiver slots not only to enable individuals with IDD to receive waiver-funded services in the community, so they are able to continue to live in their communities, but also to transition children and adults from living in nursing facilities and large ICFs. Training Centers are large state-operated ICFs.

The Independent Reviewer's Individual Review Studies have consistently found that waiver slots provide individuals and families with critical supports that significantly improve their quality of life. For those individuals previously on wait lists, their access to waiver-funded services is vital to their good health, safety, and prevention of institutionalization. While these new slots have been created and the census of the Training Centers has declined, the number of individuals on Virginia's wait lists has continued to increase significantly, by more than an additional thousand individuals in each

of the past four years. The widely publicized increase in the incidence of Autism Spectrum Disorders in recent decades has been, and will continue to be, a major influence. The chart below shows that between June 30, 2011 and October 23, 2015, there has been a very significant overall increase in the number of individuals with ID/DD, which has increased by 6,284 (39.5%), and in the number of individuals on the wait lists, which has increased by 4,457 (77.1%).

TABLE 1
Increase in the Number of Individuals with ID/DD

# Individuals	**June 30,2011**	**October 23,2015**	**# change**	**% change**
Waiver Slots(1) # living in the community	9,035	11,490	+2,455	**+27.2%**
Wait Lists living in the community	5,783	10,240 (5)	+4,457	***+ 77.1%***
Training Centers # living in	1,084	455	-628 (3)	- 58%
Total number of Individuals with ID/DD (2) *(4)*	**15,902**	**22,185**	**+6,283**	***+39.5%***

In Fiscal Year 2012, the Commonwealth began funding initiatives that it would commit to accomplish when it settled the Agreement on January 26, 2012, and when the Court approved the Agreement on August 23, 2012. Between July 1, 2011 and October 23, 2015, the Commonwealth created 1900 new waiver slots to provide community services for individuals on Virginia's wait lists and for children living in nursing facilities and large ICFs. During that same period, 6,357 individuals have been added to the wait lists. This has resulted in the wait lists growing by 4,457 people. After creating the new waiver slots, the number of individuals on the wait lists still has increased by more than a thousand individuals each year. The Commonwealth also created waiver slots to transition individuals from Training Centers.

The Commonwealth is in compliance with *Section III.C.1.a.i.- iii.*

(1) All waiver slots are not being used on any specific dates. Slots are held in reserve for emergencies and for individuals who will transition from Training Centers, Nursing Facilities, and large ICFs.
(2) Total "individuals with ID/DD"= the sum of waiver slots, Training Center residents, and individuals on wait lists.
(3) The decline in the census at the Training Centers is greater than the number of individuals who moved to live in community settings. The two primary reasons for the difference is that 105 residents of Training Centers on June 30, 2011, had died by October 23,2015, and some were discharged to skilled nursing facilities
(4) All individuals have a level of need that makes them eligible for institutional care.
(5) More than a third of these individuals are receiving some services through either the EDCD or Tech waivers.

2. Transition of Children from Nursing Facilities and Large ICF's

For children with ID and DD, other than ID, who live in nursing facilities and the largest ICFs, DBHDS plans to initiate its process to facilitate their transitions to community homes in March 2016. The Commonwealth reports that it prioritized the waiver slots and that slots are currently available for these children. As reported previously, the Commonwealth has prioritized diverting children to alternative community-based services that address their needs and away from possible admission to a nursing facility. If a child is admitted to a nursing facility, the specific purpose of the admission will be identified and the Commonwealth will conduct 90-day reviews. The purpose of the review will be to determine whether the individual continues to need skilled nursing services in a hospital-like setting and to offer home- and community-based services alternatives.

By first focusing on diverting possible institutional admissions to needed community-based services, the Commonwealth has learned lessons that will improve its effective implementation of the second phase to transition individuals who have been living in nursing facilities. The Commonwealth plans to establish the baseline number and to begin transitions of children living in nursing facilities in April 2016. The Commonwealth reports that it has restructured the PASSR II screening process that is required for any individual with ID/DD who has been referred for admission to a nursing facility. DBHDS reports that it has significantly improved its ability to identify, develop and provide alternative community-based services for adults and children who have been referred for admission to nursing facilities. The Commonwealth has not yet planned its initiative to identify and determine the needs of children and adults with ID/DD who are referred to or currently living in the large private ICFs, or to offer alternative services to these individuals in settings that will not separate them from their schools, families and communities.

The Commonwealth decided to begin implementation of its plan to transition children who live in nursing facilities near the end of the next review period. The Agreement requires that the transition plans for children living in institutions lead to quality services provided in the most integrated setting appropriate to meet their needs in all domains of their lives. It is the intent of the Agreement that individuals with HCBS waiver slots will be offered available and accessible community-based supports that are designed to promote skill development, self-sufficiency and community integration and that are of good quality.

The Individual Services Review study conducted during the eighth review period (December 7, 2015 - April 6, 2016) will focus on the adults and children with ID and DD, other than ID, who reside in nursing homes and the large ICFs.

Conclusion: The Commonwealth created 1500 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who were/are on the urgent waitlist for a waiver during FY 2012 – 2016. This is 250 more waiver slots than the required minimum number of 1250. It created 325 slots in FY 2016, 50 more waivers than required. The Commonwealth created 400 waiver slots between FY 2012 and FY 2016 for individuals with DD, other than ID; 150 more waivers than the minimum required number of 250 waivers. The Commonwealth has met the quantitative requirements for these provisions. It has not, however, developed or implemented a plan to transition individuals under 22 years of age from large ICFs and has not implemented its transition plans for children living in nursing facilities.

The Commonwealth is in non-compliance with *Section III.C.1.b.i.-iii.* and *III.C.1.c.i.-iii.*

3. Discharge Planning and Transition from Training Centers

Overall, the discharge planning and transition process to support individuals who move from the Training Centers has been effectively implemented and well documented. This process and the provision of waiver slots have enabled 477 individuals to move from Training Centers to community-based living between October 11, 2011 and October 26, 2015. As of that latter date, 456 individuals were living in the Training Centers.

During the seventh review period, the Independent Reviewer's Individual Service Review Study focused exclusively on forty-two individuals who moved from the Training Centers, as did similar studies during the first, third, and fifth review periods. In total, the Independent Reviewer's individual services review teams have carefully studied the discharge and transition process and the community based-services for 114 individuals who transitioned from Training Centers. (This sample size was selected to provide a 90% confidence level and a 10% confidence interval: it, therefore, offered a sufficient degree of confidence that findings can be generalized to the 194 former residents of Training Centers who moved to community settings in all five Regions.) Since more individuals (227) moved from the Southside Training Center, most of these individual service reviews occurred in Regions IV (greater Capitol area) and Region V (tidewater). During this review period, the study focused on twenty-four who were randomly selected from forty-two residents of Training Centers who moved between mid-July 2014 and mid-June 2015 to live in Virginia's Health Planning Regions I (northwestern/central) or II (northern).

Although there were individual exceptions, the study of services for individuals who transitioned from Training Centers to community settings found the following themes and examples of positive outcomes and areas of concern:

- **The individuals' new community homes were clean and well maintained.** Homes were accessible based on the individuals' needs for environmental modifications. Needed adaptive equipment and supplies were available. The DBHDS Licensing Specialists had recently inspected all homes.

- **Fourteen (58.3%) of the twenty-four individuals transitioned to congregate settings of five or more individuals or to settings with residential programs clustered together.** Some congregate group homes had the appearance of a medical facility or business, not that of a typical home. Arrangements typical of institutions continued for many, such as: a central nurses' station enclosed in plexi-glass; day programs in their own or other's residential settings; the use of a shower trolley rather than the available state-of-the-art free standing accessible walk- or roll-in bath tub; standing orders for PRN medications rather than individualized parameters; and maintenance of pureed diets for individuals who drank clear liquids without apparent difficulty.

- **Referrals to the Regional Support Team to address and resolve barriers to living in more integrated settings occurred too late to have any chance of success.** The Personal Support Team delayed referrals for months after it presented a list of primarily larger congregate homes to the Authorized Representative. Referrals occurred with too little time for the RST to act. Referrals occurred after a larger congregate home was selected, after transition planning with the residential provider, after transition visits were completed and after the move date was scheduled.

- **The individuals lacked community integration opportunities** and did not have individual support plans with goals that promoted the development of skills to increase self-sufficiency. None of the individuals were offered integrated day programs or had typical days that involved integrated activities.

- **The discharge planning and transition process was well organized and well documented.** The selected residential providers were involved in the discharge planning process. The residential provider staffs were trained in the individuals' support plan protocols. The Post-Move Monitor visits occurred. Transition planning, provider training and post-move monitoring, however, did not ensure that all essential needs were addressed. Three individuals were not referred to the RCSC dentist, as expected in their discharge plans, until the individual review nurse consultant raised the issue during a site visit months later.

- **There were many positive healthcare process outcomes for virtually all the individuals studied.** All individuals had a physical within a year and the Primary Care Physicians' recommendations were implemented within the prescribed time frames.

- **The individuals made successful transitions and had settled-in well into their new home environments.** After living in their new homes, there were several examples of individuals with previously documented histories of problematic behaviors experiencing significantly fewer and less severe incidents of shorter duration, than had been expected at the time of discharge from the Training Center.

The themes identified from the findings from the study of the individuals who transitioned from the Training Centers are consistent with the themes identified in earlier studies.

The demographic information of the individuals studied during the third, fifth and seventh periods indicate that of every twenty individuals who moved:

- eleven (56.3%) were males,
- fifteen (75%) were age 51 or older,
- eight (40%) used wheel chairs for all mobility,
- thirteen (67.5%) used gestures as their highest form of communication,
- eighteen (88.8%) moved to congregate residences, and
- seventeen (83.8%) had a parent or sibling as Authorized Representative.

The Commonwealth had previously achieved, and in the seventh period maintained, a rating of Compliance with most of the Discharge Planning and Transition provisions. As exemplified by the themes described above and by the tables (found in Appendix A) resulting from this period's Individual Services Review study, consistent compliance with the provisions of the Agreement has resulted in many positive outcomes for the transitioned individuals. Significant areas of concern remain. The Independent Reviewer has previously reported these concerns and made recommendations for improvement. Most areas of concern involve the continued predominance of larger congregate residential and day settings, the lack of day opportunities for individuals with

intensive medical and behavioral needs, as well as the lack of community integration opportunities and habilitation. The Commonwealth reports broad initiatives to address these areas of concern:

- the planned reform of its HCBS waiver program for ID/DD;
- the DBHDS effort to reorganize case management and individual service planning; and
- the actions proposed for provider development and capacity building.

The Independent Reviewer has provided the Individual Review reports to the Commonwealth so that it will review the issues identified for each individual. The Independent Reviewer has asked the Commonwealth to share the reports with the individual's residential service provider and case manager and, by March 30, 2015, to provide updates on actions taken and the results in regard to the issues identified.

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

During the ninth review period, April – October 2016, the Independent Reviewer will again prioritize the Individual Review Study to focus exclusively on the services and supports of individuals who have transitioned from Training Centers.

4. Regional Support Teams

The Independent Reviewer previously reported that the Commonwealth had created five Regional Support Teams (RSTs) and that they were composed of professionals with the required expertise. Community Integration Manager (CIM) positions are found at each of the Training Centers and Community Resource Consultants (CRCs) are located in each Region; the CIMs and CRCs are members of the RST in their respective Regions. The RSTs review cases that are referred and work to resolve barriers, including those that prevent individuals from moving to more integrated settings.

During this review period, the Independent Reviewer's consultant reviewed and confirmed that the Commonwealth utilizes an appraisal process for the Community Resource Consultants; the process includes evaluating the CRC's performance of the functions and responsibilities required by the Agreement. The evaluation correctly describes the core responsibilities. However, one area is missing. The DBHDS performance appraisal does not include responsibility for "'ongoing planning and development of community-based services."

The Independent Reviewer's consultant found that the Regional Support Team's referral, barrier resolution and quality improvement processes were still in the development phase. Some early challenges have been resolved. Other problems continue.

In its early phases of development, the RST focused on ensuring "informed choice" and on effective processing of referrals. It has now developed better systems, including how to generate information for future quality improvement. For example, its survey of RST members in May 2015 yielded useful information that was used to make some significant changes to policy and practice. These included such new practices as creating an urgent meeting, case manager presentations, and providing referral

information before meetings. The RST policy now requires that it survey RST members every eighteen months. The RST's next survey should occur in the Fall of 2016.

The consultant found that the reliability of referrals from CSB case managers, and the timeliness and thoroughness when submitted to CRCs, has been inconsistent. This appears to be improving for many individuals living in the community, but not for individuals transitioning from the Training Centers or who need emergency placements. For individuals planning to transition from the Training Centers to larger congregate settings, referrals to the RST confirmed that only a home of five or more was selected; the referral was submitted after a transition plan had been developed and after the individual completed transition visits. As a result, by the time a referral occurred, there was not sufficient time to review and resolve barriers. DBHDS has improved its ability to secure needed community-based services for individuals with very intense needs by developing its Critical and Complex Consultation Team. It helps to address and to resolve barriers early in the process. When referrals are not submitted to the RSTs when required or are submitted too late for the RSTs to effectively resolve barriers, the process cannot and does not achieve its intended purpose.

The Commonwealth's Quality Improvement processes for the RSTs have evolved. The RSTs devoted initial attention to their processes to ensure "informed choice" and to process referrals effectively. This attention led to improvement in these processes. The RST's ability to resolve barriers related to the absence of needed resources in local community-based services is its greatest continuing challenge.

The CRCs and the RSTs now are actively involved with individuals who are referred to skilled nursing facilities. Their involvement has contributed to securing alternative community-based services. As a result, skilled nursing facilities are used primarily for short-term convalescent or acute care activities.

CRCs reported positive relationships with the RSTs, including availability of the RSTs to consult with the CRC at any time. Interviews with RST members suggest that most RSTs function as effective collaborative entities with the CRC. RST members report regular networking within the Team to find innovative barrier resolutions for some individual cases.

The quality of the RST data collection and analysis system to determine recommendations and actions to elevate quality and effectiveness is improving. The RST now portrays trends and patterns discovered in barrier identification and case resolutions in the Provider Development Sections of the RST *Quarterly Reports* and the annual *Aggregate RST Report.* DBHDS has added resources to support the RSTs that should lead to further improvements in the quality of its data collection and analysis system. For example, the RST *Quarterly Reports* are beginning to illustrate referral patterns. The data the RST collected in 2013-2014 may have been undercounted or under reported, so its current trending analyses may not be valid. The RSTs have identified, tentatively, that when waiver slots allocations occur at the end and beginning of fiscal year, the number of referrals are higher. If the RSTs confirm this pattern, then it may be able to modify processes to enhance the timeliness of referrals to the RST. RSTs have recently begun to classify cases referred to RSTs (success, pending, critical-complex, etc.). These steps are on the right track and will permit ongoing evaluation and quality improvements.

Conclusion: RST members were unanimous in reporting that their initial effectiveness in resolving barriers in individual cases was poor. With changes to the RST process in the last year, some improvement has been noted, except in cases that are not referred or that are submitted with too little time to act. Barriers that continue to be confronted by RSTs include the failure to receive timely referrals, late involvement in the decision-making process about placement settings, the scarcity of residential settings of four or fewer people and the gaps in the availability of community supports (medical, behavioral, etc.). The Commonwealth's strategy to implement a redesigned Waiver will support CRC efforts on provider development, as well as being used by local officials and advocates to recruit new vendors or convince existing providers to expand.

The Commonwealth is in compliance with *Sections III.E.1* and *3, IV.B.14,* and *IV.D.1.*
The Commonwealth is in non-compliance with *Sections III.D.6, III.E.2, IV.B.15,* and *IV.D.3*

5. Crisis services

Crisis services are a cornerstone in a community-based services system that prevents the unnecessary institutionalization. In the Agreement, the Parties agreed that a statewide crisis system would be available for all Virginians with ID and DD as of June 30, 2012. The Independent Reviewer reported previously that the Commonwealth had complied with provisions requiring the development and operation of the structural elements of statewide crisis services for adults. The Independent Reviewer raised serious questions about gaps, quality, and effectiveness in his June 6, 2015 Report to the Court. The Independent Reviewed initiated a study during this review period to determine whether the Commonwealth's adult crisis system performed adequately and as expected.

The Commonwealth decided to develop crisis services for children separately from these services for adults. This decision led to a substantial delay of at least four years. By April 2015, the Commonwealth had begun to implement a statewide crisis service system for children. Due to Regional differences in resources, demographics and organizational relationships, the Commonwealth decided that Regions would develop unique plans to create crisis services for children. All Regions, however, were and will be expected to meet statewide standards and to achieve core milestone timelines. Funds had previously been allocated to plan and begin development of children's crisis services. As of July 1, 2015, DBHDS expected all Regions to be operating three initial program elements: a single point of entry, on-site crisis response and data collection. Additional appropriated funds were available, on July 1, 2015, to further develop this system and to achieve future milestones. The timeline projected that all statewide elements would be operating by December 2015 and that statewide quality and effectiveness standards would be achieved by December 2016. This would be four and a half years after these services were due.

During this review period, the Independent Reviewer engaged an expert consultant to complete a review of the status of crisis services development for children and an in-depth study of the quality and effectiveness of crisis services for adults with ID and DD, other than ID, who had experienced psychiatric hospitalization. The Independent Reviewer has attached the consultant's report on the quality of the adult crisis services and the status of the development of the children's crisis services is attached (Appendix B). The report includes a detailed description of the review process, the information gathered, findings, analysis, conclusions and recommendations. The consultant's study included a review of twenty randomly selected individuals who are affiliated with either Region I (northwestern and central) or Region IV (greater Capitol district). Ten of the individuals utilized the adult crisis services and ten did not. In this report all determinations of compliance with the crisis services provisions are based only on services that are documented for adults with ID.

A. Review Of The Status Of Crisis Services To Serve Children And Adolescents

DBHDS completed the program standards for children's crisis services that it had drafted during the previous review period. While each Region developed a plan with unique features, DBHDS expected each to meet statewide standards and to achieve milestones by certain dates on a timeline. The documents provided by the Commonwealth did not clarify whether the REACH standards and "data dictionary" for adult crisis services also apply to children's crisis services. Some of the Regional Children's Crisis Services are part of REACH and some of are not. The REACH standards for data collection and for training are not considered in the analysis of children's crisis services program standards. The attached consultant report (Appendix C) includes descriptions of the standards, the timeline milestones, the status of each Region's development, and unique Regional crisis program features.

DBHDS has developed statewide Children's Developmental Disability Crisis Services Program Standards for many of the requirements of the Agreement, including:

- crisis services for all children and adolescents with a diagnosis of ID or DD, other than ID;
- single point of entry;
- response time and availability of mobile crisis teams;
- training and outreach
- crisis education and prevention plans for each child;
- minimum prevention services requirements, and
- data collection.

The DBHDS children's standards do not include some provisions and others are not complete. For example:

- requirements for out-of-home crisis stabilization programs are not included;
- data collection does not include the information necessary to determine whether the provisions are properly implemented (e.g. the type of service provided, the use of out-of-home respite, admissions to and the length of stay in psychiatric facilities, or information about the provision of out-of-home crisis stabilization services);
- training topics do not include training for CSB Emergency Services, person-centered planning, transitions from in-patient settings, cross-system comprehensive planning, and training for ID and DD case managers.

As noted above, the DBHDS standards do not include requirements to provide out-of-home crisis stabilization programs for children. It is laudable that DBHDS has stated a goal of supporting children in their homes. The Agreement requires providing in-home crisis services for that purpose. The Agreement also requires, however, that the Commonwealth provide crisis stabilization programs that offer out-of home crisis stabilization services as an alternative, a "last option," to avoid institutionalization or hospitalization. The Regional plans mention out-of-home options, but not whether they are to be in community-based homes. Three Regions include plans to provide crisis stabilization services on the grounds of a former institution and in a hospital. The Independent Reviewer has determined that such locations would be in non-compliance.

The DBHDS statewide program standards for crisis services for children, as written, are not complete and are not all inclusive of the Agreement's requirements. The Commonwealth will not achieve compliance until its standards include all of the crisis services provisions of the Agreement.

While planning the development of their crisis services for children, each Region completed a needs assessment. The Regions used data sources that varied considerably, so it is not possible to estimate the number of children who will need access to these services. Four of the Regions project having a single "Navigator." The Regions expect the individual who fills the Navigator role to provide outreach, to be involved with daily triage calls, to discuss crisis plans, as well as to follow-up monthly for six months with each child who is referred for crisis services throughout the Region. The Independent Reviewer is concerned whether any one individual will be able to fulfill all these responsibilities. The Commonwealth has reported that it will monitor whether the Regions have allocated sufficient human resources to effectively fulfill the assigned responsibilities.

Four of the five Regions created a single point of entry during this review period, as expected. The Commonwealth's quarterly report did not include first quarter data three months after the data collection system for the children's crisis services for was to be in place. These data are necessary to determine the Regions current status and whether each Region is able to respond timely and will be able to meet the timely response standard for 60% of crisis intervention calls, as of December 2015. The Commonwealth's current timeline target is to achieve compliance with quality standards for children's crisis services by December 2016. Although it is not an indication that response times are not meeting the standard, the Independent Reviewer is concerned that data system development, one of the first milestones, appears to be behind schedule.

B. Outreach to the DD Community

DBHDS reports that it is implementing a plan to reach out to individuals with DD, other than ID. DBHDS reports that it distributes information about DD, other than ID, by offering various trainings and by distributing brochures. For example, DBHDS offers trainings to DD case managers that includes crisis services. The required crisis services, however, are for all individuals with DD, not only those on waiting lists or with a case manager. Details of the Commonwealth's efforts are included in the consultant's report (Appendix B). In focus groups in Region I and IV, workers in the DD field expressed concerns about the lack of outreach. DD case managers were invited but did not attend, possibly because the rate paid under the existing HCBS waiver for DD case management is substantially less than for ID case managers; therefore, attending the focus group is not a billable activity.

The Independent Reviewer has previously reported concerns that there has not been sufficient outreach to individuals with DD, other than ID, and their families about the availability of, and contact information for, crisis services. The Independent Reviewer cannot determine compliance with the provision of crisis services for adults with DD, other than ID, because the Commonwealth does not maintain sufficient data and records that demonstrate that the provisions of the crisis services are being properly implemented for them. During this period, REACH documented that only eight of the 323 referrals (i.e. one of every forty) it received were for individuals with DD, other than ID. No information was provided that trainings about REACH included DD case managers.

The Commonwealth is in non-compliance with *Section III.C.6i, 6.a.ii, and 6.a.iii.*

DBHDS does not yet have the elements of a statewide crisis system in place for children who experience a crisis; nor can DBHDS ensure that it is reaching many individuals with DD, other than ID, who need and may benefit from the crisis system.

At the current time, compliance ratings for the remainder of the crisis services provisions are based only on services provided to adults with ID. The quality and effectiveness concerns with crisis services for adults are described below.

C. REACH Crisis Services For Adults

DBHDS issued revised Crisis Services (i.e. REACH) Program Standards on August 1, 2015. These include improvements that address systemic concerns about whether crisis services were available and effective for adults with ID and DD, other than ID. Individuals who do not have a case manager or a discharge plan and those with significant physical care needs may no longer be excluded from receiving crisis stabilization services. The new requirements will increase the competencies and expertise of staff providing crisis prevention and stabilization support.

The DBHDS crisis services standards for adults now require:

- crisis services staff to have direct experience with individuals with ID or DD, college degrees, and credentials and licensing appropriate to their roles;
- mobile crisis services staff to join the CSB ES staff for all on-site assessments;
- provision of a Crisis Education Prevention Plan (CEPP) and preventive follow up services to individuals accepted; and
- crisis staff to follow all individuals admitted to psychiatric hospitals.

D. Utilizing CSB Emergency Service and Existing CSB Hotlines Which Operate 24/7

All Regions utilize CSB hotlines and operating twenty-four hours per day, seven days per week.

E. Training of CSB Emergency Services staff, case managers and other stakeholders

The Regions continue to train CSB Emergency Services staff and report on this quarterly. During the reporting period, twenty-four additional CSB Emergency Services staff received training. REACH reported training a total of 1,860 individuals across the five regions. Trainings were provided for 396 CSB case managers and 125 hospital staff. Training materials are now available on the DBHDS website and DBHDS requires new DD Case managers to be trained.

REACH teams continue to train police officers through the Crisis Intervention Training (CIT) program. During the two quarter 332 police received training. This is an increase over the 224 law enforcement staff trained during the previous reporting period.

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

F. Qualitative Review of Crisis Services to Adults with ID/DD

At the request of Independent Reviewer, the consultant randomly selected twenty individuals who experienced psychiatric hospitalizations and were affiliated with Region I (northwestern/central) or Region IV (greater Capitol area). Ten individuals had received REACH crisis services; ten had not. The individual reviews included extensive document review and interviews with involved case managers, discharge planners, behavior specialists, residential providers and family members. The consultant held in-person meetings with the REACH crisis services teams in both Regions and convened two focus group to gather information and examples of experiences with REACH crisis services. Each focus group included a diverse group of participants who had experiences with crisis services. The information gathered through these sources was consistent with the themes derived

from the individual reviews. Systemic strengths and areas of concern with crisis services for adults are described in the themes listed below.

REACH crisis services staff generally accompanied CSB Emergency Services staff to pre-screen crisis requests. DBHDS now requires that this occur.

Case managers and residential providers deemed in-home mobile crisis services as not effective in a majority of cases. The interventions and techniques offered were already in place or had been tried previously. More expertise may be required for effective support of individuals with challenging behaviors who are at risk of institutionalization or hospitalization.

Out-of-home crisis stabilization services sometimes can successfully divert an individual from a psychiatric hospitalization and can reduce lengths of stay. The success of the crisis stabilization programs seems to result from providing a comprehensive assessment, a therapeutic milieu and structured activities that participants usually enjoy.

The consultant did not find evidence that REACH teams assisted individuals' support teams to identify and secure the resources needed such as, providers with expertise in co-occurring conditions; behavioral supports; counseling; and training of law enforcement personnel with whom they regularly interact as a result of elopement or aggression. DBHDS intends to address the lack of these services, in part, through the restructuring of the waiver.

Crisis Education and Prevention Plans (CEPP) were not provided for many of the individuals studied. As of August 2015, DBHDS now requires that CEPPs be provided for individuals served by REACH. These individuals were admitted before DBHDS required CEPPs.

Residential Providers discharged individuals without a discharge plan. Case managers did not assemble the individual support team and the residential provider to identify what was needed, to determine a workable plan to assist the individual to access needed services, or to learn from experience to better plan for the individual in the future.

The consultant did not find evidence of effective discharge planning when individuals were released from hospitals or jails.

REACH provided psychiatric supports for all individuals reviewed who received REACH crisis services in both Regions.

Case managers were involved with all individuals reviewed who received REACH services. Some were very involved.

Additional information is included in Appendix C. The Independent Reviewer has submitted the summary notes of each individual review to the Court and to the Parties "under seal" to protect the confidentiality of the individuals and families, as required by *Section VI.C.*

The Commonwealth is in non-compliance with *Section 6.b.ii.A.*

Conclusion: The Commonwealth has developed a comprehensive training program and a process to reinforce learning through supervision, team meeting discussions and peer review. The training that REACH provides has not resulted, however, in good quality or effective and timely assessment, in-home supports and treatment. The Commonwealth reports that among other quality improvement initiatives, it continues to review and revise the training for crisis services staff regarding the provision of effective interventions.

The Commonwealth is in non-compliance with *Section 6.b.ii.B.*

The data in Table 4 *"Crisis Education and Prevention Plans and Crisis Prevention (CEPP) Follow-up"* indicate that REACH programs are not consistently developing CEPPs or providing good quality strategies and follow-up that effectively prevent recurrences of crises. It is very positive that DBHDS now requires REACH staff to complete CEPPs for all individuals referred. As a result, REACH programs significantly improved follow-up during the second half of the review period.

Table 2
Crisis Education and Prevention Plans and Crisis Prevention Follow-up

Quarter	Individuals	CEPP done	Percentage done	Follow-up done	Percentage done
QIV-15	329	188	57%	34	10%
QI-16	299	189	63%	273	91%
Overall Compliance			**60%**		**49%**

G. Admissions to Psychiatric Facilities

DBHDS programs reported that 167 individuals were admitted to psychiatric facilities. If correct, this represents a decrease from the 216 admissions that DBHDS reported during the prior reporting period. These data, however, do not appear to be reliable. The data reported were not consistent across Regions. Three Regions under report while two Regions over report. REACH is not aware of the disposition of all individuals who were admitted to psychiatric facilities. The Commonwealth has committed to offering alternatives to institutionalization or hospitalization. It reports that it has not yet developed a mechanism so that it knows when individuals with ID/DD are admitted to private psychiatric facilities or their disposition when discharged.

H. Mobile Crisis Services

REACH mobile crisis teams are available around the clock and respond at off-hours. Disposition data indicate that REACH served 495 individuals and received 323 new referrals. This is an increase in referrals from 272 individuals during the previous reporting period. Case Managers make the majority of the referrals, followed by families. On average, most Regions provided individuals with more than three days of in-home support services.

The Commonwealth is in compliance with *Sections III.C.6.b.ii.D. and E.*

I. Crisis response on-site within two hours and within one hour on average in urban areas

The Commonwealth is required to respond on-site to each crisis call within two hours or to create two or more mobile crisis teams to achieve this measurable standard. Compliance is achieved when violations are incidental and not systemic. The Commonwealth did not create two teams in each region as the Agreement required. Instead, it added staff to existing teams. The Commonwealth did continue to address the systemic issues that delayed responses and to improve on-site response times. For the most recent two quarters, between April 1, 2015 and September 30, 2015, the REACH Teams responded to 434 (94%) of 461 crisis calls within two hours. REACH exceeded the two hour standard with twenty-seven (6%) of the 461 responses. The amount of time that responses exceeded the two-hour standard was generally minor. The two primary reasons were usual weather or traffic.

The improved response times are important and significant. They are important to the individuals and families in crisis. They are significant because the improved response times indicate that the mobile crisis teams have substantially resolved the systemic issues that have delayed past responses. The REACH mobile crisis teams should continue their efforts to improve and to demonstrate that it can sustain timely responses to all crisis calls. "REACH achieved the two hour response standard in 434 (94%) of the 461 responses. Of the twenty-seven responses that exceeded the standard most exceeded by only a minor amount of time and there did not appear to be one or two systemic causes of the delays."

