

I. APPENDICES

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APPENDIX A.

INDIVIDUAL SERVICES REVIEWS

October 1, 2016 - September 30, 2017

Completed by:

Donald Fletcher, Independent Reviewer/Team Leader

Elizabeth Jones, Team Leader

Rebecca Wright, Team Leader

Marisa Brown RN, MSN

Kimberly Chavis RN BSN

Julene Hollenbach RN BSN NE-BC

Barbara Pilarcik RN BSN

Shirley Roth, RN MSN

Demographic Information

Sex	n	%
Male	15	57.7%
Female	11	42.3%

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

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

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

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

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

Healthcare

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

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

Healthcare Items –Psychotropic Medications - areas of concern				
Item	n	Y	N	CND
Is the individual receiving supports identified in his/her individual support plan? Mental Health (psychiatry)	13	76.9%	23.1%	0.0%
If the individual receives psychotropic medication: is there documentation of the intended effects and side effects of the medication?	13	84.6%	15.4%	0.0%
is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	13	84.6%	15.4%	0.0%
does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?	13	7.7%	92.3%	0.0%

Individual Support Plan

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

Individual Support Plan Items – positive outcomes				
Item	n	Y	N	CND
Is staff assisting the individual to use the equipment as prescribed?	18	100.0%	0.0%	0.0%

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

Case Management

Case Management – positive trend, sustained				
<i>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.</i>				
1st review period 2012	3rd review period 2013	5th review period 2014	7th review period 2015	9th review period 2016
46.9% (15 of 32)	88.9% (24 of 27)	96.4% (27 of 28)	95.8% (23 of 24)	96.2% (25 of 26)

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

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

Community Residential Services

<i>Residential Staff – positive outcomes Items</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Is residential staff able to describe the individual's likes and dislikes?	25	100.0%	0.0%	0.0%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	25	96.0%	4.0%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's talents/contributions and what's important to and important for the individual?	25	96.0%	4.0%	0.0%
Is there evidence the staff has been trained on the desired outcome and support activities of the individual's support plan?	26	100.0%	0.0%	0.0%

APPENDIX B.

Behavioral Support Services

By: Patrick Heick Ph.D., BCBA-D, LABA

To: Donald J. Fletcher, Independent Reviewer
From: Patrick F. Heick, Ph.D., BCBA-D, LABA, Manager, PFHConsulting, LLC
RE: UNITED STATES v. VIRGINIA, CIVIL ACTION NO. 3:12cv59-JAG
Date: November 5, 2017

The following *Summary* and *Addenda* were prepared and submitted in response to the Independent Reviewer's request to summarize a small sample of reviews completed as part of his larger Individual Services Review (ISR) Study. More specifically, the following summary is based upon the reviews of the behavioral services for eight individuals, a sample selected from a larger sample (N=25) by the Independent Reviewer. These reviews compared the behavioral programming and supports that are currently reported to be in place with generally accepted standards and practice recommendations with regard to components of effective behavioral programming and supports. These components included:

- (1) level of need (i.e., based on behaviors that are dangerous to self or others, disrupt the environment, and negatively impact his/her quality of life and ability to learn new skills and gain independence);
- (2) Functional Behavior Assessment (FBA);
- (3) Behavioral Support Plan (BSP);
- (4) ongoing data collection, including regular summary and analysis; and
- (5) care provider and staff training.

It should be noted the Reviewer does not intend to offer these as reflective of an exhaustive list of essential elements of behavioral programming and supports. Furthermore, these reviews were based on the understanding that all existing documents were provided in response to the Independent Reviewer's request. It should be noted that REACH Crisis Education and Prevention Plans were found in the provided documentation for several of the individuals. After consultation with the Independent Reviewer, this Reviewer considered these plans as provisional and supplemental in nature and not the primary on-going resource directing the current behavioral programming implemented by families and other care providers. Consequently, this Reviewer did not include evaluation of the REACH Crisis Education and Prevention Plans within the current review.

This Summary is submitted in addition to Individual Summary of Findings (Addendum D – submitted under seal) completed for each of the eight individuals sampled as well as Data Summaries (Addendum C). It should be noted that the following Summary as well as documents and data summaries within the Addenda are based upon off-site review of the ISR study's Monitoring Questionnaires, which were completed using information obtained during on-site observations and interviews with care givers, as well as documentation provided in response to the Independent Reviewer's document request (Addendum B).

Summary

Findings

1. Based on a review of the completed individuals' service records and other provided documentation as well as the completed ISR Monitoring Questionnaires, most of the individuals sampled had significant maladaptive behaviors that were not under control. These behaviors had dangerous and disruptive consequences to these individuals and their households, including negative impacts on the quality of these individuals' lives and their ability to become more independent. More specifically, of those sampled, eight (100%) engaged in behaviors that could result in injury to self or others, eight (100%) engaged in behaviors that disrupt the environment and seven (88%) engaged in behaviors that impeded his/her ability to access a wide range of environments. In addition, of those sampled, six (75%) engaged in behaviors that impeded their abilities to learn new skills or generalize already learned skills. Of those sampled, however, only five (63%) individuals (i.e., J.B., J.S., D.P., B.D., & J.E) were receiving formal behavioral programming through Behavior Support Plans (BSPs) at the time of the on-site visit. A sixth individual (i.e., J.O.) was reported by caregivers as receiving behavioral therapy at the time of the ISR on-site visit, however a formal behavior support plan was not yet in place. Overall, all (100%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence. Consequently, it appeared that all of these individuals would likely benefit from positive behavioral programming and supports implemented within their homes or residential programs (see Addendum C). Indeed, in lieu of these types of supports, one of the

families (i.e., C.W.) appeared to have designed their own behavioral programming without expert support and guidance.

2. As noted above, five (63%) individuals had BSPs. However, provided documentation revealed that the BSPs were not revised as planned for two (40%) of these individuals. That is, documentation was not provided that indicated that two initial BSPs (i.e., for B.D. & J.E.), which were designed to assist during the transition from a Training Center to a community-based home, were not revised as planned after sixty days in their new setting. More troubling was the finding that the development and implementation of a BSP for one individual (i.e., J.B.) was inexplicably delayed for almost one year after her admission to a group home. This appeared highly problematic as her challenging behavior placed her and others at significant risk. In fact, it was noted that her group home provider requested a change in her residential placement just weeks after the plan was finally implemented.
3. As noted above, five (63%) had BSPs. However, of these five, only three (60%) appeared to have had Functional Behavior Assessments (FBA) completed within their current settings (see Addendum C). When closely examined, of the three FBAs, only two (66%) appeared to be completed using descriptive methods. Generally accepted practice recommendations include developing a BSP based on results of a comprehensive FBA completed within the natural environment (current setting), including an emphasis on the use of descriptive (e.g., systematic direct observation) methods, in addition to indirect methods, when identifying and supporting potential hypotheses regarding underlying function(s) of target behavior.
4. As noted above, five (63%) of the individuals sampled had BSPs. Upon closer examination of these BSPs, it was noted that prescribed behavioral programming appeared inadequate (see Individual Summary of Findings for specific information). For example, although all of the BSPs identified target behaviors for decrease, none (0%) of the BSPs clearly identified and operationally defined specific functionally equivalent replacement behaviors (FERB). In addition, although evidence was provided demonstrating ongoing data collection and review of target behaviors for two (40%) of

these five individuals (note that the adequacy of this collection and review was questioned – see below), evidence that similar data collection and regular review was completed for functionally equivalent replacement behaviors was not found for any (0%) of the individuals sampled. Generally accepted practice recommendations include specifying target behaviors and FERB as well as ongoing data collection and regular review to promote data-based decision making and facilitate revisions, when necessary. Overall, of the individuals sampled, zero (0%) appeared to have adequate behavioral programming in place.

5. As noted above, five (63%) individuals had BSPs. Upon closer examination of these BSPs, it was revealed that only two (40%) were developed and monitored by a Board Certified Behavior Analyst (BCBA). The BCBA is the nationally accepted certification for practitioners of applied behavior analysis. This certification is granted by the Behavior Analyst Certification Board (BACB), a nonprofit corporation established to develop, promote, and implement a national and international certification program for behavior analyst practitioners.

Conclusions:

1. All of the sampled individuals demonstrated unsafe behavior that placed them and others at risk. Nearly all engage in behaviors that limited their ability to learn new skills and improve their independence and quality of life.
2. Many of the sampled individuals were not receiving formal behavioral supports (e.g., BSPs) to address unsafe and disruptive behavior as well as skill deficits that would likely improve their independence and quality of life.
3. For those individuals currently identified as receiving formal behavioral supports, most did not have adequate functional behavioral assessments; and behavioral programming did not meet standards of generally accepted practice.

4. For those individuals currently identified as receiving formal behavioral programming and supports, only two (40%) received supports from BCBAs.

Strengths:

1. Most of the BSPs identified potential antecedents and consequences of target behaviors as well as contained proposed hypotheses regarding the underlying function(s) of behavior. It should be noted, however, that this information did not appear to be based on current information for several individuals.
2. All of the BSPs included environmental modifications and supervision strategies aimed at preventing or reducing the likelihood of maladaptive behavior.
3. Most of the BSPs identified a method of measurement for target behaviors as well as described data collection procedures, including when the author was expected to summarize and analyze target behavior data.
4. All of the BSPs included proactive and reactive strategies aimed at preventing and responding to target behavior.
5. All of the BSPs identified potential reinforcers and prescribed the use of positive reinforcement.
6. Some of the BSPs included specific strategies designed to promote skill acquisition (i.e., of more adaptive responses).

Recommendations:

1. Individuals whose behaviors are dangerous to self or others, disrupt the environment, and negatively impact his/her quality of life and ability to learn new skills and gain independence should be offered formal behavioral programming and supports. These should:

- a) be developed, trained, and monitored by a qualified professional (e.g., Board Certified Behavior Analyst);
- b) include the completion of a comprehensive functional behavioral assessment, using at least indirect and descriptive methods, conducted within his/her current setting;
- c) include a behavior support plan containing the following key components (note: this list is not intended to be an exhaustive list of essential elements):
 - i. Clear specification of behaviors targeted for decrease, which are often referred to as target behaviors. This includes operationally defining target behavior using observable and measureable terms.
 - ii. Clear specification of behaviors targeted for increase, including functionally equivalent replacement behavior (FERB). The identified FERB should be based on findings of the FBA and, similar to target behaviors, should be operationally defined using observable and measureable terms. It should be noted that other adaptive, acceptable or alternative behaviors, that may not be considered functionally equivalent, may also be targeted for increase.
 - iii. Clear specification of measurement procedures regarding data collection of target and replacement behavior(s). At times, data collection on the use of restrictive or intrusive interventions is also prudent. Overall, the plan should specify how regularly these data will be collected, summarized and analyzed by the author of the plan in order to facilitate data-based decision making over time.
 - iv. Clear specification of environmental modifications or necessary supports (i.e., what should or should not be in place in the individuals' environment) to prevent or lessen the likelihood of target behaviors and support adaptive behavior.
 - v. Clear identification of antecedents (or 'triggers') and the provision of related preventative or antecedent-based strategies to lessen the likelihood of target behaviors and support the demonstration of replacement behavior.
 - vi. Clear specification of teaching strategies aimed at teaching and/or eliciting adaptive behavior, including FERB. Indeed, the key to effective reduction

of maladaptive behavior is the effective instruction of more effective and efficient FERB.

- vii. Clear identification of potential reinforcers (e.g., highly preferred items, activities, etc.) and the use of reinforcement – this should include procedures on how FERB will be reinforced. It should be noted that the BSP may specify reinforcement for other adaptive behaviors as well.
 - viii. Clear specification of reactive or consequence-based strategies that provide strategies of how to respond to target behaviors as well as FERB and acceptable/alternative behaviors.
 - ix. In general, the BSP should be individualized (e.g., based on the student's needs as well as skills, preferences, etc.) and emphasize positive behavior interventions and supports.
- d) include ongoing data collection of target behaviors and FERB(s) and, at times, other variables (as noted above) as well as regular summary, review and analysis by the author of the plan. Ongoing data collection and regular summary and review promotes data-based decision making and facilitates timely revision of the BSP, when necessary; and,
 - e) include evidence-based strategies.

2. Of the BSPs reviewed, three (60%) contained recommended interventions that are considered by many researchers to be controversial. These included sensory-based therapies (e.g., brushing, weighted vests, deep pressure) prescribed in three BSPs (J.S., D.P., & J.E.) as well as a Therapeutic Listening program prescribed in one BSP (J.S.). Researchers report that the amount of evidence supporting the effectiveness of interventions based on Sensory Integration Therapy (SIT) and Auditory Integration Training (AIT) is limited and inconclusive. In its policy statement, the American Academy of Pediatrics (AAP) recommended discussing the limited empirical support of SIT with parents as well as talking with families about conducting a trial period and teaching them how to evaluate the therapies effectiveness. In their technical report, the American Speech-Language-Hearing Association (ASHA) concluded that AIT should be considered an experimental procedure and cautioned its members to avoid its use. Given

these recommendations as well as the likelihood that some families and individuals may report a preference for the use of sensory-based strategies, this Reviewer recommends that authors of the BSPs discuss the limited evidence as well as the noted guidance presented above with families and providers. This Reviewer recommends that, if these strategies continue to be implemented, authors of BSPs work closely with families and providers to accurately monitor and evaluate the effectiveness of these interventions. In addition, it would be important to review current programming and examine whether or not the use of these strategies may be counter-therapeutic. That is, several of the BSPs included procedures that directed the use of these interventions contingent upon target behavior. This may have the unintended outcome of inadvertently reinforcing maladaptive responding (i.e., if the sensory-based strategies are highly preferred). Consequently, there is a risk that current procedures may maintain the occurrence of the target behavior through positive reinforcement. Lastly, alternative strategies (e.g., providing sensory-based strategies non-contingently, emphasizing their use as an antecedent-based intervention, and/or providing them contingent upon an alternative, adaptive response) and their potential role in lessen the likelihood of inadvertently reinforcing maladaptive behavior should be discussed with families and care providers.

Respectfully submitted by,

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

ADDENDA

A: Individual Services Review Monitoring Questionnaire, Section 9

B: Document Request

C: Data Summaries

D: Individual Summaries of Findings (submitted under seal)

Addendum A

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 9: SUPPLEMENTAL QUESTIONS

212.	Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others? If Yes, describe the behavior and how often it occurs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
213.	Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment? If Yes, describe the behavior and how often it occurs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
214.	Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)? If Yes, describe the behavior and how often it occurs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
215.	Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills? If Yes, describe the behavior and how often it occurs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
216.	Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence? If Yes, describe the behavior and how often it occurs: If Yes, is there a written plan to address the behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

Addendum B

The Independent Reviewer document request for each individual included:

1. Service Eligibility Assessment, (e.g. SIS, Level of Functioning).
2. All Sections* of the current Individual Support Plan / Plan of Care, including assessments, ISP/POC meeting minutes (include information that was distributed at the meeting), and any amendments. Also include Case Manager/Service Coordinator progress notes and any required monthly or quarterly reports for the period from 7/1/16 through 7/31/17. (If kept separately include any monitoring assessments of risks in the new setting and monitoring/assessment tools used). *Include for all services that may occur in the individuals' homes such as service facilitation, behavior specialist, in-home nursing care, on-site crisis response or in-home services, or respite care.
3. All Investigations/CAPs for the individual's residence (7/1/16-6/30/17).
4. Behavior Support Plan, a record of who was involved in its development, review, and approval; Psychological Assessment and/or Functional Behavioral Assessments; blank daily data sheet, behavior related staff training records; data for target and replacement behaviors (last three months); monthly data summaries and/or monthly graphed data (last three months); and any reassessments or BSP amendments since the BSP was initially approved; and consents (guardian, physician, etc.) and or review documentation (e.g. Human Rights Committee) for the Behavior Support Plan and/or for any rights restrictions, as appropriate.

If applicable:

- a. Any reports of serious injuries; allegations of abuse or neglect; and involvement with protective services, law enforcement, crisis or emergency psychiatric services, Emergency Medical Services (i.e. 911), or unexpected hospitalizations.
 - b. Referrals to Crisis Services; Crisis Education Prevention Plan.
 - c. Investigations completed by the Residential Provider/OLS/Adult Protective Services or other similar oversight organizations.
 - d. Health and Safety Support Protocols, related medical/clinical assessments; baseline data for any identified risk; documentation/data of monitoring the risk; records of data summary and review by the clinician; and any reassessments or Protocol modifications since the Protocol was initially approved.
6. Additional documents requested for the individuals who moved from a Training Center
- a. Discharge Plan and Discharge Plan Memo;
 - b. Assessments from the TC, including the annual psychological report;
 - c. Post-Move Monitoring Reports;
 - d. Social Worker notes

Addendum C:

Data Summaries:

Note: The Individual Services Review Monitoring Questionnaire items 212-216b are below)

Name	current FBA	current BSP	item 212	item 213	item 214	item 215	item 216a	item 216b
#1	1	1	1	1	1	1	1	1
#2	1	1	1	1	1	1	1	1
#3	1	1	1	1	0	0	1	1
#4	0	0	1	1	1	1	1	0
#5	0	0	1	1	1	0	1	0
#6	0	0	1	1	1	1	1	0
#7	0	1	1	1	1	1	1	1
#8	0	1	1	1	1	1	1	1
Total (N=8)	3	5	8	8	7	6	8	5
Percentage	38%	63%	100%	100%	88%	75%	100%	63%

Addendum D

(submitted under seal)

The following documents include Individual Summaries for eight individuals, selected from a larger sample (N=25) by the Independent Reviewer, based on off-site review of provided documentation, including individuals' service records and other documentation as well as the Individual Services Review Monitoring Questionnaires. These summaries assume that all available documents were provided in response to the Independent Reviewer's formal document request (see Addendum B).

APPENDIX C.

CASE MANAGEMENT

BY: Ric Zaharia Ph.D.

And

Deni DuRoy-Cunningham M.Ed.



Consortium on Innovative Practices

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

Case Management/Support Coordination
Requirements

By

Ric Zaharia, Ph.D.

&

Deni DuRoy-Cunningham, M.Ed.

November 1, 2017

Executive Summary

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a year-long, two-phase review of the case management/support coordination requirements of the Agreement. This review found that the Department of Behavioral Health and Developmental Services (the Department) has exerted concentrated efforts on additional case manager/support coordinator training. The Department has contracted for support from Virginia Commonwealth University (VCU) to complete a manual, a supervisory review tool, core competencies, and to update the Case Management Modules for online training. And there is an invigorated emphasis on supporting case managers/support coordinators in the Provider Development Section of the Division of Developmental Services.

For this Phase II, follow-up review we focused on 46 individuals with intensive behavioral challenges who live in 21 Community Service Boards (CSBs). Each review included at least a qualitative review of the Individual Support Plan (ISP) and recent case manager/support coordinator progress notes. We then conducted a discrepancy analysis using our review tool for key questions (see Attachment B) to determine what gaps exist between the individual's assessed needs and ISP goals, as documented in the case management/support coordination system reports and documents, and the services and supports that were actually being provided.

Our discrepancy analysis suggested that the most frequent shortcomings in the individual service plans for this population remains, as it was in our earlier review: ISP has specific and measurable outcomes. Other significant systemic trouble spots were:

- Documentation of being offered choice to change case managers/support coordinators,
- Employment services and goals must be developed and discussed
- Modifying the ISP as needed
- All essential supports listed in ISP

Finally, DBHDS has proposed that its Data Dashboard as the systemic measurement of the achievement of goals in the Agreement. To improve the reliability of the information in the Data Dashboard, DBHDS staff have worked to improve CSB data entry rates. However, this review identified eleven CSBs who have not met the DBHDS face-to-face goal of 90% since 2015. DBHDS has identified flaws in electronic data interfaces that may account for some of this underreporting. DBHDS projects that the system improvements associated with the interfaces should be evident later in FY18.

Methodology for Phase II Report

- Conducted discrepancy analyses of 21 Level 7 Individual Support Plans (ISPs) using a case management/support coordination review tool and based on a review of the case record notes and selected case manager/support coordinator interviews (see Attachment B);
- Conducted discrepancy analyses of 25 Level 7 ISPs during the Individual Service Review (ISR) using a case management/support coordination review tool;
- Reviewed *PC ISP 2015*, Provider Development Section;
- Reviewed selected Data Dashboards, October 2015 to March 2017;
- Reviewed minutes and selected work products of the Case Management Data Workgroup from CY 2017;
- Reviewed DBHDS PowerPoint: *Support Coordination/Case Management Quality Improvement*;
- Reviewed *My Life, My Community – DD CM Transition Questions*, 6/27/16, 8/29/16;
- Interviewed VCU (Virginia Commonwealth University) case management/support coordination contract liaison group members;
- Interviewed DBHDS leadership.

Phase I Findings Recap:

DBHDS has sponsored numerous trainings, which have been conducted statewide; many were focused on case management/support coordination. A DBHDS draft Risk Assessment Tool is being field tested by several CSBs; the goals are to provide insights about individuals with life threatening health conditions and to ensure heightened vigilance by case manager/support coordinators and providers.

In general, the case manager/support coordinators who were interviewed in Phase I knew the individuals on their caseloads well. The median length of time supporting the individual was eighteen (18) months with a range of one month to six years. The average caseload size was 1:33.

The results from the expanded analysis of items in the ISR and the case management/support coordination Review Tool for 47 individuals suggested the overwhelming problem among the 47 individuals was again the lack of measurability of outcome statements. A typical example we observed among outcomes was: *“John is supported to navigate his environment.”* *“I no longer want this outcome when ... John no longer has vision impairments.”* We observed this pattern of discrepancies across CSBs and Regions. These outcome statements are clearly difficult to monitor for accomplishment and to verify independently.

Other significant trouble spots in ISP case management/support coordination were: ISPs not modified as needed; examples included: sudden, and eventually long-term, loss of vision due to detached retina, the lack of an updated BSP after a change in residence, changed health and safety plans, and the lack of meaningful and integrated day activities. All essential supports were not listed in ISP; examples included: the lack of needed health and safety related assessments (e.g. for behavioral support), the absence of needed support protocols (e.g. no cardiac protocol in place for a pacemaker), and the lack of employment as a stated need (e.g. employment services and goals not included for individual with a history and interest in work).

Thirty-five (35) of the 47 (74%) were receiving enhanced case management/support coordination (ECM).

Phase II Findings

As in Phase I we conducted discrepancy analyses during Phase II of ISPs for 21 Level 7 individuals (“... *have intensive behavioral challenges, regardless of their support needs to complete daily activities or for medical conditions. These adults typically need significantly enhanced supports due to behaviors.*” *My Life, My Community*, 2016) using a case management/support coordination review tool and based on a review of the ISP record, case manager/support coordinator notes and selected case manager/support coordinator interviews. We also conducted discrepancy analyses of 25 cases that were reviewed during the Individual Service Review (ISR) study using a case management/support coordination review tool. The two studies combined gave us a total review population of 46 across 21 CSBs, with at least one CSB in each DBHDS service Region. Of the 46 individuals reviewed 34 (75%) were identified as receiving enhanced case management (ECM) by the case manager/support coordinator.

As we identified previously, including during the Phase I review, and now during the phase II review, the lack of ‘measurable, observable and specific outcomes’ was the most frequent problem in the ISPs. We found only a handful of appropriately stated outcomes that were written the way DBHDS trains case managers/support coordinators or that met the following criteria: *outcome statements that address community integration, increased independence and skill development in Part 5 of the ISP should demonstrate measurability in the section which asks "I will no longer need these supports, when...."; must reflect an accomplishment, not only an activity; must reflect the individual's participation, not only the activity of staff or others ; must be tied to the ISP time period - year, quarters, months; and must be realistic and achievable within the time period.* We specifically reviewed whether outcomes that address community integration, increased independence and skill building are included, where appropriate, as these are overall goals of the Settlement Agreement, as well as goals for individual members of the target population.

The few acceptable outcome statements were sprinkled through the several hundred we reviewed. However, taken as a whole, not one ISP met the standard we set or the way DBHDS trains; that is, out of 46 individual ISPs, zero had a complete, appropriate set of outcomes. We observed goals that were observable, but were very long term, and not tied to the ISP period ("when I no longer have Pica"); measurable but not specific ("when I can take medications on my own"); or unrealistic ("when I no longer need assistance in being understood or understanding others"). Very few put it all together for a good set of outcomes such as DBHDS suggests in their exemplar: "When I can purchase 5 outfits that fit my style..." (DBHDS, Provider Development Section, *PC ISP 2015*).

As DBHDS contemplates ways to address this issue, we want to be sure the scope of the issue is understood. The Provider Development Section is reportedly implementing a change that would electronically store ISPs, amendments, and outcomes in WaMS (the Waiver Management System) for centralized reviewing. The aim of this review is to ensure accountability for services by determining whether case managers/support coordinators craft outcome statements that meet the DBHDS standard and the goals of treatment (as described in the Settlement Agreement) and that can be assessed for accomplishment. We do not suggest that DBHDS should move toward highly detailed precision-teaching/ behavioral objectives. Again, because the outcome statements we observed were, on the whole, more alike than different, we believe case managers/support coordinators are being trained and

supervised to this result. Very few of the outcome statements we saw among these 46 individuals qualify as outcome statements that are measurable, observable and specific. (OLS Rules 12VAC35-105-20R.)