The Commonwealth came into compliance with the provision that requires respond on-site to crises within two hours and with the standards to respond in urban areas, within one hour, and in rural areas, within two hours, as measured by the average annual response time. (See Table 5, in Appendix C)

The Commonwealth remains in compliance with *Sections III.C.6.b.ii.G., and H.*

J. Crisis Stabilization Programs

All Regions have a crisis stabilization program that offers short-term out-of-home emergency and planned respite as alternatives to institutionalization or hospitalization for individuals who may otherwise need inpatient stabilization services. Four of the five Regions' crisis stabilization programs have no more than six beds, as required. Region III, to address unmet need, increased its home to seven beds and, therefore, is no longer in compliance. During this review period, DBHDS revised its REACH policies to allow crisis stabilization services for individuals without a case manager or a discharge plan. This change will help more individuals avoid admissions to psychiatric hospitals. The policy change likely contributed to the average length of stay increasing to 20-24 days, to waiting lists growing, and to reported prolonged stays of more than 30 days. The Commonwealth reports that it monitors the frequency of prolonged stays. This systemic problem occurs when individuals' residential providers discharge them without another home placement. Prolonged stays in crisis stabilization homes are reported to undermine the quality outcomes that are otherwise reported. An increase in prolonged stays, beyond the rare exception, would result in a determination of non-compliance.

Four of the five Regions' crisis stabilization programs remain community-based. DBHDS reported that Region IV "broke ground" in October 2015 to build a new crisis stabilization home and to

complete its plan to move its existing program from its temporary location on the grounds of a former institution. The Pathways Program at SWVTC ceased providing crisis stabilization during this period.

The Commonwealth is in compliance with *Sections III.C.6.b.iii.A, B,* and *F.* It is in substantial compliance with *Sections III.C.6.b.iii.D* and *E.* and it is in non-compliance with *Sections III.C.6.b.iii.G.*

The Commonwealth is in substantial compliance with *III.C.6.b.iii.D* and *E.* because four of five Regions are in full compliance with each provision. Region IV is moving forward with its plan to come into compliance. Region III reports that its non-compliance is temporary and that it has a plan to return to compliance.

The Agreement requires the Commonwealth to determine whether it is necessary to develop an additional crisis stabilization program to meet the needs of the target population for crisis stabilization services in a Region. Although the Commonwealth disputes this conclusion, there appears to be clear and compelling evidence that additional crisis stabilization capacity is needed. One Region has increased its bed capacity beyond six beds to address unmet need knowing that it would move into non-compliance with the Agreement. Waiting lists exist in other Regions. Individuals have been unable to avoid psychiatric hospitalization, in part, due to crisis stabilization beds not being available. Case managers report that they frequently do not make referrals for individuals who need crisis stabilization because beds are rarely available.

The crisis services program elements are in place for adults with ID. The REACH teams are responding to crises directly more of the time. DBHDS has put in place the program elements of mobile response, in-home supports, crisis stabilization programs, prevention planning and transition from hospitals. The REACH programs, however, need to improve the systemic concerns with its mobile in-home supports. Evidence of these systemic concerns come from the service review of ten individuals who experienced multiple hospitalizations and the reports of case managers, residential providers, and behaviorists involved in many other crisis situations. The concerns identified during the seventh period also align with the concerns identified by independent consultants who completed a review for the DOJ during the sixth review period.

REACH is one part of the system that provides a variety of temporary crisis supports. The Commonwealth needs to continue to implement systemic improvements to support individuals to help them avoid experiencing multiple and unnecessary hospitalizations. There is not sufficient current community capacity to provide the essential complements that REACH crisis services require:

- well trained residential and day providers with expertise in mental health and behavioral supports;
- the availability of mental health community supports;
- the availability of behavioral support specialists;
- psychiatric settings with expertise in ID and DD; and
- effective discharge planning for individuals who are hospitalized or incarcerated.

During the ninth review period, the Independent Reviewer will study whether the Pathways Program has been replaced with off-site crisis stabilization programs with sufficient capacity to effectively meet the needs of the children and adults with ID/DD in that Region.

6. Integrated Day Opportunities and Supported Employment

A. Integrated Day Opportunities

The Commonwealth's community-based system of day services is characterized by individuals with ID/DD being provided day support services in large congregate centers. The Commonwealth recognizes that its existing HCBS waivers have service definitions and a rate structure that supported this type of service in larger congregate centers rather than providing more integrated day opportunities. The Commonwealth developed the required plan for Supported Employment, but did not develop an adequate or complete plan to "develop community volunteer and community recreation and other integrated day activities." The Independent Reviewer has previously reported that the Commonwealth's initial planning efforts for integrated day activities had been inadequate and incomplete. For more than two years, the Commonwealth has recognized that its HCBS waiver must be redesigned to bring about the changes required by the Agreement. While the Commonwealth has implemented a long-term multi-phased effort to redesign its HCBS waivers, its efforts to make substantial changes in its system of congregated day services has largely been on hold. Although the General Assembly did not approve the requested changes during its session in 2015, the administration has since devoted much greater effort to explain why the existing waivers require the redesign of more integrated services called for by the Settlement Agreement. In fact, the Commonwealth's ability to comply with the Center for Medicaid Services' *Final Rule* also would likely require redesign of its HCBS ID/DD waivers.

During this review period, the Commonwealth renewed planning to develop integrated day opportunities. As it explained at the recent status conference, a newly revised draft plan, *Community Engagement Plan*, was being developed. The Commonwealth completed a draft of the *Community Engagement Plan* Independent Reviewer stopped reviewing information for this report. The Outcome Timeline report that the Commonwealth provided to the Court includes milestones for coming into compliance with several related provisions of the Agreement. The Outcome Timeline is based on the assumption that the General Assembly will approve the proposed HCBS waiver redesign. If so, DBHDS intends to initiate integrated day activities in July 2016. Providers may already be implementing more integrated activities. Because such activities are not defined services under the existing waiver, the Commonwealth has no record of the extent to which integrated services currently exist. With the existing HCBS ID/DD waivers, all day services, regardless of the service delivery model, are billed using the day support services definition. It is not possible at this time, therefore, to delineate center-based rather than community-based day services. The Commonwealth plans to determine the number of individuals receiving integrated day activities in December 2016, six months after the redesigned waiver is implemented and after the tenth review period.

Conclusion: The Commonwealth has not finalized a completed plan for the implementation of all Integrated Day Opportunities. The redesign of its HCBS waivers is the Commonwealth's primary strategy to develop the required community volunteer, community recreation and other integrated day activities. The Commonwealth will remain in non-compliance until it finalizes a complete implementation plan and effectively implements its strategy to make the substantial changes that are required.

B. Supported Employment

The Commonwealth submitted a plan to develop the Supported Employment portion of the provision that requires "to the greatest extent practicable…to provide individuals in the target population…with integrated day opportunities, including supported employment."

The Commonwealth has provided extensive training related to Employment First, including training and technical assistance to other state agencies. Between July and September 2015, the DBHDS Employment Specialist conducted ten trainings in four Regions of the Commonwealth and trained 303 State, CSB and employment service organization staff and other stakeholders.

As reported previously to the Court, the Commonwealth had developed and, with the input of the SELN AG (Supported Employment Leadership Network – Advisory Group), had updated its plan to increase supported employment. The Commonwealth had also implemented a positive new approach to gather data. It changed its data sources and began collecting data about a significantly increased number of individuals. These new draft data include information about individuals with ID and DD, including those whose services are temporarily funded by Virginia's Department for Aging and Rehabilitative Services (DARS), rather than only those individuals who receive employment supports through the Commonwealth's HCBS waivers.

For the Draft DBHDS *Semi-Annual Report On Employment, Summer 2015,* the Commonwealth continued to strengthen its supported employment data collection for all individuals with ID and DD whose services are funded by Virginia's Department of Rehabilitative and Aging Services (DARS) and through the Commonwealth's HCBS waivers. Fifty-seven (95%) of sixty employment providers submitted data, but for only 86% of individuals in group supported employment. The supported employment data include information about individuals who earn below minimum wages, which does not align with the definition in the Agreement. The Independent Reviewer commends the Commonwealth for the extensive and collaborative efforts of its employment service organizations, DARS, and the data subcommittee of the SELN AG. The Commonwealth reports that the national SELN has recommended that the Commonwealth determine the number employed annually by counting the number at two points in time during the year. The Independent Reviewer will study the Commonwealth's final data and next semiannual report to determine whether this approach is sufficient during the next review period. The Commonwealth learned important lessons during the seventh review period and appears to have developed a growing and sustainable collaboration for the ongoing effort needed to successfully collect the annual baseline data.

The SELN AG did establish a new target of having 3,660 of 14,640 (25%) of all individuals with ID/DD employed. The target was based on the total number of individuals with ID/DD waiver slots plus the number of individuals on the wait list who are age eighteen and older. It also set percentage Case Management targets that 100% of individuals will have discussed employment options at least annually and that 35% will have an employment-related goal in their Individual Service Plans. The Commonwealth also established annual targets of increasing number of individuals in supported employment by five percent annually. For example, a five percent increase between the start of Fiscal Year 2015 and the start of Fiscal Year 2016 establishes the target increasing from 204 individuals with waiver services (2.8%) to 568 (7.8%) and to 932 individuals employed by the start of Fiscal Year 2017 932 (12.8%). It is positive that the SELN AG decided to establish goals related to employment for individuals who are awarded new waiver slots and for those who transition from the Training Centers. It decided to delay establishing these targets until it collects sufficient data to establish baselines. Importantly, the SELN AG and the DBHDS are reviewing and reporting these data in

relationship to the cultural and organizational shifts away from providing center-based congregate day services and toward meaningful integrated employment services.

The draft point in time data of the number of individuals in supported employment that have been collected for one day (June 30, 2015), although important and helpful, do not establish the required annual baselines and cannot be used to determine meaningful increases of the number of individuals enrolled through the subsequent year. The data in the draft semiannual report count individuals in supported employment who earn below minimum wage which is not consistent with the definition in the Agreement. In addition, to comply with the requirements of the Agreement the case management goal that "individuals will have discussed employment options, at least annually" must include that "goals are *developed* and *discussed*…". Meaningful discussions of employment for individuals with ID/DD and their authorized representatives should include the interim steps to explore employment interests and options. Developing these interim-step goals, as required for any thoughtful discussion, will help participants to better understand the possible paths that might lead to meaningful employment activities. Thinking through these paths may also inform goals that ISP teams can then use to develop community volunteer activities as part of the community engagement process for some individuals.

The Commonwealth implemented an improved method of collecting data. Data reported includes only 86% return rate for group supported employment. The Commonwealth has not determined the number of individuals who are receiving supported employment, as defined in the Agreement, and cannot determine meaningful increases in each year.

Conclusion: The Commonwealth made positive and collaborative efforts to achieve an important milestone in gathering point in time data for the larger group of individuals who receive DARS and waiver funding on the final day of the fiscal year. These data, however, are incomplete, include individuals who earn below minimum wage, and are not sufficient to establish the required annual baselines. The percentage goals for employment and case management have been established, but one case management goal needs to be refined to comply with the Agreement. The SELN AG is making important and positive contributions to the dedicated work of the Employment Service Coordinator who continues to provide training on supported employment policies and strategies throughout the Commonwealth.

The Commonwealth remains in compliance with *Sections III.C.7.b.i.A., C.7.b.i.B.1.d.- e., III.C.7.c - d.* It remains in non-compliance with *Sections III.C.7.a., III.C.7.b.* and *b.i., 7.b.i.B.1.a-c,* and *B.2.a-b.*

7. Community Living Options

The Commonwealth made significant progress with some of its housing initiatives during this review period. The Independent Reviewer previously reported that the Commonwealth had developed the "Independent Living Option Plan" in collaboration with other state agencies. The Commonwealth also set a measurable targets of creating 847 new independent living options by June 2021 and supporting more than 1,800 adults living independently. It reported that through its Housing and Support Services consortium and local stakeholders in three Regions, the Commonwealth had exceeded its first year target by creating 115 options as of September 2015. "Available options," are a prerequisite to achieving what the Agreement describes as the Commonwealth's requirement "to facilitate individuals to live in their own home or apartment." The Commonwealth reports that sixty-nine individuals with ID and DD who receive waivers have achieved that goal as of September 2015. Two collaborative initiatives with state and local agencies contributed to this progress.

In late 2014, the Commonwealth formed an Interagency Housing Committee. In the spring of 2015, DBHDS, the Virginia Housing Development Authority (VHDA) and the Department of Housing and Community Development (DHCD) convened a Housing and Supportive Services (HSS) Consortium to create collaborative strategies that can be applied in Region II (northern), Region IV (greater Capitol), and Region V (Tidewater). The goal of this collaboration is to create strategies and action plans to connect individuals with ID/DD to integrated, independent housing opportunities. During this reporting period, the Commonwealth's HSS Consortium implemented its "100-day housing challenge" in three of Virginia's most populated communities, replicating previous successful housing development initiatives. Local agencies are working hard to identify individuals and to take other preliminary steps for those who may choose the independent housing options that become available. Both of these collaborative initiatives are working to expand independent living options for members of the target population. As of September 2015, two initiatives in the "Independent Living Option Plan" have achieved the desired outcome for individuals living in their own home or apartment. Both succeeded, in part, because they offered rental subsidies that helped make the housing affordable.

The Commonwealth's Rental Choice VA program, which utilizes rental choice subsidies from the one-time $800,000 fund established in 2012, has become fully operational. As of September 30 2015, the Rental Choice Voucher Program is now supporting fourteen individuals with ID/DD who are living in rental units. Six other individuals are in the housing search process. Five Rental Choice slots remain. The Commonwealth has not yet provided permanent rental subsidies to sustain these independent living arrangements.

The Virginia Housing and Development Agency (VHDA) set aside ninety-seven rental vouchers for individuals with ID/DD with waiver services. Forty-seven individuals are now using these vouchers and living in their own apartments. Eight other individuals with ID/DD are in rental units of their own through other non-VHDA programs. Fifty rental vouchers remain.

The Commonwealth's initiative through the Low Income Housing Tax Credits (LIHTC) program also made important but initial progress between July1, 2015 and September 30, 2015. The LIHTC program offers the possibility of independent housing for individuals. Realizing this goal, however, will take time and likely require additional and permanent rental vouchers. The LIHTC Qualified Allocation Plan was modified to help expand the inventory of affordable accessible units for members of the target population. Two projects in northern Virginia have received an allocation of competitive tax credits to provide a marketing preference for people with ID/DD. Both projects have a Memorandum of Understanding with the CSB to make referrals. The Commonwealth reports that additional applications for tax credits through the LIHTC program may occur in the coming months. The effectiveness of the program's guidelines, for producing applications that will help provide housing for the target population, will also be evaluated. The developers of approved LIHTC projects have eighteen to twenty-four months to make these units available. If rental subsidies are provided and the LIHTC units become available, they may be able to serve more than one individual per unit. The Commonwealth did not project a separate number of individuals with HCBS waivers who will live in the LIHTC units. The outcome will depend on multiple factors including the provision of rental subsidy vouchers needed to afford to live in some LIHTC units.

The Commonwealth has reported that other housing initiatives are underway. For example, VHDA's Capacity Building grant program may be able to help sustain some of the work. The

Commonwealth's Interagency Committee continues to search for additional capital funding opportunities to support the creation of independent living options. Most importantly the Commonwealth reports that, as of September 30, 2015, VHDA and Rental Choice VA had a total of fifty-five rental subsidies available for individuals with ID/DD waiver services.

Setting aside rental vouchers for the target population was the most important step. These vouchers have the potential for providing housing options in both the short- and long-term. Other initiatives currently underway reflect an increased awareness about integrated housing options and the possibility of more success over time. The housing options that the Commonwealth provides in Training Centers, nursing and private Intermediate Care facilities and in sponsored and group homes all include the cost of the housing for individuals in the target populations. More independent community living options do not. The ninety-seven rental vouchers set aside by VHDA will support nine-tenths of one percent of the individuals with waiver slots. The eighteen rental slots provided by Rental Choice VA are temporary. Additional permanent rental assistance is needed for individuals with ID/DD waivers to afford independent living options.

The Commonwealth recognizes that its current HCBS waiver provides a financial incentive for larger congregate homes rather that the more integrated options described by the Agreement. It will not be able to achieve compliance until the service definitions and rate structure are amended to create and promote a more integrated array of residential options for those who do not choose to live in independent housing.

Conclusion: The Commonwealth's housing plan initiatives have made important progress. It began to facilitate individuals receiving waivers to live in their own home or apartment. In September 2014, in an early phase of the housing plan, there were only two individuals living in their own apartments. Just one year later, there are sixty-nine individuals who have been supported to live in their own apartments. Other housing initiatives are in various preliminary stages of development. They will take time to become "options" and more rental subsidies will be needed, in most cases, if they are to become the apartments that members of the target population can call "home." The eighteen rental slots provided by Rental Choice VA are temporary. More actual progress for individuals with ID/DD is likely during the next review period because fifty-five rental vouchers are available. To achieve compliance, further progress is needed in resolving systemic barriers, including necessary rental subsidies, and in demonstrating sustained ability to achieve its Independent Living timeline and outcome targets in all Regions.

The Commonwealth remains in compliance with *Sections III.D.3.a., III.D.3.b.i-ii,* and *III.D.4.*
The Commonwealth is in non-compliance with *Sections III.D.1., III.D.2, III.D.3 and III.D.5*

8. Transportation

The Independent Reviewer's consultant evaluated whether the Commonwealth provides effective transportation services to the target population, as required by the Settlement Agreement. The review also sought to determine the extent to which the Commonwealth has implemented a quality system to ensure that its transportation services are of good quality, appropriate, available and accessible to the target population.

The Virginia Department of Medical Assistance (DMAS) administers the Non-Emergency Transportation through a brokerage system contracted to a multi-state private sector contractor, Logisticare. The effective functioning of the DMAS transportation brokerage is critical to the goal

of improving the lives of people with intellectual and developmental disabilities. The Independent Reviewer's studies, over multiple review periods, have confirmed that transportation services are included in most of the Individual Service Plans for individuals with HCBS waivers. The approximately 10,000 individuals with intellectual and developmental disabilities with HCBS waivers are but a small percentage of the 1.2 million Virginians who are eligible for Medicaid. They also account for a small percentage of the four million trips taken annually by those Virginians provided transportation services through the brokerage.

In its databases, Logisticare does not separate out individuals with ID/DD waivers. Since implementation of the provisions of the Settlement Agreement began, DMAS/Logisticare has not completed an analysis related to the delivery of transportation services for the target population. For this review, with the assistance of DMAS, Logisticare eventually sorted complaints it has received to identify those that were made on behalf of individuals with ID/DD with waiver services. This gives encouragement that DMAS and Logisticare have the records to conduct additional analysis of the quality of transportation services for the target population. Only with information about the transportation experiences of these individuals will DMAS/Logisticare be able to undertake the quality improvement processes required by the Agreement to ensure that their transportation services are of good quality.

The DMAS and Logisitcare quality improvement systems exist for the general population of Medicaid transportation users; operational processes are in place to monitor safety. For example, both Logisticare and DMAS inspect vehicles and drivers under contract with Logisticare. Logisticare provides reports to DMAS about its most persistent problems and the actions taken to remedy them. "Rides not on time" is the most common complaint. The lack of reliability, especially with substitute driver for Logisticare subcontractors has been reported through the Individual Service Reviews. Logisticare provides DMAS with a weekly and monthly recap reports on operational problems based on a jointly developed implementation plan. Logisticare utilizes a performance feedback report with all providers to give positive and negative performance information. Logisticare issues Corrective Action Plans and DMAS exercises its sanction "liquidated damages" to address non-compliant behavior. Logisticare convenes quarterly meetings with stakeholders to seek input. A recent assessment of the satisfaction of users of the transportation system by an outside vendor reported that, through telephone interviews, 92.7% of 370 transportation users were pleased with the arrival time for their pickup. Alternative Transportation approaches also have been implemented to address service gaps. The DMAS/Logisticare quality improvement processes do not, however, provide information about the quality of transportation services for individuals with ID/DD waiver services. There are several indicators that these users have a disproportionately higher rate of complaints with Logisticare sub-contractor transportation services.

With the help of DMAS, Logisticare identified 12,867 complaints from ID/DD waiver users for fiscal year 2015; whereas, Logisticare reported 8,603 complaints from all users during one 90-day period in 2015. By extrapolation, this is an annual overall complaint rate of .9% or 9 per 1,000 trips (34,890 complaints per 4,000,000 trips). These data further suggest that complaints from the ID/DD Waiver users constitute about 37% (12,867 Waiver complaints versus 34,890 from the general Medicaid population) of the total complaints received by Logisticare.

The Independent Reviewer has found that residential service providers for individuals with ID/DD widely use alternatives approaches to provide transportation services for their residents.

Of the randomly selected 161 Individual Service Reviews conducted from 2012-2015, one in seven individuals (14.3%) reported problems with their transportation services, no matter who provided it. Of those who depended on transportation services provided by Logisticare subcontractors, six of ten individuals (60%) reported problems with their transportation. This is a small number of users because the studies have focused primarily on individuals who moved from Training Centers and who live in group or sponsored homes. The individuals who live with their families or in homes of their own are more frequent users of transportation services provided by Logisticare subcontractors.

Recent record reviews and focus groups conducted for the Independent Reviewer have surfaced frequent anecdotal reports of problems with DMAS/Logisticare transportation for ID/DD Waiver users. The most disruptive transportation problems appear to occur for individuals attending day or work programs, usually five days a week. When the "ride" is not there on time, individuals may get upset or may cause supervision issues for parents who work or group home staff who might be scheduled to go off duty.

Conclusion: DMAS and Logisticare do not have records that indicate that transportation services are being properly provided to individuals with ID/DD with waiver services. The existing DMAS/Logisticare quality improvement processes cannot fulfill the requirements of the Settlement Agreement without data that ensure that transportation services provided to members of the target population are of good quality.

The Commonwealth is not in compliance with *Section III.C.8.a.* It is also in non-compliance with the relevant provisions in *Section V: Quality and Risk Management.*

QUALITY AND RISK MANAGEMENT

The Independent Reviewer's consultant assessed the status of the Commonwealth's progress in developing and implementing a Quality and Risk Management System. The purpose of the required system is to "identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement." (*Section V.B*). There were due dates for only about half of the sixty provisions in *Section V. Quality and Risk Management*. The Independent Reviewer's consultant previously assessed the baseline performance of the Commonwealth's progress with quality provisions in 2013 and the progress that the Commonwealth had made one year later in 2014. The overview below is based on the findings of the consultant's third annual review (see Appendix D) of Quality and Risk Management provisions and additional facts gathered by the Independent Reviewer.

9. Risk triggers and thresholds

The Commonwealth's list of risk triggers and thresholds has grown and improved. The list now includes not only events that have already occurred and caused harm, but also those with risk potential. The Commonwealth has improved its lists by analyzing data it has collected. The Commonwealth also has identified the data that are currently available to measure the risks that it has identified and those that are not. The expanded lists and measures set the stage to proactively address risk. DBHDS does not consider the lists of triggers and thresholds as final. The Commonwealth plans to include risk triggers and thresholds in the redesigned Individual Service Plan (ISP) format and to begin implementing the medical triggers for individuals transitioning

from the Training Centers to the community. The Commonwealth has taken initial steps that could assist providers to implement risk triggers and thresholds. The Commonwealth recognizes, however, that although a report format and a process that encourages sharing information might be helpful steps, its licensing regulations must be revised to require reporting of data beyond a narrow and incomplete list of risks

The Commonwealth' risk management system does not address a significant and well known risk to vulnerable individuals with ID/DD. It does not have a current system or registry for service providers to determine whether job applicants have had one or several substantiated acts of abuse, neglect, or exploitation against a vulnerable adult with ID/DD. Providers have reported to the Independent Reviewer that job applicants who have committed and been terminated for such acts can and do easily find employment providing direct care to vulnerable and non verbal adults with other service providers.

The Commonwealth continues to be in non-compliance with *Section V.C.1.*

10. The web-based incident reporting system and reporting protocol

The DBHDS web-based incident reporting system, the Computerized Human Rights Information System (CHRIS), was examined to determine whether the Commonwealth has taken sufficient actions to achieve compliance. The consultant's assessment determined that providers are reporting incidents using the web-based incident reporting system (CHRIS). These reports, however, were not consistently submitted in "real-time" (i.e. within 24 hours). The Commonwealth had taken some steps to evaluate and increase providers' compliance with "real-time" (i.e. within 24 hours) reporting.

The CHRIS reporting form has not been improved since it was created in 2012. It is inadequately designed, inconsistently completed and does not produce reliable incident data. Although widely adopted throughout the licensed provider system, there are several shortcomings with the CHRIS report form. It does not include a "report of the incident;" the name of the reporter who first witnessed the event and/or how the reporter became aware of the incident. The check boxes are for both incidents (i.e. falls) and for harms (i.e. sprain). The filers, however, rarely check more than one box. The most frequently checked box is "other" and many reports do not have any box checked. These deficiencies, which are well known, contribute to data that are not complete or reliable.

The Commonwealth has gathered some useful data from the CHRIS system and it has been shared with the Regional Quality Councils.

The Commonwealth continues in non-compliance with *Section V.C.2.*

11. Guidance and training on investigation of allegations and critical incidents

Since the last review, DBHDS has extended considerable thought and effort related to offering guidance and training on investigation of allegations and critical incidents. To assist service providers in risk assessment and corrective action processes, DBHDS has:

- revised portions of its draft training on investigations;
- published (i.e. on its website) webinars of two of seven investigation-training modules;
- finalized and published a root-cause analysis training; and
- developed and published an initial training module on risk assessment and tools.

These materials include some basic and some higher level information. Details are described in the consultant report (Appendix D). The Commonwealth is providing investigation training to the DBHDS Human Rights Advocates and to its Licensing Specialists. The Commonwealth distributed a flier inviting providers to use the training. However, providers are not part of the Learning and Management System (LMS) that the Commonwealth uses to track required training. Until the Commonwealth's regulations are revised, using the trainings is optional for providers. The training materials do not include competency components. Because five of the seven webinars for investigations are still works in progress, the consultant could not determine whether, as a whole, they will provide the information that providers need. For example, the completed trainings include limited information about the conduct of interviews or the different types of evidence. The investigation and root cause analysis training materials do not reflect as broad a range of instructional techniques as is needed to ensure reliability and competency in performance.

As indicated in the Independent Reviewer's previous Report to the Court, current DBHDS licensing regulations (12 VAC 35-115-50.D.3.e., page 11), require community providers to have "trained investigators." The existing regulations, however, do not include standards for what represents an adequately trained investigator, investigation process, or investigation report.

The Commonwealth staff recognize that, after publishing these training materials, additional steps are needed. These include:

- additional trainings and technical assistance;
- "live" training and other methods to assess the competency of investigators;
- published resources which will strengthen provider's efforts to reduce risks only if used; and
- new regulations to establish standards for the adequacy of investigations.

Conclusion: The Commonwealth made progress in finalizing the root cause analysis webinars, two of seven modules of investigation training and in publishing these online. The release of the technical assistance materials and completion of the initial module on risk analysis are also positive. The Commonwealth still must address a number of substantive issues.

The Commonwealth is in non-compliance with *Section V.C.4.*

12. Data to assess and improve quality

The consultant found that collaborative work within DBHDS contributed to the Commonwealth taking significant steps in its ability to collect and use data to assess and improve quality. These steps included:

- developing of the OneSource Data Warehouse;
- pulling data from various sources into the warehouse;
- cleaning the data and developing reports so that the data can be easily queried;
- developing standard reports from the Warehouse in a usable format; and
- identifying individuals in the target population by type of waiver or institution.

The development of the Data Warehouse and reports and the addition of staff resources were significant accomplishments with both short- and long-term benefits. DBHDS now has the ability to:

- share data among offices and divisions;
- use data to influence DBHDS operations; and
- take more proactive approaches to the protections, services and supports that it offers and oversees.

For its Data Warehouse, the Commonwealth needs to do additional work to:

- organize the data collected;
- increase the scope of data available;
- ensure reliability; and
- make the data useful.

The Commonwealth's staff continues to refine the data for the eight domains required by the Agreement. The Independent Reviewer previously reported that the Commonwealth had collected data for one or more measures for each domain. Nevertheless, it needed to further define and expand the measures, and to take effective steps to ensure that the data were reliable. Since that report, the Commonwealth has moved toward the collection of more comprehensive data for use in the eight domains. Data for the eight domains are now prominent in the Warehouse, in the revisions to the ISP format and in the design of the Quality Service Reviews. The Independent Reviewer remains concerned with the reliability of case management data regarding individuals' health and wellbeing and the "halo effect" of case managers self-judging whether ISP goals, that they participate in developing, are accomplished.. A DBHDS work group is now reviewing each of the measures and is attempting to identify reliable and valid measures. Some progress has been made. The group responsible for developing the data to be collected and used for the eight domains, however, should incorporate the recommendations that the Independent Reviewer and his consultant made in the attached report (Appendix D) and in previous reports. These concerns relate to improving the:

- definitions of terms;
- comprehensiveness of the measures;
- completeness and reliability of the data;
- methodology of data collection; and
- measures of the quality of services, rather than only the presence.

Conclusion: The Commonwealth has made significant progress by developing the Data Warehouse and by building its reporting capability. Limited progress has occurred in expanding the identification of data to assess and improve quality or to ensure that the data are complete and reliable. A number of challenges still need to be overcome. The quality improvement reviews by the CSBs at the local level and by DBHDS/DMAS at the regional, and state levels, have not utilized data, especially from the ISPs and from case managers, that is not collected is a consistent manner, is not complete or reliable; and only limited analysis occurred. The Commonwealth is working on the development of a revised QI Plan that will be submitted with its redesigned HCBS waiver redesign.

The Commonwealth is in non-compliance with *Section V.D.1.-3.*

Report publicly on the availability and quality of services and recommendations for improvement

The Commonwealth has made a good beginning to compile information so that it can report publicly both on the availability of and gaps in services as well as on the quality of supports and services in the community. The information will include recommendations for improvement. DBHDS provided initial information publicly at the end of this review period. It added an "Annual Reporting" tab with this information on the "DOJ Settlement Agreement" page (i.e., http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/doj-settlement-agreement). The Commonwealth recognizes that this site does not yet have all the information that is required. The included reports target a variety of audiences with information regarding demographics, the quality and quantity of supports and recommendations for improvements. DBHDS plans to add the initial information, and then to update it annually. The Commonwealth should ensure that the data and reports that are included accurately reflect the current system. This should include unmet needs in the Regions of the Commonwealth.

Conclusion: The Commonwealth had recently developed and implemented a format and location to report, at least annually, information described in the Settlement Agreement. The Commonwealth recognizes that the information provided is not complete and that this effort is a work in progress.