Several additional areas emerged in this review as trouble spots: documentation of being offered choice to change case managers/support coordinators was not confirmed in 25 of the 46 cases (61%). Many case managers/support coordinators reported that they had presented this choice verbally in the annual ISP meeting. However, case manager notes frequently stated that an offer of choice of case managers/support coordinators was conditional. The individual/AR had to first express dissatisfaction with the case managers/support coordinator's work. Although, the Agreement requires that the Commonwealth maintain records that document proper implementation of the provisions, DBHDS confirms that it has not established an expectation that there be documentation of this choice notice for individuals and authorized representatives, although it is a DBHDS requirement that they question satisfaction with services (*My Life, My Community – DD CM Transition Questions*, 6/27/16, 8/29/16). Development and discussion of employment service goals was missing in 7 of the 23 cases (30%) where applicable. Modify the ISP when needed did not occur in 2 of the 11 (18%) cases where our reviewers found that a major event had significantly changed the circumstances related to the Individual's Support Plan or high-risk factors and that the ISP should have been modified. All essential supports listed in the ISP was missing at least one service in 6 of 46 (13%) cases where we determined it should have been included.

We have previously raised concerns about the use of the Data Dashboard reporting as a response to SA requirements to report data. DBHDS has made efforts to drill down on these reporting issues and has identified some potential sources of the unreliable and under-reporting. DBHDS has convened a Case Management Data Workgroup to fine tune definitions of the data elements and troubleshoot data problems with the goal of more accurate and more complete reporting. There appears to be progress being made to clear up data entry problems at the electronic interfaces on data entries between CSBs and the DBHDS reporting platform, CCS3 (Community Consumer Submission 3); in particular changes that make the measures of Health & Wellbeing, Living Arrangements, and Day Activity more criterion based and that clarify the reporting window for face-to-face visits for enhanced case management (e.g. within 5 weeks of each other or within 40 days - 30 plus 10 days grace). There is not similar progress in the Community Inclusion and Choice & Self-determination reporting sections of the CCS3. There is also no change in the practice of case managers/ support coordinators completing their own unverified assessments of ISP goal accomplishments in the five domains included in the Data Dashboard. Their assessments frequently lead to reports that goals have been accomplished, or partially accomplished, when the goals are not written in a way that "accomplishment" can be observed or objectively verified.

It is not clear that the issue of complete and accurate reporting will be fully resolved through the implementation of data entry edits and improved electronic interfaces. While the Data Dashboard reports that most CSBs have achieved 90% or better on the critical measure of face-to-face visits, eleven (11) CSBs with a target population of 20 or more did not report over 86% between October of 2015 and March of 2017. This suggests the possibility that in these eleven underreporting CSBs with an extrapolated enhanced case management caseload of 1,547, at least 217 individuals each month may have not received the monthly face-to-face

visit required under Enhanced Case Management; alternatively, their face-to-face visits may have occurred, but not have been reported or registered. Furthermore, the statewide average on this measure does not appear to have improved much beyond 86% for the past two years, probably because of reported under-performance of these eleven CSBs. DBHDS reports that changes (i.e. data entry edits and clarifications at the state level) impacting these measures should be realized later in FY18.

To improve future case management performance, the Department has contracted for support from VCU to complete a manual, a supervisory review tool, CM/SC turnover study, core competencies, and updating to the Case Management Modules for online training. It is critical that the liaison group focus on the larger issue of case manager/support coordinator performance management to achieve compliance. The focus on case management performance is also necessary to foster system navigators who complete documentation which allows planning processes to work for the individual, whatever his or her needs and aspirations.

Conclusions

DBHDS is in compliance with the requirements of III.C.5.a.

DBHDS is not yet in compliance with III.C.5.b.i-iii., case managers/support coordinators assembling teams, assisting to access services, monitoring and amending ISPs.

DBHDS is not in compliance with the requirements of III.C.5.c. Offers of choice among residential and day service providers were documented. Although it may occur in some, or even many cases, offers of choice of case manager providers were consistently not documented. In addition, in current practice an offer of choice is conditional. It requires the individual and/or the Authorized Representative to take the lead by first expressing dissatisfaction directly to the case manager about the inadequacy of that very case manager's work.

DBHDS is not in compliance with the requirements of III.C.5.d, a mechanism to monitor compliance with performance standards for case management/support coordination. The DBHDS regulations do not align with the requirements of the Agreement. The OLS effort to increase scrutiny of CSB case management/support coordination has continued and the VCU project gives hope that a non-licensing approach to quality improvements in case management/support coordination performance is achievable.

DBHDS is not in compliance with the requirements of III.C.7.a. or with III.C.7.b. Case managers are frequently not developing and discussing employment service goals at the ISP Team level, particularly for individuals with more significant disabilities.

DBHDS is not in compliance with the requirements of III.D.5, regarding offering an unconditional choice of case management providers, as required by reference (IV.B.9).

DBHDS is not in compliance with the requirements of III.D. 6., regarding Regional Support Team and Community Resource Consultant review.

DBHDS is in compliance with the requirements of III.D. 7. The annual education regarding less restrictive options is now part of the annual ISP process. The ISP now includes a section

outlining the range of more to less restrictive options for residential and day choices. The ISP is reviewed, including this outline, and signed by, indicating the approval of, the individual or AR.

DBHDS is in compliance with the requirements of V.F.1 and 3.

DBHDS remains in non-compliance with the requirements of V.F.2.

DBHDS remains in non-compliance with the requirements of V.F.4., because DBHDS does not yet have evidence at the policy level that it has reliable mechanism/s to track case manager/support coordinator contacts.

DBHDS remains in non-compliance with the requirements of V.F.5. DBHDS does not yet have evidence at the policy level that it has reliable mechanism/s to capture case manager/support coordinator findings regarding the individuals they serve.

DBHDS remains in non-compliance with the requirements of IX.C. DBHDS does not yet maintain sufficient records to demonstrate the proper implementation of these provisions.

Recommendations to achieve compliance:

Work should continue on developing measurable criteria for the goal domains of Community Inclusion and Choice & Self-determination. For example, see the MH definition for employment on the Data Dashboard; not only is the terminology content useful, but the goal itself lends itself to stretching the ID system to meet SA goals. A verification strategy (perhaps by supervisors) should be evaluated to minimize the built-in bias possible in these measures by case manager/support coordinator reporting.

DBHDS should require that CSBs achieving less than 80% on all Data Dashboard measures provide a 'data entry improvement plan'; CSBs achieving less than 90% should provide a 'case management/support coordination performance improvement plan.' CSBs not meeting DBHDS targets over time should be provided additional support and technical assistance.

DBHDS should require documentation of annual choice offerings among providers, specifically including case managers/support coordinators. This offer could be added to the annual ISP process, as has the annual requirement to provide education of less restrictive services. The annual ISP process could include a meaningful discussion and standard offer of choice of service providers including case managers and sign off by the individual/AR.

DBHDS should rely on the VCU contract to enhance its systems to monitor and to improve CSB case management/support coordination performance, in order to ensure compliance with the Commonwealth's standards and the requirements of the Settlement Agreement. The monitoring methods that are used should include tools so that CSBs can be held accountable for acceptable performance. This enhancement must take into account that there are now at least three case manager/support coordinator auditing efforts ongoing in the system (Del Marva, SA, and DMAS)

Suggestions for Departmental consideration:

DBHDS might consider introducing a step-down goal tied to the ISP year to make measurable the Outcome statement tied to, “I will no longer need these supports when...”; this approach would leave intact most currently drafted Outcome statements for the future but give DBHDS a real clear method to insist on a time bound, measurable, achievable and specific goals.

DBHDS should consider conducting an annual refresh or validation of the enhanced case management/support coordination database, above and beyond the monthly, voluntary update.

DBHDS should also consider prioritizing VCU work on the case management/support coordination Manual and the CM/SC Review Tool.

DBHDS should consider specialized competency certification above and beyond the basics for serving individuals with autism, with behavioral health challenges, with medical complications, etc.

Attachment A Settlement Requirements

I.A.

The Parties intend that the goals of community integration, self-determination, and quality services will be achieved.

III.C.5.a-d.

5. Case management

a. The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.

b. For the purposes of this Agreement, case management shall mean:

- i. Assembling professionals and non-professionals 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.*
- 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; and*
- iii. Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.*

c. Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case manager 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 manager to give individuals a choice 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.

d. The Commonwealth shall establish a mechanism to monitor compliance with performance standards.

Section III.D.1-2 and III.D.5-7

Community Living Options

- 1. The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.*
- 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, including local, State, or federal affordable housing or rental assistance programs (tenant-based or project-based) and the fund described in Section III.D.4 below.*
- 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.*
- 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 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.*
- 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 (and, if relevant, to their authorized representative or guardian).*

Section 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.

Section III.C.7.b.

.....The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in ISPs.

Section V.A.

To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships)...

Section V.F.1-4.

F. Case management

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.*
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. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.*
3. *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:*
 - a. Receive services from providers having conditional or provisional licenses;*
 - b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS") category representing the highest level of risk to individuals;*
 - c. Have an interruption of service greater than 30 days;*
 - d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;*
 - e. Have transitioned from a Training Center within the previous 12 months; or*
 - f. Reside in congregate settings of 5 or more individuals.*
4. *Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case manager on the number, type, and frequency of case manager contacts with the individual.*

V.F.5.

5. *Within 24 months from the date of this Agreement, key indicators from the case manager/support coordinator's face-to-face visits with the individual, and the case manager/support coordinator's observations 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 Section V.D.3 above.*

Case Management/Support Coordination

Note: Answers are based in part by verbal responses from Case Managers

35. (1)	<p>Has the Individual's Support Plan/Plan of Care been modified as necessary in response to a major event for the person, if one has occurred?</p> <p>If No, describe the major event:</p> <p><i>(A major event is one that significantly changes the circumstances related to the Individual's Support Plan/Plan of Care goals or high risk factors.)</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
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39. (1a)	<p>Does the Individual's Support Plan/Plan of Care have specific and measurable outcomes and support activities?</p> <p><i>(DBHDS expects measurable statements to be included in the ISP template section, "I will no longer want/need supports when...")</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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40. (1b)	<p>Are all essential supports listed?</p> <p>If No, identify what is missing or not provided:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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34. (10)	<p>c. Was the individual or family given a choice of service providers, including the Case Manager/Support Coordinator?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
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139.	<p>Does the individual qualify for additional case management review?</p> <p>a. If Yes, is there evidence of a face-to-face meeting with the individual at least every 30 days, with at least one such visit every two months being in the individual's place of residence?</p> <p>b. If No, and receiving ID waiver funded services, is there evidence of case management review at least every 90 days as required for the ID Waiver?</p> <p>c. If No, is the individual residing in a nursing home or without active needs and does not meet criteria for case management services under Medicaid?</p> <p>d. If No, is the Case Manager meeting with the individual face-to-face on a regular basis and conducting regular visits to the individual's residence, as dictated by the individual's needs?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> NA <input type="checkbox"/> No</p>
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41. (11), (11a)	<p>If applicable, were employment goals and supports developed and discussed?</p> <p>a. If Yes, were they included?</p> <p>b. If No or NA, were integrated day opportunities offered?</p> <p>c. Does typical day include regular integrated activities?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
Comments:		

APPENDIX D.

CRISIS SERVICES

By: Kathryn du Pree MPS

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

***PREPARED BY KATHRYN DU PREE, MPS
EXPERT REVIEWER
November 6, 2017***

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SECTION 1: OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer, has contracted with independent consultant, Kathryn du Pree, as the Expert Reviewer, to perform the review of the crisis services requirements of the Settlement Agreement. This review, which is for the time six-month period 4/1/17-9/30/17, is Phase II of a yearlong two-phase study. This review will analyze the Commonwealth of Virginia's status toward implementing the following requirements:

The Commonwealth shall:

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

SECTION 2: PURPOSE OF THE REVIEW

This, the Phase II review of crisis services and prevention, will focus on the findings from the Phase I study that was completed during the tenth review period and the recommendations made by the Independent Reviewer in his December 23, 2016, Report to the Court.

All areas of the crisis services requirements for both children and adults will be included and reported on in terms of accomplishments and compliance in this, the second report of the two-phase study. It includes a qualitative review of the crisis supports and other needed and related community services for thirty-six individuals who were referred to REACH to determine what services were needed and provided, how effective the supports were, and whether the community service capacity is sufficient to assist individuals to remain in their homes with appropriate ongoing services.

The focus of this review will be on:

- The Commonwealth's ability to provide crisis prevention and intervention services to children with intellectual or developmental disabilities (DD), that are other than DD, including the status of providing out of home crisis stabilization services.
- The Commonwealth's plan to reach out to law enforcement and criminal justice personnel to effectively work with individuals with intellectual and developmental disabilities to address crises and crisis intervention services to prevent unnecessary arrests or incarceration.
- The quality of crisis services that individuals are receiving from the eight regional REACH programs. Three Regions have combined their REACH programs for children and adults under one administration. Regions III and IV have separate programs for children and adults

SECTION 3: REVIEW PROCESS

The Expert Reviewer reviewed relevant documents and interviewed key DBHDS administrative staff, REACH administrators, REACH staff, and families to gather the data and information necessary to complete this study. This information was analyzed to determine the current status of implementation of the requirements of the Settlement Agreement. The documents reviewed included those provided by the Commonwealth that it determined demonstrated its progress toward achieving compliance.

Documents Reviewed:

1. Children's REACH Quarterly Report: FY17 Q4
2. Children's REACH Quarterly Report: FY18 Q1
3. Virginia Children's REACH Annual Report: FY17
4. Adult REACH Quarterly Report: FY17 Q4
5. Adult REACH Quarterly Report: FY18 Q1
6. Virginia Adult REACH Annual Report: FY18
7. DBHDS Quarterly Qualitative Reviews of Children's and Adults REACH Programs for FY17 Q4
8. Records of the sixteen children selected for the qualitative study

Interviews with DBHDS and REACH staff: I interviewed Heather Norton, Director, Community Support Services; Sharon Bonaventure, DBHDS REACH Coordinator for Regions I and II, Katherine Long, Children's REACH Program Director for Region II, and Brandon Rodgers, Children's REACH Program Director for Region V and numerous staff from the REACH teams in Regions II and V. The staff were all interviewed as part of the qualitative study of sixteen children who received REACH services during this reporting period. I appreciate the REACH Directors involvement to coordinate the schedules for all of these interviews and the time that everyone gave to contributing important information for this review.

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

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

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

- i. Provide timely and accessible support to individuals who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families;*
- ii. Provide services focused on crisis prevention and proactive planning to avoid potential crises; and*
- iii. Provide 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. Review of The Status of Crisis Services to Serve Children and Adolescents

The information provided below is from the two Children's REACH Quarterly Reports that DBHDS provided for March 1-June 30,2017, Quarter 4 of Fiscal Year 2017(FY17) and July 1-September 30, 2017, Quarter 1 of Fiscal Year 2018 (FY18).

REACH Referrals- The number of referral to Children's REACH Programs continued to increase for the third review period: 636 referral calls occurred during the 11th review period, 507 referrals during the tenth reporting period, and 363 during the ninth reporting period. There was a 75% increase between to ninth and eleventh review periods

The number and percentage of crisis versus non-crisis referral calls were 175 (57%) during FY17Q4 and 167 (51%) in FY18Q1. The percentage of crisis calls across this period is 54% of all of the referrals. This is a comparable percentage to the crisis versus non-crisis calls in the tenth period, which was 55% of all referrals. The number of crisis calls has been relatively stable over the past three quarters, averaging 167 per quarter. This average was 42% higher than the number of calls during FY 17 Q2 period when there were only 118 crisis calls. Non-crisis calls have steadily increased over the past four quarters: 106, 121, 133 and 161.

Region V received the most crisis calls and Region II received the most non-crisis calls in the eleventh period, which was the same distribution in the tenth reporting period.

Families and CSB's Emergency Services (ES) are the primary sources of referrals for REACH services. Referrals made by families and ES combined accounted for 66% of the total referrals during the eleventh review period and 65% of the referrals in the tenth period. In most regions ES is the primary referral source and families are the second highest source. Case Managers provide 15% of all referrals, which is the third most frequent source as was evidenced in the tenth period. Hospitals made 11% of the referrals during the eleventh reporting period and 10% in the previous reporting period

Conclusion: These data indicate that ES and hospital personnel are aware of, and the need to contact, REACH when a referral for a hospital admission is made. The sources of the referrals are remaining very constant across reporting periods.

Table 1 summarizes the number of referral calls across both quarters.

Table 1: Total Children's Referral Calls

Call Type	RI-Q4	RI-Q1	RII-Q4	RII-Q1	RIII-Q4	RIII-Q1	RIV-Q4	RIV-Q1	RV-Q4	RV-Q1	Total
Crisis	46	33	33	40	24	29	18	18	54	47	342
Non-Crisis	14	38	45	55	16	23	35	19	23	26	294
Total	60	71	78	95	40	52	53	37	77	73	636

Time of Referral- The REACH programs track the time and dates of referral calls. This information is presented in a separate chart. The numbers in this review period match the numbers in the Referral Breakdown by Type, which reflects the total referral activity. Of the referral calls, 87% were received Monday through Friday, whereas, 13% were received on weekends or holidays. This is the exactly the same as the comparison by percentage of weekday versus weekend calls as occurred during the tenth reporting period.

The time of the day during which a call is received is not broken down by weekdays versus weekend days, but reflects that, during the eleventh period 51% of the 636 calls were received between 7AM and 3 PM, and 42% between 3PM – 11PM time period, 42%. The data do not distinguish calls that were made after 5 PM. The remaining 7% of the calls were received between 11PM and 7AM. During the tenth period, slightly higher percentage (44%) of the calls were received between 7AM and 3PM and the same percentage (7%) were received between 11PM and 7AM. This pattern of referral calls occurring during the typical work hours on weekdays is a similar for adults with IDD. It would be helpful if future reports could differentiate the calls that were received during the typical workday ending at 5PM. The data are not currently displayed this way because the reports reflect the hours of the three shifts of REACH crisis call coverage.

Referrals for Individuals with ID and DD- The Children's REACH Program continues to serve a high percentage of individuals with developmental disabilities, other than intellectual disabilities, versus individuals with intellectual disabilities. These data are broken out by three categories: intellectual disability only (ID-only); ID and DD; and a developmental disability only (DD-only). During the reporting period 412 (65%) of the individuals served were reported to have a DD-only, compared to 44% in the tenth period, but similar to the 64% in the ninth reporting period. Only 18% of children served by REACH had an ID-only diagnosis in the eleventh reporting period. During both the ninth and tenth review periods 16% of individuals referred to REACH ID- only.

Conclusion: The REACH Children's Program continues to receive an increased number of referrals in each reporting period. The increase was 25% in the eleventh period after a 39% increase in the number of referrals between the ninth and tenth reporting periods. These increases demonstrate that the program's efforts to reach out are connecting children in need with the statewide children's crisis services. Although the rate of increased may slow, the number of referrals per review period is likely to increase further. The Commonwealth's outreach efforts are reaching individuals with diagnoses that are across the spectrum of intellectual and developmental disabilities.

The Children's REACH programs also receive many other non-crisis and information calls. These totaled 3,290 additional calls in the eleventh period and 939 additional calls in the tenth period. DBHDS will need to remain mindful of the growing number of referrals and non-crisis and informational contact calls to ensure that each REACH Children's program has sufficient staffing resources to answer these calls and to meet the needs of these children and their families.

The distribution of diagnoses remains relatively constant with the prevalence being children with DD only. This pattern may indicate that there is a higher number of children with autism or mental health diagnoses than adults. This was borne out by the diagnosis of many of the children in the qualitative study. This may have implications for the training REACH staff will need and the type of community resources and clinical expertise that will be needed to maintain children in their home settings.

Response Time- In all five Regions, and in both quarters, the REACH staff responded onsite within the required **average** response times. Only Regions III and IV, however, responded to every call within their required time periods. Regions I and V responded on-time to 94% and 96% of the calls, respectively. Region II had the most significant difficulty responding to calls within the one-hour expected timeframe. Region II had 115 calls that required a face-to-face response and was able to only respond to 92 (80%) of the calls within the one-hour expectation. This is an improvement over the last reporting period when Region responded only to 60% of the calls within the one-hour expectation. DBHDS had previously designated all of Region II as “urban”. However, Region II now, with the addition of CSB area previously assigned to Region I, has areas that are designated as rural, as a result of the regional reconfiguration that occurred during the tenth period. Region II had twenty-seven calls from these rural areas, and responded to all of them within the two-hour time requirement. DBHDS has the Region report on calls from its “rural” and “urban” areas separately, and reports whether the calls from its rural were responded to within the two-hour requirement.

DBHDS has included a new table in the quarterly REACH reports that provides a breakdown of response time in 30-minute intervals. This is useful information as it helps to determine how many of the calls can be responded to fairly quickly. While the Settlement Agreement requires a one or two-hour response time depending on urban or rural geography, these expectations may not be consistent with the time needed to actually have a REACH staff respond on site in time to participate fully in the crisis screening. During the eleventh review period, 71% of all of the calls were responded to within sixty minutes; 26% were responded to within thirty minutes including crisis calls in the rural regions. The REACH team in Region I, which is a large geographic area and is designated as a rural area, was able to respond to 50% of its crisis calls within thirty minutes.

The state’s overall timely onsite response rate was 92% with 439 of the 478 calls responded to within the expected one-hour or two-hour timeframes. This compares very positively to the tenth period when only 83% of the 386 calls were responded to on-time. This is particularly noteworthy because 92 more calls required a face-to-face on-site response during this review period. DBHDS did not report formally on the reasons for the delays, but Heather Norton explained the reason was usually related to traffic delays.

The average response times ranged from 43-74 minutes in FY17 Q4 and 43-63 minutes in FY18 Q1, which meets the Settlement Agreement’s requirement for average length-of-response time.

Of interest is that all Regions respond onsite to every crisis call. The number of crisis calls responded to is higher than the crisis referrals during the period because the number includes responses to individuals who are already involved with REACH who experienced a crisis. The number of mobile crisis assessments completed during the eleventh review period was 478, which is a 95% increase over the 245 assessments during the ninth period, a year earlier, and a 24% increase over the 386 assessments during the tenth period.

The locations where mobile assessments occur are also included in the data provided. During the eleventh review period, hospitals, where 212 (44%) of the 478 assessments occurred remained the most frequent assessment settings, which is the same percentage that was reported for the tenth period. The next most common location for assessments was again family homes where 147 (31%) were completed, which also matches the 31% of assessments that occurred in family homes during the tenth period. The ES/CSB location, the third most frequent, is where ninety-three (19%) assessments were reported to have been completed during the tenth period. The percentage of crisis assessments that occurred in these three settings during the eleventh and tenth periods was similar during the ninth period.

Conclusion: The fact that 212 assessments were conducted in hospital settings and ninety-three were performed at the ES/CSB locations, which accounts for 63% of all crisis assessments, indicates that REACH continues to be notified of more pre-admission screenings by CSB ES staff. The REACH Children's programs continue to experience a significant increase in both referrals and requests for mobile crisis assessments. REACH is being informed of possible psychiatric admissions for far more individuals now that the program is more established and the Commonwealth's outreach efforts have continued.

Mobile Crisis Support Services- During the eleventh review period, the Children's programs provided mobile crisis support to 365 children, an increase of forty-five children from the number who received mobile supports in the tenth period. Of the 365 children, thirty-four were readmitted to the program. The Regions vary considerably in terms of how many individuals receive mobile crisis supports. The number of children served by region is as follows:

Region I	131
Region II	130
Region III	17
Region IV	57
<u>Region V</u>	<u>30</u>
Total	365

This review did not find that DBHDS had completed an analysis as to of the reason Region III provides mobile crisis support services to far fewer individuals than any other region. Similar to the eleventh period, the Region III REACH program served only nineteen children during the tenth review period, whereas the REACH programs in Regions I and II are served 71% of the total number of children in the state who receive mobile supports. The numbers above, of the children who receive mobile crisis supports, are all higher than the number of

children who were reported to have used REACH as a result of a crisis assessment as described below. The number who receive mobile crisis supports includes open cases and non-crisis cases, as well as the number of children who were served as the result of a crisis assessment during the review period.

DBHDS reports on the disposition at both the time of the crisis assessment and after completion of the mobile support services. Of the 479 individuals assessed by REACH, 176 (37%) were hospitalized when the assessment was completed, whereas 298(62%)children were able to remain with their families. Of these 298 children 198 (66%) needed mobile crisis support services to remain-home. Unfortunately, the maturing of the REACH crisis service for children did not result in reducing the percentage of children who were hospitalized at the time of the crisis assessment During the tenth period, only 27% of the children assessed were hospitalized and 70% of the children were able to remain at home. Far more children who did remained at home during the eleventh period, however, were provided mobile supports (66%), compared with the tenth period when only 37% of the children received mobile supports. In Region II, all but one family used mobile supports after the crisis assessment. This may be an indication of families' increased willingness to accept REACH services for their children and the ability of the REACH programs to provide a needed service.

Table 2: Disposition at the Time of Crisis Assessment- 4/1-9/30/17

Region	Psychiatric Admission	Other	Community Crisis Stabilization Program	Home with Mobile Supports	Home without Mobile Supports	Total
I	26	0	0	42	11	79
II*	46	0	0	95	1	142
III	30	0	3	10	16	59
IV	30	1	0	23	45	99
V	44	1	0	28	27	100
Total	176	2	3	198	100	479

The quarterly reports for the eleventh review period include data on the disposition for individuals at the completion of mobile crisis supports. The data demonstrates that 305 (85%) were able to remain living in their home. It is positive that only two of these children needed further mobile crisis supports at the end of the reporting period. Fifty-five of the children (15%) who received REACH crisis services during the eleventh period were hospitalized for psychiatric reasons at the end of mobile supports being provided. The two percentages for the eleventh period are generally comparable to those reported in the ninth and tenth reporting periods when 85% and 90% respectively, remained living in their home, with very few needing additional mobile supports. However, the hospitalization of 15% of the children who received mobile supports is higher than the previous periods when 9% in the tenth period and 7% in the ninth period were hospitalized. During all three periods 85% of the children who received crisis assessments and provided mobile supports were able to remain living with their families.