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

13. Regional Quality Councils and Quality Improvement Council

The Independent Reviewer previously reported that the Commonwealth implemented Regional Quality Councils (RQC) and a Quality Improvement Council (QIC). These Councils met during the review period. They discussed issues and completed basic but limited analysis of the data available. It was positive that the QIC identified concerns with the limited data available (e.g. mortalities and allegations of abuse) and discussed mechanisms for improvement. The consultant's report describes other examples, including where limited actions were taken to address identified trends (Appendix D). It also describes areas where data are not complete or reliable. These include the data that emerge from Individual Service Plans, the quality of which vary substantially. It also included goal accomplishment data reported by case managers of whether the ISP goals, that they participated in developing, had been achieved.

The consultant reviewed membership lists (August 2015) and the operational guidelines and voting rules of the Regional Quality Councils. They indicate that the DBHDS Quality Improvement Council clearly directs their work as required by the Agreement. Evidence also indicates that DBHDS supports the work of these Councils. The consultant also reviewed the RQC and QIC meeting minutes and interviewed members of three RQCs who had different expertise and perspectives. All verified that the RQCs continued to make progress during the past year. They reported that the meetings were efficient and that diverse membership contributed different perspectives. DBHDS has shared Regional Support Team, employment, mortality and National Core Indicator (NCI) data with the RQCs. In some instances, the RQCs made recommendations. For example, a recommendation was made regarding the need to expand community living options for individuals with complex medical and/or behavioral needs. The RQCs made some systemic recommendations to the QIC. The RQC meetings have also allowed for a more regional focus on problem solving discussions.

Effective functioning is a challenge for the RQCs due to the limited data that are currently available, the unreliability of the data and the inability to drill down into the data to the regional level. Some data shared with the RQCs identified potential areas of need. The RQC meeting minutes, however, indicated only limited discussion of trends or recommendations. RQC members recognize that more growth and development is needed to achieve the desired and intended results of their work.

Conclusion: As reported previously, the Quality Improvement Committee and Regional Quality Councils have been created and have met regularly. The RQC's include members with the required expertise and stakeholders. The QIC is directing the work of the RQCs, as required by the Agreement. These groups are using some of the data currently available, are conducting limited analyses of such data and are beginning to use such analyses to determine what, if any, actions should be taken. The data reviewed at the local and state levels was not reliable or complete. The Commonwealth should increase these activities over time, particularly as more data become available, reliable and more in-depth analyses of the data are made available to both groups.

DBHDS is in compliance with *V.D.5.* It continues in non-compliance with *Sections V.D.1-4*

14. Providers

A. Quality Improvement

As previously reported, the Commonwealth added Quality Improvement program requirements to the draft Performance Contract with CSBs, beginning with Fiscal Years 2015 and 2016. The Commonwealth has conducted a survey of all forty CSBs. The survey results indicated different levels of experience and knowledge of Quality Improvement processes. The next step in the DBHDS assessment is to survey a sample of the 900 community providers to ascertain a baseline regarding providers' current Quality Improvement practices. These activities are positive first steps that will assist DBHDS staff in determining the scope and type of technical assistance necessary to assist providers to comply with the Agreement. The Commonwealth has targeted December 31, 2015 to set clear expectations about the processes and the reporting requirements for providers' Quality Improvement programs. The Commonwealth also reports that it plans to provide technical assistance and guidance to providers.

The Commonwealth is in in non-compliance with *Section V.E.1. and 2.*

B. Statewide Core Competency-Based Training Curriculum

The Agreement requires a statewide competency-based training curriculum for all staff who provide services under the Agreement. Complying with this provision, however, is a complex undertaking that will involve both breadth and depth. The training curriculum must be statewide and for all staff. The Commonwealth's curriculum must address both general elements, such as in community integration and self-sufficiency, and individual service elements. Staff must also be determined competent to deliver the required elements of service. The Commonwealth has accomplished some of initial pieces of the curriculum. The Commonwealth has not, however, developed the comprehensive plan that is needed. The plan must include the general elements and the individual service elements, as well as coaching and supervision. The ultimate measure of success should be that each staff demonstrates competence in delivering the elements of services for the specific individuals he or she supports. This is especially important for the health and safety

service elements for individuals with intensive medical and behavioral needs, and for the community integration and personal growth/self-sufficiency goals of all individuals served under the Agreement.

The Commonwealth has established basic expectations for providers to train Direct Support Professionals (DSPs) on a variety of topics. Providers are expected to certify that DSPs have successfully completed a written quiz with a minimum score of 80% prior to providing ID or DD waiver services. Other than the quiz, confirmation of competence (i.e. demonstrated ability to implement the skills that are taught) has not yet been required. The Commonwealth has begun developing some competencies. A draft document, "Behavioral Support Competencies for Direct Support Providers and Professionals in Virginia," shows a significant amount of thoughtful work, such as the delineation of competencies for different staff and different levels of training. The goal is to add this to the DSP training.

In finalizing these and developing other competency-based trainings, it will be important for the Commonwealth to ensure that competencies are measurable, that when numerous competencies are included in one standard/skill there should be standards to determine when a staff member has "implemented skills" and/or demonstrated "proficiency." For different trainings, it might be helpful to think in terms of various types or levels of competency-based training, including knowledge-based competency, skills-based competency, and ability- or expertise-based competency. The consultant's report (Appendix D) gives examples of other trainings offered (i.e. for case managers and investigators), additional situations when trainings have been offered (Provider Roundtables, case manger meetings, webinars) or as required by licensing and audit staff, or by request. These additional trainings do not generally include competency components and are not specific to the service elements of individuals (i.e. demonstrating competency with the knowledge and skills needed to prepare a meal and assist a specific individual to eat, given his/her degree and type of dysphagia).

Conclusion: The Commonwealth has developed some trainings for certain staff who provide services under the Agreement. Some of the trainings that are in place for DSPs, their supervisors, case managers, and investigators include a knowledge-based test. A plan to develop a statewide core competency-based training for all staff providing services under the Agreement has not been developed. Compliance with these provisions of the Agreement will require careful and comprehensive planning, effective implementation and on-going evaluation to improve over time.

The Commonwealth is in non-compliance with *Sections V.H.1-*

15. Quality Service Reviews

The Independent Reviewer previously determined that the Commonwealth's planned use of the National Core Indicators (NCI) Survey tools to implement Quality Service Reviews (QSRs) would not fulfill the requirements of the Agreement. In response, the Commonwealth decided to supplement the NCI process. On May 18, 2015, subsequent to a Request for Proposal process, the Commonwealth's contract went into effect with the Delmarva Foundation, a Quality Improvement Organization (QIO)-like entity. The Commonwealth's contract states the purpose of the QSRs as defined in *Section V.I.2.* of the Agreement. The contract includes a multi-tiered approach to conduct the QSRs. These include:

- conducting Person-Centered Reviews of a statistically significant sample of individuals;
- conducting Provider Quality Reviews (PQRs) of the selected individuals' direct service providers;
- completing Quality Service Review Assessments that will involve reviews at the Community Services Board, regional, and statewide levels; and
- submitting Quality Service Review Assessment reports.

At the time of the Independent Reviewer's consultant's study, implementation of the QSR process had just begun. The contract required Delmarva to complete 400 individual and family interviews, and 50 provider reviews. Delmarva selected the sample using a regional approach. It also took into account certain demographics (e.g., service type) to attempt to ensure that large enough numbers of individuals are surveyed to allow Delmarva and the Commonwealth to draw statistically valid conclusions.

It is positive that the contractor established a web portal for key DBHDS staff to access and to review reports as they are posted and that an alert system is in place. If the auditors note urgent concerns, then DBHDS staff can take immediate action, as needed.

The Independent Reviewer is concerned that a sample of only 50 providers (out of 491 licensed ID providers and an undetermined number of DD and unlicensed service providers) is sufficient to effectively evaluate the quality of services, especially for different types of services and in different geographic areas of Virginia. On August 5, 2015, the Independent Reviewer notified DBHDS of initial concerns identified with the contractor's draft protocol and audit tools. These concerns included:

- lack of definition of standards/terms;
- lack of definition of methodology;
- lack of criteria for determining compliance;
- scope of review without definition of auditor qualifications; and
- missing components.

The consultant's findings and analysis are described in the consultant's report (see Appendix D).

Conclusion: The Commonwealth has worked steadily to modify the Quality Service Review process to meet the requirements of the Agreement. The selected contractor had recently begun conducting reviews in September 2015. The Commonwealth will achieve compliance when the QSRs are completed have utilized processes and protocols that would provide reliable indicators of quality services and when the Commonwealth is using the results to improve practice and the quality of services on the provider, CSB and system-wide levels.

The Commonwealth is in non-compliance with *Sections V.I.1-3*

16. Mortality Reviews

The Independent Reviewer previously reported that DBHDS had established the Mortality Review Committee (MRC) under the direction of its Medical Director. At that time, the membership of the MRC possessed appropriate experience, knowledge and skills. The MRC met the requirements of the Agreement; it operated in accord with the basic elements of a statewide mortality review process.

The stated purpose of the DBHDS MRC is to:

- identify safety issues that require action to reduce the risk of future adverse events; and
- implement Quality Improvement initiatives at the individual and systemic levels to reduce mortality rates.

During the current review period, the Mortality Review Committee continued to operate in accordance with the basic elements of a statewide mortality review process, as described by the Center for Medicaid Services. It completed ongoing data collection and analysis; it met regularly to organize and complete reviews of deaths. The MRC also made recommendations and has taken some meaningful systemic actions to reduce mortality rates. This is a substantial and challenging ongoing undertaking given the number of individuals with ID/DD and the number of deaths of individuals who reside in state-operated and private provider residences and in individuals' own and their families' homes. The Mortality Review Committee has completed hundreds of mortality reviews since being established by the Commissioner of DBHDS in 2012.

The Mortality Review Committee has broadly distributed many Safety Alerts on risk factors associated with unexplained deaths to case management agencies and DBHDS Licensing Specialists and to state operated and private service providers for individuals with ID and DD. The Director of ID/DD Health Services has convened a group of nurses to gather and share health information with hospitals when individuals are being hospitalized. A food consistency group developed and distributed information about the importance and the specifications of food consistencies. The DBHDS Medical Director wrote to medical providers known to serve individuals with ID. The letter informed these medical providers of the "fatal five" medical conditions that are common causes of death for individuals with ID/DD. The letter described other factors that frequently contribute and conditions that are common early indicators of these conditions. The Mortality Review Committee has contributed information about these risks to the revised Individual Service Planning process and to the DBHDS Quality Improvement Committee. The Mortality Review Committee has not implemented a quality improvement program and has not evaluated whether its initiatives have led to expected results.

The MRC has drafted its second DBHDS Annual Mortality Report, "Mortality Among Individuals with an Intellectual Disability." The Report includes an analysis of Virginia mortalities including sections titled: "Reported Deaths," "Mortality Rates," "Community Tenure," "Causes of Death," "Unexpected Deaths," "Leading Causes of Unexpected Deaths," and "Community Death Trends."

The Mortality Review Committee has attempted to review all deaths, expected and unexpected, of individuals with an intellectual disability who died while under the care or supervision of a DBHDS licensed provider. Individuals with DD, other than ID, do not receive waiver funded residential services and are not under the care or supervision of a DBHDS licensed provider. The MRC determined that during 2014:

- 226 individuals died who served in community programs.
- 13 of the 447 individuals died who had moved from the Training Centers since October 2011
- 23 of the Training Center residents died. The census declined from 688 to 551 during 2014.

Qualified staff for both the Mortality Review Committee and the Department of Justice independently determined that the mortality rates have not been higher for individuals who were discharged from the Training Centers under the Settlement Agreement compared with those who continued to reside in the Training Centers.

The mortality rates of both groups are substantially higher than that of Virginia's general population, or of all Virginia citizens with ID/DD. The average age of residents of the Training Centers and those who have transitioned to community settings is significantly higher than that of the general population. For example, of the eighty individuals who were randomly selected from individuals who had moved from the Training Centers, sixty (75%) were over age 51. Most individuals who transitioned from, and those who remain in the Training Centers, also have severe or profound intellectual disability. In the general population, the average age of death is significantly lower for individuals with severe and profound intellectual disability. Mortality rates of relatively small populations and over short durations of time will vary more than rates of larger groups over longer durations. The mortality rates of a fixed group of individuals will generally increase over time as the group's average age increases. The Independent Reviewer recommends that the MRC continue to study and to publicly report its findings and conclusions on the causes of unexpected death, on mortality rates and on safety issues that require action to reduce the risk of future adverse health events.

The Mortality Review Committee continued to have difficulty in obtaining reliable and complete information. The information process has been labor intensive and slow. The mortality reviews, therefore, continue to be based on limited information that reduces the extent of the many reviews. Most mortality reviews have not been completed within the ninety-day period required by the Agreement. The Mortality Review Committee recognizes that it has limited access to information and records from hospitals, medical providers, nursing facilities and private unlicensed homes and that its mortality data are not reliable or complete. During the recent review period, the Mortality Review Committee did not include a member who was independent of the Commonwealth. Although the MRC maintained an extensive database for information related to hundreds of deaths, it did not "review or document the unavailability" of all the required records. It is the Independent Reviewer's considered opinion that the slow flow and the lack of reliable information, the lack of staff to keep up with the work, and the resulting delays in completing required reviews all contribute to insufficient development and implementation of recommendations to reduce mortality rates.

Conclusion: The Mortality Review Committee and its process have been implemented in accord with the applicable requirements of the Agreement. Its membership does not, however, include an independent member qualified to conduct mortality reviews. The MRC reviews are not complete and recommendations are not made within ninety days. There appears to be too few staff available to complete the required work. The data available to the Mortality Review Committee, although improving, are not consistently reliable or complete. The lack of reliable information is especially true for individuals who live at home and for information from hospitals and nursing homes. The Commonwealth has made and implemented some recommendations; however, it has not implemented a Quality Improvement process to determine whether its actions have been sufficient to have had the expected effect and have reduced mortality rates.

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

IV. CONCLUSION

The Independent Reviewer reported in his last Report to the Court that the Commonwealth had achieved compliance with certain requirements of the Agreement. During this, the seventh review period, the Commonwealth through its lead agencies, DBHDS and DMAS, and their sister agencies has maintained compliance with most of these same provisions. It received a new rating of non-compliance, however, in three areas due to concerns with quality. The Commonwealth's leaders have continued to meet regularly and to collaborate with stakeholders and have made significant progress in several areas. It continues to develop and implement plans to address the Agreement's requirements to improve people's lives.

The Independent Reviewer also reported in his previous and in this Report to the Court that the Commonwealth lagged significantly behind schedule, and that it will remain in non-compliance until it successfully implements needed system reforms. The Commonwealth has not been able to move toward achieving compliance in two areas that involve many requirements of the Agreement: in creating residential and day activity programs that offer smaller more integrated services rather than larger more congregated community-based opportunities, and in implementing aspects of its quality and risk management system. Both areas are critical to an effective community-based services system for individuals with ID/DD.

For more than two years, the Commonwealth's primary strategy to come into compliance has been the redesign of it HCBS waiver program. The Commonwealth's state agencies report that during this review period it provided new and more extensive information to the members of the General Assembly about how and why approval will benefit Virginia's citizens with ID/DD and why the Commonwealth's effective implementation of its redesigned waivers is needed to achieve compliance.

The Commonwealth's progress toward achieving compliance with the quality and risk management provisions of the Agreement is delayed by its outdated regulations. The Commonwealth continues to report that it is not able to require the reporting of data and implementation of investigations that align with the requirements of the Agreement. It also reports that progress with achieving certain provisions is largely on hold until its regulations are revised, approved, and implemented. The Commonwealth is reviewing draft revisions to its regulations. It has not projected in which year of the ten-year implementation schedule regulations that align with the requirements of the Agreement will be in effect.

As described in the previous Report, the Commonwealth has made continued efforts and progress on its planning for the implementation of its redesigned HCBS waiver. If approved by the General Assembly, it expects to kick-off a tighter implementation schedule and to catch up with its previously scheduled implementation timeline within Fiscal Year 2017.

The Independent Reviewer has continued to find that the Commonwealth has successfully

- implemented and refined a discharge planning and post-move monitoring processes
- increased frequency of visits and oversight by case management and licensing, the
- implemented the required program elements of crisis services for adults,
- increased community supports for individuals with complex needs by creating Bridge Funding and exceptional rates,

The Commonwealth has also ensured that case managers offer choice of service providers, and that the Regional Quality Councils have met and reviewed employment targets.

During this review period it made additional progress in several areas. It successfully implemented a100-day challenge and provided additional rental assistance vouchers to increase independent living options. DBHDS built a data warehouse as a foundational element for its quality and risk management system, the Commonwealth developed and adopted a new collaborative method to gather point in time data about all individuals in supported employment who receive supports from either DARS or waiver-funded programs

The Commonwealth has not, however, made substantive progress implementing planned changes to achieve compliance with many core structural and programmatic provisions of the Agreement. It has not put into effect the strategies that it has presented as necessary to bring about systems reforms needed for compliance, and it has not revised its regulations. The Independent Reviewer has continued to determine that during this review period the Commonwealth is in non-compliance with many provisions that must be implemented effectively to fulfill its promises to members of the target population and their families "to prevent unnecessary institutionalization and provide opportunities to live in the most integrated setting appropriate to their needs and consistent with…their informed choice."

The Commonwealth's leaders continue to express strong commitment to vigorously continue its planning and full implementation of new service and system reforms to achieve compliance. Substantial progress with the implementation of the needed reforms is vital to fulfill the requirements of the Agreement and its promises to all Virginians with intellectual and developmental disabilities and their families.

V. RECOMMENDATIONS

The Independent Reviewer's recommendations to the Commonwealth are listed below. The Independent Reviewer requests a report regarding the Commonwealth's actions to address these recommendations and the results by March 30, 2016. The Commonwealth should also consider the recommendations and suggestions included in the consultants' reports that are included in the Appendices. The implementation and impact of these recommendations will be studied during the ninth review period (April 7, 2016 – October 6, 2016).

Transition of Children from Nursing facilities and Large ICFs

1. The Commonwealth should facilitate the transition of children from nursing homes and large ICFs. To determine what community-based services are needed and to comply with the Regional Support Team provisions of the Agreement, the Commonwealth should:

- determine what services children and the adults with ID/DD need to continue to live and to transition from living in nursing homes and large ICFs
- establish a single-entry point early in the process of the potential admission of children and adults with ID/DD to these facilities.

2. For the transition process for children from nursing facilities and large ICFs, the Commonwealth should adopt five discharge planning and discharge plan (provisions (IV.B.1-5) and 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 (IV.B.7) .

Discharge Planning and Transition from Training Centers

3. The Commonwealth should modify its post-move monitoring process to comply with the Agreement's requirements that PMM visits also occur after thirty days. Completing a visit after thirty days will allow post-move monitors to verify that each individual has had appointments with all his or her medical practitioners, as planned. These visits should also confirm that planned actions to ensure out-of-home day activities and supported employment opportunities have occurred.

Crisis Services for adults with ID and DD, other than ID.

4. The Commonwealth should require all Regions to complete, and maintain records that document, trainings that include:

- CSB Emergency Service employees, until all in their region are trained;
- outreach and training of law enforcement;
- ID and DD Case Managers; and
- the number of REACH staff who complete and pass each required training.

DBHDS should facilitate sharing of the different Regions' trainings for law enforcement. Combining the strongest components of each Region's current law enforcement training would significantly improve the quality and the impact of the law enforcement training.

5. The DBHDS should maintain records and report to the Independent Reviewer the number of individuals with DD, other than ID, who are referred and served in each Region.

6. The DBHDS should maintain records that document more specific information about individuals who experience psychiatric hospitalizations in each Region. This information should include whether the hospitalizations were appropriate or were necessitated by the lack of community crisis stabilization and/or behavioral support services. It should also document the involvement of REACH staff, the duration of hospitalization, the number of individuals who experience multiple hospitalizations, and the number of individuals who are not allowed to return to their previous placement.

7. The Commonwealth should assess and determine the need for additional crisis stabilization programs. It should report within thirty days of the end of each quarter the:

- number of individuals who exceed the 30-day stay
- number of individuals on waiting lists for the crisis stabilization programs in each Region
- progress in Regions III and IV to come into compliance with a crisis stabilization home of no more than six beds in a community-based home

8. Regional Support Teams

DBHDS should establish standards for the time needed for proper implementation of the CIM/CRC/RST process. The standards should identify and track the elements of a complete referral and the dates when the:

- CRCs/CIMs received complete referral information and provided technical assistance
- CRCs/CIMs forwarded the referral to the RST
- RSTs forwarded the referral information to RST members to review the case

- RST's work with the PSTs to resolve barriers and to recommend additional steps was completed.

DBHDS should determine whether a referral was submitted to an RST for each admission to any nursing facility, ICF, or setting with five or more individuals during CY 2015 and 2016. These records should be maintained and submitted quarterly to the IR within thirty-days after the second, third and fourth quarters of Fiscal Year 2016.

9. Transportation

DMAS should develop a plan with measurable milestones and a timeline so it can ensure that the transportation services provided to individuals with ID/DD with HCBS waivers are of good quality, appropriate, available, accessible, and safe. DMAS maintain and submit quarterly progress reports to the Independent Reviewer and should begin within thirty-days after the fourth quarter of Fiscal Year 2016.

9. Quality Improvement Programs

The Commonwealth's Crisis Services, Transportation, Quality Service Reviews, Mortality Review, and Regional Support Teams should maintain records that they have implemented quality improvement programs to:

- identify gaps in quality and effectiveness
- develop plans to address and resolve them.
- evaluate whether improvement initiatives achieve desired and expected outcomes, and
- determine what subsequent improvements are considered and implemented.

The Commonwealth should document that these quality improvement programs monitor whether program performance complies with the requirements of the Agreement and that the Commonwealth takes corrective action, as needed.

10. Web-based Incident Reports

The Commonwealth should improve the CHRIS reporting form so that data reported are more complete, accurate and reflects "direct reporting". For example, information reported should include:

- "direct reporting" i.e., a report of the incident as provided by the staff who witnessed, or first became beware of an allegation of abuse or neglect, or who noticed a change in behavior, physical condition, injury, death
- a separate set of check boxes for events or alleged events (falls, peer to peer aggression, missing person) and for results of the events (i.e. sprain, swelling, laceration), and for actions taken (contact emergency personnel, unexpected hospitalization, "unplanned evacuations",)
- any contact with contact with law enforcement, infections reportable to the Department of Public Health, reports of missing persons, and allegations of theft of individuals' funds or property

11. Risk Triggers and Thresholds

DBHDS should add to the triggers and thresholds the early indicators of the conditions that the Mortality Review Committee has identified that uniquely contribute to the deaths of individuals with ID/DD. The Commonwealth should identify the early indications of the increased likelihood that these conditions have developed: urinary track infection, constipation/bowel obstruction, aspiration pneumonia, decubitus ulcers, sepsis, seizures, falls, and dehydration.

The Commonwealth should establish highly sensitive triggers for individuals who are over age forty-five and who are considered medically fragile based on their Support Intensity Scale (SIS) assessments. One trigger should be a negative change in health status. Such a change should trigger a reassessment by the appropriate health care professional. The mortality reviews have found that negative changes in health status frequently precede unexpected deaths.

12. Provider Training

The Commonwealth should complete a plan to guide its work to ensure training for all staff who provide services under the Agreement. The training plan should:

- define the service elements
- identify the type of competency-based training required for each
- determine how competency will be measured
- identify the staff to be trained
- specify the frequency with which retraining should occur and competency should be determined

13. Guidance and Training: Provider Investigations

The Commonwealth should offer classroom training, as well as online training, including the equivalent of experiential-based learning, such as role-plays and discussion in the online training for both the Investigation Process training and the Root Cause Analysis training,

The Commonwealth should develop a complete set of standards for what constitutes a trained investigator, adequate investigations, and an adequate investigation report.

14. Quality Service Reviews (QSRs)

The Commonwealth should identify areas for improvement and implement needed corrective actions prior to implementation of its second annual cycle of QSRs. The Commonwealth should answer questions related to whether its QSR contractor utilized processes and protocols that would provide reliable indicators of quality services. These questions include:

- Were the standards used in its audit tools clearly defined?
- Were the methodologies used to answer the questions in the audit tools clearly defined?
- Were the data sources used to answer the audit tools questions identified?
- Were the criteria used for determining compliance (i.e. met or not met) with the standards identified?
- What confidence interval is provided by the statistically significant sample for types of service?
- Were the auditors' qualifications sufficient to assess and evaluate the clinically driven indicators?

15. Mortality Reviews

The MRC should review options and then implement the most promising improvement initiatives to:

- gather more complete information
- conclude mortality reviews in ninety days
- ensure membership that includes an independent member (i.e. a family physician)
- evaluate the impact of its completed initiatives
- strengthen its recommended initiatives with residential, primary care and emergency room providers to reduce mortality rates

VI. APPENDICES

A. INDIVIDUAL REVIEWS

B. REGIONAL SUPPORT TEAMS AND TRANSPOTATION SERVICES

C. CRISIS SERVICES REQUIREMENTS

D. QUALITY AND RISK MANAGEMENT

E. LIST OF ACRONYMS

APPENDIX A

INDIVIDUAL SERVICE REVIEWS
April 7, 2015 – October 6, 2015

Completed by:
Donald Fletcher, Independent Reviewer/Team Leader
Elizabeth Jones, Team Leader
Marisa Brown MSN
Barbara Pilarcik RN
Shirley Roth MSN

Demographic Information

Sex	n	%
Male	16	66.7%
Female	8	33.3%

Age ranges	n	%
Under 21	1	4.2%
21 to 30	0	0.0%
31 to 40	1	4.2%
41 to 50	5	20.8%
51 to 60	10	41.7%
61-70	4	16.7%
71-80	3	12.5%

Note: 70.9% (17 of 24) of the individuals were age 51 or older

Levels of Mobility	n	%
Ambulatory without support	11	45.8%
Ambulatory with support	4	16.7%
Uses wheelchair	9	37.5%
Total assistance	0	0.0%

Relationship with Authorized Representative	n	%
Parent or Sibling	22	91.7%
Public Guardian	2	8.3%

Type of Residence	n	%
ICF-ID	8	33.3%
Group home	13	54.2%
Sponsored home	3	12.5%
Family home	0	0.0%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	2	8.3%
Limited spoken language, needs some staff support	4	16.7%
Communication device	1	4.2%
Gestures	15	62.5%
Vocalizations, Facial Expressions, Other	2	8.4%

COMPARISON: Demographic information 80 individuals who moved from Training Centers during the third, fifth and seventh review periods				
	Twenty-eight 3rd period study	Twenty-eight 5th period study	Twenty-four 7th period study	**Totals** Eighty individuals 3rd, 5th and 7th periods
Gender	16 (57.1%) males	13 (46.4%) males	16 (66.7%) males	**45 (56.3%) males**
Age Ranges	21 (75%) age fifty-one or older	22 (78.5%) age fifty-one or older	17 (70.9%) age fifty-one or older	**60 (75%) age fifty-one or older**
Levels of **Mobility**	13 (46.4%) use wheelchairs	11 (39.3%) use wheelchairs	9 (37.5%) use wheelchairs	**33 (41.3%)** use **wheelchairs**
Highest Level of **Communication**	19 (67.8%) use gestures	18 (64.3%) use gestures	17 (70.8%) use gestures	**54 (67.5%)** use **gestures**
Type of Residence	24 (85.7%) live in congregate residential programs	26 (92.9%) live in congregate residential programs	21 (87.5%) live in congregate residential programs	**71 (88.8%) live in congregate residential programs**
Relationship w/ Authorized Representative	21 (75%) parent or sibling	24 85.7%) parent or sibling	22 (91.6%) parent or sibling	**67 (83.8%) AR is his or her parent or sibling**

Discharge Planning – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Did the individual and, if applicable, his/her Authorized Representative participate in discharge planning?	24	95.8%	4.2%	0.0%
Was the discharge plan updated within 30 days prior to the individual's transition?	24	100.0%	0.0%	0.0%
Did person-centered planning occur?	24	100.0%	0.0%	0.0%
Were essential supports described in the discharge plan?	24	91.7%	8.3%	0.0%
Did the discharge plan include an assessment of the supports and services needed to live in most integrated settings, regardless of whether such services were currently available?	24	100.0%	0.0%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	24	100.0%	0.0%	0.0%
Does the discharge plan (including the Discharge Plan Memo) list the key contacts in the community, including the licensing specialist, Human Rights Officer, Community Resource Consultant and CSB supports coordinator?	24	95.8%	4.2%	0.0%
Did the Post-Move Monitor, Licensing Specialist, and Human Rights Officer conduct post-move monitoring visits as required?	24	100.0%	0.0%	0.0%

Discharge Planning – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists?	24	95.8%	4.2%	0.0%

Discharge Planning Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Was it documented that the individual and, as applicable, his/her Authorized Representative, were provided with opportunities to speak with individuals currently living in the community and their families?	24	45.8%	54.2%	0.0%
Was it documented that the individual, and, if applicable, his/her Authorized Representative, were provided with information regarding community options?	24	83.3%	16.7%	0.0%
If a move to a residence serving five or more individuals was recommended, did the Personal Support Team (PST) and, when necessary, the Regional Support Team (RST) identify barriers to placement in a more integrated setting?	12	0.0%	100.0%	0.0%
If barriers to move to a more integrated setting were identified above, were steps undertaken to resolve such barriers?	0			
Were all essential supports in place before the individual moved?	24	87.5%	12.5%	0.0%
Was placement, with supports, in affordable housing, including rental or housing assistance, offered?	24	33.3%	66.7%	0.0%

Discharge Planning Items – areas of concern TRENDS – 2013 – 2014 – 2015		
3rd review period 2013	**5th review period 2014**	**7th review period 2015**
Was it documented that the individual and, as applicable, his/her Authorized Representative, were provided with opportunities to speak with individuals currently living in the community and their families?		
14.3% (4 of 28)	64.3% (17 of 28)	50% (12 of 24)
Was placement, with supports, in affordable housing, including rental or housing assistance, offered?		
0% (0 of 28)	0% (0 of 28)	17.4% (4 of 24)
Were all essential supports in place before the individual moved?		
78.6%% (22 of 28)	71.4%% (20 of 28)	87.5% (21 of 24)

Below are the positive outcomes and areas of concern related the individuals' 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?	24	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?	24	91.7%	8.3%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	23	95.7%	4.3%	0.0%
If ordered by a physician, was there a current psychological assessment?	12	91.7%	8.3%	0.0%
If ordered by a physician, was there a current speech and language assessment?	14	92.9%	7.1%	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?	15	100.0%	0.0%	0.0%
Does the provider monitor food intake?	19	100.0%	0.0%	0.0%
Does the provider monitor bowel movements	24	100.0%	0.0%	0.0%
Does the provider monitor weight fluctuations?	24	100.0%	0.0%	0.0%
Does the provider monitor seizures?	14	100.0%	0.0%	0.0%
Does the provider monitor positioning protocols?	10	100.0%	0.0%	0.0%
Does the provider monitor tube feedings?	3	100.0%	0.0%	0.0%
If applicable, is the dining plan followed?	21	95.2%	4.8%	0.0%
If applicable, is the positioning plan followed?	11	100.0%	0.0%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	23	95.7%	4.3%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	22	90.9%	4.5%	4.5%
Is there any evidence of administering excessive or unnecessary medication(s) (including psychotropic medication?	24	8.3%	91.7%	0.0%
If applicable, is there documentation that caregivers/clinicians				
Did a review of bowel movements?	23	100.0%	0.0%	0.0%
Made necessary changes, as appropriate?	12	100.0%	0.0%	0.0%
After a review of tube feeding, necessary changes were made, as appropriate?	3	100.0%	0.0%	0.0%

COMPARISON Healthcare – positive outcomes improvement – 2013-2014-2015		
3rd review period 2013	**5th review period 2014**	**7th review period 2015**
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?		
74.1%% (20 of 27)	96.4%% (27 of 28)	95.7% (22 of 23)
Does the provider monitor weight fluctuations, if applicable per the physician's orders?		
83.3% (20 of 24)	92.9% (26 of 28)	100% (24 of 24)

COMPARISON Healthcare – areas of concern – 2013-2014-2015		
3rd review period 2013	**5th review period 2014**	**7th review period 2015**
If weight fluctuations occurred, were necessary changes made, as appropriate?		
77.8% (14 of 18)	88.0% (22 of 25)	68.8% (11 of 16)
Is there documentation of the intended effects and side effects of the medication?		
66.7% (8 of 12)	75.0% (9 of 12)	66.7% (6 of 9)

Healthcare Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Were appointments with medical practitioners for essential supports scheduled for and, did they occur within 30 days of discharge?	24	87.5%	12.5%	0.0%
Are there needed assessments that were not recommended?	24	29.2%	70.8%	0.0%

Healthcare Items –Psychotropic Medications - areas of concern				
Item	**n**	**Y**	**N**	**CND**
If the individual receives psychotropic medication: is there documentation of the intended effects and side effects of the medication?	9	66.7%	33.3%	0.0%
is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	9	77.8%	22.2%	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)?	9	77.8%	22.2%	0.0%

Below are the positive outcomes and areas of concern related the individuals' support plans.
Note: All items in the listed "Individual Support Plan Items – positive outcomes" were also found to have positive outcomes in the Independent Reviewer's previous Report to the Court

Individual Support Plan Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the individual's support plan current?	24	100.0%	0.0%	0.0%
Is there evidence of person-centered (i.e. individualized) planning?	24	100.0%	0.0%	0.0%
Are essential supports listed?	24	91.7%	8.3%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	24	100.0%	0.0%	0.0%
Medical	24	100.0%	0.0%	0.0%
Recreation	23	100.0%	0.0%	0.0%
Mental Health	9	100.0%	0.0%	0.0%
Transportation	22	100.0%	0.0%	0.0%
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her individual support plan?	24	87.5%	12.5%	0.0%
For individuals who require adaptive equipment, is staff knowledgeable and able to assist the individual to use the equipment?	21	100.0%	0.0%	0.0%
Is staff assisting the individual to use the equipment as prescribed?	21	100.0%	0.0%	0.0%

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?	3	33.3%	66.7%	0.0%
Does the individual's support plan have specific outcomes and support activities that lead to skill development or other meaningful outcomes?	24	37.5%	62.5%	0.0%
Does the individual's support plan address barriers that may limit the achievement of the individual's desired outcomes?	24	83.3%	16.7%	0.0%
If applicable, were employment goals and supports developed and discussed?	20	10.0%	90.0%	0.0%
Does typical day include regular integrated activities?	24	100.0%	0.0%	0.0%

The 2012 to 2014 comparison indicates there has been significant progress with case managers review for individuals who qualify for monthly face-to-face visits.