It is concerning, however, that as the REACH programs for Children have matured, a trend over three review periods indicates that a larger percentage of children were hospitalized. None of the children in the qualitative study were hospitalized after REACH supports were offered. All of the Regions, except Region V, experienced increases in the number of children hospitalized after REACH provided services. No child was hospitalized in Region V after receiving REACH mobile supports. The increase in hospitalizations after REACH programs have been involved, is the opposite outcome that was expected and desired by the creation of the REACH teams. DBHDS should carefully study this negative outcome and determine what changes are needed to the provision of crisis services that reduce psychiatric admissions, when alternatives are available or are not clinically necessary.

Table 3: Disposition at the Completion of Mobile Supports- 4/1/17-9/30/17

Region	Psychiatric Admission	Alternative Residential	Home with extended Mobile Supports	Home without Mobile Supports	Medical Hospital	Total
I	26	0	0	105	0	131
II	17	0	0	112	1	130
III	5	1	0	11	0	17
IV	7	0	6	45	1	59
V	0	0	0	30	0	30
Total	55	1	2	303	2	367

Number of Days of Mobile Support- REACH is expected to provide three days of mobile crisis support on average for children and adolescents. Every Region provided at least an average of three days of mobile support. The average ranged from 3-14 days. Three days was the average for Region IV in both quarters of the eleventh review period and was also the average for Regions I and V in FY18 Q1. Region III served the fewest children in both quarters but continues to provide the highest average number of days of mobile supports: an average of fourteen days in FY17 Q4 and of ten days in FY17 Q4.

The mobile crisis support services include: comprehensive evaluation, crisis education prevention plan (CEPP), consultation, prevention follow-up, and family/provider training. The CEPP and prevention follow-up are required elements of service for all REACH participants. It is difficult from the presentation of the data to determine if everyone received a CEPP who should have one because the child may have had a CEPP completed during an earlier interaction with REACH. The following table is comprised from two data sets in the REACH quarterly reports. The column that is labeled Mobile Supports is from the table in the REACH quarterly reports that summarizes the total number of children who received mobile supports. The data regarding evaluations, CEPPs, consultation and provider training are derived from the table in the REACH quarterly reports that summarizes all of the service elements the REACH team provides to participants. Table 4 portrays this information below.

Table 4: Children Receiving Mobile Supports and CEPP

Region	Mobile Support	Evaluation	CEPP	Consultation	Provider Training
I	131	131	131	131	131
II	130	114	113	114	100
III	17	17	17	17	17
IV	59	41	41	41	41
V	30	30	23	30	23

The number of children who received mobile supports in the review period may be higher than the number who have a CEPP developed, because some children may have been REACH participants before the reporting period, had previously been evaluated, and had a CEPP completed. However, everyone who receives mobile support is required to have an evaluation and consultation. The reports from Regions I, III and V reflect compliance with this requirement. These three Regions have evaluated everyone who received mobile supports and provided them with consultation. In Region II the 114 individuals who were evaluated received consultation, but sixteen individuals receiving mobile supports were not evaluated. In Region IV the forty-one individuals who were evaluated received consultation, but eighteen individuals receiving mobile supports were not evaluated. The data from Regions II and IV included the most variation in the total number of children who received mobile supports compared to those who received any of the service elements.

Conclusion: It is evident that a significant number of children served (9%) did not receive the required evaluation or consultation that DBHDS requires, although this program deficiency was reduced from 19% in the tenth period.

Training- Children's REACH staff have provided extensive training during the reporting period. The following groups and number of individuals has been trained:

- Law Enforcement- 196
- CSB employees- 324
- Family members 719
- Residential staff- 823
- ES staff- 72
- Hospital staff- 78
- Other community partners- 329

More hospital employees were trained in the eleventh period compared to the tenth period; whereas, significantly more family members and residential staff were trained during the eleventh period. Fewer law enforcement, CSB staff, and other community partners were trained in the eleventh period compared to the numbers trained in the tenth period. The total number of individuals trained during the eleventh was 2541, which is a significant increase over the 1619 individuals trained in the tenth period. However, there are

noticeable differences across the Regions. These high numbers are dramatically influenced by the training initiatives in Region V. Region V' REACH staff trained the most individuals in all categories, except ES staff. They trained 45% of the CSB employees, 67% of the residential providers, 73% of the hospital staff, and 78% of the families.

Neither Regions I or II trained any law enforcement, and Regions I, II and III did not train any hospital staff. Overall, Region I provided training to only 3% of all of the stakeholders who were trained in the eleventh period. There was a similar pattern in the tenth period, during which Region I did not train any hospital staff; Region II did not train any law enforcement, CSB employees or hospital staff; and Region IV did not train any hospital staff. Region I's REACH team has not trained any hospital staff in the past year and Region II has not trained any law enforcement or hospital staff in the past year.

Conclusion: A significant amount of training was provided during this reporting period. However, Region V, and to some extent Region IV, provided the vast majority of the training. It is difficult to determine if each Region is meeting the training needs of its communities without information about the total number of CSB, provider, ES or hospital staff that may need to be trained or information about turnover in these areas. However, it is likely that all Regions have more similar than different training needs in these groups. The wide variation in the amount of training that has been accomplished indicates that some Regions REACH teams are not meeting the training expectations of the program. This lack of training may contribute to difficulties with timely referrals, appropriate intervention by law enforcement and families not being well informed about this resource for their children.

Crisis Stabilization Programs (aka Crisis Therapeutic Homes – CTH) The Children's REACH programs still do not have crisis stabilization homes, which DBHDS now calls Crisis Therapeutic Homes (CTH) in any of the Regions. In the Settlement Agreement, the Commonwealth committed to develop such programs for children as of June 30, 2012. DBHDS issued an RFP May 1, 2016, to develop out-of-home crisis respite services during FY17. There is funding available to develop two homes in the Commonwealth; each will have the capacity to serve six children. DBHDS believes that these two homes when supplemented with respite services and therapeutic host home options will be sufficient to meet the needs of children who need time out of their family homes to stabilize and for in-home supports to be put in place, if needed. DBHDS did not receive suitable responses from prospective providers to its initial RFP. At the time of this review, DBHDS was in the process of finalizing contracts with recently identified providers.

DBHDS reported in the spring of 2017 that out-of-home respite services will be available in the fall of 2017 and that two CTHs will open early in calendar year 2018. However, these scheduled developments have both been delayed. The planned opening of the two CTHs is now delayed to the end of FY18. The architectural plan of the CTH for adults in Region IV will be used for both of the CTH's for children. The sites for both of the CTHs have been selected. Richmond CSB, which operates the adult and children's REACH programs, will also operate Virginia's southern CTH for children. The CSB plans to start hiring staff in January 2018. The Rappahannock/Rapidan CSB will operate the northern CTH for children. DBHDS is planning to execute sole source contracts for the out-of-home therapeutic respite,

because it did not receive suitable responses to the RFP. DBHDS is now projecting that these services will become available as early as January, but no later than June 2018.

Psychiatric Admissions- DBHDS reported that 207 children were admitted to psychiatric hospitals during the eleventh reporting period. This is a 51% increase over the 137 children who were admitted to hospitals during the tenth period, which was a 37% increase over one hundred children who were reported admitted in the ninth period. The number of children admitted to psychiatric hospitals was more than double the number that was reported in the eighth period. It remains unclear whether some of the increase reflects better reporting or a significant increase of children being admitted to psychiatric facilities. However, the fact Virginia has experienced steady increases over three reporting periods is very troubling. For the third reporting period in a row, sixty-eight (68%) returned home upon discharge. During the eleventh period, seven of the children, compared to eleven of the children in the tenth period, were placed in an alternative residence. Thirty-eight (15%) remained hospitalized compared to twenty-seven (19%) who remained hospitalized in the tenth period. Again, DBHDS did not report on what settings were used for alternative placements. It will be helpful in the future to know if these are sponsor homes, group homes or residential treatment facilities. The Other category was higher than in previous reports, accounting for 14% of the reporting with the majority in Regions II and V. REACH was aware of 231 psychiatric admissions as reported in Tables 2 and 3 (176 at the time of crisis assessment and 55 after using mobile supports). This is the first reporting period when the number of known hospitalizations was lower in the addendum than the numbers reported in Tables 2 and 3.

Conclusion: The Children's REACH programs continue to be involved with almost all children with IDD once they are admitted to psychiatric institutions. There are a few examples of where this did not happen in the qualitative study, but these admissions occurred because REACH was not contacted at the time of the hospital screenings. REACH still cannot offer crisis stabilization homes as a diversion to hospital admission. Without the availability of these settings, it is impossible to determine if some of these admissions could have been appropriately prevented, or if the length of time a child was hospitalized could have been reduced. It is particularly troubling that these settings remain undeveloped in light of the dramatic and, for at least three periods, steady increase in the number of hospitalizations for psychiatric reasons in the eleventh reporting period. The Commonwealth should carefully study the factors that have and continue to contribute to an increased number of children being hospitalized, and determine what corrective actions might be taken. Separate from whether all of the admissions of these children were clinically appropriate, during the period when REACH programs were put into place to prevent and provide alternatives to psychiatric hospitalizations, the reported number of children admitted for psychiatric hospitalization has increased. If the reported numbers are accurate, an increase in the number of children admitted for psychiatric hospitalization would be the opposite of what was expected, desired, or planned.

Performance Indicators for Children's Crisis Services- DBHDS has developed seven performance indicators for Children's REACH services. These include expectations for:

- A plan to track the use of crisis stabilization beds and the disposition of those served (*on hold until homes are developed*);
- the creation of respite beds as a preventative strategy (*not yet available*);
- Quarterly reviews of the Regional programs' adherence to standards and clinical reviews (*ongoing*);
- Annual quality reviews of psychiatric hospitalizations and the involvement of REACH crisis services programs (*will be done a part of regional quality review process*);
- A retrospective review of psychiatric hospitalizations during FY15 (*completed*);
- The development and implementation of improvement plans to address identified areas of improvement (*ongoing*); and
- Data collection regarding individuals who come into contact with law enforcement (*ongoing*).

DBHDS continues to undertake quarterly quality reviews of each REACH program. DBHDS staff examines contract requirements and program standards alternately. DBHDS staff includes a review of two cases during each qualitative review. DBHDS did share one of the quarterly reviews with me for children services. This was not a focus of the review during the eleventh period, but reading it added to my understanding of the qualitative issues.

Involvement of Law Enforcement-DBHDS reports the number of crisis responses that involve law enforcement. DBHDS reported that law enforcement was involved in a total of seventy of the 252 (28%) crisis responses during FY17 Q4 and sixty- nine (31%) of the 224 crisis responses in FY18 Q1. These percentages were 17% in FY17 Q2 and 28% in FY17 Q3. Region I did not report any involvement of a police officer in either quarter, which may be a reporting error. It is unclear what the involvement of law enforcement indicates about the crisis system, since police always accompany ambulances that transport an individual to a hospital and families may call them to respond to an emergency. The high number of crisis cases that involve police officers is strong support for the need for REACH staff to continue to train police officers so they are better prepared to address crises involving children with an I/DD, especially those with autism spectrum disorders.

B. Reach Services for Adults

REACH Referrals- the data from two quarters of the Fiscal Year, FY17 Q4 and FY18 Q1, were reviewed for this study. Regions received a total of 845 referrals of adults with IDD during this review period. This compared with a total of 677 referrals in the tenth period and 570, during the ninth review period. The number of referrals received in this review period is a 25% increase from the previous period. The number of referrals of adults per review period has continued to increase since DBHDS established the REACH programs. DBHDS reports that a total of 574 adults received REACH services in the eleventh period: 266 individuals who had received mobile crisis support services and 308 adults who used the crisis stabilization homes (i.e. CTHs. This compares with 239 and 227 adults using these services respectively in the tenth period. The above numbers are not an unduplicated count of individuals because they include both admissions and readmissions.

Overall 50% of the calls to Adult REACH programs were of a crisis nature, which is similar to the percentage of crisis calls in the previous two reporting periods. CSB Emergency Services made the majority of the referrals (38%). ES and hospitals together made 48% of all referrals compared to 45% of the referrals in the tenth period. In addition, Case Managers referred 26%, and families 14%, of the individuals, both percentages are consistent with those in the tenth period. DBHDS reported that providers made 7% of the referrals during this reporting period, compared to 11% in the tenth period, both a significant increase over the 2% reported in the ninth period. No referrals have been made by law enforcement in the tenth or eleventh periods.