Case Management – positive trend				
There is evidence of case management review, e.g. meeting with the individual face-to-face at least every 30 days, with at least one such visit every two months being in the individual's place of residence.				
1st review period 2012	**3rd review period 2013**	**4th review period 2014**	**5th review period 2014**	**7th review period 2015**
46.9% (15 of 32)	88.9% (24 of 27)	100% (19 of 19)	96.4% (27 of 28)	95.8% (23 0f 24)

Below are areas of concern related to the development of the individual support plans and integration outcomes of individuals in their communities.

Integration items – areas of concern				
Item	n	Y	N	CND
Do you live in a home in a home licensed for four or fewer individuals with disabilities and without other such homes clustered on the same setting?	24	41.7%	58.3%	0.0%
Were employment goals and supports developed and discussed?	20	10.0%	90.0%	0.0%
If no, were integrated day opportunities offered?	20	5.0%	95.0%	0.0%
Does typical day include regular integrated activities?	23	0.0%	100.0%	0.0%
Have you met your neighbors?	23	34.8%	65.2%	0.0%

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

Below are positive outcomes and areas of concern in the residential programs where case managers monitor the implementation of support plans.

Residential Staff – positive outcomes Items				
Item	**n**	**Y**	**N**	**CND**
Is residential staff able to describe the individual's likes and dislikes?	24	95.8%	4.2%	0.0%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	24	100.0%	0.0%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's talents/contributions and what's important to and important for the individual?	24	91.7%	8.3%	0.0%
Is there evidence the staff has been trained on the desired outcome and support activities of the individual's support plan?	24	100.0%	0.0%	0.0%

Residential Environment Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the individual's residence clean?	24	95.8%	4.2%	0.0%
Are food and supplies adequate?	24	91.7%	8.3%	0.0%
Does the individual appear well kempt?	24	91.7%	8.3%	0.0%
Are services and supports available within a reasonable distance from your home?	24	100.0%	0.0%	0.0%
Do you have your own bedroom?	24	91.7%	8.3%	0.0%
Do you have privacy in your home if you want it?	24	95.8%	4.2%	0.0%
b. Has there been a Licensing Visit that checked that smoke detectors were working, that fire extinguishers had been inspected, and that other safety requirements had been met?	24	95.8%	4.2%	0.0%

Residential Environment Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Is there evidence of personal décor in the individual's room and other personal space?	24	83.3%	16.7%	0.0%

Note: all four individuals' rooms without evidence of personal décor were in congregate homes of five or more, ICFs, or settings with more with one such home clustered on a setting.

APPENDIX B.

TRANSPORTATION
and
REGIONAL SUPPORT TEAMS

REQUIREMENTS OF THE SETTLEMENT AGREEMENT

By: Ric Zaharia Ph.D.



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

Transportation
and
Regional Support Team
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D., FAAIDD
Vice-President
Consortium on Innovative Practices

Introduction

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a review of the Transportation and Regional Support Team (RST) requirements of the Agreement. This review was based on key indicators that would produce a baseline assessment of these requirements.

Non-Emergency Medical Transportation (NEMT) in Virginia is administered by DMAS (Department of Medical Assistance Services) through a brokerage system contracted to a multi-state private sector contractor, Logisticare. Because almost all but a small percentage of Waiver users depend on transportation services in their service plans (Individual Service Reviews, 2012-2015), the effective functioning of the DMAS transportation brokerage is critical to the goal of improving the lives of people with intellectual and developmental disabilities in Virginia. However, this is in the context that DMAS is responsible for transportation services to 1.2 million Virginians who are eligible for Medicaid and for over 4 million trips annually by those Virginians through their brokerage, Logisticare.

Many important aspects of transportation are not part of this review. Effectiveness of incident investigations, successful provider implementation of corrective action plans, and the management of substandard or poor performing providers were not examined in this review.

Logisticare does not separate out individuals in the ID/DD Waivers in their databases. For analysis related to this review of transportation services for the target population, with DMAS assistance, Logisticare was eventually able to and did sort their data to identify which complaints were made by or on behalf of individuals with ID/DD waiver services. This gives encouragement that DMAS/Logisticare have the records needed to conduct additional Waiver sub-group analysis. Only with information about the transportation experiences of individuals in the target population is DMAS/Logisticare able to undertake quality improvement initiatives that may be needed to ensure that their transportation services meet the needs of individuals with ID/D.

Two themes in the Settlement Agreement guide Regional Support Teams: a) diverting individuals from nursing homes, ICF's and other larger congregate settings (five+) and b) ongoing quality improvements in discharge planning and development of community-based services. In order to meet the expectations of the Agreement, RSTs and their staff need to operate at the micro level of individual situations and then generate insights and actions at the macro level.

RSTs have gone through an evolution during their two year existence. The larger system (services planning teams, providers, CSBs, etc.) has had to adapt and adjust to their presence in the service planning and delivery environment. That adjustment is not yet complete. Beyond the Agreement requirements of barrier identification and resolution, data analytics and promoting residential settings of four or fewer, the RSTs have wrestled with the operational issue of receiving referrals with sufficient time to address barriers and the core systemic issues of inadequate resources and insufficient numbers of providers willing and able to serve individuals with more challenging needs (i.e. medical, behavioral, dually diagnosed, etc.) in smaller more integrated settings.

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

Compliance Table

Settlement Agreement Section	Settlement Agreement Language	Compliance as of 9/15/2015	Page
Section III.C.8.a	*The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.*	Non-Compliance	7
Section III.D.6	*Community Living Options* *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 and, under circumstances described in Section III.E below, by the Regional Support Team.*	Non-Compliance.	11
Section III.E.1-3	*Community Resource Consultants and Regional Support Teams* *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 provide on-site, electronic, written, and telephonic technical assistance to CSB case managers and private providers regarding person-centered planning, the Supports Intensity Scale, and requirements of case management and HCBS Waivers. The CRC shall also provide ongoing technical assistance to CSBs and community providers during an individual's placement. The CRCs shall be a member of the Regional Support Team in the appropriate Region.*	Compliance	11
	2. The CRC may consult at any time with the Regional Support Team. Upon referral to it, the Regional Support Team 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 Regional Support Team shall have the authority to recommend additional steps by the PST and/or CRC.	Non-Compliance	11
	3. The CRC shall refer cases to the Regional Support Teams for review, assistance in resolving barriers, or recommendations whenever…	Compliance	11
Section IV.B.14	*The State shall ensure that information about barriers to discharge from involved providers, CSB case managers, Regional Support Teams, Community Integration Managers, and individuals' ISPs is collected from the Training Centers and is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services.*	Compliance	13
Section 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 below, and such placements shall only occur as permitted by Section IV.C.6.*	Non-Compliance	14
Section IV.D.3	*The Commonwealth will create five Regional Support Teams, each coordinated by 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. The CIM may consult at any time with the Regional Support Teams and will refer cases to the Regional Support Teams when:….*	Compliance	15
Section IX.C	Requires that there be *"…sufficient records to document that the requirements of the Agreement are being properly implemented…"*	Non-Compliance	n.a.

1) Transportation Services

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.

Methodology

Reviewed DMAS's quality improvement policies and processes for transportation.

- Reviewed DMAS's data collection and analysis processes, including actions to improve the quality, availability, accessibility, and safety of transportation services.
- Reviewed relevant work group minutes.
- Reviewed transportation complaints log for ID/DD (Intellectual Disability/Developmental Disability) members in the Waiver.
- Reviewed response patterns to transportation questions in the Independent Reviewer's *Individual Service Reviews* (ISR).
- Reviewed DMAS transportation policy.
- Reviewed DMAS contract boilerplate, terms and conditions for contractors/sub-contractors.
- Interviewed key managers at Logisticare (Echols, Franklin, Gaston).
- Interviewed DMAS transportation managers (Bevan, Cors, Zieser).

Findings

The DMAS and Logisticare quality improvement processes for transportation are well established for the general population of Medicaid transportation users. For example, after drivers who arrive late for pickup, No Vehicle Available (NVA) appears to be the most consistent problem discovered statewide by Logisticare processes. Consequently, Logisticare has implemented a weekly tracking system and report for DMAS showing where unfulfilled trip requests occur due to NVA, as well as their actions to redress these problems. In addition, Logisticare provides weekly and monthly recap reports to DMAS on all operational problems experienced during the period based on a jointly developed implementation plan. With DMAS, Logisticare has developed Alternative Transportation approaches, which have attempted to ease these gaps: mileage reimbursement to group homes and individuals, public transit bus passes, and a volunteer driver program. However, there were anecdotal reports that the mileage reimbursement program is overly complex and cumbersome to use.

The quality improvement processes for transportation services for the target population, however, do not provide information that documents that transportation services are being properly implemented and, therefore, do not comply with the Quality and Risk Management provisions of Sections V.B. and V.D. of the Agreement. This includes identifying and addressing risks to ID/DD Waiver users, determining the sufficiency and quality of services to ID/DD Waiver users, and collecting and evaluating data for continuous improvement to ID/DD Waiver users.

Logisticare was able, with help from DMAS, to identify 12,867 complaints from ID/DD Waiver users through their Rider Assist line for the FY 15 period. By comparison DMAS reported 8,603 complaints from all users during one 90-day period in CY15; by

extrapolation this is annual overall complaint rate of .9% or 9 per 1,000 trips (34,412 complaints per 4,000,000 trips). These data further suggest that complaints from the ID/DD Waiver users constitute about 37% (12,867 Waiver complaints versus 34,412 from the general Medicaid population) of the total complaints received by Logisticare. This appears to represent a disproportionate share of complaints made by approximately 10,000 potential ID/DD Waiver users compared with the overall group of 1.2 million Medicaid eligible users.

There are also other indicators that the target population of the Agreement may have a disproportionately higher rate of complaints about the DMAS/Logisticare transportation services. Of the randomly selected 161 Individual Service Reviews conducted 2012-2015 by the Independent Reviewer indicate that of the 95% of Waiver recipients have transportation included in their service plans, 1 (14.3%) in 7 individuals reported problems with their transportation services no matter who provided it. Of those who used Logisticare subcontractors, however, rather than their residential provider or family, 6 of 10 (60%) reported problems with their transportation.

Recent record reviews and focus groups conducted for the Independent Reviewer have surfaced frequent anecdotal reports of problems with DMAS/Logisticare transportation for ID/DD Waiver users. The most disruptive transportation problems appear to occur for individuals attending day or work programs usually five days a week. When the 'ride' is not there on time, individuals may get upset, may get into mischief, or may cause supervision issues for parents who work or group home staff who might be scheduled to go off duty. In fact, one individual was cited whose psychiatric placement was triggered, in part, by behavioral difficulties that occurred subsequent to 'no shows' of daily transportation to a day program. These reports may also point out a higher rate of problems and ones that are unique to ID/DD users. For many individuals with disabilities the regularization and predictability of their daily schedule is very important. After DMAS assisted Logisticare to separate out the FY 2015 complaints from ID/DD users for this review, the largest portion of the ID/DD Waiver complaints reported to Logisticare was with callers who had a problem with a late ride (on time is defined as 15 minutes before or 15 minutes after the reservation time).

Quality implementation by DMAS/Logisticare is variable. For example, Logisticare convenes and documents stakeholder advisory committee meetings quarterly in each Region in order to provide a venue for stakeholder input. However, only one Region appeared to have user or personal representatives actively involved in these stakeholder meetings based on a review of the meeting minutes.

Operating processes are in place to monitor individual safety. Both entities use field monitors to inspect vehicles and drivers under contract with Logisticare. Logisticare uses five Field Monitors to inspect all provider vehicles every six months; DMAS uses three Field Monitors to randomly inspect all vehicles. Most recently these Field Monitors have inspected an average rate of 35 vehicles each week. In addition, Logisticare maintains an Accident/Injury log to track vehicular accidents and user injuries. However, no analysis was available that demonstrated that the ID/DD Waiver population was not disproportionately impacted by accidents or injuries.

Logisticare uses a Rider Assist section to handle and resolve immediate problems with individual trips, a Quality Assurance section to follow-up and assess unresolved individual problems with transportation trips, and Health Care Manager-initiated site visits and other interventions to try to develop solutions to more systemic and complex individual issues.

Finally, Logisticare has the option of accepting or rejecting complaints from users. These rejected complaints do not appear in the database and there is apparently no trending, reporting or follow-up analysis of rejected complaints after the initial rejection decision.

Corrective action plans have been used with two transportation contractors/subcontractors to address non-compliant behavior during the past three years. There are some indications that the brokerage is reluctant to terminate problem providers due to ongoing shortages of providers in many areas. However, a monthly Logisticare performance feedback report ("scorecard") is used with all providers to give them positive and negative performance information. In addition, DMAS exercises its sanction option ("liquidated damages") by reducing billed charges from Logisticare for reasons such as no show, non-compliant vehicle, etc. These "performance penalties" to Logisticare totaled over $1 million in FY 15. Although Logisticare has no appeal rights on these sanctions, DMAS does review these reductions with Logisticare and may negotiate specific amounts – the $1 million in FY 15 represents the final amounts after all negotiations.

Logisticare periodically assesses the satisfaction of users of the transportation system using an outside vendor, GreatBlue. Most recently Logisticare provided a sample of 400 users to GreatBlue (2015), who reported that through telephone interviews 92.7% (370) of transportation users were pleased with the arrival time for their pickup. A revised satisfaction study methodology is needed, given the presence of 8,603 complaints reported by DMAS for one quarter from all transportation users in the Medicaid general population, the absence of a stratified sample that would have ensured representation of all user groups, and the potential for bias in a Logisticare provided sample.

Logisticare's complaint management system appears to be effective through the Rider Assist system. Their website, however, does not advertise the Rider Assist telephone number. The more formal complaint system is administered on the Logisticare website through the WeCare tab with the possibility of electronic submission. There are anecdotal reports that ID/DD Waiver users do not use, are unaware of, or are frustrated by the Rider Assist line.

Conclusion

The Commonwealth is not in compliance with the requirements of III.C.8.a. as to ID/DD Waiver users.

Recommendations toward Achieving Full Compliance

DMAS/Logisticare should separate out ID/DD (Waiver users) in its quality improvement processes, to ensure that transportation services are being properly implemented for the members of the target population. The quality improvement processes would be improved by including the following:

DMAS/Logisticare should request review by a qualified researcher/statistician of future proposed methodologies for assessing user satisfaction, including ensuring ID/DD Waiver users are sampled.

DMAS should ask Logisticare to encourage more users, including ID/DD Waiver users or their representatives, to participate in the Advisory Board process. This should include making meetings accessible, attractive and convenient for their attendance. ("Nothing about me without me".)

DMAS should request Logisticare analyze its complaint database, its Accident/Injury database, its No Vehicle Available (NVA), etc. by ID/DD Waiver users. Transportation needs are not uniform in the Medicaid population and population-based analyses might yield new data leading to quality improvements.

DMAS should request that Logisticare periodically sample survey transportation users to identify problems for the subset of ID/DD Waiver users who have complained to the Rider Assist line to see if their problem continues or is recurring.

DMAS should request that Logisticare conduct focus groups with the ID/DD Waiver population, in order to identify root causes for their over-representation in the complaint database.

DMAS should request that Logisticare increase their marketing of the Rider Assist telephone number (e.g. refrigerator magnets, business cards), particularly to the ID/DD Waiver users.

DMAS should ask Logisticare for a publicly available Network Development Plan down to the zip code level, so that all parties agree on where there are transportation gaps. Furthermore, this Plan should include an assessment of the need for wheelchair accessible and other adapted vehicles, since many individuals in the ID/DD Waivers require these specialized services.

DMAS should require Logisticare to report on rejected complaints. When a user takes the time to file a formal complaint, the service delivery system should utilize that information to examine services no matter its adjudication about the merit of the complaint.

Suggestions for DMAS Consideration

DMAS should consider including an expectation in the next RFP (Request for Proposal) for the use of GPS and tablets in provider vehicles. Incentive rates for individuals whose behavior may on occasion be challenging should also be considered.

DMAS should consider a re-evaluation of the mileage reimbursement program. This program has the greatest potential for relieving stress in the transportation network due to unreliable drivers and unhappy users. Streamlining the process does not imply surrendering accountability expectations.

2) Regional Support Teams – Barrier Resolution

III.D.6
Community Living Options
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 and, under circumstances described in Section III.E below, by the Regional Support Team.

III.E.1-3
Community Resource Consultants and Regional Support Teams
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 provide on-site, electronic, written, and telephonic technical assistance to CSB case managers and private providers regarding person-centered planning, the Supports Intensity Scale, and requirements of case management and HCBS Waivers. The CRC shall also provide ongoing technical assistance to CSBs and community providers during an individual's placement. The CRCs shall be a member of the Regional Support Team in the appropriate Region.
2. The CRC may consult at any time with the Regional Support Team. Upon referral to it, the Regional Support Team 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 Regional Support Team shall have the authority to recommend additional steps by the PST and/or CRC.
3. The CRC shall refer cases to the Regional Support Teams for review, assistance in resolving barriers, or recommendations whenever:
a. The PST is having difficulty identifying or locating a particular community placement, services and supports for an individual within 3 months of the individual's receipt of HCBS waiver services.
b. The PST recommends and, upon his/her review, the CRC also recommends that an individual residing in his or her own home, his or family's home, or a sponsored residence be placed in a congregate setting with five or more individuals.
c. The PST recommends and, upon his/her review, the CRC also recommends an individual residing in any setting be placed in a nursing home or ICF.
d. There is a pattern of an individual repeatedly being removed from his or her current placement.

Methodology

- Reviewed RST operating data collection and analysis system to improve the quality and effectiveness of RST performance.
- Reviewed the Commonwealth analysis and actions taken to improve the RST referral process.
- Reviewed a sample of those admitted to homes of five or more, to nursing homes or to ICFs between 1/1/15 and 7/15/15.
- Reviewed data on individuals placed in settings of 4 or fewer during FY15.
- Reviewed RST policies and procedures.
- Reviewed RST minutes and work products.
- Reviewed the pattern of responses to the Monitoring Questionnaire from the Independent Reviewer's *Individual Service Reviews.*
- Reviewed ID/DD Waiver QI Strategies: Waiver Application, Appendix H.
- Interviewed DBHDS leadership responsible for RSTs (Poe, Rheinheimer, Balak).
- Interviewed one Community Resource Consultant (CRC) from each Region.
- Telephone interviewed DBHDS Director of Health Services (Adams).

- Telephone interviewed a sample of RST members from across the regions (five picked by DBHDS, five picked by the writer).

Findings

The quality improvement processes used for RSTs are still in a developmental phase. The early years focused primarily on ensuring 'informed choice' and secondarily on processing referrals. The systems now appear to be in place that will result in better information being generated regularly for quality improvement. For example, survey polls completed in May 2015 of RST members yielded useful information that resulted in some significant changes to policy and practice (urgent called meetings, case manager presentations, referral materials available before meetings, etc.). Policy requires this survey polling to be taken of RST members every eighteen months, so that the next survey should be fall 2016.

The quality of the operating data collection and analysis system to determine actions to improve the quality and effectiveness of RST performance is maturing with the recent addition of resources. DBHDS acknowledges that data collected in 2013-2014 may have been undercounted or underreported, so that trending analyses may not be valid at this time (e.g. are referrals increasing or decreasing?). Again, systems appear to be in place that will result in better quality data being generated regularly for quality improvement. For example, the RST Quarterly Reports are beginning to illustrate referral patterns over the fiscal and calendar years; if hypotheses can be confirmed going forward that referrals to RSTs correlate to end of the fiscal year/beginning of the fiscal year slot allocations, DBHDS may be able to consider modifying some processes to enhance the timeliness of RST referrals.

The performance evaluation format for Community Resource Consultants (CRC) is consistent with assessment formats commonly used for appraisal of state employees. However, the DBHDS performance appraisal is missing the CRC Core Responsibility for 'ongoing planning and development of community-based services'. The evaluation form for CRCs correctly describes their role at the macro systems level, where the goal is to get the job done through others, and steers them away from the super-case manager role. This is a dilemma DBHDS will confront as it seeks to achieve the Agreement's requirements for the RST – over commitment to the micro role and sacrificing systems work at the macro level: "Should I call several more providers to encourage consideration of an individual's placement?" or, "Should I attend a provider meeting to talk up expanding more behavioral settings in our region?" The former is an intrusion into the case manager role, while the latter goes to the larger issue of a need for more providers.

Timeliness and thoroughness of RST reviews have been inconsistent over the past few years. They appear to be improving for many individuals living in the community, but not for individuals transitioning from the training centers or when referrals are made too late in the process, such as with emergency placements. One improvement has been that, 'urgent called telephonic meetings' of the RST for the purposes of more timely review of referrals were recently instituted and authorized this past summer.

For individuals planning to transition from the Training Centers to larger congregate settings, referrals to the RSTs do not occur until there is no time to address barriers to living in a more integrated setting. The most recent individual service review study of twelve (12)

individuals who moved from Training Centers to congregate residences during FY 15 found that referrals to the RST did not occur when the Personal Support Team (PST) offered a list of residential programs (most offered only congregate residential services). After the individual/ AR had visited and selected one of the options from the offered list (usually a congregate setting), then the PST organized a schedule of trial visits, the individual completed the trial visits, and, finally, the individual/AR agreed to a specific transfer date and transfer logistics. Only then, typically a few weeks before the transfer was to occur, did these twelve (12) individuals get referred by the PST to the RST (for instance, one individual's AR signed the RST notification on 3/10/15 and then the individual moved on 3/24/15). In practice, the process functions such that for most cases there is no chance that the barriers to living in a less congregate setting could be addressed or resolved by the RST.

The CRCs and the RSTs are now actively involved with individuals who are referred to large congregate skilled nursing facilities. In 2014 DBHDS and DMAS revamped the PASARR process into an ID/DD directed effort to divert potential placements to skilled nursing facilities to alternative community-based alternatives. Processes are now established that ensure that skilled nursing facilities are primarily used for short-term convalescent or acute care activities.

CSB referrals to the RSTs for community placements are not yet reliably undergoing RST review prior to placement. Again, the RSTs do not have the time to identify and address barriers. As with individuals who are considering transitions from Training Centers, referrals are not made when a list of initial options are first offered to the AR or individual, but rather after the AR/individual has visited and chosen an option, which is typically the larger congregate settings. This process defeats the intent of the Agreement requirement, which is to ensure early enough presentation such that the benefits of four or less settings can be discussed with the individual/AR.

Emergency or crisis placements are clearly not undergoing RST review prior to placement. RST's do not always have enough time to address and resolve barriers early in the emergency placement decision-making process so that technical assistance efforts can be offered to case managers, individuals, families, etc. The insertion of an RST referral in the middle of a true emergency would not generally provide thoughtful and timely barrier identification and resolution. Requiring such a referral may also undermine the ability of case management to resolve the emergency and, therefore, protect the individual's well being. The development of the 3CT procedure (Critical & Complex Consultation Team) and its implementation to address the most challenging cases in the system is an improvement that may assist with these and other situations.

CRCs reported positive relationships with the RSTs including availability of the RSTs to consult with the CRC at any time. Interviews with RST members suggest that most RSTs function as effective collaborative entities with the CRC. RST members report regular networking within the Team to find innovative barrier resolutions for some individual cases.

RST members were unanimous in reporting that their effectiveness at resolving barriers in individual cases was poor initially but that has improved somewhat over the last year with changes to the RST process, except in cases where it receives referrals too late. Late involvement in the decision-making process about placement settings, a scarcity of residential settings of four or fewer, and gaps in community supports (medical, behavioral, etc.) were the most frequently mentioned barriers being confronted by RSTs. The Provider Development Section at DBHDS generally perceives that these system gaps/local needs are well known from the CSB level up to the state level, but nowhere is there a documented statewide/regional/local identification of gaps/needs and the actions the Provider Development Section is undertaking to address these gaps, or what steps DBHDS plans to address them. (The Quarterly Report issued by the Provider Development Section aggregates resource barriers by Regions but does not provide the detail to know what is needed at the CSB, township or zip code level.) Along with the new rates planned for in the Waiver redesign, these plans could better focus CRC efforts on provider development, as well as being used by local officials and advocates to recruit new vendors or convince existing providers to expand.

Conclusion

DBHDS is not in compliance with the requirements of III.D.6.

DBHDS is in compliance with the requirements of III.E.1.

DBHDS is not in compliance with the requirements of III.E.2.

DBHDS is in compliance with the requirements of III.E.3.

Recommendations toward Achieving Full Compliance

DBHDS should revise its RST referral process to occur when the PST first provides a selected list of recommended options that it endorses as very likely to meet the individual's/AR needs and preferences. DBHDS should require PSTs/case managers to consult with a CIM/CRC and make a referral to the RST when any residential recommendation is made for a congregate facility or setting with five or more individuals.

DBHDS should revise Waiver slot allocation processes so that CRCs are "in the loop" in the Individual Service Authorization Request (ISARs) system or are an approval stop earlier in the slot allocation process before a CSB can place a named individual in a slot. The point is to move the activation of the CRC/RST process earlier upstream, so that technical assistance efforts can be initiated earlier with case managers, individuals, families, etc.

DBHDS should revise its approach to RST review of true emergency placements (i.e. those that could not have been anticipated and threaten the individual's well being if not addressed immediately). By their nature emergency placements need to move quickly due to pressures from law enforcement, provider actions, individual safety, etc. An alternative approach to an immediate (and likely fruitless) referral to the RST might include immediate notification of the CRC and designating such as emergency placement that do not go through

the RST review as temporary (e.g., 90 days) and RSTs working assertively with CSBs to find appropriate placements during the temporary period.

DBHDS should request that RSTs with CRC leadership create annual Regional Network Development Plans illustrating/describing community support needs down to zip codes. This will contribute to ensuring compliance with the Agreement's requirement (V.D.6.) for a public annual report of services utilized and gaps in services.

Suggestions for DBHDS Consideration

DBHDS should continue to prioritize training and technical assistance for case managers and providers about the system goal of smaller and more integrated home like settings. This should include educational materials as to why more integrated settings are more effective at increasing opportunities to participate in one's community and to develop a network of support.

DBHDS should steer the role of the CRC away from super-case manager or crisis-case manager, which appears to be a direction some of their roles are drifting. If crisis-case managers are needed, those roles should be established within the case manager structure and outside the CRC and the RST process.