Conclusion: Referrals to REACH continue to increase with a similar pattern of referral sources. The number of individuals who received either mobile crisis supports or support from the CTH has also increased. These increases are 11% for mobile crisis supports and 36% increase in the number of adults utilizing the CTH programs. Both increases may have implications for resource allocation for these programs depending on the number of days of crisis support.

This data also includes all non-crisis calls and calls seeking information support. The total number of calls received is more than the number of referrals. This occurs when the same individual is the subject of multiple crisis calls and counted more than once. The total number of calls statewide during the review period, including calls for information only, was 4385 compared to 3549 in the tenth period. Of these calls, 1855 were non-crisis calls compared to 1921 in the tenth period, whereas 1003 were crisis calls, which was an increase of 18% over the 844 crisis calls in the tenth period. The remaining 1477, were calls for information. This number is almost double the 784 information-only calls received in the tenth period.

REACH responded onsite to all 1003 crisis calls. REACH responded to 928 of the 1003 (92%) crisis calls within the required time periods (one hour in Regions that DBHDS has designated as urban, and two hours in Regions that it designated as rural). This is the same on-time response rate as in the tenth reporting period. The average response time in all Regions was within the required timeframes. Regions I, III and V, the Regions, which are required to respond to a crisis onsite within two-hours, averaged response time within 62-78 minutes across both quarters. Regions II and IV, the Regions that are required to respond to a crisis onsite within one-hour averaged response time of 42-49 minutes. It should be noted, however, that DBHDS now reports two averages for Region II to include its recently acquired rural CSBs that were transferred from Region I. The average response times for Region II's rural section were 97 minutes in FY17Q4 and 101 minutes in FY18Q1.

DBHDS does include specific information on the number of calls responded to in thirty minutes intervals as was referenced in the section about children's services. Across all regions, 180 (18%) of the calls were responded to within thirty minutes and an additional 483 (48%) had a response between 31- and 60 minutes. This indicates 66% of the calls were responded to within an hour across all five regions.

Table 5 below summarizes the call information and demonstrates that the more urban Regions are having greater difficulty meeting the one-hour onsite response expectation set for these areas. Region I responded to its every crisis call within the 120-minute timeframe. Region V responded to all but four of its calls within the 120-minute time frame. Region IV increased its performance measurably in the eleventh period achieving a 91% rate of responses within the time cap compared to 87% in the previous period. This level of compliance was achieved with an additional 135 crisis calls needing a face-to-face response. Region II had a similar number of crisis calls in both review periods yet its percentage of on-time responses dropped from 86% to 77%. The majority of the late responses were in the urban areas of the region. DBHDS did not provide reasons for these delays in the report but Heather Norton did provide this information in answer to a question.

Table 5- REACH Calls and Response Time

Region	Within Time	Over Time	Total Calls	% Within Time
I	113	0	113	100%
II	101	30	131	77%
III	145	10	155	94%
IV	319	31	350	91%
V	250	4	254	98%

DBHDS reported the dispositions for adults who received crisis services statewide during the reporting period, as follows:

- 266 adults after receiving Mobile Crisis Supports
- 308 adults after receiving Crisis Stabilization Home/CTH services
 - 111 *individuals served required crisis stabilization in the CTH*
 - 96 *individuals served received planned respite or crisis prevention in the CTHs*
 - 74 *received step-down services at the CTH*
 - 27 *were re-admitted to the CTH*

The most significant increases in utilization in the eleventh period compared to the tenth period were for the crisis stabilization homes (39%) and for step-down services (54%). Far more individuals, 266 (+55%), were reported to have received mobile crisis support services during the eleventh review period than the 171 who received mobile supports in the tenth period. The utilization of mobile supports did not reach the level of utilization in the ninth period when 304 individuals used it.

The following two tables provide information on the dispositions for individuals referred for crisis services. Table 6 provides the disposition after the individuals' initial assessments by REACH. Table 7 lists the disposition after the individuals received either mobile or crisis stabilization/CTH services from REACH.

The disposition of a majority of individuals, 588 (59%), retained their residential setting at the time of the assessment. This number is almost 200 more individuals than the number who retained their setting in the tenth period. This illustrates the increase in the number of individuals referred to REACH. This included 119 individuals who used mobile crisis support. More than four out of five of the individuals (86%) retained their home settings after receiving REACH mobile crisis supports and 73% after using the CTH program. A higher percent (31%) of individuals were hospitalized at the time of assessment compared with the (4%) who were hospitalized after receiving REACH mobile crisis support services and the 5% who were hospitalized after using the CTH program. Forty individuals either continued to use the CTH's past this reporting period (21) or after receiving mobile supports (19), compared to twenty-nine individuals who used the CTH after the tenth review period ended.

Table 6 below shows the outcomes for individuals at the completion of their crisis assessments. The "Retain Setting" row indicates individuals who did not require or receive REACH mobile support services. The number of individuals who retained their home setting with the assistance of mobile support services is captured in the "Mobile Support" row. The data for FY18Q1 appears to exclude two individuals who were assessed at the time of the crisis.

Table 6- Outcomes for Individuals After the REACH Assessment

Outcome	QIV	QI	Total	%
Retain Setting	220	249	469	47%
Hospitalization: Psychiatric	150	164	314	31%
Hospitalization: Medical	6	9	15	1%
Jail	1	1	2	0%
Crisis Stabilization (CTH)	44*	30*	74	6%
Mobile Support	64	55	119	12%
Other	2	6	8	1%
Total	487	514	1001	100%

** includes Community Crisis Stabilization Unit admissions*

Table 7 below shows the outcomes for individuals supported by a REACH program during the reporting period. The same percentage (76%) of individuals retained their setting after using REACH services in periods ten and eleven. A similar percentage of individuals were hospitalized or had a new residence after using REACH in periods ten and eleven.

Table 7- Outcomes for Individuals Using REACH Services

Outcome	Mobile	CTH	Total	%
Retain Setting	220	200	420	76%
Hospitalization: Psychiatric	15	14	29	5%
Hospitalization: Medical	0	2	2	>1%
Jail	0	1	1	>1%
CTH	19	21*	40	7%
New Residence	4	42*	63	11%
Other	3	8	14	2%
Total	261	288	549	100%

Conclusion: Many more individuals retain their home setting and avoid hospitalization if they receive REACH mobile supports or crisis stabilization homes/CTH program. Fewer individuals who use REACH services are admitted to hospitals than individuals who did not use REACH services. Crisis Stabilization programs may not be consistently available to divert individuals from hospitalization when they are first screened in response to a crisis.

Use of the Crisis Stabilization Program (CTH)- The Crisis Stabilization Program continues to provide both crisis stabilization and planned crisis prevention as the Commonwealth intended in its design of these programs. All Regions also use the CTH programs for individuals as a step-down setting after discharges from psychiatric hospitals. During the eleventh reporting period, the **Crisis Stabilization Programs (CTH's)** reported having served individuals for the following purposes:

- Stabilization- 36%
- Prevention- 31%
- Step-down- 24%
- Re-admittance- 9%

These percentages are comparable to the tenth period for stabilization and step-down from a psychiatric hospitalization. However, the use for the Crisis Stabilization Homes for prevention is lower in the eleventh period than in the tenth (31% versus 41%).

The number and percentage of readmissions to the Crisis Stabilization Programs is somewhat higher than in past review periods. Eight individuals were readmitted for stabilization, twelve for prevention, and seven for step-down. It is understandable that the CTH will be used on multiple occasions for prevention. Including these individuals who were readmitted for prevention increases the percentage somewhat, but the CTH is still used more often as a resource for stabilization and step-down which is appropriate. The use of the CTH for respite or to prevent a crisis is part of many individuals' crisis prevention

plans. It is not known from the data if the individuals who were re-admitted for step-down were re-hospitalized. This would be valuable data to keep and to analyze for future reviews. During previous reporting periods the CTH was more equally used for stabilization and prevention. However, data from the tenth and eleventh periods indicate increased use of the CTH as an appropriate step-down program for individuals who are ready to be discharged from psychiatric hospitals.

Table 8, Utilization of the CTH in Average Bed Days, depicts the average lengths-of-stay at the CTH's for each purpose. Excessively long stays for stabilization occurred in two Regions during FY17 Q4. Region II's average use was fifty-four days and Region V's average use was seventy-four days. These two Regions dramatically reduced these averages in FY18 Q1 to thirteen and twelve days respectively. Region II had high average use of the CTH for stabilization or step-down or both in each quarter of the tenth review period. Other individuals are precluded from using the CTH for crisis stabilization or prevention when the number of days particular individuals use is high.

The Crisis Stabilization Programs (CTHs) were designed to offer short-term alternatives to institutionalization with stays greater than thirty days not allowed. The premise or capping the length of stay is that the setting is most effective as a short-term crisis service. The averages show the range for the five Region's CTHs for each quarter. All of the regions *average lengths of stay* for stabilization and step-down were under the expected 30-day maximum in FY18 Q1. This is the first quarter in which the average in all of the Regions has not exceeded the 30-day expectation. While this does not mean any one individual did not use the CTH for more than 30 days, it is encouraging that the highest average use was 21 days for stabilization and 23 days for step-down, both of which occurred in Region III.

Conclusion: The CTHs will be more readily available for more individuals if the trend, of shorter average lengths of stays, continues. If this trend continues, then the adult REACH programs may be able to offer the CTH for the purpose of prevention more frequently in the future. DBHDS has not been able to open the two transition homes for adults that it had planned, one is planned to serve individuals in Regions I and II, and the other individuals in Regions III, IV, and V. DBHDS now anticipates opening these settings by the end of FY18. These settings will add to the Commonwealth's capacity to respond to crises by providing a therapeutic alternative residence that can support individuals who need stays of more than thirty days of crisis stabilization to make a positive transition to a new permanent residence.

Table 8: Utilization: Crisis Stabilization Programs (CTH) - Average Bed Days

Type of Use	FY17 Q4 Average Days Range	FY18 Q1 Average Days Range
Stabilization	13-74	12-21
Prevention	4-15	3-9
Step-down	18-44	12-23

DBHDS does not report the length of the actual stays in the Crisis Stabilization Programs (CTHs). DBHDS reported it would include information on the actual length of stays for individuals using the CTH for more than thirty days in the FY17 Annual REACH report. These data are not in this annual report. It will be helpful going forward to have information about the number of stays greater than 30 days and the reasons for the prolonged use of the CTH program. These extended stays may be less frequent once the transition homes are opened.

DBHDS reports on the waiting lists for each Region's Crisis Stabilization Program's beds. Seven individuals were on the waiting list in FY17 Q4: Region I (4), Region II (1), and Region III (2). Four individuals accepted mobile supports; and three individuals, who were ready for discharge, remained hospitalized. In FY18 Q1 only two individuals were on the waiting list for a CTH bed in Region III. DBHDS did not report on any alternatives for these two individuals or if they remained hospitalized.

Conclusion: DBHDS did not have sufficient capacity in its five Crisis Stabilization Programs. Individuals with IDD, who were ready for discharge, continued to be institutionalized as a result of a lack of available beds in the existing Crisis Stabilization Programs (CTH). Evidence that supported this concern was also found in the clinical case reviews completed for twenty selected adults in the tenth review period who were referred for crisis services. The regional REACH teams all acknowledged that it might have been possible to divert a few of the individuals who were hospitalized if the CTH had an opening. It appears the numbers reported on the Waiting Lists may not fully reflect the number of individuals who could have been diverted from a hospital admission if a CTH opening was available.

It is evident from these data that the Crisis Stabilization Programs (CTHs) are improving their ability to be a source of short-term crisis stabilization, intervention and prevention as required by the Settlement Agreement. The longer stays of individuals who need crisis stabilization or step-down services have reduced significantly during FY18Q1. In this period only one Region had a waiting list affecting two individuals for a total of eleven days. The fact that twelve individuals were able to use the CTH more than once for crisis prevention is evidence of the program's availability as originally intended. The ability of families to use this out-of-home support may assist them in being able to support their adult child for a longer period of time in their family home.

DBHDS has planned and secured funding to develop two transition homes for adults who require extended stays. Each home will be able to serve up to six individuals at one-time. Individuals will be served who are in need of up to six months of supports in a temporary residential setting. One home will serve Regions I and II and the other home will serve Regions III, IV and V. The Region IV REACH Program has already been selected to develop and operate the transition home for the southern part of the state. Region IV plans to use the same architectural design for the transition program as it used for its CTH. DBHDS has selected the provider to develop and operate the home for Regions I and II to use and expects the same physical layout as used by Region IV. DBHDS plans that both transition homes will open by June 2018.

Psychiatric hospitalizations-DBHDS provides an addendum to its quarterly report. The addendum reports additional data on the outcomes for individuals who are hospitalized as a result of crises. DBHDS also reports whether these are new or active cases. DBHDS is to report whether these individuals eventually return home or whether an alternative placement needed to be located. A total of 343 individuals who had contact with REACH were reported admitted to psychiatric hospitals in *Tables 7 and 8*. The addenda provide different data regarding psychiatric hospitalizations and the known dispositions. These data indicate that DBHDS is aware of 426 psychiatric hospitalizations of individuals with IDD; 107 more than occurred during the tenth period and 130 more than were known in the ninth reporting period. The department notes that these data do not reflect, and that it does not know, the total number of individuals with IDD who are admitted to private psychiatric institutions.

This is the third consecutive reporting period during which the REACH programs were aware of most of the individuals who were admitted to state operated psychiatric facilities. However, the REACH programs were only aware of 80% of the admissions during this, the eleventh review period; whereas it was aware of 88% of the admissions to state operated psychiatric facilities during the ninth review period, and 92% during the tenth review period. In fact, Regions I and IV actually reported more individuals who were hospitalized in Tables 6 and 7 than DBHDS reported for their Regions in the Addendum. Although DBHDS reported being aware of 80% of the admissions statewide to state operated psychiatric institutions, three of the Regions' REACH programs did not know about many of the individuals who were hospitalized. Specifically, Region II knew of only 56%; Region III 71%; and Region V 80% of the total number of individuals from their Regions who were admitted to psychiatric hospitals. DBHDS reports that the difference in the two data sources is that the Addendum of Psychiatric Admissions includes all involuntary and voluntary admissions. Heather Norton explained that the CSB ES is not involved in screenings for individuals who are seeking voluntary admission. The state psychiatric hospitals do not always notify REACH of these admissions. A family member may inform REACH during or subsequent to the hospitalization. DBHDS and these Regions' REACH teams should work with hospitals to increase their awareness of the importance of informing REACH of these admissions so REACH staff can be involved in proactive discharge planning.

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

The DBHDS report identifies fewer known dispositions than the known number of admissions. This may be the result of one individual having multiple admissions, but only one final disposition. However, it is concerning because DBHDS reports being aware of 426 admissions, but only knows of 341 dispositions. This number of known dispositions, as reported in the addendum, is higher than the 314 admissions reported in *Table 6*. DBHDS cannot report on how many individuals have actually been hospitalized but rather how many hospitalization admissions occurred in the reporting period. Some individuals may have had multiple hospitalizations. It is necessary to have DBHDS be able to report specifically on the actual number of:

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

Since we now know that the number of psychiatric admissions in *Table 7* are also included in the numbers in *Table 6*, it is evident that there must be multiple admissions for individuals.

DBHDS reported in the Admissions to Psychiatric Hospital Addendum the following dispositions for these individuals:

- *57% retained the original placement or moved with family*
- *19% remained hospitalized, as of the end of the review period*
- *9% moved temporarily to the REACH Crisis Stabilization Homes (CTHs)*
- *8% moved to a new appropriate community residential setting*
- *7% "others" were discharged, but with no known disposition*

These percentages are similar to the percentages reported occurring during the tenth period. Outcomes were not positive (remained hospitalized) or were only temporary (stayed in the CTH) for 28% of the individuals who were admitted to public psychiatric hospitals. A comparable percentage of individuals retained their residential setting in each of the three most recent review periods. The percentage of individuals (19%) who remained hospitalized at the end of the tenth and eleventh review periods increased compared to 11% at the end of the ninth review period. These data do not provide sufficient information to determine whether the individuals who remain hospitalized need continued hospitalization or whether they remain in the hospital because of the lack of an available CTH bed or other community supports. The individuals who are hospitalized for extended periods may benefit if the CTHs are able to continue the experience during FY18 Q1 when the average stays were of more limited duration than during previous quarters. By reducing the number of extended stays, the CTH programs will have more available beds to offer as alternatives for individuals who would otherwise be admitted to a psychiatric hospital or as a step-down option for individuals who are ready to be discharged.

DBHDS reports that the REACH programs remain actively involved with all individuals who are hospitalized when REACH staff are aware of their hospitalizations. The revised REACH standards require REACH to join with the ES staff for every admission screening and to stay involved with everyone who is hospitalized as a result of the screening. REACH staff

participates in the admission, attends commitment hearings, attends treatment team meetings, visits, and consults with the hospital treatment team. The community-based service alternatives to institutionalization that the Settlement Agreement required be available cannot be effective unless the CSB ES and hospital's staff contact REACH for all psychiatric screenings of individuals with I/DD.

Training-The quarterly reports for FY17Q4 and FY18 Q1 document that the REACH Adult Programs continue to provide extensive training to a range of stakeholders. The five regional REACH programs trained more than 1801 individuals during the reporting period, compared to 2227 in the tenth period. This included:

- *Law Enforcement- 315*
- *CSB employees- 381*
- *ES staff-116*
- *Family and other caregivers-311*
- *Hospital staff-47*
- *Residential Providers-526*
- *Other community partners- 105*

The numbers of staff that were trained in various groups differ across the Regions. Regions I and III trained the fewest law enforcement personnel, which was similar in the tenth period. Region II trained 46% of the law enforcement employees, and trained the most ES, CSB employees and residential providers. Many more families were trained in this reporting period (311 compared to 27). Regions I and IV provided 83% training for families. There was no training of hospital staff in Regions I, II, or III. This was the second review period in a row where Regions I and II did not train any hospital staff. It is of interest that Regions I and II knew of the fewest psychiatric hospitalizations during the eleventh reporting period, which may be impacted by the lack of outreach to and training of hospital screeners.

Conclusion: All Regions completed extensive training in the tenth review period. Region II trained 30% and Region IV trained 24% of all of the stakeholders who were trained. However, the small number of hospital staff trained and the fact that they were only trained in two regions is concerning particularly recognizing the continued increase in psychiatric hospitalizations for individuals with I/DD.

Serving individuals with developmental disabilities-The REACH programs reported serving more individuals with DD, other than ID, than has been reported during past review periods. REACH served 186 individuals with DD only, which was 22% of the total number of individuals referred. This is a 78% increase over the 104 individuals with DD only who were referred and 5% more than the 16% of all referrals in the tenth period.

Conclusion: Outreach to the DD community has resulted in REACH serving more and an increased percent of individuals considered DD only. There may be greater outreach by

CSBs who now have the responsibility to provide or arrange for case management for individuals who have a developmental disability that is not an intellectual disability.

Building Behavioral Capacity- I noted in my previous Crisis Services Requirements Report, REACH crisis services programs provide short-term services for individuals, many of whom have long-term behavioral challenges. REACH services, therefore, can only be effective as part of a continuum of ongoing community-based behavioral supports and other needed services for individuals with co-occurring conditions or challenging behaviors. DBHDS reports that it is working to develop greater capacity among its providers to address individuals with challenging behaviors by supporting providers to develop specific community-based residential settings. This effort started in Region III with a Request for Proposals published in July 2015. The plan was to replicate this effort in other parts of Virginia. DBHDS did not provide a status report for this initiative but reported that there would be residential capacity for sixty-three more individuals in Southwest Virginia who have co-occurring conditions.

DBHDS has funded Behavioral Support Professional (BSP) training for staff of the REACH Children's and Adult's Programs. It is expected that by the end of FY18 all REACH Coordinators and Navigators will be certified BSPs.

The Commonwealth has established a differential pay rate for BCBAs. The new pay rates took effect when the new HCBS waiver was implemented in September 2016. DBHDS did report that the number of PBS, Licensed Behavior Analysts (LBA) and Licensed Assistant Behavior Analysts (LABA) has increased from a combined total of 734 in FY16 to 966 in FY18. Although comparative data are not available to determine whether, overall, there are more behavioral professionals involved with individuals in the target population, there are more staff with LBA certification who are involved. Two years ago, only fifty-five PBS staff were billing under the I/DD waiver. As of October 2017, 149 LBAs and PBS are billing for behavior supports under the waiver. This number does not include billing by residential providers that may have staff with various behavioral certifications.

More than 120 staff have attended training to become PBS's although not all have become endorsed, which requires the staff to develop and submit a portfolio. This PBS training has taken place in all parts of Virginia except Northern Virginia. Another training is planned to occur in Fredericksburg in February 2018. It is important to note that Board Certified Behavior Analyst (BCBA) is the only certification that is accepted nationally. The number of individuals with BCBAs participating in the IDD waiver programs in Virginia has not been reported.

Conclusion: The Commonwealth recognizes that its community service system continues to lack sufficient capacity to meet the needs of individuals with behavioral challenges. The short-term REACH crisis support services cannot effectively address the ongoing needs of individuals with behavioral challenges. The use of the REACH Teams' Crisis Education and Prevention Plans is not intended to be the basis for ongoing behavioral support services. The Commonwealth has increased the number of staff with BSP certification, continues to train REACH staff to be BSPs, is developing greater residential provider expertise, and building new transition homes for individuals who require longer transitions. These

planned actions are necessary and very positive aspects of the DBHDS plan to build sufficient behavioral capacity. At this time, it cannot be determined whether these actions will result in sufficient capacity to meet the needs of individuals with IDD who need quality behavioral support services. The DBHDS should report on the number of individuals with BSP and BCBA certification who are billing under the IDD waivers, the number of REACH employees so certified, the status of developing provider expertise, and the number of individuals experiencing crises who have access to a BSP or BCBA in the twelfth reporting period.

Qualitative Study of Individuals Referred to REACH- The Independent Reviewer seeks to inform these reviews with a qualitative analysis of the supports and services that have been provided to individuals served by REACH. This qualitative analysis makes the findings of this review more robust and not based solely on a review of documents, data and reports developed by REACH and DBHDS. The report for the tenth period included findings from the first phase of the two-phase study. The full study is now complete. It includes a study of sixteen children served by the REACH programs in either Regions II and V. The crisis services for twenty adults served by the REACH programs in Regions II, IV and V were reviewed during the tenth review period. The review of children's crisis services was scheduled to occur during the eleventh review period to give the Commonwealth more time to implement its children's crisis services programs.

The report of findings from the first phase of the study was produced for the Independent Reviewer in July 2017. The findings and summary for both phases of the study are included in Attachment A of this report on page 37.

SECTION 5: ELEMENTS OF THE CRISIS RESPONSE SYSTEM

6.b. The Crisis system shall include the following components:

i. A. Crisis Point of Entry

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

The REACH programs in all Regions continue to be available 24 hours each day and to respond onsite to crises. DBHDS reported that there were 845 calls during the eleventh period compared to 696 calls to REACH during the tenth reporting period. Only 16% of the 845 calls were received on weekends or holidays, which is similar to the 14% of calls received on these days during the tenth period. Seven percent (7%) of the calls were received between 11PM and 7AM. The remainder of the calls were received from 7AM-3PM (50%), or 3PM-11PM (43%). These data do not specify the calls that were received after 5PM because the calls are reported by the three REACH program shifts. The types of call are

reviewed in greater detail earlier in this report. REACH is available 24 hours a day, 7 days a week to respond to crisis calls.

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

The Regions' REACH staff continues to train CSB ES staff and to report on this quarterly. During the eleventh review period, all five Regions provided training to CSB ES staff. The total ES staff trained during this review period was 116, compared to 164 ES staff trained in the tenth review period. It is difficult to draw a conclusion from this since the number of ES personnel who have not been previously trained about REACH has not been reported.

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 developed a training program to provide similar training for their staff. DBHDS has reviewed and approved the curriculum for use across the three Regions, as reported previously. The DBHDS standards for the REACH programs require comprehensive staff training 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, and must conduct a case presentation and receive feedback from a licensed clinician on their development of Crisis Education and Prevention Plans.

From the data in the Quarterly Reports, REACH services are providing preventative support services for a significant percentage of adults with IDD who are referred. The majority of individuals who receive mobile crisis services are maintained in their home settings as detailed in Table 8. In this reporting period 76% maintained their residential setting and 11% moved to a new appropriate community setting. Another 7% used the CTH, but their final dispositions are reported as unknown. These are similar percentages to those reported for the tenth period. In the tenth review period, the number of hospitalizations was 339 compared to 426 in the eleventh period. This is a 26% increase in the number of hospitalizations in a six-month period. However, the correlation over three review periods is deeply concerning. While there has been an increase in the number of hospitalizations the Adult REACH Programs have been involved in screening a higher percentage of the adults who were admitted. REACH screened 314 of the 341 adults admitted to psychiatric hospitals in the eleventh period, which represents 92% of the admissions. This compares to REACH screening 85% of the psychiatric admissions during the tenth review period (282 of 346 admissions). The 314 admissions to psychiatric hospitals in the eleventh period represents 31% of all the individuals who had a crisis and were screened by REACH,

compared to the 282 admissions in the tenth period, which was 33% of the individuals who were screened by REACH at the time of the crisis. The dispositions for individuals after their discharge from psychiatric hospitals are similar over the tenth and eleventh reporting periods. In the tenth period, 65% either retained their setting (59%) or moved to an alternative community setting (6%). In the eleventh period 57% retained their residential setting and 8% moved to an alternative community setting for a total of 65% of the dispositions after a hospitalization.