DBHDS's Office of Licensing Services (OLS) should examine its front end certification processes to determine if there are opportunities to fast track a) existing providers who have a good track record and who wish to expand and b) out-of-state providers (with good references for the provision of quality and most integrated services) who hope to enter the state. The addition of internal accountability timelines to the OLS Office Protocol may also positively impact provider recruitment.

3) Regional Support Teams – Data Analytics

IV.B.14
The State shall ensure that information about barriers to discharge from involved providers, CSB case managers, Regional Support Teams, Community Integration Managers, and individuals' ISPs is collected from the Training Centers and is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services.

Methodology

- Reviewed the operating data collection and analysis system used for quality improvement.
- Reviewed data reports for FY 13-15.
- Interviewed data analysts (Poe, Kuhn, Williams).

Findings
The Commonwealth's quality improvement processes for the RSTs and their compliance with the Quality and Risk Management provisions (IV.B. 14-15) of the Agreement are in place. RSTs have devoted most of their attention (and frustration) to "informed choice" and the absence of needed resources in local community based services.

The quality of the data collection and analysis system to determine recommendations and actions to elevate the quality and effectiveness of RST performance is improving as the RST processes mature. For example, the Aggregate FY 15 RST Report… includes the data on final options selected by individuals who have been through the RST process. This provides the RSTs with the ability to evaluate the results of their work by establishing success benchmarks. However, DBHDS does acknowledge that data collected in 2013-2014 may have been flawed, so that historical trend analyses may not be valid for another fiscal year.

Trends and patterns discovered in barrier identification and case resolutions are now portrayed in the Provider Development Section's Quarterly Reports and the annual Aggregate RST Report. Efforts in the most recent reports to classify cases referred to RSTs (success, pending, critical-complex, etc.) are on the right track and will permit ongoing evaluation and quality improvements.

Conclusion
The Commonwealth is in compliance with the requirements of IV.B.14.

Recommendations toward Achieving Full Compliance
None.

Suggestions for DMAS Consideration
DBHDS should consider developing separate aggregate reports for individuals remaining at a TC and for individuals from community based setting

4) Regional Support Teams – Placements at TC or five/plus Facility

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 below, and such placements shall only occur as permitted by Section IV.C.6.

Methodology

- Reviewed a sample of records of those referred to RSTs in FY 15.
- Reviewed RST documents for those remaining at a TC and referred to RST (as of 8/27/15).

Findings

CRCs are not reliably receiving referrals from communities with sufficient time, so that the RSTs have time to recommend steps to remove barriers before an individual or AR (Authorized Representative) chooses a facility or a five + residential setting. Processes have been revised to ensure quicker RST response and earlier RST referral, such as the implementation of Urgent Meetings when a regularly scheduled RST meeting is not soon enough to offer recommendations. However, additional process revisions are needed to ensure a 100% pre-placement RST referral for community, non-crisis situations. Additionally, the consistent delays in making referrals to the RSTs for individuals transitioning from Training Centers to congregate settings of five or more requires procedural and guideline revisions to ensure timely RST referrals for Training Center transitions.

Individuals who remain at a TC are clearly identified and tracked. At NVTC 45 individuals or ARs have selected a facility or setting of five+, at SWTC 31 individuals have been unable to locate a provider, and at CVTC 24 individuals have been unable to locate a provider. RST minutes clearly record the widespread resistance of ARs to more integrated options and/or the unresponsiveness of ARs to outreach and educational efforts.

Conclusion

The Commonwealth is not in compliance with the requirements of IV.B.15.

Recommendations toward Achieving Full Compliance

See recommendations above on page 13 of this report

DBHDS should identify all the barriers and choices made by those remaining at a TC and create a master plan for settings and resource development in the community to meet their needs.

Suggestions for DBHDS Consideration

DBHDS should consider developing a tiered protocol for use by CRCs, community integration managers, and case managers in dealing with ARs who are resistant or non-responsive.

5) Regional Support Teams – Structure and Process

IV.D.3
The Commonwealth will create five Regional Support Teams, each coordinated by 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. The CIM may consult at any time with the Regional Support Teams and will refer cases to the Regional Support Teams when:

a. The CIM is unable, within 2 weeks of the PST's referral to the CIM, to document attainable steps that will be taken to resolve any barriers to community placement enumerated in Section IV.D.2 above.
b. A PST continues to recommend placement in a Training Center at the second quarterly review following the PST's recommendation that an individual remain in a Training Center (Section IV.D.2.f), and at all subsequent quarterly reviews that maintain the same recommendation. This paragraph shall not take effect until two years after the effective date of this Agreement.
c. The CIM believes external review is needed to identify additional steps that can be taken to remove barriers to discharge.

Methodology

- Reviewed membership of RSTs.
- Telephone interviewed a sample of RST members from across the five regions (five picked by DBHDS, five picked by the writer).
- Reviewed a sample of referrals to RSTs from the period 1/1/15 to 7/15/15.
- Reviewed minutes of RST meetings.
- Interviewed two CIMs and five CRCs.

Findings
The RST membership composition and expertise in each Region is in compliance with the Agreement, except for where a resignation or vacancy has occurred. There is some indication that attendance is irregular for some members.

RST recommendations are captured in individual referral documents, urgent or regular RST meeting minutes, and aggregated data reported in the Provider Development Section's Quarterly Report.

Cases that remain at a TC and have been referred to RST are clearly identified and followed by the RST quarterly.

Conclusion
DBHDS is in compliance with the requirements of IV.D.3.

Recommendations toward Achieving Full Compliance
None.

Suggestions for DBHDS Consideration
DBHDS should consider an annual statewide electronic or face-to-face meeting of RST members or representatives in order to network and share resources.

Summary Conclusions

The Commonwealth is not in compliance with the Settlement Agreement's requirements for Transportation services. This is due primarily to practice of not including ID/DD Waiver users in the DMAS and Logisticare data analysis and quality improvement processes.

The Commonwealth is not in compliance with the RST requirements for diversion via barrier resolution and the promotion of four or less residential settings. The latter are due to a) late RST involvement in placements originating in the community resulting in no time to make recommendations, b) gaps in the needed services for individuals in their home communities, and c) AR resistance or non-responsiveness. The Commonwealth is in compliance with RST data analytics and the functioning of Regional Support Teams.

It is clear that the implementation of the RST process has positively impacted the system. During the past fiscal year 34 individuals reviewed by RSTs were placed in more integrated settings. While there will continue to be dilemmas for the system managers (accepting congregate settings in the absence of more integrated settings), the Waiver Redesign gives hope that the entire system will begin to shift structurally in this direction. Until it is implemented DBHDS will be caught in the proverbial bind, that there are too few good options for "outs" to get people "out" to.

APPENDIX C

CRISIS SERVICES REQUIREMENTS

By: Kathryn du Pree MPS

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

PREPARED BY KATHRYN DU PREE, MPS
EXPERT REVIEWER

November 3, 2015

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SECTION 1: OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the crisis services requirements of the Settlement Agreement for the time period 4/7/15- 10/6/15. The review will determine the Commonwealth of Virginia's compliance with the following requirements: The Commonwealth shall:

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

This will be the sixth review of crisis services and prevention. It will focus on the recommendations made by the Independent Reviewer in his report of June 2015.

SECTION 2: PURPOSE OF THE REVIEW

This review will build off the review completed last spring for the review period through 4/6/15 and the recommendations the Independent Reviewer made in his last Report as a result of the conclusions and findings of that review.

It will focus on those areas that were not in compliance and the Independent Reviewer's related recommendations. This focus will be on:

- The Commonwealth's ability to provide crisis prevention and intervention services to children with either intellectual or developmental disabilities. The DBHDS was still in the planning stages last during the Spring 2015 review and had not implemented crisis services for children in all regions
- The Commonwealth's plan to reach out to law enforcement and criminal justice personnel to link individuals with intellectual and developmental disabilities with crisis intervention services to prevent unnecessary arrests or incarceration
- The number of individuals who were removed from their homes to a psychiatric hospitalization, the involvement of REACH, and the system's ability to respond to the needs of these individuals to effectively transition them back to the community and to avoid unnecessary hospitalizations
- The status of locating a permanent crisis therapeutic home in Region IV
- The quality of crisis services that individuals are receiving from the five regional REACH programs

SECTION 3: REVIEW PROCESS

The Expert Reviewer reviewed relevant documents and interviewed key administrative staff of DBHDS, REACH administrators and stakeholders to provide the data and information necessary to complete this review and to determine compliance with the requirements of the Settlement Agreement.

Document Reviewed:

1. The Children's Crisis Standards
2. Updates on Regional Children's Crisis Services Development
3. REACH Program Standards
4. Psychiatric Hospitalization Report: 4/1/15-6/30/15
5. State Quarterly REACH reports for 4/1/15-6/30/15 and 7/1/15-9/30/15
6. REACH Quarterly Report Data Summary-Operational Definitions
7. Work Plan for Law Enforcement Outreach
8. FY16 Community Services Performance Contract Renewal and Revisions

Interviews with DBHDS and REACH staff: I interviewed Heather Norton the Director of Community Supports and Services, Michele Ebright, Behavioral Psychologist, the Region IV ID/D Director, REACH Director, CTH Coordinator, REACH Coordinators, Behaviorist and Medical Director; the Region I ID/D Director, REACH Director, CTH Director, Medical Director, Children's Coordinator, REACH Coordinators, In-home Support Coordinator, Clinical Director and START Liaison. I visited the CTHs in Region IV and Region I. I appreciate the time that everyone gave to contributing important information for this review.

Focus Groups: I conducted focus groups in both Regions I and IV. These included Emergency Services staff, case managers, behaviorists, providers, and advocates from the ARC of VA and Autism Society. The participants were very candid and provided a richer understanding of the crisis response system.

Individual Reviews: Twenty individuals were randomly selected who experienced one or more psychiatric hospitalizations between January and June 2015. Ten individuals who used REACH services and ten individuals who were not referred to REACH were included. The review was to determine the quality of the services provided to them by both REACH and other service providers. It was also to determine the responsiveness and effectiveness of the crisis service delivery system to respond to crises to keep individuals from experiencing unnecessary hospitalizations and to provide successful transitions and support for individuals post hospitalization. This study included document review and interviews with case managers, providers, REACH Coordinators, behaviorists, and family members.

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

The Commonwealth is expected to provide crisis prevention and intervention services to individuals with either intellectual or developmental disabilities as part of its obligation under Section III.6.a. of the Settlement Agreement that states:

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 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.*

A. <u>Review Of The Status Of Crisis Services To Serve Children And Adolescents</u>

Children's Crisis Services Program Standards: I have reviewed the Program Standards that have been finalized. I have previously reported on the draft standards so will confine my report to changes in the draft. The standards parallel the REACH Program Standards as they relate to service and response requirements of the Settlement Agreement. The only exclusionary criteria is that the child not be actively abusing substances or require medical detoxification. They must meet the medical necessity criteria as defined by the Department of Medical Assistance Services (DMAS). Staff training and licensure requirements are included.

The Navigators link children and families to community resources. The Crisis Responders are expected to respond onsite to all pre-screenings for hospitalizations and to remain with the child and family throughout the process and to stay involved until the case is closed.

The Settlement Agreement requires that the Commonwealth provide a residential setting of no more than six beds that can provide crisis stabilization not to exceed thirty days. The department's goal to support children in their homes is laudable. However the Commonwealth must be able to respond timely and appropriately when a child needs a short term out of home setting for crisis stabilization. The Children's Developmental Disability Crisis Services Program Standards do not include any description or requirement to provide out-of-home crisis stabilization as an option to avoid unnecessary institutionalization.

Data will be collected by each region and will include: date and time of the call; basic demographic information; call source; nature of the crisis; consultation; and summary of resolution. Data also needs to include information about the type of crisis services provided; any use of out-of-home respite or inpatient hospitalization and the length of time a child is admitted; and information about the child's placement after an out-of–home crisis intervention.

There is a description of the basic training topics and expectations for outreach to providers, schools, law enforcement, and other community partners. The training topics include important areas. It does not include, however,-modules on person-centered planning, transition from inpatient settings, or cross-system comprehensive planning. The topics list also does not include training for CSB ES or case managers. DD Case Managers will also need to be trained to understand how to access these services for the children they support.

Each region's Child Navigator is responsible to develop training materials and conduct workshops. The Navigator is also responsible for outreach and to follow up on a monthly basis for the first six months after initial contact for a child referred for crisis services. I still question whether the Navigator will have sufficient time to fulfill all of the responsibilities assigned to this position. The Regions each undertook a needs assessment last year but data sources varied considerably so it is difficult to know the number of individuals who will need and access these services. DBHDS cannot provide data yet on the number of referrals that have been received through this reporting period. It is concerning that most regions are hiring one Navigator while Region I has determined the need to hire eight Navigators, one for each CSB.

Status of Children's Crisis Services

DBHDS provided a status report for each region's children's crisis program.

Region I- This region has planned the most unique approach to providing crisis services to children. They are funding a Navigator for each of the CSBs. Three of the eight Navigators has been hired and these CSBs are providing 24/7 mobile crisis responses. Each CSB will respond to individuals in its catchment area rather than a single point of entry for the region. The region has hired a Program Director who will be responsible for overall coordination and data management. She has established the data collection protocols with the CSBs. The region does not have any out of home crisis stabilization capacity.

Region II- This region is linking its Children's Regional Crisis Response (CR-2), with its REACH program. The CR-2 provides the initial crisis response. It has been in operation since July 2014 but has not provided any data. Staff hiring is underway but has not been completed. Region II plans to use two crisis stabilization beds at St. Joseph's Villa in Richmond. This is located on the same campus as the existing CTH for REACH Region IV. The Independent Reviewer has deemed this former institutional site as not community-based and is in non-compliance with the crisis stabilization requirement of the Agreement.

Region III- This region is extending its REACH program to children by hiring additional clinicians and cross training existing REACH staff. Region III has had an operational children's crisis program since October 2014 with a single point of entry. I reviewed children served during the last reporting period. There is currently no crisis stabilization unit, but Region III has funding and plans to build a facility operated by a CSB.

Region IV- This region is also expanding its REACH program to children by hiring additional clinicians and cross-training REACH staff. It has been in operation since May 2015 but reportedly has not served many children. It too has a single point of entry. Region IV will fund out-of-home respite and also plans to use the crisis stabilization unit at St. Joseph's Villa on the grounds of a campus location. This facility has already been determined to be in Non-compliance.

Region V- This region is developing its program, which will be managed by Western Tidewater CSB. This region plans to have satellite offices to improve on-site response time. It has a single point of entry. They have hired three of the five crisis specialists. The region has devoted a full-time staff member to prevention efforts. The program has a link to a Hospital's crisis stabilization unit and has funding for crisis respite beds. A hospital does not meet the requirements of the Settlement Agreement for community settings that offer out-of-home crisis stabilization.

DBHDS established timelines for the outcomes of the Children's Crisis Service System. The department anticipates the following:

- ✓ A single point of entry in each region by July 2015
- ✓ A data system and data collection by July 2015
- ✓ All crisis calls responded to within defined standards 60% of the time by December 2015
- ✓ All crisis calls responded to within the defined standards 80% of the time by July 2016
- ✓ All crisis calls responded to within defined standards 90% of the time by December 2016
- ✓ Mobile crisis available 95% of the time by December 2016

The DBHDS has developed a comprehensive set of standards that incorporate the recommendations in the last Crisis Services Review.

The DBHDS has set timelines for two major outcomes of crisis services: response time and the availability of mobile crisis services. All regions with the exception of Region I have a single point of entry. Region I is implementing a different approach that requires each CSB to provide 24/7 crisis response for children with ID and DD. There was no data submitted by DBHDS for children in this reporting period so I cannot determine that the data system was operable starting in July 2015. It is not possible to confirm that the regions will be able to respond to 60% of the requests for crisis intervention by December 2015. Most have additional staff to hire and none have evidence of or plans for capacity to provide out-of-home crisis stabilization in community settings within their regions when this is needed. The development of the team approaches with a focus on prevention and the DBHDs' commitment to consistent standards is encouraging. The lack of standards for out-of-home services is troubling. The plan to have a data system in place by July 2015 and no data available through September 2015 indicates that the plan to achieve compliance by December 2016 is already substantially behind schedule.

B. Reach Services For Adults

1. ***Program Standards***-DBHDS has revised its REACH Program Standards and issued them on August 1, 2015. I have reviewed the Program Standards in previous reports so I will highlight changes that have been made. The exclusionary criteria for the CTH (Crisis Therapeutic Homes) program have been narrowed in the revised standard. Individuals who currently abuse substances or require a medically managed detoxification program can be excluded. Or individuals that pose a serious threat to others. REACH is expected to meet with the support teams to develop alternatives. Individuals are no longer excluded due to a lack of Case Manager; because of significant physical care needs; or due to the lack of a discharge plan.

The Commonwealth is increasing the expectation for credentialed staff that work in the REACH programs to have credentials. Required credentials not include direct experience with individuals with ID or DD, in addition to college degrees and licensing as applicable. For some positions a background in mental health and appropriate licensure is required. These new requirements will increase the competencies of the individuals providing direct crisis prevention and stabilization support. I fully support the DBHDS' efforts to increase the expertise of its REACH staff in both ID/DD and mental health.

The revised DBHDS standards now require REACH Coordinators are to join the CSB Emergency Services (ES) staff for all on-site assessments and to follow all individuals admitted to psychiatric hospitals. All individuals accepted into the REACH programs must have a Crisis Education Prevention Plan (CEPP) and preventive follow up services. Staff's training requirements are included in the standards and a program quality monitoring and evaluation process has been designed although not implemented yet.

2. ***REACH Services***- the data from two quarters included in this review period includes FY15 Quarter IV (QIV-15) and FY16 Quarter I (QI-16). Regions received a total of 323 referrals in this review period compared with a total of 272 during the previous review period. Region V had the lowest number of referrals in each quarter. The Quarterly Reports do not specifically indicate how many individuals are served by REACH in a quarter but from the data on dispositions of individuals using REACH it can be extrapolated that REACH served 495 individuals during the reporting period.
Table 1- REACH Calls and Responses summarizes the call information. Overall only 73% of the crisis calls received a face-to-face response. Regions I and IV responded to 100% of the crisis calls with staff onsite in both quarters.

Table 1
REACH Calls and Responses

Calls	**Quarter IV**	**Quarter I**
Total Calls	1317	Not Reported
Crisis Calls	293	338
Face to Face Response	214	247
% of Crisis Calls w/ Direct Responses	73%	73%

In this reporting period, Case Managers continue to make the majority of the referrals followed by families. Emergency Services staff made between 5-15% of the referrals in QIV and between 9-27% of the referrals in QI. ES staff did not make any referrals in Regions IV or V during the review period. There are few data that demonstrate that individuals with DD (i.e. other than ID) are being referred to REACH. DD Case Managers made 4% of the referrals in Regions II and IV in Quarter IV. There were no referrals from a DD Case Manager during Quarter I.

DBHDS no longer reports on the disabilities or diagnoses of individuals referred to REACH so there was no data to indicate how many individuals with DD may be referred from another referral source. During the previous reporting period DBHDS did report on individuals with DD but included those individuals with both ID and DD. I requested that this data be broken out to specify individuals referred whose primary diagnosis is DD. However, after discussion this information was added to the Q1-16 Report and the QIV-15 report was revised and re-issued. There were only five individuals with DD referred in QIV-15 and only three individuals with DD referred in QI-16. Data did indicate that no one with DD only was referred in either quarter in Regions II or V. It is not possible to make a determination that REACH is effectively serving individuals with DD whether they are on the DD waiver, the waiting list, or who have a DD diagnosis and are not involved with the waiver program.

Services were provided as follows during the reporting period:

- ✓ 327 adults received CTH services and 240 adults received Mobile Crisis Support
- ✓ 170 individuals served in the CTHs required crisis stabilization in the CTH program
- ✓ 157 individuals served in the CTHs received planned respite and crisis prevention support

Table 2- Outcomes for Individuals using REACH services shows the outcome for individuals supported by a REACH program during the reporting period who were referred for a crisis and received a face-to-face response from the REACH team.

Table 2
Outcomes for Individuals Using REACH

Outcome	**QIV**	**QI**	**Total**	**%**
Retain Setting	138	134	272	**55%**
Hospitalization: Psychiatric	54	55	109	**22%**
Hospitalization: Medical	1	1	2	**>1%**
Jail	1	1	2	**>1%**
CTH	14	22	36	**7%**
Mobile Support	N/A	72	72	**15%**
Other	2	0	2	**>1%**
Total	210	285	495	**100%**

DBHDS reports on the outcomes for individuals who are hospitalized as a result of the crisis and what involvements REACH has with them prior to and post hospitalization. DBHDS is to report if these individuals eventually return home or if an alternative placement needs to be located for them. A total of 109 individuals who had contact with REACH were reported admitted to psychiatric hospitals. However an Addendum has been added to the Quarterly

Reports starting with QIII-15. These provide different data regarding psychiatric hospitalizations and the known dispositions. These revised data indicate the DBHDS is aware of 167 psychiatric hospitalizations. The department notes that the data may not reflect the total number of hospitalizations in private facilities.

The report contains the known dispositions for 156 of the 167 individuals but this includes the use of CTHs and MH Crisis Stabilization Units (CSU), which are not final placements for individuals and therefore may duplicate some data. Also the data is not always consistent for regions. In QI-16 three regions do not know the disposition of all of the individuals, and two regions over report. However the percentages of the dispositions is constant across the two quarters. The following dispositions occurred:

- 55-56% of individuals retained the original home or group home placement
- 7% were able to move to a new appropriate community residential setting
- 1-7% moved in with a family member
- 16% used the REACH CTH of MH CSU

This is a decrease of psychiatric hospitalizations over the last reporting period of 216. This may not be a true reflection of the number of hospitalizations given some data inconsistencies and without full reporting from private hospitals. The majority of presenting problems noted at the time of admission to REACH across both quarters include: physical aggression, increase in mental health symptoms, and suicide ideation, followed by the need for a step down from a hospital admission and the family's need for support. These problems often lead families and providers to access the police and ES screening which may lead to a hospitalization if the individual is deemed to present a safety risk to him or others. Many of the individuals reviewed for this report were hospitalized as a result of a safety risk and the person's reluctance to agree to a safety contract, which is required before a return to the community from a hospital screening is considered viable.

DBHDS reports that the REACH program remains actively involved with all individuals that are hospitalized when they are aware of the hospitalization. The revised REACH standards require REACH to join the ES staff for every screening and stay involved with everyone who is hospitalized as a result of the screening. REACH staff participates in the admission, attend commitment hearings, attend treatment team meetings, visit and consult with the treatment team. However the data in the Quarterly Reports indicate that REACH is not aware of the disposition in all cases yet even though it has been a requirement since August 2015. CSBs need to make REACH aware of everyone with an ID or DD diagnosis who is being screened for hospital admission for this standard to be met. The Commonwealth is exploring ways to acquire data on admissions to private hospitals.

Training- The REACH programs provide training to stakeholders every quarter. The audiences include law enforcement personnel, CSB Case Managers, ES workers, and other community partners. During the reporting period a total of 1,860 individuals were trained across the five regions. This is a substantial increase from any previous reporting period. This included 332 law enforcement officers, 396 CSB Case Managers or other CSB staff, 24 ES staff, 125 hospital staff, and 583 noted as other. There continues to be no specific information to determine if any DD Case Managers have been trained although training

materials are now available on the website and required for new DD Case Managers. DBHDS should report on training for this staff category.

Outreach to the DD Community- DBHDS is implementing a plan to reach out to individuals with DD, their families and providers, and the broader community serving individuals with DD, other than ID. DD Case Managers are now receiving training and information regarding REACH services. Each region shares its brochure with all case managers. ES staff are trained to understand that REACH services are also a resource for individuals with DD. DBHDS is enhancing its communication with state and private mental health hospitals. REACH staff present to statewide and local conferences to educate families and providers. DBHDS continues to work with other partners including Commonwealth Autism Service, Virginia Autism Center for Excellence and the Arc of Virginia to help distribute information about the REACH Program. The Virginia 211 site was updated in December 2014 to include current information about the REACH crisis services and its availability to both individuals with ID or DD. No additional information regarding outreach was reviewed during this reporting period. This was a topic of the two focus groups. DD Case Managers were invited but none attended possibly because attendance at such an event would not be billable for them. Individuals who advocate or work in the DD field did attend. It appears outreach to the DD community is more of a concern in Region IV than in Region I at least anecdotally.

Recommendations:

DBHDS should monitor and document compliance with its standards and expectations and take corrective action, as needed. DBHDS should report the number of individuals with DD, other than ID, who are referred and served. It should also provide more specific information about individuals who experience psychiatric hospitalizations. This should include whether hospitalizations were appropriate or necessitated by the lack of community crisis and behavioral support. It should also document the involvement of REACH staff; the duration of hospitalization; and the number of individuals who experience repeated hospitalizations.

DBHDS should determine how to insure existing ES staff; ID and DD Case Managers are all trained. It should also establish expectations for the ongoing outreach to law enforcement personnel in each REACH area to expand upon the training module and to develop cooperative working relationships.

C. Reviews of Individuals Experiencing Psychiatric Hospitalization

The Independent Reviewer noted an increase in reported psychiatric hospitalizations in his last Report to the Court (June 2105). The US DOJ conducted individual reviews last spring and expressed many concerns about the crisis system's responsiveness and ability to avoid unnecessary institutionalization. This review focused on twenty individuals that were admitted to psychiatric hospitals between January and June 2015. The DBHDS provided a list of all individuals with an ID or DD diagnosis who experienced one or more hospitalizations in this time period. Twenty individuals were randomly selected. Ten had involvement with REACH and ten did not, and are affiliated with either Region I or IV. DBHDS was able to provide records and contact information for all of the individuals

affiliated with REACH and for eight of the ten individuals who were not affiliated with REACH.

The goal of this review was to achieve a greater understanding of what leads to these hospitalizations; what services and supports are available to the individual to prevent crises and successfully live in the community; what interventions REACH offers and the impact of these supports to address crises and prevent future crises that lead to hospitalization or loss of ones residential provider.

The review included: REACH and CSB document review; in-person meetings with the REACH Teams; interviews with REACH Coordinators; and telephone interviews with Case Managers or Discharge planners and psychiatric hospital liaisons, behavioral specialists, residential providers and family members who used REACH. There were only two of the twenty individuals that had a current behavioral specialist.

I greatly appreciate the time that various staff and family members contributed to this process and to DBHDS administrators for assisting with logistical arrangements. I was able to meet with many members of the REACH Team in each Region. This included the ID Directors, REACH Coordinators, CTH Coordinators, Clinical Directors, Psychiatrist (same for both regions), and the REACH Mobile Support Directors. In Region I, I also met with the Children's Coordinator and START liaison.

Following is a summary of findings based on the ten individual reviews. The Individual Reviews are summarized in Appendix 1.

Summary of the Individual Reviews Involving REACH

Screening and hospitalization-REACH is generally responding to crisis requests and accompanying the ES staff to pre-screen. Region I is more regularly involved than Region IV in providing support to individuals while they are hospitalized. Four of the individuals that were hospitalized had medical complications that contributed or led to their hospitalization. Three of the individuals are still hospitalized at the time of this report. Only one of these three individuals had a provider identified and a discharge plan.

Mobile Support- REACH does offer Mobile Support, which includes in-home support. Generally the providers and/or Case Managers did not deem in-home support effective in the majority of situations. In some cases the presence of the REACH staff seemed to increase the individual's negative behavior. In other cases the REACH staff worked alone with the individual rather than observe staff interactions or train staff in new techniques. In one case in the summary below I indicate mobile support was offered because a new sponsored provider was beginning and indicated that she would take advantage of the supports that REACH had developed. However the young woman's previous sponsored provider would not accept REACH in -home supports from which she probably would have benefitted.
It appears from this small sample that in-home support is a less effective crisis support than crisis stabilization and prevention in the CTH. This lack of effectiveness may be in part because all of the individuals in this review exhibit serious behaviors that may put them or others at risk. Providers served all ten of the individuals and none were home with their

family at the time crisis supports were needed. Providers reported that often the REACH staff did not offer any new interventions or techniques but rather replicated what the provider was already implementing or had tried before. It may be that individuals with challenging behaviors require greater expertise than the REACH in-home staff possess to address the needs of individuals whose quality of life is so impacted by their mental health needs. REACH requires a discharge-planning meeting for individuals using the CTH. There does not appear to be the same requirement for use of Mobile Crisis Support for providing crisis stabilization. Although most REACH Coordinators stay in close contact with the Case Managers for updates there is no formal meeting to discuss the plan for mobile supports or to determine its success. This service may be strengthened if there was more formalized discussion with the provider and CM and feedback on the success of the mobile supports. Such feedback is critical to determining how services might be improved in the future.

CTH Support- REACH offers significant support to individuals in the CTH. The crisis stabilization services offered by CTHs can sometimes divert someone from a hospital admission and other times are a successful step down program while the provider prepares to return the individual or a new provider is found. The CTH program success seems based on providing comprehensive assessment, a therapeutic milieu and structured activities that participants usually enjoy. In most cases reviewed, the CTH developed thoughtful stabilization plans and thorough discharge planning. It is of interest that the CTH team often recommends that the provider increase the structured activities for the individual, address down-time and improve the transition between day services and the home. Providers and Case Managers report that most providers do not offer the same level of structure available in the CTH. Yet, this is frequently the core of what the individual needs. Part of the ineffectiveness of the Mobile Supports for the individuals in this sample may be the result of this incongruity. REACH staff in the CTHs sometimes worked individually with the person ŧ to offer greater structure and meaningful activity.

Linkages- REACH is designed to help identify the service and support gaps for individuals in crisis, and to assist the team to secure and coordinate these resources. Individuals in crisis often needed providers with expertise in co-occurring conditions; behavioral supports; counseling; and training of police officers with whom they regularly interact as a result of elopement or aggression. I found no evidence that the REACH teams provided these linkages for these ten individuals. These linkages are critical to providing crisis prevention in the future for individuals that experience crises especially those that lead to hospitalization. While this is a responsibility of the REACH program it cannot be accomplished unless these resources are developed and available in Virginia. There is a lack of these resources and it is incumbent for the Commonwealth to continue its efforts through waiver design, rate changes and capacity building to create these supports to meet the existing need.

CEPP- the revised REACH Program Standards require the REACH teams to always develop a Crisis Education and Prevention Plan, as of August 2015. Many of the individuals reviewed for this study did not have this comprehensive plan, however, they were admitted to REACH prior to August. Many did have crisis assessments and stabilization plans developed by the CTH team.

Providers- Table 3 below notes whether individuals had a consistent provider. The three who didn't moved between providers. There does not seem to be a protocol or requirement that a provider maintain services to someone until a new provider is found and a transition is planned and implemented. Providers seem to be able to discharge individuals with little notice and without any team meeting to determine what is needed to maintain the individual or to learn from the experience to better plan for the individual in the future. The practice of discharge without a transition harms individuals with ID/DD.

Behavioral Support Specialists and Plans (BSP)- this review revealed that there is a lack of behavioral support professionals and BCBAs available to support these individuals. These gaps were described during the Focus Groups held in Regions I and IV. DBHDS is planning to address this through its waiver redesign and changes to the rates. This will be critical to the successful implementation of the community crisis system.

Psychiatrists (PSY)- everyone in this review had a Psychiatrist. Many are available through the CSBs. REACH does coordinate with the community psychiatrists. Regions I and IV have a psychiatrist on the REACH teams who helps with this linkage.
I do not include a column about Case Managers but want to report that a case manager followed all individuals. In the majority of cases the CM was very involved and had good communication with REACH.

Table 3:

Summary of Supports for Individuals Receiving REACH Support that were Hospitalized

	Crisis Response	Hospital Support	Mobile Support	CTH	CEPP	Linkage	Provider Changed	BSP	PSY
1	Yes	No	No	Yes	Yes	No	No	No	Yes
2	Yes	No	No	Yes	Yes	N/A	No	No	Yes
3	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes
4	No	Yes	No	Yes	No	No	Yes	Yes	Yes
5	Yes	Yes	No	No	No	N/A	Yes	Yes	Yes
6	Yes	Yes	N/A	No	No	No	Yes	No	Yes
7	Yes	Yes	N/A	No	No	No	Yes	N/A	Yes
8	Yes	Yes	Yes	Yes	No	N/A	Yes	No	Yes
9	N/A	N/A	N/A	N/A	N/A	N/A	Yes	N/A	Yes
10	Yes	Yes	N/A	Yes	No	N/A	No	No	N/A
%	**89%**	**67%**	**17%**	**67%**	**33%**	**0%**	**70%**	**30%**	**100%**

Summary of Individual Reviews for Individuals without REACH
DBHDS provided me with a list of all of the individuals' known to the department, hospitalized between January-June 2015 who was not involved with REACH. This was a total of thirteen individuals in Regions I and IV. DBHDS was able to provide some documentation and contact information for eight of these individuals. The summary of each individual review is in Appendix 2.

One individual has no diagnoses of ID or DD; one has anecdotal information but needs to be tested; two have borderline ID and no indication of a DD; and one individual has Asperger's. All of these individuals have significant mental health issues and have interacted with the mental health system through the CSBs. Six of the eight individuals are lacking the supports they need. Effective discharge planning is not evident upon their releases from jail or discharge from hospitals. A discharge planner may be involved that offers an intake appointment. There is no Case Manager assigned until that occurs. There is rarely support or a definite plan to insure the individual accesses the mental health system. With one exception these individuals have not been referred for ID case management, waiver services or REACH. Individual 8 has been linked and will be transitioned to a GH. He was discharged to REACH while a suitable home and provider are located. Individual 1 has a history of ID services but there has not been any attempt to re-establish this connection. Individual 4 is an example of one individual who receives appropriate mental health supports and services from his CSB.

The Commonwealth has taken a positive step to require REACH to participate in all pre-hospital screenings. The success of this involvement is predicated on the CSB's realizing the presence of ID or DD and notifying REACH. Many of the individuals reviewed for this report were hospitalized for assessments of competency and restoration training. CSB ID services should also be made aware of these individuals to insure a proactive discharge planning process is initiated at the time of admission so the individual has a transition plan that can assist them to remain in the community one they are released. REACH will only be one component of this potential success. The expertise of REACH staff can contribute to the planning process including provider training. These individuals will only be maintained in the community with well-coordinated services from both the ID and MH systems. The approach that the CSB took to serve Individual4 provides an example of the necessity to include effective mental health supports for individuals that have co-occurring conditions. This population requires the expertise of both mental health and intellectual disability professionals.

Conclusions: The DBHDS is not in compliance with *Section III.C.6i, 6.a.ii, and 6.a.iii.* The program elements are in place for adults with ID and the REACH teams are responding to crises directly more of the time, providing mobile supports, and offering the CTH program for crisis stabilization, prevention and transition from hospitals. The REACH program needs to improve its mobile supports as evidenced by the review of ten individuals that experience multiple hospitalizations.

The Commonwealth also needs to continue to address its systemic improvements if individuals are to stop experiencing multiple and unnecessary hospitalizations. REACH is one part of the system that provides a variety of temporary crisis supports. REACH must be complimented by a strong, well trained residential and day provider network with expertise in mental health and behavioral supports; the availability of mental health community supports; the availability of behavioral support specialists; psychiatric settings with expertise in ID and DD; and effective discharge planning for individuals that are hospitalized or incarcerated.

DBHDS does not have a statewide crisis system in place for children and adolescents who experience a crisis; nor can DBHDS assure that it is reaching all of the individuals with DD who need and may benefit from the crisis system.

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.

In all Regions REACH continues to be available 24 hours each day to respond to crises. There were 322 calls to REACH included in the data the DBHDS provided about the time of day referrals were made for this reporting period. This is a significant increase over the 204 calls made in the previous reporting period. Only 15% (21) and 13% (23) of the calls respective to QIV-15 and QI-16 were received outside of regular business hours. This continues the trend from previous reporting periods. This is reviewed in greater detail earlier in this report.

Conclusion: The Commonwealth is in compliance with *Section III.C.6.b.i.A.*

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 continue to train CSB ES staff and report on this quarterly. During this reporting period only three regions provided training to CSB ES staff. The total ES staff trained during this reporting period was twenty-four compared to sixty-three during the previous reporting period. Region I did not train any ES staff during period. It is impossible to tell what these numbers reflect since there is no data as to how many ES personnel remain in need of training, if any.

The Independent Reviewer requested a plan from DBHDS by June 30, 2014 to specify that all CSB ES personnel will be trained using a standardized curriculum and this training will be tracked. The DBHDS now has a draft of the training but it has not been finalized.

Conclusion: The Commonwealth remains in compliance *with Section III.C.6.b.i.B* because the REACH programs continue to train ES staff. DBHDS has not fully responded to the Independent Reviewer's requirement to develop a standardized training curriculum. The DBHDS continues to be unable to track if all existing ES staffs have been trained but REACH staff continues to make training available.

Recommendation: All regions should be required to provide this training unless all ES employees in their region have already been trained. DBHDS should develop a tracking mechanism with the CSBs to document the staffs that are trained and follow up with any who is not.

ii. Mobile Crisis Teams

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

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

However, it is not evident from the qualitative review of the ten individuals that received REACH services that timely assessment, services support and treatment is consistently occurring to de-escalate crises without removing individuals from their current placements. Individuals are experiencing multiple hospitalizations in part because REACH has not always responded directly to the crisis prior to August 2015; the CTH was not always available when it was appropriate for a hospital diversion; there was no alternative to the hospital for individuals who may continue to elope from their residential programs or REACH; REACH in-home supports are not consistently effective in changing staff's interactions with the individuals; there are not enough highly trained waiver providers to address individuals' co-occurring conditions; and there are not always the needed community mental health and behavioral resources for REACH to link to for individuals they serve.

Conclusion: The Commonwealth is in non-compliance with *Section 6.b.ii.A.*

It has developed a comprehensive training program and a process to reinforce learning through supervision, team meeting discussions and peer review. However this has not resulted in the expected outcomes of this provision the Settlement Agreement. This finding is supported by the qualitative review that was undertaken during this review period to expand the information that has been available in terms of quantitative data reporting.

Recommendations: The REACH programs may want to include person-centered planning, discharge planning and family training in its training programs. DBHDS should report in the future about the number of REACH staff who complete and pass the required training. Future reviews will continue to evaluate the staffs' ability to effectively respond to crises as a measure of the success of the program and its staff training and preparation.

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 teams continue to provide response, crisis intervention and crisis planning. DBHDS reported providing these services to 659 individuals in the reporting period: 329 individuals in QIV-15 and 299 individuals in QI-16. These numbers are extrapolated from the quarterly reports that list service type by three categories: Mobile Crisis Support; Crisis Stabilization-CTH; and Planned Prevention-CTH. There may be some duplication in the numbers, if some individuals received more than one of these services. This is a small decrease from the 673 individuals that received these services during the previous reporting period.

These services included crisis prevention, crisis intervention/prevention planning, crisis stabilization, medication evaluation, therapeutic treatment planning and follow up. Once again more of these services were provided in the CTH than through Mobile Support: 324 in the CTH program versus 304 that received them from the Mobile Support Team. There numbers are not an unduplicated count of individuals. Some individuals are likely counted more than once since some individuals receive both mobile support and use the CTH program.

The REACH Standards now require that all individuals receive both crisis education prevention planning and crisis prevention follow up. The planning results in a Crisis Education Prevention Plan (CEPP). The other services may or may not be needed depending on the needs of the individual. The REACH programs did not consistently provide these required elements with the exception of Region III during QIV-15. Region III reached a level of 100% for the CEPPs during QI-16 and for the crisis prevention follow up for individuals that used the CTH program but not for those that used the Mobile Crisis Support.

The revised standards were in effect July 2015. The performance of the regions improved during this quarter. During this quarter Regions I, II, and III, achieved 100% compliance with the requirement to complete a CEPP and to provide crisis prevention follow-up. The overall statewide level of achievement is not in compliance because of the lack of this consistency in Regions IV and V. Table 4 provides a summary of the plans and follow up completed and the level of compliance by quarter and overall for the reporting period.

Table 4 ***Crisis Education and Prevention Plans and Crisis Prevention Follow-up***					
Quarter	Individuals	CEPP done	Percentage done	Follow-up done	Percentage done
QIV-15	329	188	**57%**	34	**10%**
QI-16	299	189	**63%**	273	**91%**
Overall Compliance			**60%**		**49%**

Conclusion: The Commonwealth is not in compliance with *Section 6.b.ii.B.* The REACH programs did not consistently develop CEPPs, or provide strategies and quality follow-up that was adequate to help prevent recurrences of crises experienced by individuals and their families. It is very positive that REACH is now required to complete CEPPs and the programs significantly improved follow up during QI-16.

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 the first quarter of this review period 167 officers were trained and 165 were trained during the second quarter for a total of 332 trained police. This is an increase over the 224 law enforcement staff trained during the previous reporting period. This training was provided in all five regions, which is an improvement over the past reporting period when training only occurred in Regions I, III, and V. CIT is offered to approximately 20-25% of police officers. Four of the five regions are part of the training for two CSB areas in their regions. Region V is part of CIT training in three of the CSBs. No REACH program is offering training as part of CIT in all of the CSBs in their catchment areas. DBHDS reports the REACH staff does also reach out to smaller law enforcement entities.

I reviewed the CIT modules on ID and DD and the REACH program. The five regional training modules vary. The modules provide an introduction to ID and DD and are instructional but all stress different disabilities. Region II provides an excellent overview about autism; Region IV provides a brief overview to many rare syndromes; and Region V includes dementia. The Regions vary more significantly regarding the information they provide about REACH. Two regions only give contact information and two give short descriptions. Region V provides the most comprehensive description. This region uses the module developed by DBHDS.

It was instructive to learn about collaboration with local police involved in some of the crisis situations the ten individuals experienced that were part of the individual reviews. Providers often attempted to debrief with police officers or approach the police unit to talk about approaches to use with these individuals when they eloped or caused property destruction outside of the home. These efforts were not always successful in part because certain units have so many police and it is not always the same responder. There was not evidence that

REACH Coordinators or mobile staff attempted to work with law enforcement personnel to preemptively discuss individuals who were prone to crises or to debrief with police officers after an individual crisis to determine if there are more effective ways to respond in the future.

DBHDS reported during the last reporting period that an online training module was to be made available to police officers through the Department of Criminal Justice Services (DCJS) website starting in July 2015. This had not occurred at the time of this report. DBHDS does have a Law Enforcement Initiative that will compliment the CIT training provided in the regions. They are collaborating with the Commonwealth Autism (CA) on its existing autism specific training initiative and with DCJS. Information flyers have been requested for Police Chiefs to use in roll call and training of new recruits. DBHDS has developed a flyer on REACH and Children's Crisis Services for law enforcement that is on the DBHDS website. The informational flyer has been distributed to Sherriff's and will be distributed to Police Chiefs, Dispatchers and the Police Training Academies by November 1, 2015. The DBHDS plans to develop a comprehensive training program to include REACH contact information, introductory training on ID and DD, and provide options for police officers' responses to crises with individuals with ID or DD. The plan includes follow up with CA and DCJS in March 2016 and development of training material through the training portal in July 2016. The numbers of individuals using the training will not be monitored until July 2017.

Conclusion: The Commonwealth is in compliance with *Section 6.b.ii. C* since many officers have been trained in this reporting period and the DBHDS has made some information available to law enforcement departments through its website.

Recommendation: Every region should be required to provide training until the training is available to all law enforcement personnel online.

DBHDS should facilitate sharing of the trainings for Law Enforcement used in different regions. A single effort to combine what each Region has determined is its strongest component into a single training for law enforcement would significantly improve the quality and the impact of the training

Suggestion: Consideration should be given to providing more information about REACH's direct involvement with particular individuals to law enforcement, especially regarding those who frequently interact with law enforcement as a result of elopement, aggression, and assault. REACH staff will not necessarily arrive at the scene of the crisis while the law enforcement officers are involved because of the response time of one and two hours. REACH staff should make contact following crisis responses either independently for individuals at home with their families or in cooperation with waiver providers.

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

As reported earlier in Section 4 the REACH Mobile crisis teams are available around the clock and respond at off hours. There were 260 mobile assessments performed during the reporting period of which 151 (58%) were conducted in individuals' homes, day programs, or the community location where they were when the crisis occurred. This compares to 56 % of the assessments being performed in these settings during the previous reporting period. Thirty-eight percent of the individuals were assessed in the hospital or ES/CSB, compared to 35% last reporting period. The other individuals were assessed at the CTH setting.

The number of individuals assessed in their family home compared to a residential program is substantially equal (64 in the family home and 65 in a residential program). This continues the pattern in the previous period and may indicate that providers have a greater understanding of the benefits of the REACH program and are seeking the expertise of the REACH staff.

The trend of referrals being made during normal business hours continues. REACH received a total of 322 referrals during the reporting period of which not all require an assessment or onsite response. Forty-four of these calls came in on weekends (14) or after 5 PM weekdays (30). Eighty-six percent of all of the calls are made during the normal workday. Neither Regions IV nor Region V received calls on weekends or holidays.

All Regions report that all calls are answered and the availability of a REACH Coordinator is maintained continuously. However, there were anecdotal reports from some Case Managers and CSBs that they have experienced calls not answered or that REACH did not accompany them to the site. One CSB provided a log of calls to REACH since 4/15. The ES had screened five individuals with ID. REACH was called three times and was already onsite in the fourth case; the ES staff neglected to contact REACH once. The ES reported that REACH did not respond with an onsite staff in two situations. However, the REACH program was able to show evidence through its logs that a joint decision was made in these cases between ES and REACH staff to not respond. One person was highly dangerous and was quickly admitted; the other was sent home and provided with information to contact REACH the next day.

Conclusion: The Commonwealth is in compliance with *Section III.C.6.b.ii.D.*

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

DBHDS collects and reports data on the amount of time that is devoted to a particular individual. Most regions provided individuals with more than three days on average of in-home support services with the exception of Region V in QIV that averaged 2 days that is the same as the last reporting period. Region V increased to 7.5 days in QI.

Regions provided community based crisis services as follows:

Region I*: twenty-four individuals for an average of seven days in QIV*
Thirty-one individuals for an average of five days in QI
Region II: *twenty individuals for an average of four days in QIV*
Thirty-one individuals for an average of three days in QI
Region III: *thirty-six individuals for an average of eleven days in QVI*
Twenty-four individuals for an average of nine days in QI
Region IV: *twenty-seven individuals for an average of four days in QIV*
Thirty-two individuals for an average of four days in QI
Region V**:** *thirteen individuals for an average of two days in QIV*
Forty-three individuals for an average of 7.5 days in QI

Regions vary in the number of individuals served and the total numbers of days of community based crisis services but had becoming more similar by the last Quarter (QI FY16). The range of individuals is 24 (Region III) – 43 (Region V) but the other three regions served either 31 or 32 individuals. The range of days varies from 1-8 (Region IV) to 1-19 (Region V)

Conclusion: The Commonwealth is in compliance with the requirement of *Section III.6.C.b.ii.E.*

F. By June 30, 2012 the Commonwealth shall have at least one mobile crisis teams in each region to response to on-site crises within two hours
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 not resulted in sufficient capacity to provide the needed crisis response within the one- two hours as required. Regions II and IV are urban areas and should meet the expectation of responding to a crisis referral within one hour.

There were 214 onsite responses in QIV and 247 onsite responses in QI for a total of 461 onsite responses. DBHDS reported on the response time for all of these responses. Eleven calls in QIV and sixteen calls in QI were not responded to in the required time period. The number of on-time responses total 434. The state's records indicate that it responded to 94% of crisis calls within the one to two hours required.

I learned during the course of the last review that the regions calculate the response time based on the time the team makes the decision that the referral requires a face-to-face assessment or consultation. For the first half of this review period, the REACH Data Dictionary still defined response time as from the point the REACH Coordinator determines an onsite response is needed. The DBHDS administrators have assured me this is not the

operational definition the REACH programs use and are changing the REACH data dictionary to define response time as the time between the time the call is received and the time the REACH staff arrives onsite. The purpose of establishing required timeframes for crisis response is to assist families and providers to effectively assist a person in a crisis. The acceptable timeframe of one to two hours is already causing REACH teams to recommend to families that they first call the police or the CSB ES team in the case of future crises.

The REACH teams reported average times that are all comply with the on-site response times: in urban areas, within one hour, and in rural areas, within two hours, as measured by the average annual response time.

TABLE 5
Mobile Crisis Teams: Average On-site Response Time

Health Planning Region	Average response time 4/1/15 - 6/30/15	Average response time 7/1/15 – 9/30/15
I – northwest/central	60 minutes	60 minutes
II - northern	44 minutes	41 minutes
III - southwest	80 minutes	64 minutes
IV - greater Capitol	65 minutes	36 minutes
V - tidewater	38 minutes	63 minutes

The Commonwealth did not create two or more teams in each region as the Settlement Agreement required. Instead, it added members to the existing team in each region. The Commonwealth did continue to address the systemic issues that delay responses and to improve on-site response times. For the most recent two quarters, between April 1, 2015 and September 30, 2015, the REACH Teams responded to 434 (94%) of 461 crisis calls within two hours. The amount of time that the twenty-seven (6%) responses exceeded the two-hour standard was generally minor. The two primary reasons for exceeding the time standard was usual weather or traffic. The improved response times are important and significant. Dependable response times are especially important to the individuals and families in crisis. They are significant because the improved response times indicate that the mobile crisis teams have substantially resolved the systemic issues that have delayed past responses. The REACH mobile crisis teams should continue their efforts to improve and to sustain timely responses to all crisis calls.

Conclusion:
The Commonwealth remains in compliance with *Sections III.C.6.b.ii.G. and H.*

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

All regions now have a crisis stabilization program providing both emergency and planned respite. All Regions have six beds available. Region IV remains in its temporary location. During my last review, I visited the CTH operated by Region IV, which is on the grounds of a former institution that is outside of Richmond. The REACH team with the input of the REACH Regional Advisory Council has found land in Chester. The plan was to break ground in September and open by March 2016. DBHDS reported that the ground breaking was 10/15/15. The Region still hopes to transfer the CTH to the new location by March.

The Regional Plans to provide crisis stabilization beds at this same location for children will also be determined in Non-compliance.

There were a total of 327 visits to the CTH programs, which is a slight increase over the number reported during the last reporting period. There were more visits for crisis stabilization (170) than for crisis prevention (158). It is also positive that DBHDS continues to offer planned respite in the REACH Crisis Stabilization Units for individuals at risk of crises. This type of planned respite is very beneficial to families who continue to care for their relative at home.

The average length of stay continues to meet the requirement that stays not exceed 30 days. The average lengths of stay are as follows:

- *Prevention- 4-12 days in QIV and 4-8 days in QI*
- *Crisis Stabilization- 9-19 days in QIV and 10-24 days in QI*

DBHDS does not report on each length of stay but did indicate as an example that four individuals remained in the Region II CTH at the time of the QI-16 report and they exceeded the 30-day requirement. The individuals with prolonged stays are all from providers that

indicated an inability to continue to serve the person, not from families refusing to have their loved one return home.

There were four individuals on the Waiting List in Regions III (3) and V (1) in QIV-15 and twelve on the Waiting List in QI-16 including Region II (4); Region IV (5) and Region V (3). Region III continues to temporarily operate with seven beds that is one over the maximum allowed by the Settlement Agreement.

The data does not indicate if these individuals need it for emergency support or planned crisis prevention. These numbers may also underrepresent the need. I found that some of the individuals in the Individual Reviews could not go to the CTH every time it was considered as an alternative to hospitalization. Also Case Managers at the Focus Groups stated they and their colleagues have stopped referring because there is rarely an available bed. I visited the Region I CTH. Two individuals were there on stays of longer than 30 days because they did not have a placement. Thus was causing behavioral concerns for one of the individuals because of the uncertainty of his own future while he observed others leaving the CTH to return home.

The DBHDS has required the REACH programs to admit individuals who do not have a firm discharge plan to ensure that crisis stabilization services are available as a last resort to avoid unnecessary institutionalization. These individuals are in great need for this last resort, in part, because the Commonwealth allows residential service providers to discharge individuals without a discharge plan or alternative home setting. The Commonwealth must maintain its commitment to continue to meet the crisis stabilization needs of all of the target population and not allow the needs of one particular group to negatively impact the needs of others. There must be continued review of the plans and resources for individuals that need a new home so that the crisis stabilization homes do not become emergency residences for individuals who are homeless. The outcome of prolonged stays is not always in these individuals best interest as they observe others leaving the CTH after shorter visits. Longer use of the CTH precludes others that need this resource from accessing it in timely manner.

The REACH program continues to provide community–based mobile crisis support and offers it as the first alternative when appropriate. Mobile crisis timely in-home support was provided to a total of 240 individuals with the majority of these individuals (162), receiving this stabilization in QIV-15. Some of these individuals still required psychiatric hospitalization as has been noted in an earlier section.

There is no indication that any other community placements were used for crisis stabilization during the reporting period for individuals who could not remain in their home setting. Two individuals were supported in the MH CSU program. The Settlement Agreement requires the state to attempt to locate another community alternative before using the REACH Crisis Stabilization Unit. REACH teams are attempting to maintain individuals in their own homes with supports as the preferred approach to stabilize someone who is in crisis.

The REACH programs are not currently seeking community residential vacancies before using the Crisis Stabilization Units. In my professional opinion using vacancies in community residential programs is not a best practice. I have expressed my reasoning in previous

reports. I will not recommend a determination of compliance regarding this provision until the Parties discuss it and decide if they want to maintain it as a requirement of the Agreement. I continue to recommend that it not be a REACH practice.

The DBHDS is to determine if there is a need for additional crisis therapeutic homes to meet the needs of individuals in the target population. Based on past reviews of the average number of beds that were occupied per day in the existing programs, I previously determined that additional CTHs might not be needed because of unused capacity. However, this more in-depth qualitative review of individuals in Region I and IV determined that it is common for there not to be sufficient capacity for individuals in need. During the previous report period Region III discussed adding crisis stabilization beds to address unmet needs. Case Managers reported during this review not making referrals because of the lack of availability. This lack of capacity existed when policies were in place that excluded individuals with an ID or DD diagnosis who did not have a case manager or were evicted by residential providers without a discharge plan or receiving home. With the current placement of individuals for longer periods of time; the continuation of waiting lists for crisis stabilization beds; the unavailability of the CTHs as a step down, there is compelling evidence that more crisis stabilization beds are required to meet the needs of the target population. The Commonwealth has not fulfilled it responsibility to assess and determine whether it is necessary to meet the needs of the target population.

Conclusion: The Commonwealth of Virginia is in compliance with Sections III.C.6.b.iii. A., B. and F.; and is in substantial compliance with D and E.

The Commonwealth of Virginia is in non-compliance with Sections III.C.6.b.iii.G.

I will not make a determination about Section III.C.6.b.iii.C until the Parties make a decision about the practice of using community residential resources for crisis stabilization.

Recommendations: The Commonwealth should study the need for additional CTHs. It should report on the number of individuals that exceed the 30-day stay in the CTH. It should indicate the impact of individuals on the waiting list for the CTH. It should report on Region III's plan to bring its CTH capacity back to six individuals.

SECTION 6: SUMMARY

The Commonwealth of Virginia continues to make progress to implement a statewide crisis response system for individuals with I/DD. It is promising that DBHDS has finalized its REACH Program Standards and has developed Children's Developmental Disability Crisis Services Program Standards. The REACH Program Standards increase the requirements for MH and ID/DD experience for staff and require licensure for most positions. The standards also reduce the exclusions for participation in the CTH Program and require REACH Staff to respond onsite to crises and participate in all screenings for hospital admissions. The Children's Standards are thorough and comprehensive.

More individuals are utilizing REACH and there is an increase in training
The issue of the actual response time to crises must be addressed to determine if the Commonwealth is meeting its obligation under the Settlement Agreement. The Commonwealth needs to analyze whether individuals with DD are getting appropriate access to REACH services.

There is better data regarding individuals that are psychiatrically hospitalized and the required involvement of REACH should be beneficial. However, there is a need to report more specifically on multiple hospitalizations and the reasons for admission. The review of the twenty individuals indicate the system still needs to develop and expand its capacity to effectively prevent unnecessary hospitalizations and reduce the multiple admissions individuals experience. This will only be accomplished with a sufficient number of well-trained and expert REACH staff and sufficient capacity of CTH programs. This however, is only one aspect of a service delivery system that can provide appropriate community supports for individuals with co-occurring conditions. Individuals need highly specialized providers with well- trained staff in sufficient numbers to provide the structure and programming individuals' need. The story of Individual 7 in Addendum 1 demonstrates what a difference this makes in the life of an individual. These individuals also need behavioral supports and access to mental health supports. REACH will be ineffective if the other components of the system are not available. DBHDS' plan to revise its waiver and rates is an essential initiative to expanding service options but alone will not create the service delivery system capacity individuals with co-occurring conditions need.

I conducted two Focus Groups during this review period. Fourteen individuals attended including providers, case managers, behavioral specialists, ES staff, autism and disability advocates, and disability rights professionals. They were asked to comment on the following issues:

- The existing elements of the community crisis services system
- The capacity of the crisis services system to address the needs of individuals with ID and DD
- The availability of behavioral supports, family support, residential services and day services for this population
- The response to crises by ES and REACH staff and how they interface
- The coordination of REACH services and the individual's service planning team
- The ways in which the crisis system can be enhanced

Concerns were expressed as to whether REACH has sufficient staff to serve all individuals referred; that there is an insufficient number of CTH settings and CSBs have often stopped referring because of this; that ES and REACH Coordination is inconsistent across CSBs ranging

from very good to frustration at a lack of response or poor coordination with the team after using REACH; that there is a woeful lack of BCBAs and Professional Behavioral Support Specialists; there is a lack of individuals trained and a lack of services and supports to address the needs of the DD population; there is a lack of residential and day providers that can effectively address co-occurring conditions; there is a need to expand the training of police officers; and individuals need access to mental health supports including services to address substance use. Both groups expressed dissatisfaction with the psychiatric hospitalizations available to these populations because there is little expertise in these settings to address the unique needs of individuals with ID or DD. REACH was often complimented for specific work. The individuals at the Region IV Focus Group unanimously supported the changes to that program under its new REACH Director who assumed the role two years ago. These comments support my findings that the system needs to develop capacity at many levels for both REACH and the entire crisis support system to be effective and responsive.

The Commonwealth is in compliance with the following Sections of the Settlement Agreement:

III.C.6.b.i.A
III.C.6.b.i.B
III.C.6.b.ii.C
III.C.6.b.ii.D
III.C.6.b.ii.E
III.C.6.b.iii.A
III.C.6.b.iii.B
III.C.6.iii.F

The Commonwealth is in substantial compliance with the following Sections of the Settlement Agreement:

III.C.6.b.iii.D
III.C.6.iii.E

The Commonwealth is in non-compliance with the following Sections of the Settlement Agreement:

III.C.6.a.i
III.C.6a.ii
III.C.6.a.iii
III.C.6.b.ii.A
III.C.6.b.ii.B
III.C.6.b.ii.G
III.C.6.b.ii.H

APPENDIX D

QUALITY AND RISK MANAGEMENT

by: Maria Laurence

INTRODUCTION

The Settlement Agreement requires the Commonwealth to develop and implement a Quality and Risk Management System that will "identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement." (V.A-I.)

At the request of the Independent Reviewer, this is the third Report prepared to assess the Commonwealth's progress in meeting these terms of the Settlement Agreement. (The first Report was issued on November 15, 2013; the second Report was issued on November 15, 2014. References are made to previous reports, as relevant to recent findings.)

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

1) Risk triggers and thresholds;
2) The web-based incident reporting system and reporting protocol;
3) Investigation of allegations and critical incidents;
4) Data to assess and improve quality;
5) Providers;
6) Statewide Core Competency-Based Training Curriculum; and
7) Quality Service Reviews.

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

METHODOLOGY

The fact-finding for this Report was conducted through a combination of interviews and document review. Interviews were held with staff from the Department of Behavioral Health and Developmental Services (DBHDS), as well as with representatives from the provider community and other stakeholders. (Appendix B includes a list of the individuals interviewed and the documents reviewed.) Additionally, the Individual Reviews completed by the Independent Reviewer and his consultants provided information about the reporting of allegations of abuse and neglect. It is important to note that many of the Commonwealth's initiatives in relation to the Quality and Risk Management System are in the process of development and implementation. As a result, a number of draft documents formed the basis for this Report.

FINDINGS AND RECOMMENDATIONS

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

> *The Commonwealth shall require that all Training Centers, CSBs [Community Services Boards], and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risk of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.*

A goal of this Review was to determine whether the Commonwealth has established and implemented risk triggers and thresholds that enable it to adequately identify and address harms and risk of harms.

The Commonwealth continues to revise the list of triggers and thresholds. At the time of the last review, Commonwealth staff were working only on incident-based triggers and thresholds (i.e., events that have already occurred). Since then, although they view these as important, they are expanding their thinking to ways to identify the potential for risk. For example, they started looking at annual risk assessment triggers, medical triggers, and behavioral triggers. They also began looking at triggers and thresholds from a provider, as well as an individual, perspective. These are positive additions that address some of the concerns identified in previous Reports, including the concern that most of the triggers and thresholds were dependent on harm actually occurring. Now, some of the draft annual risk assessment, medical, and behavioral triggers and thresholds set the stage to <u>proactively</u> address risk.

The most recent draft of Triggers and Thresholds identifies the domains (e.g., restraint, aggression, mortality, falls, etc.), the measure (e.g., restraint use annual data, restraint use with injury, etc.), and the sub-measure (i.e., for trends, triggers, and thresholds). This document also identifies for which measures and sub-measures data currently are available, and for which data reports are still needed.

Although some triggers and thresholds were considered final, and the Commonwealth had begun to collect some data, the medical and behavioral risk triggers and thresholds are in a draft stage. The Mortality Review Committee was involved in the development of the medical triggers. The current plan is to finalize them, include them in the Individual Support Plan (ISP) format to move interdisciplinary teams towards thinking about individuals' risks and planning for any identified risks, begin implementing the medical triggers for individuals transitioning from the Training Centers to the community, revise the licensing regulations to require providers to report triggers and thresholds, and develop/revise the information system to capture this information. Although Commonwealth staff were taking some reasonable actions to collect data, the need for revised regulations to facilitate data

collection continues to be an obstacle to the Commonwealth's full implementation of these provisions of the Settlement Agreement.

Commonwealth staff made progress toward creating a more complete list of triggers and thresholds. However, concerns continue to exist. Therefore, the following recommendations are offered:

- As discussed in previous reports, definitions for some terms (e.g., fragile skin, frequent diarrhea, difficulty swallowing, etc.) should be added to assist in data reliability.
- The Settlement Agreement provides a fairly inclusive definition of harm (i.e., "Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes"). Since the last review, the Commonwealth added some important triggers or thresholds, and should continue to identify others. Now that data collection has begun, and as other triggers and thresholds are finalized, it will be important to regularly review the list (e.g., semi-annually), as part of an ongoing quality improvement cycle, to determine if others should be added.
- The Commonwealth should utilize existing data from its mortality review process. The Mortality Review Committee has identified eight conditions that uniquely contribute to the deaths of individuals with ID/DD (i.e., urinary track infection, constipation/bowel obstruction, aspiration pneumonia, decubitus ulcers, sepsis, seizures, falls, and dehydration). As Commonwealth staff recognized, the early indicators of these conditions should be included in the ISPs and on lists of triggers and thresholds for individuals with ID/DD. Highly sensitive "triggers" should be included for individuals who are older (i.e. over age 45) and who are considered medically fragile based on their Support Intensity Scale (SIS) assessments.
- The Commonwealth should consider triggers or thresholds that identify deficits in staff skills or knowledge, or in residential provider support systems. Often, these are the factors that put individuals most at risk. (One example would be neglect findings that illustrate repeated failures on staff's part to meet individuals' needs.)
- As noted in previous Reports, it will be important to identify mechanisms to gather data from providers not licensed by DBHDS to provide ID/DD services or DBHDS-operated Training Centers, including nursing homes, private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and private homes.

Based on review of minutes, thus far, the role of the Risk Management Review Committee largely has been to review and provide recommendations about the draft lists of triggers and thresholds. Now that the data warehouse allows some reports to be run of existing data, plans are for the Committee to begin reviewing risk trigger and threshold data. If not already occurring, the Risk Management Review Committee also should review data, recommendations, and Alerts from the Mortality Review Committee to ensure that risk triggers and thresholds include indicators that families and residential provider staff might observe of the health conditions that "more commonly cause death for individuals with intellectual disability."

In terms of assisting providers to implement the risk triggers and thresholds, the DBHDS website includes a webinar entitled Risk Management: Monitoring Risk Using Triggers and Thresholds – Part 1. It provides a good basic description of the use of risk triggers and

thresholds. This training, however, is currently optional for providers. The presentation references risk triggers and thresholds that DBHDS has already published on the website and indicates that further training will be provided.

Commonwealth staff indicated that a next step is the development of a report format that will be user-friendly for providers. As staff identified, it will be important to identify a report format and process that encourages providers to continue to report.

In summary, the Commonwealth continues to make progress in building a more complete list of risk triggers and thresholds, and des working to develop a report format that is user-friendly. The significant challenge continues to be the ability of the Commonwealth to collect data on a complete list of risk triggers and thresholds. The plan to expand the current narrow list of triggers and thresholds on which data is available, expand the provider data reporting requirements in current regulations, as well as to use existing data sources more effectively (e.g., revise the ISP format to include goals/objectives and/or risk assessment, and collect data through the ISP development and implementation process). These activities are essential, because without adequate triggers and thresholds, the potential for harm will likely not be caught early enough to prevent actual harm. The Commonwealth should continue to identify and/or develop relevant sources of data to allow expansion of the list of relevant risk triggers and thresholds.

> *The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol. The protocol shall require that any staff of a Training Center, CSB, or community provider aware of any suspected or alleged incident of abuse or neglect as defined by Virginia Code § 37.2-100 in effect on the effective date of this Agreement, serious injury as defined by 12 VAC 35-115-30 in effect on the effective date of this Agreement, or deaths directly report such information to the DBHDS Assistant Commissioner for Quality Improvement or his or her designee.*

The web-based incident reporting system was examined in order to determine whether the Commonwealth has taken sufficient action to ensure:

- "Any staff" report all suspicions or allegations of abuse, neglect, serious injuries and the deaths of all individuals receiving services under this Agreement, including individuals in DD services;
- Complete a comparison between reports that come into licensing versus the Computerized Human Rights Information System (CHRIS) reports; and
- Implement appropriate action whenever providers do not report, as required, within 24 hours, and maintain related data.

Since his last Report, the Independent Reviewer determined that reporting by "any staff" of all suspicions or allegations of abuse, neglect, serious injuries and deaths means reports can be made by the provider staff authorized to access the electronic CHRIS system (It is not required that the staff who first becomes aware of an incident directly enter it into the CHRIS system). However, for compliance to be achieved, providers must have systems in place to obtain first-hand reports from any staff who are aware of allegations, serious injuries, or deaths and must be able to input these reports verbatim into its system.

Based on discussions with DBHDS staff, as well as the Independent Reviewer's analyses of CHRIS reports involving individuals who moved to the community from Training Centers, it was evident that providers, although using the CHRIS system, were not consistently submitting reports in "real-time" (i.e. within 24hours). As part of its risk management training, DBHDS developed a sample Internal Incident Report form. However, this sample form does not include a "report of the incident." It also does not identify the reporter who directly witnessed the incident and/or how the reporter became aware of the incident. The form provides check boxes "for serious injuries." The form requests that all applicable boxes be checked. Some of the check boxes are for events (e.g., falls) and some are for the results of the events (e.g., sprains). There is a space for "Injury Description." The Independent Reviewer has found that there is rarely more than one box checked, that the most frequently checked box is "other," and that many forms are submitted with no boxes checked at all. The "Injury Description" section is rarely completed with a description of the injury. Although these shortcomings contribute significantly to the data that are deficient, the form has not been modified since it was implemented more than three years ago. It is recommended that DBHDS make these additions/changes.

The Commonwealth reports that it has begun to implement steps to evaluate and increase, as necessary, providers' compliance with the 24-hour reporting requirement. Specifically:

- To facilitate providers' entry of information into CHRIS, the Commonwealth relaxed the requirements of only allowing each provider to have two staff with access to CHRIS. A banner on the CHRIS web portal now alerts providers that the systems administrators can give more staff access.
- A reminder of the 24-hour requirement was included on the CHRIS system portal.
- At the time of the review, DBHDS staff were working to fix a problem with the CHRIS system that only allows entry of the date of discovery of an incident, but not the specific time of discovery. This will allow easier confirmation of timely reporting. The goal is to proactively run reports monthly, and to notify providers of instances of late reporting.
- Reportedly, when Licensing Specialists identify an occurrence that is not in CHRIS, they tell the provider to enter it, and then cite them. Similarly, if the Human Rights Specialists identify a missing report, they tell the provider to report it. They then send notification to Licensing, who has the ability to issue a citation.
- Case Managers frequently submit CHRIS reports after becoming aware of incidents that the service provider did not report. However, it is not clear whether the Office of Licensing then cites the service provider.
- A product of the development of the DBHDS data warehouse and the creation of standard reports is a report that shows repeat citations or compliance issues. DBHDS staff can run reports by provider, region, citation, etc. At the time of this review, staff were just beginning to generate reports identifying providers cited for the failure to observe the regulation requiring 24-hour reporting. It is intended that Licensing will generate a monthly report of providers who were late in reporting. The Licensing Specialist then will be notified for follow-up. On August 28, 2015, the Acting Director of the Office of Licensing sent a memo to all licensing staff reminding them to cite the regulations that require 24-hour reporting, as appropriate. The memo stated: "…DBHDS will also be closely monitoring this particular area in the near future.

Towards the middle or end of September, you may start receiving a report that identifies providers who reported serious incidents and deaths outside of the 24-hour timeframe. You may be required to reach out to these providers and assist with understanding the reason for their noncompliance. As you know, there may [be] many reasons why providers may not be able to report in the CHRIS database including the need for technical assistance or computer system failures, which is not the provider's error. Licensing Specialist will have to determine, based on the provider's response, if their noncompliance warrants a citation/corrective action plan, letter of notice, technical assistance, etc.…" When a lack of compliance is noted, Licensing staff initially would provide warnings to providers for a grace period and then would initiate enforcement actions, if the provider did not comply.

- The Regional Quality Councils (RQCs) and the Quality Improvement Committee (QIC) will also be given a summary of the regional compliance issues as it relates to the 24-hour reporting requirement.

CHRIS is a legacy system requiring ongoing modifications to allow its integration into the data warehouse and other systems, and to ensure that the data in the CHRIS system are complete and accurate. For example, DBHDS staff continue to change the fields to provide some checks and balances on data reliability (e.g., require specific formatting, such as last name, first name).

In summary, problems continued to be documented with meeting the requirements for direct reporting in real time, but the Commonwealth had made progress in developing mechanisms to identify and address late reporting. As noted in the last Report, the Commonwealth developed capacity to generate reports to make the CHRIS data useful on a statewide level and to inform the Regional Quality Councils and provider agencies. Further progress has been made with the completion of the data warehouse and standard and customizable report formats.

The following recommendations, offered in the previous Report, continue to apply:

- Through their Quality Improvement systems, Training Centers, CSBs, and community providers should be expected to implement mechanisms to identify incidents or allegations that should have been reported, but were not, and to report them promptly if/when they are identified. Efforts are needed to ensure <u>all</u> allegations of abuse, neglect, and exploitation, serious injuries, and deaths are reported, including for individuals in the DD Waiver system.
- The Commonwealth should work with Training Centers, CSBs, and provider agencies to develop mechanisms to ensure that information entered into CHRIS reflects "direct reporting" by the staff first aware of allegations of abuse or neglect, serious injuries, or deaths, and that reports are submitted in real time.

Finally, the Settlement Agreement only requires the web-based system to include reports of abuse, neglect, and exploitation, serious injuries, and deaths as defined in the Commonwealth's regulations. However, as noted elsewhere in this Report, these regulatory limitations significantly impact the Commonwealth's awareness of events and, therefore, constrain a more proactive approach to incident management. Some of these events/incidents may be indicators of increased risk of harm. Other categories of incidents

reasonably expected to be reported by provider agencies include, but are not limited to, contact with law enforcement or emergency personnel; unexpected hospitalizations; peer-to-peer aggression, regardless of level of injury; community incidents that have had or have the potential to negatively impact the individual or provider; unplanned evacuations; infections reportable to the Department of Public Health; missing persons; and theft of individuals' funds or property.

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

The actions taken to complete this Report were designed to obtain a status update on the development and implementation of provider agency training regarding investigations and root cause analyses, as well as the status of guidance or training to providers on proactively identifying risks of harm, and developing and monitoring corrective actions.

Since the last review, Commonwealth staff revised portions of the draft training on investigations, published webinars on the DBHDS website for two of the seven investigation training modules, finalized root cause analysis training and published it on the DBHDS website, and developed and published the initial module for training on risk assessment, as well as some tools and templates to assist providers in the risk assessment and corrective action processes. Beginning on June 22, 2015, the Commonwealth began to roll out these training and technical assistance options for providers. However, it remains optional for providers to access them. It is not part of the Learning Management System (LMS) system that the Commonwealth uses to track required training. There is no competency-component to this training. A flier inviting providers to participate was widely distributed.

As noted in the previous Report, the training and technical assistance materials DBHDS provided demonstrated considerable thought and effort. The webinars outlining the procedures for root cause analysis impart excellent information, including a realistic example that illustrates the root cause process in an easy-to-understand format.

The initial risk-assessment training module also provides some basic information in an easily digestible format. Resources made available include a Risk Management Plan with the following attachments: Incident Reporting Form, Organizational Risk Assessment Tool, Risk Reduction Plan, Status Report, Root Cause Analysis Directions, Root Cause Worksheet, and Mortality Review Worksheet. The Commonwealth also is making available documents such as High Risk Areas for Provider Focus, which identifies common medical and behavioral health issues on which providers should focus; and Best Practices for Risk Management, which describes many of the basic components of a risk management system (e.g., incident management, risk assessments, monitoring and analysis of key program components, risk triggers and thresholds, mortality review, etc.). Commonwealth staff recognize that publishing these resources on the DBHDS website is a first step, that additional training and technical assistance is needed, and that these resources will not strengthen providers' efforts to reduce risks if they are not used.

In the last Report, the reviewer noted that definitions of the levels of risk required scrutiny. For this review, it was positive to see that the risk matrix included in the presentation "A Simple Approach to Risk Assessment" now indicates that actions involving moderate-risk situations should be taken within no more than 60 to 90 days (i.e., as opposed to no later than the next Fiscal Year), and that any high-risk situations should be addressed within no more than 30 days (i.e., as opposed to within no more than six months). Appropriately, acute and extreme risk is noted to require immediate action (e.g., examples would be individuals with significant medical complexities who have recently experienced a change in health status or who do not have ISPs that identify needed supports or when such supports are not consistently implemented). With regard to a comment in the previous Report, an area in which further beneficial clarification now has been provided relates to expectations for coordinating investigations with other investigatory agencies when a crime is suspected or evidence must be preserved without contamination.

Because five of the seven webinars for investigations are still works in progress, the reviewer could not determine whether, as a whole, they will provide the information providers need. For example, limited information is included regarding the conduct of interviews (e.g., information about methods for taking witness statements is minimal). Similarly, as part of the investigation plan, the review of different types of evidence is not discussed in detail (e.g., documentary and physical evidence).

As noted in the last Report, the investigation and root cause analysis training materials do not reflect as broad a range of instructional techniques as needed to ensure reliability and competency in performance. For example, role playing the various interviewing techniques and protocols would be especially important, as would be the critical review of samples of written documentation.

As indicated in the last Report, current regulations (12 VAC 35-115-50.D.3.e., page 11), state that "The director shall initiate an impartial investigation within 24 hours of receiving a report of potential abuse or neglect. The investigation shall be conducted by *a person trained to do investigations* and who is not involved in the issues under investigation." .
The regulations, however, do not include standards for investigator training, the investigation process, or investigation reports. At the time of this review, although some training is being implemented, it remains optional for providers, and is not yet competency-based. Commonwealth staff reported that new regulations that are in the Governor's office for review hopefully will address these issues.

Reportedly, many providers have been asking for training on investigations. At the end of each investigation training webinar, contact information is listed for the Human Rights Advocates. They can mentor community providers and/or conduct investigations themselves. On October 7, 2015, all Human Rights Advocates, as well as Licensing Specialists, were scheduled to attend an investigations training that the internal audit team was conducting. Many of these staff also had completed investigator training offered to Training Center investigators.

In addition to the online training, Commonwealth staff recognize the need for "live" training opportunities and other methodologies for assessing the competency of staff completing the investigation training. However, developing a certification process for investigators similar to the one used at the Training Centers would take time, and has not yet begun.

Although, according to 12 VAC 35 105-400, providers are expected to conduct criminal background checks (i.e., criminal checks and checks of the registry of child abuse and neglect maintained by the Virginia Department of Social Services), the Commonwealth does not currently have a system or registry to allow providers to determine whether or not an applicant had substantiated allegations of abuse, neglect, and/or exploitation against a vulnerable adult. Similarly, on an annual basis, providers cannot conduct a recheck of current employees to determine if any allegations related to vulnerable adults had been confirmed over the year (e.g., in another job). As a result, a person who had committed acts of abuse, neglect, and/or exploitation easily could find employment with another provider. This places vulnerable individuals at significant risk of harm. Providers have complained to the Independent Reviewer of not being provided information available about substantiated abuse and neglect that could help them avoid hiring staff who would increase the risk of harm to the individuals they serve, especially those who are do not communicate verbally and are not able to verbally report abuse or neglect.

In summary, the Commonwealth made progress in finalizing the root cause analysis webinars, as well as two of seven modules of investigation training, and publishing these online. The release of the technical assistance materials and initial module on risk analysis also are positive steps forward. However, a number of issues should be addressed. The following recommendations are offered:

- As the DBHDS Investigations Process training and related guidelines and manual are finalized, consideration should be given to addressing the areas identified above in which the provision of additional information is recommended.
- Although "A Simple Approach to Risk Assessment" touches on this, further training should be developed and implemented related to the development of corrective action plans and an ongoing quality improvement process to assess their effectiveness. Commonwealth staff indicated this is part of the plan.
- For both the Investigation Process training and the Root Cause Analysis training, the Commonwealth should offer classroom training, as well as online training, including the equivalent of experiential-based learning, such as role-plays and discussion.
- The current investigation training modules do not have a competency-based component. Given the specific skills required to conduct thorough investigations and to write reports that include strong bases for the findings, the training should include specific competency-based components. These should include, but not be limited to, competencies in the development of an investigation plan, securing evidence, conducting interviews, interviewing individuals with intellectual disabilities, reconciliation of evidence, and investigation report writing.
- It will be important to define standards for what constitutes a "trained investigator." If training other than the Commonwealth-developed training will be acceptable, the requirements for such training should be defined.

- The Commonwealth should develop a complete set of standards for adequate investigations and investigation reports for use by Licensing Specialists and Human Rights Advocates.
- A system should be developed and implemented to ensure that community providers do not hire staff confirmed to have perpetrated abuse, neglect, and exploitation.

1. *The Commonwealth's HCBS [Home and Community-Based Services] waivers shall operate in accordance with the Commonwealth's CMS [Centers for Medicare and Medicaid Services]-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers; identification, response and prevention of occurrences of abuse, neglect and exploitation; administrative oversight of all waiver functions including contracting; and financial accountability. Review of data shall occur at the local and state levels by the CBSs and DBHDS/DMAS, respectively…*
2. *The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement. The Commonwealth shall use data to:*
    a. *Identify trends, patterns, strengths, and problems at the individual, service-delivery, and systemic levels, including, but not limited to, quality of services, service gaps, accessibility of services, serving individuals with complex needs, and the discharge and transition planning process;*
    b. *Develop preventative, corrective, and improvement measures to address identified problems;*
    c. *Track the efficacy of preventative, corrective, and improvement measures; and*
    d. *Enhance outreach, education, and training.*
3. *The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area:*
    a. *Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);*
    b. *Physical, mental, and behavioral health and well being (e.g., access to medial care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status);*
    c. *Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);*

d. Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);
e. Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);
f. Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);
g. Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and
h. Provider capacity (e.g., caseloads, training, staff turnover, provider competency)…

5. The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.
a. The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.
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.

6. At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvements.

The fact-finding for this Report was designed to:

- Obtain a status of the Commonwealth's efforts to develop a Centers for Medicare and Medicaid Services (CMS)-approved QI plan to determine if it aligns with the Settlement Agreement, including how it applies to the transition plan (what are the indicators of successes or failures).
- Obtain updates on the Commonwealth's efforts to both identify the data to be collected and to collect valid and reliable data for the eight domains (i.e., as listed in Section V.D.3, a through h).
- Determine the status of the validity of the measures and reliability of the data (V.D.2, a through d) and the status of data analyses (i.e., Section V.D.4).
- Obtain updates on the status of the Regional Quality Review Councils (V.D.5.a and b) and the status of assessments of relevant data, review of trends, and recommendations.
- Determine whether the Commonwealth reported publicly on the availability, quality, and gaps in services, and made recommendations for improvement (V.6).

Based on interviews with Commonwealth staff, staff at DBHDS are working collaboratively to develop a Quality Improvement Plan for inclusion in the revised Waiver application. However, the draft was not yet available for this consultant's review.

Since the last review, the Commonwealth's took significant steps forward in its ability to collect and use data to assess and improve quality. These steps include the development of the OneSource Data Warehouse and the development of standard reports that allow users to pull data from the warehouse in a usable format. Staff from the DBHDS Office of Information Services and Technology and the Virginia Information Technologies Agency (VITA), as well as the newly-hired Data Quality and Analytics Coordinator with the Division of Quality Management and Development, worked together to pull data from various sources into the warehouse, clean the data, and develop reports so that the data could be easily queried. Of note, shortly prior to the completion of this report, staff responsible for the data warehouse, who previously worked with the Information Services and Technology Office, were transferred to the Division of Quality Management and Development.

Some of the sources of data included in the warehouse are: case management data from the CSBs (i.e., CCS3 data, which includes demographics, services, admission and discharge information, wellness measures, etc.); CHRIS data (i.e., abuse/neglect data for both community providers and Training Centers, and serious injuries in the community); Office of Licensing data (i.e., OLIS); AVATAR data (e.g., billing data, etc.); data from the Intellectual Disabilities Online System (IDOLS) (e.g., preauthorization data for the ID Waiver, services requested and authorized, interest list data, etc.); PAIRS data (i.e., serious injury and death data for the Training Centers); crisis intervention and jail diversion data,; and triggers and thresholds, some of which are now part of CHRIS. At the time of the review, seclusion and restraint data had not yet been incorporated, but was expected to be soon. In addition, for purposes of the data warehouse, individuals in the "DOJ population" are identified by whether they are on the ID or Day Support Waivers or waitlist or are in a Training Center. Individuals on the DD Waiver, in private ICFs/IID, or in nursing facilities are not included in data warehouse reports at this time.

Although Commonwealth staff recognize that additional work is needed to organize the data collected, increase the scope of data available, as well as to ensure its reliability, they have taken some initial steps to ensure the data in the warehouse is usable. For example, they:

- Created an application that assigned unique identifiers to individuals, so that individuals could be matched across all of the various data sources and reports could be run by individual.
- Developed a mechanism to discern events within the incident data. In other words, one event might generate numerous incident reports (e.g., from the residential provider, as well as the day/vocational provider). It is important to have the ability to identify how many events occurred, while at the same time having the detail of the various reports.
- Are developing and implementing business rules to identify when data are missing or incomplete. A data management group is meeting monthly. It includes programmatic as well as information technology staff. One of its roles is to review data and identify problems (e.g., CSBs who are not extracting data correctly).

The development of the data warehouse and the development of reports was a significant undertaking with some immediate and other long-term benefits. DBHDS now has the ability to share data amongst offices and divisions that previously existed only in separate siloes. The addition of analytical staff and information technology staff to the Division of Quality Management and Development should increase DBHDS' ability to use data to influence business practices, and to take a more proactive and predictive approach with the protections, services, and supports it offers and oversees.

As of the end of September 2015, 26 Data Warehouse Enterprise Reports were in production. The following list provides examples of the types of reports that users now can run and customize (i.e., select certain parameters to run a query of the data), and which offer improved functionality of the data currently available:

- Incidents of Abuse Report – shows numbers of substantiated abuse cases, as well as the percent per the Settlement Agreement target population;
- Integrated (Supported) Employment Opportunities Report - presents the percent of individuals in the Settlement Agreement target population who have received integrated (supported) employment opportunities;
- Provider Injury Rate - is used to identify providers with high incidences of trigger events for individuals in the Settlement Agreement target population. The report shows, for each CSB or provider, the number of specific trigger events (e.g., medication event) that occurred within the selected and prior time periods and the rate per 1,000 individuals in the DOJ population;
- Triggers and Thresholds - lists all individuals in the Settlement Agreement target population engaged in a specific event (e.g., medication event, abuse) and the number of events per individual. It can be used to identify individuals with high incidences of trigger events;
- Changes in Service Utilization following Discharge from Jail Diversion Program - is used to show a comparison of services provided by CSBs for each individual pre-enrollment and post-discharge from the Jail Diversion program;
- Change in Service Utilization following Crisis Assessment - is used to show a comparison of services provided by the Community Service Boards pre-crisis intervention assessment and post-assessment;
- Licensing Regulation Compliance Report - reports on providers who were cited for selected regulation(s) within the selected time period and all prior citations for the same regulation within the selected look-back period. Data can be aggregated by provider or by regulation;
- Services Needed by Individuals on Waiver Waitlist – two different reports provide either individual or summary data, including information about services needed; and
- Death and Serious Incident Reporting Time Detail - contains details of report times related to incident disclosures. The report is organized by DBHDS region and provider organization. Days from discovery to notification that exceed two are highlighted in red.

Commonwealth staff continue to refine the data for the eight domains. As discussed in previous Reports, the Commonwealth was collecting data for one or more measure for each of the eight domains, but further definition of the measures, as well as expansion of the measures, and the collection of reliable data will be needed.

Since the last review, the Commonwealth has undertaken some activities to move towards more comprehensive data collection and use in the eight domains. Specifically, the Assistant Commissioner for Quality Management and Development emphasized the need for the eight domains to be prominent in the data warehouse (for which a document identifies data in the warehouse that relate to six of the eight domains), in the revised ISP format, as well as in the work that Delmarva is doing with the Quality Service Reviews. An initial meeting was held with staff throughout the DBHDS organization. This group developed concepts for what should be included in the eight domains. A smaller group now will meet weekly. This smaller group will include the Data Quality and Analytics Coordinator, two statisticians, the Case Management Coordinator and other case management representatives, a representative from the Division of Intellectual Disabilities, and the Community Resource Consultant, who is the architect of the revised ISP format.

In addition, in January 2015, a workgroup began review of the measures included on the Secretary's dashboard. As noted in previous reports, questions remained about the reliability of the data case managers collect related to individuals' health and wellbeing. Through a slow and thoughtful process, the workgroup is reviewing each of the measures, and is attempting to identify reliable and valid measures.

Although some progress has been made, the group responsible for developing the additional data to be collected and used for the eight domains should incorporate comments from previous Reports. (Not all of the comments from the previous Reports are repeated here, but should be referenced, as appropriate.) Briefly, continuing issues of concern include:

- **Comprehensiveness of Measures:** Although the current measures include some important information, they do not yet represent a full listing of data to assess and improve quality. As discussed in further detail in the previous Report, only limited reliable data sources are available; measures that should have been considered were not. Suggestions made previously include: expanding protection from harm indicators to include measures related to unexpected hospitalizations, elopements/missing persons, law enforcement contacts/arrests, etc.; including capacity indicators such as training or competencies to provide services; and including measures that represent a proactive rather than a reactive approach. The Commonwealth should continue to identify and/or develop relevant sources of data, ensure these data are reliable, and expand the measures to assess and improve quality.
- **Complete Data:** As noted above, the data included in the data warehouse did not yet include data for individuals under the DD Waiver, or for individuals in nursing facilities and private ICF/IIDs.
- **Measuring Quality:** As noted previously, the quality of services or supports should be targeted for measurement, as opposed to simply measuring the presence or absence of supports. Examples to be considered include the numbers of individuals using crisis services or the numbers of individuals in supported employment. Even when quality is reportedly a target for measurement (e.g., extent to which desired health and well-being or community inclusion outcomes are achieved), the measures rely on the individuals' ISPs and case managers' assessment of progress as the basis to determine whether or not individuals are achieving these quality outcomes. The

possibility of bias in the case managers' reporting of goals, achieved in the ISP that they authored, should be assumed and addressed. As noted above, improvement in case management measures is an area of focus for a workgroup. In addition, efforts are underway to improve the quality of ISPs.

- **Definition of Terms:** Although some definitions existed, a clear set of definitions for the measures should be provided.
- **Reliability of Data:** As Commonwealth staff recognize, they continue to improve the reliability of the data, but this is an area in which focused efforts continue to be needed.
- **Methodology for Data Collection:** It will be important to detail the methodology used to collect the data and to ensure data are collected the same way each time.

In summary, Commonwealth staff reported working on a QI Plan for inclusion in the revised Waiver. Significant progress was made in the development of a data warehouse, as well as in a series of standard reports to allow queries of existing data. The Commonwealth made limited progress in expanding the identification of data to assess and improve quality and in ensuring that the data are complete. However, a number of challenges still need to be overcome. Previous recommendations related to these efforts remain relevant, including:

- The Commonwealth should continue to identify and/or develop relevant sources of data.
- For each of the indicators identified for the Settlement Agreement domains, in addition to identifying the data source, definitions and methodologies should be developed; as appropriate, baselines or benchmarks should be identified; and targets or goals should be set.
- At a minimum, and as appropriate to the particular indicator, the methodology section should include the following: 1) how the data will be collected (e.g., through a monitoring tool, through review of records, through a database, through review of the implementation of individuals' ISPs, etc.); 2) how often and when (e.g., end of the month, within the first five days of the month for the preceding month, etc.) the data will be pulled; 3) the schedule for assessing data reliability and validity and who will be responsible for this; 4) what subpopulation or percentage of the population will be included in the sample (e.g., 100% or some lesser but valid sample); 5) the standards that will be applied to judge conformance with the measure; 6) who will be responsible for collecting and/or reporting the data; 7) clear formulas for calculating the indicator/measure, including how the "N" and "n" will be determined, and what mathematical or statistical procedures will be used (i.e., this might be included in the definition discussed above); and 8) who will be responsible for analyzing the data.

Based on a review of the DBHDS Quality Improvement Committee minutes for the months of October 2014 through July 2015, some discussions are occurring regarding data; basic analyses of the data are sometimes referenced. As noted elsewhere in this Report, the Quality Improvement Committee continued to have access to limited data, due to the ongoing development of data sources and measures. It was positive that, at times, the Quality Improvement Committee identified issues with data (e.g., the need for more complete data related to mortalities, especially for people living at home, or the need to ensure providers are correctly reporting allegations of abuse) and discussed mechanisms to

correct the issues. Some limited in-depth analyses have been completed and some limited actions have been taken to address trends identified and implemented. For example:

- In July 2015, "The Committee recommended that the ISP be updated to include a review of the medical areas recommended by the Mortality Review Committee." Based on discussions with Commonwealth staff, some changes occurred to the ISP format, but further training is needed to improve the quality of ISPs, particularly with regard to fully capturing individuals' health needs and related goals/objectives and supports.
- The Quality Improvement Committee identified peer-to-peer aggression as an issue that required additional investigation. The providers with the highest numbers of incidents were identified, and it appeared follow-up was occurring with the provider with the highest number. It remained unclear, though, whether a thorough analysis was completed, or if potential causes and solutions were identified and implemented. On a positive note, although a formal response had not yet been formulated, staff reported that Human Rights Specialists now were better informed about the specific individuals involved as victims or aggressors in peer-to-peer incidents. As a result of this important information, follow-up now could occur.
- Data related to employment showed the need for improvement. The Quality Improvement Committee sought recommendations from the RQCs, reviewed the resulting recommendations, and agreed upon a set that would be incorporated into the employment plan.

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

DBHDS staff continue to work to ensure broad membership on the Regional Quality Councils. Based on a membership list, as of August 24, 2015, all Councils include staff experienced in data analysis, residential services providers, employment services providers, day support providers, ID Case Management providers, DD Case Management providers, other Community Services Board staff, family members, individuals served, and Community Resource Consultants.

In terms of the Regional Quality Councils' role in "assessing relevant data, identifying trends, and recommending responsive actions," since the last review, continued progress occurred, but the Councils need to continue to effectively use data to identify areas requiring improvement and to issue recommendations. There is evidence to confirm that members of the Division of Quality Management and Development regularly support the Councils' activities and that the Commonwealth shares the data that are currently available. For example, in recent Council meetings, DBHDS shared Regional Support Team data, employment data, and National Core Indicator (NCI) data. Regional Quality Councils are conducting limited analysis of the data shared. In some instances, the Regional Quality Councils made recommendations, for example, related to employment, and, to a limited extent, the need to expand community living options for individuals with complex medical and/or behavioral needs. The NCI data identified potential areas of need, but minutes showed limited discussion of possible trends or recommendations for improvements.

Based on discussions with members of three different Regional Quality Councils (including a family member and advocate, an executive staff person from a residential provider, and a quality improvement director from a case management agency), the meetings are efficient and Commonwealth staff provide good support. The Councils have wide membership, which helps bring different perspectives to the table, including, importantly, the individual and family perspectives. Over the past year, the Councils have increasingly reviewed data (e.g., NCI, employment, mortality), and the Councils have begun to provide recommendations on some topics. The meetings have provided a focus on what is occurring within the regions on certain topics (e.g., employment), and have allowed systemic recommendations to be offered to the QIC. Another benefit that has been articulated is a greater regional focus on resolving issues. However, the limited data available to both investigate topics in depth as well as across topics remains a continuing challenge. Another challenge is the inability to drill down to the regional level with some existing data (e.g., NCI). Overall, members viewed the Regional Quality Councils as a positive addition, but recognize that more growth is needed to fully realize their potential.

In summary, the Quality Improvement Committee, as well as the Regional Quality Councils, are using some of the data currently available, are conducting limited analyses of such data, and are beginning to use such analyses to determine what, if any, actions should be taken. These are activities that should increase over time, particularly as more data becomes available, and more in-depth analyses of the data are made available to both groups.

On October 6, 2015, the Senior DD Administrative and Policy Analyst sent a link to a page on the DBHDS website (i.e., http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/doj-settlement-agreement) that includes a tab for an annual report. In the cover email, the Commonwealth indicated that this site is not yet complete, but includes reports targeted to a variety of audiences that offer information regarding demographics, the quality and quantity of supports, and makes recommendations for improvements. The intention is to finalize it, and then update it semi-annually. Based on a review of the site, it includes valuable information, and is a good start to meeting the requirement of the Settlement Agreement. It will be important to ensure that the data included accurately reflects the current system, as well as unmet needs. For example, the information does not identify information about barriers to "most integrated housing" from the Regional Support Teams; gaps in the transportation service availability, quality or safety for individuals with ID on HCBS waivers; or the adequacy of crisis services for adults or children, or whether data about employment is complete.

In summary, at the time of the review, the Commonwealth had recently developed and implemented a format on its website to provide the "annual report" information described in the Settlement Agreement. However, the website was not yet complete, and the Commonwealth considered it a work in progress. This will require further review in the future.

1. *The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of this Agreement.*
2. *Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3 above. The measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from the Regional Quality Councils, described in Section V.D.5 above. The DBHDS quality improvement committee will assess the validity of each measure at least annually and update measures accordingly.*
3. *The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.*

Goals for this Review included: 1) determine whether or not the Commonwealth's draft expectations for CSBs and other community providers' risk management and quality improvement systems will lead towards compliance (i.e., Section V.E.1); 2) per Section V.E.2, determine whether the Commonwealth has identified measures that CSBs and community providers are to report, including both negative and positive indicators; and 3) determine the status of the Commonwealth's implementation of Quality Service Reviews (QSRs) that comply with the requirements of the Agreement (i.e., Section V.E.3).

As noted in the last Report, the Settlement Agreement establishes the requirement for providers to monitor and evaluate service quality; it references the DBHDS Licensing Regulations at 12 VAC 35-105-620. Specifically, the regulations require: "The provider shall implement written policies and procedures to monitor and evaluate service quality and effectiveness on a systematic and ongoing basis. Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality assurance system. The provider shall implement improvements, when indicated."

Beginning with Fiscal Years 2015 and 2016, the Commonwealth added Quality Improvement program requirements to the draft Performance Contract with CSBs. Details regarding these requirements were included in the previous Report.

The Commonwealth's oversight of community providers' Quality Improvement programs remains a work in progress. Since the previous review, the Commonwealth conducted a survey of all 40 CSBs. As expected, CSBs have different levels of sophistication regarding their quality improvement processes. The next step is to survey a sample of the 900 community providers to ascertain a baseline with regard to quality improvement practices.

These activities are positive first steps in assisting DBHDS staff to determine the scope and type of technical assistance necessary to help providers comply with the Settlement Agreement. Once the Commonwealth sets clear expectations about Quality Improvement processes, now targeted for completion on 12/31/15, and provides technical assistance and guidance, the Office of Licensing will have a role in ensuring that providers are compliant.

As noted in the sections above, the Commonwealth has made some progress, but still is in the process of finalizing drafts of the data it intends to collect. Some of the data to be collected by providers have been identified, but, in order to address the requirements of the Settlement Agreement, additional data will likely be required. In some cases, the reliability of the data requires improvement.

As discussed in more detail above, Regional Quality Councils continue to meet and review some data. Similarly, the Commonwealth's Quality Improvement Committee meets regularly and uses some of the data available to them.

As discussed below, the Quality Service Review process has been initiated. Results from these reviews will offer providers another source of information about the quality of the protections, supports, and services they offer, although these data are not complete or, in some cases, reliable.

In summary, the Commonwealth remains in the beginning stages of developing and implementing communication mechanisms to convey to providers their responsibilities for maintaining necessary Quality Improvement processes and for sharing data with the Commonwealth. Mechanisms for reviewing provider data, such as the Regional Quality Councils and the Commonwealth's Quality Improvement Committee, are also in the beginning stages. Some initial analysis of data is occurring, but only limited data are available to inform the Committees' decision-making; more in-depth analyses will be needed over time. The following recommendations are offered for the Commonwealth's consideration:

- To ensure consistent implementation of Quality Improvement programs across providers and the collection and reporting of reliable data, the Commonwealth should pursue plans to offer training to CSBs, DD Case Management agencies, and ICF, nursing facility and community waiver-funded providers on the Settlement Agreement's quality management expectations.
- The Office of Licensing should consider developing and issuing interpretive guidance to further define how it will assess compliance with the very broad requirements for Quality Improvement programs articulated in 12 VAC 35-105-620.

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.*
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 services they are coaching and supervising.*

This review included assessing the development of a statewide core competency-based training curriculum, including general elements and person-specific service elements, as well as coaching and supervision. Based on review of documents and the report of the Assistant Commissioner of Quality Management and Development, the Director of Provider Development, and the Case Manager Coordinator, some work has been done, but significantly more work still is needed. The following provides a status of training efforts:

- As noted in the previous Report, the Commonwealth has developed a basic curriculum for case managers, with more modules being added. Training materials consist of eight modules, including one on the philosophy of employment first and methods for navigating the employment system. (The Independent Reviewer's consultant on case management has commented on the quality of these modules.) In addition, modules on crisis services and housing are in the stages of development and implementation. Although a competency checklist/tool exists for case managers, the Case Manager Coordinator recognizes the need to update/revise it, and is working towards an improved version.
- The Commonwealth is developing enhanced case management tools, which will include risk screening, as well as protocols for prevention and action. Competency-based training will be developed to correspond with these tools.
- Ten modules also are used for targeted case management services. However, when a new Waiver is approved, these modules will need modification.
- In late 2014 and early 2015, the ISP format was revised (e.g., reportedly to add health goals/outcomes). Although training for case managers on the revised ISP occurred, Commonwealth staff recognize the need to develop competency-based training to assist in the development of higher quality ISPs. A stated goal is to have specialists in ISP development at each of the CSBs. At the time of the review, the Commonwealth had begun offering six-days of ISP training over a six-week period. However, ISP competencies were still in development.
- For Waiver services, supervisors are required to complete training with direct support professionals (DSPs) on a variety of topics (e.g., introduction to intellectual and developmental disabilities, Waiver services, person-centered planning principles and processes, communication, introduction to positive behavior supports, etc.). Using a sign-off sheet, supervisors and DSPs certify that DSPs have successfully completed a written test (with a score of 80% or better) prior to providing ID or DD Waiver Services. Although there is a written quiz, confirmation of performance competence (i.e., ability to implement skills taught) has not been required.

Commonwealth staff reported that work is underway to enhance the content of the current DSP training (e.g., add more information about the "fatal five" conditions to the health and safety section) as well as to add measures of skill- and experience-based competency measures to the knowledge-based competency measures already in place through the written test. Based on conversations with Commonwealth staff, it is evident that they were thinking through many of the necessary logistics, such as who should assess competency; if the supervisor continues to play this role, how the supervisor's competence as well as his/her ability to assess a staff member's competence will be assessed; timelines for demonstrating competency, as well as the need for refresher training and confirmation of competency; and checks and balances to ensure staff competency (e.g., licensing reviews, integration into enhanced case management tools, and QSR reviews).

As part of the curricula development, the Commonwealth has begun to develop some competencies that need to be determined, and shared a draft document: "Behavioral Support Competencies for Direct Support Providers and Professionals in Virginia." The goal is to add this to the DSP training. This document shows a significant amount of thoughtful work, including delineation of competencies for different staff [e.g., DSPs, Qualified Intellectual Disabilities Professionals (QIDP) and Behavior Interventionists]. It also delineates different levels of training (i.e., training received, staff implemented skills, and proficiency determined). However, concerns are noted, including, at times, a lack of measurable competencies, numerous competencies included in one standard/skill, and no distinction of how a determination would be made as to when a staff member "implemented skills" and/or showed "proficiency." In finalizing these and developing other competencies, it might be helpful to think in terms of various types or levels of competency-based training, including knowledge-based competency, skills–based competency, and ability- or expertise-based competency.

- Other training currently available includes training offered at Provider Roundtables, and case management meetings. Providers also can currently request training through their Community Resource Consultants or Licensing or auditing staff can require training for an agency (e.g., include training in a corrective action plan).
- As discussed in more detail above, Commonwealth staff developed, and were in the process of implementing, training on investigations. Webinars also were available on topics related to risk management, including: Monitor Risk Using Triggers and Thresholds, and Root Cause Analysis. Although these webinars did not have skill- or ability/expertise-based competency components, they were available to providers online.

In summary, it is positive that the Commonwealth has some basic training in place for case managers and is expanding the modules, as appropriate. In addition, the Commonwealth has some basic training in place for direct support professionals and their supervisors, which includes a knowledge-based test. Initial efforts are underway to develop some competencies for case management, direct support professional, QIDP, and behavior support staff. The implementation of root-cause analysis training and other webinars to address risk management, as well as efforts to finalize and implement investigation training, are important priorities.

It is important that next steps include comprehensive planning for statewide core competency-based training for all staff providing services under the Agreement, including general elements and person-specific service elements, as well as coaching and supervision. As noted in the previous report, this continues to be a significant undertaking. It will be important to: 1) define training topics; 2) identify the staff to be trained; 3) determine how competency will be measured; and 4) specify the frequency with which retraining should occur. The Commonwealth should define, for each topic, the type of competency-based training required, including, for example, knowledge-based competency (assessed through a written post-test), skills–based competency (assessed through classroom demonstration), and ability- or expertise-based competency (assessed through on-the-job observation).

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

A goal of the Review was to determine the adequacy of the revised QSR process, the extent to which it aligns with the Agreement, and the status of its implementation. This includes determining the adequacy of the Commonwealth's process for selecting a statistically significant sample.

In the initial Report (November 2013), it was concluded that the Commonwealth made progress in initiating the use of the National Core Indicators (NCI) Survey tools to collect some important data. However, these surveys are not consistent with all of the

requirements included in the Settlement Agreement in relation to Quality Service Reviews. Therefore, it was recommended that the Commonwealth review the specific requirements in the Settlement Agreement for the Quality Service Reviews, and either add to the NCI process or replace it with an alternative. In response to this recommendation, the Commonwealth decided to supplement the NCI process by contracting with a Quality Improvement Organization (QIO)-like entity. On May 18, 2015, the Commonwealth's contract with the Delmarva Foundation went into effect.

In addition, the NCI surveys for 2014 were completed with generally good participation. Virginia Commonwealth University issued final reports in March 2015. As discussed earlier in this Report, results were shared with Regional Quality Councils and the QIC.

The contract with Delmarva clearly sets forth the purpose of the Quality Service Reviews as defined in Section V.I.2 of the Settlement Agreement. There is a multi-tiered approach to conducting the Quality Service Reviews, including:

- Conducting Person-Centered Reviews (PCRs) of a statistically significant sample of individuals receiving services and supports under the Settlement Agreement. In addition to reviewing documents related to the individual's supports and services, the contractor will conduct observations, as well as interviews, with the individual, family/others involved in the individual's life, the Service Coordinator and other relevant professional staff. The contractor will provide recommendations to improve practice and service quality at the provider level.
- Conducting Provider Quality Reviews (PQRs) of direct service and support providers serving the individuals selected for the Person Centered-Reviews. The contractor will conduct reviews of critical incident data, program services, policies and practices, provider performance, compliance data, and individual outcome data. National Core Indicator results also will be reviewed. The contractor will conduct interviews with program administrators/staff.
- Completing Quality Service Review Assessments will involve reviews at the Community Services Board, regional, and statewide levels, including results of Person-Centered Reviews, Provider Quality Reviews, key performance indicators, individual outcomes, incident data, National Core Indicator results, and service system compliance with contractual, regulatory and Settlement Agreement requirements.
- Submission of Quality Service Review Assessment reports, including reports on the Person-Centered Reviews and Provider Quality Reviews for individuals in the sample, as well as assessment/analysis of the systemic data. The contractor will provide recommendations to DBHDS, the Commonwealth Quality Improvement Committee, and the Regional Quality Councils for improving the quality of services and practices at the provider, Community Services Board, regional, and statewide levels.

At the time of the review, implementation of the QSR process had just begun. The contract required Delmarva to complete 400 individual and family interviews, and 50 provider reviews. The sample was selected using a regional approach, but also taking into account certain demographics (e.g., service type) to attempt to ensure that large enough numbers of individuals are surveyed to allow statistically valid conclusions to be drawn. One concern regarding the sample is the small number of providers included in the reviews (i.e., 50 out of

900). At the time this Report was being written, Delmarva had completed approximately 20 to 30 individual and family interviews as well as seven provider reviews. DBHDS staff are in the process of reviewing the draft reports.

In an email dated 8/5/15, the Independent Reviewer summarized some initial comments that he had provided verbally on the draft protocols/audit tools Delmarva planned to use. Many of the concerns expressed in this email (e.g., lack of standards, lack of definition of terms) do not appear to have been addressed in the versions of the tools provided for this review. The Independent Reviewer will be evaluating all of the tools in more detail. However, some general concerns noted as a result of an initial review include:

- **Lack of Definition of Standards/Terms –** As the Independent Reviewer noted, it is important for standards to be well defined in audit tools in order to ensure inter-rater reliability, as well as to clearly articulate expectations for providers. Although some of the tools include a column entitled "standards," these often consist of vague statements that do not set forth specific expectations (e.g., "The provider completes an assessment of the person's physical, mental, and behavioral health and well-being," or "The provider has safety protocols and plans needed to help the person stay safe"). Broad statements such as these leave open the possibility of varied interpretation by both auditors and providers. If specific licensing regulations or policies drive the expectations, then they should be cited. If not, then, clear standards should be set forth.
- **Lack of Definition of Methodology –** Similarly, the audit tools do not consistently identify the methodology that auditors would use to answer questions. For example, at times, indicators on observation tools appear to require additional document review (e.g., "Does the provider/staff provide education and resources to the person related to available and current community activities?" or "Does staff educate the person on emergency procedures?"). Record review audit tools do not identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation).
- **Lack of Criteria for Compliance –** From a PowerPoint presentation on the DBHDS website, dated 9/30/15, it appears the contractor will provide reports that indicate whether or not providers have "met" or "not met" requirements. However, the audit tools do not explain how this will be determined. The tools generally have numerous indicators, and some tools include columns with "suggested protocols" and "standards," but no explanation is provided regarding how a provider will "meet" the requirements. To this end, the Assistant Commissioner of Quality Management and Development indicated the need to identify key indicator. This is a topic of ongoing discussion in the weekly meetings DBHDS holds with Delmarva.
- **Scope of Review without Definition of Auditor Qualifications –** The audit tools cover a wide variety of topics, including, for example, healthcare and behavioral supports. However, it is unclear who will be assessing these clinically driven indicators. Judgments about behavior support plans, adequate nursing care, sufficient medical supports, etc. would generally require an auditor with specific qualifications.

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

On a positive note, Delmarva has set up a web portal to which key DBHDS staff have access. As individual reviews are completed, Delmarva posts them on the website. This allows DBHDS staff to follow-up as needed. An alert system has been established, so if urgent concerns are noted, DBHDS staff can take immediate action. Thus far, one alert was issued related to abuse/neglect.

In summary, since the last review, the Commonwealth has worked steadily to modify the Quality Service Review process to meet the requirements of the Settlement Agreement. The contractor the Commonwealth selected recently began conducting reviews. However, additional work is needed to improve the audit tools the contractor is using. The Commonwealth continues to have access to the important data collected through the National Core Indicator surveys.

CONCLUDING COMMENTS

In conclusion, the Commonwealth has made progress with regard to a number of the Settlement Agreement requirements for a Quality and Risk Management system. Since the last review, some of the needed infrastructure has begun to take shape (e.g., the development of a data warehouse, the completion of training modules and technical assistance to assist in improving providers' risk and quality systems, etc.). There continues to be support within DBHDS for developing a strong quality improvement system. As noted in previous Reports, the system is being built from the ground up and developing the infrastructure for a solid quality improvement system is labor intensive.

At this time, however, it is clear that significantly more work is required for substantial compliance to be achieved. A number of challenges remain. Sustained efforts in both the development of the basis for reliable and valid data and in the implementation of staff training are critical to successful change. In addition, an overarching theme continues to be the need to expand the scope of available data in order to allow comprehensive and meaningful quality improvement and risk management initiatives to occur.

Interviews and Documents Reviewed

Interviews:

- Dee Keenan, DBHDS, Assistant Commissioner, QM&D
- Peggy Balak, DOJ Settlement Advisor
- Adrianne Ferris, Data Steward
- Jodi Kuhn, Data Quality and Analytics Coordinator
- Carolyn Lankford, QI Specialist
- Allen Watts, Director of the Business Analytics Center of Excellence
- Marion Greenfield, DBHDS, Director of Risk, Quality, and Health Information Management
- Denise Dunn, DBHDS, Abuse Neglect Investigations Manager and Chief Privacy Officer
- Gail Rheinheimer, Director of Provider Development
- Challis Smith, Case Manager Coordinator
- Jack Barber, MD, Medical Director
- Cleopatra Booker, Acting Director of Licensing
- Deb Lochart, Director of Human Rights
- Susan Rudolph, Regional Quality Council Member
- Mary Jane Sufficool, Regional Quality Council Member
- Heather Rupe, Regional Quality Council Member

Documents Reviewed:

- 3rd and 4th Quarter FY15 Regional Support Team Reports for Regional Quality Councils (RQC) and Quality Improvement Committee
- Quality Improvement Committee Minutes and handouts, for 7/15/14, 10/16/14, 1/15/15, 4/16/15, and 7/16/15
- Sample Regional Quality Council Minutes, and draft minutes for July and August 2015 meetings
- Handouts for April/May 2015 RQC meetings
- Data Warehouse Enterprise Reports in Production as of 9/28/15
- DD Waiver Quality Indicators
- Draft DelMarva Key Performance Indicators (Criteria) as Related to the Eight Domains
- Developmental Disability Waiver Quality Improvement Strategies: Appendix H, dated 7/1/13
- ID Waiver Quality Review Measures: 7/1/14 – 6/30/15
- Day Support Waiver Quality Review Measures: 7/1/14 – 6/30/15
- Intellectual Disability Waiver Quality Improvement Strategies: Appendix H, dated 7/1/14
- Licensing Regulation Compliance sample report, for period 6/1/14 to 5/30/15
- Employment Targets, 6/26/16
- Graphs from January to February 2015 RQC meetings
- Overview of DBHDS' Data Warehouse as a Resource for Eight Domains Measurement, September 2015
- Email from Jae Benz, dated 10/6/15, regarding Response to VD6
- Recommendations from RCQs regarding Employment for the First Quarter 2015
- RQC Presentation on Employment

- RQC Membership List, dated 8/24/15
- Training Center and Community Service Board Quality/Risk Management Report: A Baseline Review of Statewide Quality/Risk Management Programs, dated 6/15/15
- Waiver Record Review Form – Survey Monkey for FY15
- Memo to Private Providers regarding System-wide Quality Improvement, dated 7/10/15
- Risk Management Plan Template, with attachments:
    - Internal Incident Reporting Form
    - Organizational Risk Assessment Checklist
    - Risk Reduction Plan
    - Risk Reduction Status Plan
    - Root Cause Analysis Directions
    - Root Cause Analysis Worksheet
    - Mortality Review Worksheet
- DBHDS Basics of Case Management Training Curriculum
- Draft Behavioral Support Competencies for Direct Support Professionals in Virginia Supporting Individuals with Developmental Disabilities, developed August 2015
- DBHDS DSP Provider Training
- DSP Orientation Manual
- ISP Training Packet
- ISP Training Slides
- Quality Service Reviews presentation, dated 9/30/15
- DelMarva Contract, effective 5/18/15
- Delmarva Foundation audit tools:
    - Administrative Review Policies and Procedures
    - ISP QA Checklist
    - Observation Review Checklist
    - Provider Record Review Guide
    - Support Coordinator Record Review Tool
- Virginia National Core Indicators Project: 2014 Adult Family Survey Report
- Virginia National Core Indicators Project: 2014 Child Family Survey Report
- Interagency Agreement with Virginia Commonwealth University, effective 8/13/15
- Memo to CSB Executive Directors and CSB ID Directors from Dee Keenan re: Quality Service Reviews and National Core Indicators Surveys, dated 7/10/15
- Example of Statewide CHRIS Summary Report
- Draft 24-Hour Reporting Action Plan from Licensing
- CHRIS Consumer Summary Report
- CHRIS Death/Injury by Date Range Reports
- Process for Enforcing 12VAC35-105-160.C.2 24-Hour Reporting Requirement
- Memo from Cleopatra Booker to Licensing staff regarding 24-hour reporting, dated 8/28/15
- Risk Assessment: A Simple Approach for Identifying Risk
- High Risk Areas for Provider Focus, dated 6/5/15
- Risk Management Program Best Practices
- Risk Management Review Committee minutes, for meetings on 4/2/15, and 9/3/15
- Risk Triggers and Thresholds Data Summary Providers of Intellectual Disability Services, dated 4/2/15

- Event-Based Individual Triggers and Thresholds
- Monitoring Risk Using Triggers and Thresholds – Part 1
- Webinar: Community Abuse/Neglect Investigation Training – Part 1 and Part 2
- Draft Module 3 of Community Abuse/Neglect Investigation Training
- Draft Manual on Community Abuse/Neglect Investigations, including chapters:
    - Definitions, Responsibilities, and Reporting Requirements
    - Recognition of the Event
    - Approach to Investigations: Guidelines for Investigators
    - Development and Implementation of an Investigation Plan: Interviews and Statements
- Flyer for DBHDS Risk and Quality Management Webinar Series, beginning June 22, 2015
- Webinar: An Introduction to Root Cause Analysis: Answering the Question "Why?"
- Root Cause Analysis: Directions for Using the 5 Whys Approach – Part 1 and Part 2
- Risk Assessment: A Simple Approach for Identifying Risk, dated 8/10/15
- DBHDS Quality Management Plan, dated 3/30/15, revised 8/28/15

State Health Authority Yardstick

Rating Tool

The State Health Authority Yardstick (SHAY) is a nationally recognized tool developed at Dartmouth University to review a state's ability to plan, develop, monitor, and evaluate Evidence-Based Practices (EBP) regarding systems development and program implementation. It provides a rating scale to evaluate and determine the adequacy of the plan.

1. EBP Plan

The State Mental Health Authority (SMHA) has an EBP plan to address the following:

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

	1) A defined scope for initial and future implementation efforts;
	2) Strategy for outreach, education, and consensus building among providers and other stakeholders;
	3) Identification of partners and community champions;
	4) Sources of funding;
X	5) Training resources;
	6) Identification of policy and regulatory levers to support EBP;
	7) Role of other state agencies in supporting and/or implementing the EBP;
	8) Defines how EBP interfaces with other SMHA priorities and supports SMHA mission;
	9) Evaluation for implementation and outcomes of the EBP; and
	10) The plan is a written document, endorsed by the SMHA.

Score

	1) No planning activities
X	2) 1 – three components of planning
	3) 4 – 6 components of planning
	4) 7 – 9 components
	5) 10 components

Evidence Used to Justify Rating:

Pieces of a plan were in place, and as discussed in detail in the body of the Report, clearly planning had occurred for the initial phases of the implementation of all of the components of the quality improvement and risk management components included in this review. However, many of the future implementation efforts remained in the development and

planning stages, and based on discussions with staff, some of these specific plans were being implemented, and for others, more planning was needed.

Planning certainly was occurring, but further development was needed. This was to be expected in a system that had only some pieces of a quality assurance/improvement system in place when the Settlement Agreement was approved.

4. Training: Ongoing consultation and technical support

Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills?

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

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

Score

X	1) 0-1 components
	2) 2 components
	3) 3 components
	4) 4 components
	5) 5 components

Evidence Used to Justify Rating:

As noted in the body of this Report, the development and implementation of training components necessary for successful implementation of the Settlement Agreement (e.g., investigations training, etc.) remained in the planning or early implementation stages.

9. **SMHA Leadership: Central Office EBP Leader**
There is an identified EBP leader (or coordinating team) that is characterized by the following:

X	1) EBP leader has adequate dedicated time for EBP implementation (minimum 10%), and time is protected from distractions, conflicting priorities, and crises;
X	2) There is evidence that the EBP leader has necessary authority to run the implementation;
X	3) There is evidence that EBP leader has good relationships with community programs; and
X	4) Is viewed as an effective leader (influence, authority, persistence, knows how to get things done) for the EBP, and can cite examples of overcoming implementation barriers or establishing new EBP supports.

Score:

	1) No EBP leader
	2) 1 component
	3) 2 components
	4) 3 components
X	5) All 4 components

Evidence Used to Justify Rating:

At the time of the review, the DBHDS Assistant Commissioner of QM&D had been in her position for approximately a year, but had worked in the intellectual/developmental system in the community for years. As the former Director of Case Management, she had developed important relationships with many stakeholders.

The DBHDS Assistant Commissioner of QM&D had oversight of the various components of quality improvement efforts. Her full-time responsibilities related to these implementation efforts. She appeared to be well respected by team members.

11. Policies and Regulations: SMHA

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

Score:

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

Evidence Used to Justify Rating:

Although the policies/regulations in place provided some of the basic structures necessary to implement quality improvement efforts (e.g., providers were required to report some incidents, conduct investigations, etc.), as detailed in the body of this Report, current regulations did not support full implementation of the requirements of the Settlement Agreement. Examples in the previous Report remain relevant.

12. Policies and Regulations: SMHA EBP Program Standards

The SMHA has developed and implemented EBP standards consistent with the EBP model with the following components:

	1) Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services. (Note: fidelity scale may be considered EBP program standards, e.g., contract requires fidelity assessment with performance expectation);
X	2) SMHA has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms;
	3) Monitors whether EBP standards have been met; and
X	4) Defines explicit consequences if EBP standards not met (e.g., contracts require delivery of model supported employment services; contract penalties or non-renewal if standards not met; or licensing/accreditation standards if not met result in consequences for program license).

Score: **Not Rated**

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

Evidence Used to Justify Rating:

Based on review of the CSB contract, requirements were included in relation to quality improvement efforts. At this juncture, formal assessment of adherence to the requirements was not occurring, but the intent appeared to be to incorporate such assessment in future licensing activities, as well as in less formal review of CSBs.

APPENDIX E.

LIST OF ACRONYMS

AR	Authorized Representative
AT	Assistive Technology
CAP	Corrective Action Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Managers
CIT	Crisis Intervention Training
CM	Case Manager
CMS	Center for Medicaid Services
CRC	Community Resource Consultants
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTH	Crisis Therapeutic Home
CVTC	Central Virginia Training Center
DARS	Department of Rehabilitation and Aging Services
DD	Developmental Disabilities
DSPs	Direct Support Professions
DMAS	Department of Medical Assistance Services
DBHDS	Department of Behavioral Health and Developmental Services
DOJ	Department of Justice, United States
DS	Day Support Services
ECM	Enhanced Case Management
EDCD	Elderly or Disabled with Consumer Directed Services
EPSDT	Early and Periodic Screening Diagnosis and Treatment
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
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
LIHTC	Low Income Housing Tax Credit
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center

ODS	Office of Developmental Services
OLS	Office of Licensure Services
PCP	Primary Care Physician
POC	Plan of Care
PMM	Post-Move Monitoring
PST	Personal Support Team
QI	Quality Improvement
QIC	Quality Improvement Committee
QSR	Quality Service Reviews
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
START	Systemic Therapeutic Assessment Respite and Treatment
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
WDAC	Waiver Design Advisory Group