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

The REACH teams continue to provide response, crisis intervention and crisis planning services. DBHDS reported providing these services to 536 individuals in this period compared to 427 individuals in the tenth period. These two numbers however, are very likely to include duplicates. These totals represent the sum of the number of individuals who received: Mobile Crisis Support; Crisis Stabilization-CTH; Crisis Step-down-CTH or Planned Prevention-CTH. The sum total includes duplicates for each individual who received more than one of these services.

REACH provides various interventions within both the CTH and Mobile Crisis Support services that include: evaluation, crisis education/prevention planning, crisis consultation, and provider training.

The DBHDS standards for REACH programs now require that all individuals receive both an evaluation and crisis prevention follow-up services. All individuals must also have a Crisis Education Prevention Plan (CEPP) but they may have a current one at the time of referral. DBHDS reports on the number of individuals who receive these interventions by service category.

DBHDS reports that all of the REACH programs provided these required services to everyone (100%) using the mobile supports or the CTH, with the exception of Region I for individuals using the CTH for prevention. This is the highest level of achievement of the DBHDS standard in this area in any review period. DBHDS reported 94% of evaluations were completed in the ninth review period and 97% during the tenth period. DBHDS reported 88% of individuals received crisis prevention follow-up in the ninth period and 100% in the tenth period. *Table 9* summarizes this information below:

Table 9 Crisis Education and Prevention Plans and Crisis Prevention Follow Up

11th Review Period	Number of Individuals	Evaluation Done	Percentage of Evaluations Done	Follow-up Done	Percentage of Follow-up Done
	536	529	99%	536	100%

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 eleventh review period, REACH teams trained a total of 315 police officers compared to 339 police officers trained in the tenth period and 320 officers trained in the ninth reporting period. This training for law enforcement was provided in all five Regions. Regions II and IV provided the training to the highest number of officers accounting for 72% of the law enforcement personnel trained in this period. These two regions also trained the most police officers in the tenth reporting period.

The Commonwealth decided to seek a contractor to develop curricula and provide training on the topic of law enforcement response to special populations. Curricula development of an overview course as well as specific courses addressing the characteristics of a number of disability groups was sought through a Request for Proposals (RFP). DBHDS expects that the standalone courses will provide in depth exploration of each population, including intellectual and developmental disabilities, that will better prepare first responders to successfully interact and communicate with these individuals. The training will take 8-12 hours. The Department of Criminal Justice Services (DCJS) issued the RFP. Responses were due on April 7, 2017. DCJS selected Niagara University to develop and offer this training. The training was piloted during this review period in Portsmouth, Richmond and Northern Virginia. The training is being revised based on feedback that it needed to be shortened and more focused. The model is to train trainers in Virginia. A one-day overview is scheduled for January to be offered in five different locations. Niagara University trainers will provide a two-day train-the-trainers session in May 2018. DBHDS should provide reports each review period on the status of this training and the numbers of law enforcement personnel trained in addition to the training REACH staff offer to police officers.

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

As reported in Section 4, the REACH Mobile crisis teams are available around the clock and respond on-site, including during off-hours. There were 1003 mobile assessments completed during this reporting period, a significant increase compared to the 838 assessments performed in the tenth period and the 730 mobile assessments performed during the ninth period. In the eleventh period 36% of the crisis assessments were conducted in the individuals' homes, day programs, or other community locations, which is comparable to the tenth period percentage of 37%. Over 60% occurred at either a hospital/ER setting (51%) or at an ES/CSB (11%) location, which is again similar to the tenth period. This is also comparable to the ninth reporting period when 53% were performed at hospitals and 6% were performed at the ES/CSBs). Five individuals (less than 1%) were assessed at a police station, compared to two in the tenth period. Twenty-five individuals (2%) were assessed at unidentified "Other" locations.

A substantially similar number of individuals were assessed in their families' homes and in residential program settings, 150 during the tenth versus 179 during the eleventh period. This continues the pattern found in the previous periods. This is an indication of the value

the residential providers place on the REACH program to assist their staff when crises occur and the knowledge families have about the program.

DBHDS reports the number of crisis responses that involve law enforcement personnel. REACH responded to 487 crisis calls in FY17 Q4. Law enforcement was involved in 176 (36%) of these calls. There were 516 crisis responses during FY18 Q1. Law enforcement was involved in 196 (37%) of these calls. DBHDS no longer reports separately about the dispositions of these calls. It is difficult to draw any conclusions without knowing about the dispositions when law enforcement is involved. If an ambulance is called to transport someone to the hospital, law enforcement is routinely involved to assist with the response and to assure everyone's safety. Families may also call 911 during a crisis with a family member. It is beneficial that REACH participates in CIT training for law enforcement officers.

The trend of referrals being made primarily during normal business hours continues. REACH received a total of 845 referrals during the reporting period. One hundred thirty-five (16%) of these calls were received on weekends. The Regions received 332 calls (39%) between 3-11 PM and sixty-eight calls (8%) between 11PM and 7 AM. Fifty-three percent (445) of all of the calls were made during the normal workday hours, reported now as 7AM – 3PM.

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 REACH devotes to a particular individual. Four Regions provided individuals with at least an average of three days in-home support services throughout the review period; Region IV in FY18 Q1 averaged only 2.6 days. It may be that some individuals needed fewer days than three for unique reasons including waiting for a bed at the CTH. Region III averaged 12.9 days in FY18 Q1 and Region V averaged 10 days in FY17Q4, which were the highest averages for each quarter. It is documented that individuals can get an additional three days of support if needed, and possibly more. The range in the number of days of in-home support is 1-15. Regions III and V both provided one or more individuals with 15 days of mobile support in both quarters of the review period.

Regions vary in the number of individuals served and the total numbers of days of community-based crisis services provided. The number served ranged from thirty-seven individuals in Region III to ninety-eight individuals in Region IV. The other Regions served fewer than fifty individuals.

G. By June 30, 2013 the Commonwealth shall have at least two mobile crisis teams in each region to response to on-site crises within two hours

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

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

There were 487 onsite responses in FY17 Q4 and 516 on-site responses in FY18 Q1 for a total of 1003 on-site responses. This compares to 844 responses in the tenth period and 668 responses in the ninth period reporting period. This continues to represent significant growth in the number of crisis responses for the adult REACH programs. Thirty-six calls in Q4 and thirty-nine calls in Q1 were not responded to in the required time period, for a total of seventy-five late responses. The majority of the delayed responses in the period occurred in Regions II (30) and IV (31). Region II was only able to respond to 77% of its calls on time. Statewide the Adult REACH programs responded to 93% of crisis calls within the time expectation of either one or two hours, compared to 92% in the tenth period. Reasons for delays were not provided in the quarterly reports, but Heather Norton indicated they were primarily relate to traffic problems.

Conclusion: The REACH programs overall have improved on the response time. The percent of Region II's timely on-site responses declined during the eleventh period, despite having fewer crisis calls. All regions met the average response time requirement for urban and rural areas

iii. Crisis Stabilization programs

A. Crisis stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services.

B. Crisis stabilization programs shall be used as a last resort. The state shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement, and if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.

C. If an individual receives crisis stabilization services in a community-based placement instead of a crisis stabilization unit, the individual may be given the option of remaining in placement if the provider is willing to serve the individual and the provider can meet the needs of the individual as determined by the provider and the individual's case manager.

D. Crisis stabilization programs shall have no more than 6 beds and length of stay shall not exceed 30 days.

G. By June 30, 2013 the Commonwealth shall develop an additional crisis stabilization program in each region as determined to meet the needs of the target population in that region.

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

DBHDS reported that, during the eleventh review period, 308 visits to the CTH crisis stabilization programs occurred, compared to 227 in the tenth period; an increase in utilization of 36%. More individuals stayed at the CTHs for crisis stabilization and for step-down from hospitals in the eleventh period compared to the tenth period: 185 compared to 128 than for crisis prevention 96 compared to 88. It is very 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 provide care for their relatives at home. The CTH was used for more individuals transitioning from psychiatric hospitals in this reporting period when seventy-four individuals used it for this purpose compared to forty-eight individuals in the tenth period. This is also positive since it reduces the number of days someone would otherwise remain hospitalized because of the lack of a permanent residential option.

The Agreement requires that no stay in the crisis stabilization home (CTH) shall exceed thirty days. Individuals admitted to the CTHs for crisis stabilization and for step down, however, routinely stay for longer the thirty-day maximum allowed. In fact, even the average length-of-stay exceeds the allowed maximum number of days. The average lengths of stay in each Region are depicted in *Tables 10 and 11* below

Table 10 Average Length of Stay in CTHs in FY17 Q4

Region	Stabilization	Prevention	Step-down
Region I	19	4	44
Region II	54	15	40
Region III	20	6	23
Region IV	13	4	22
Region V	74	0	18

Table 11 Average Length of Stay in CTHs in FY18 Q1

Region	Stabilization	Prevention	Step-down
Region I	15	3	20
Region II	13	9.5	19
Region III	21	6	23
Region IV	14	6	17
Region V	12	04	12

The average stay for stabilization was longer than thirty days in Region I for step-down, Region II for both stabilization and step-down and Region V for stabilization in FY17 Q4. Region V did not provide any prevention in its CTH in Q4. None of the Regions exceeded the average lengths of stay in FY18 Q1. In fact, the highest average utilization was 23 days for step-down and 21 days for stabilization both in Region III.

Conclusion: The Regions overall are reducing the average lengths of stay for stabilization and step-down. This has had a positive impact on the waiting lists discussed previously and should insure that more individuals can utilize this important support. The fact that the average length of stay had consistently exceeded the thirty-day requirement until this most recent quarter indicates a lack of sufficient community-based capacity to transition these individuals back to a previous residence with greater support or to an alternative residence that can meet the individual's needs. The Commonwealth has determined that additional crisis stabilization capacity is needed; and, it is in the process of implementing a plan to develop transitional crisis houses for individuals who need longer term stays of up to six months of temporary crisis support and housing. Once these homes are available Virginia may see the FY18 Q4 experience of reduced utilization become a trend.

The DBHDS continues to require the REACH programs to admit individuals who do not have a firm discharge plan. This requirement, is consistent with the Agreement's provision as it ensures that crisis stabilization services are available as a last resort to avoid unnecessary institutionalization or to transition from a psychiatric hospital when an individual is ready for discharge. Individuals who do not have an identified community-based living arrangement are in great need of supportive services in temporary housing service until alternatives are available. The Commonwealth must maintain its commitment to continue to meet the crisis stabilization needs of all members of the target populations and to ensure that the needs of one particular group do not negatively impact the needs of others. The DBHDS has instituted a weekly review with the CSBs of the status of their plans and resources for individuals who need an alternative residence. The achievement of this reporting period to reduce the average lengths of stay indicates this accountability and monitoring is having a positive impact. These shorter averages may also indicate an increase in community capacity. This may be determined if this trend continues in future reporting periods. Having two transition crisis homes available will help the Commonwealth to determine whether their availability reduces the extended stays at the CTHs that violate the specific requirement of the Agreement.

The REACH program continues to provide and to offer community-based mobile crisis support as the first option when appropriate. Timely in-home mobile crisis support was provided to 308 individuals during the eleventh period compared to 239 individuals during the tenth review period, and to the 304 individuals who received mobile crisis support in the ninth period.

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. Thirteen individuals were supported in the Mental Health Crisis Stabilization program, compared to twenty-four and nine respectively in the previous two reporting periods. The Settlement Agreement requires the Commonwealth to attempt to locate

another community alternative before using the REACH Crisis Stabilization Unit. REACH teams preferred approach is to provide supports needed to stabilize individuals who are in crisis so they are able to continue to live in their own homes.

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

SECTION 6: SUMMARY

The Commonwealth of Virginia continues to make progress to implement a statewide crisis system for individuals with I/DD. During this reporting period, DBHDS made significant effort to address previous recommendations and to enhance community capacity. The Children's REACH program is meeting most requirements, but does not yet include out-of-home crisis stabilization programs for use as a last alternative to children being admitted to institutions or psychiatric hospitals.

During the eleventh review period, REACH Children's and Adult Program continued to experience an increased number of referrals and of crisis assessments, as well as an increased use of mobile crisis support services. REACH adult and children's programs were engaged in continuing to train case managers, ES and hospital staff, providers and law enforcement officers, although the number of stakeholders varies across regions.

The Commonwealth now has better data regarding individuals who are admitted to psychiatric hospitals and regarding the involvement of REACH, which occurs when the individuals are known to them. However, the number of individuals admitted to hospitals is increasing and the data are not available to determine whether more of these individuals could be diverted if the appropriate community resources, including sufficient CTHs and transition homes, were available. Hospital and CSB ES staff does not always inform REACH staff of crisis screenings, as evidenced by 1001 crisis assessments involving REACH staff in the eleventh period compared to 844 crisis assessments in the tenth period. During the eleventh period 616 of these were done at the hospital or ES office compared to 500 completed in these settings in the tenth period. This is an area that needs improvement to prevent unnecessary hospitalizations. DBHDS and REACH should analyze the increased in hospitalizations and determine what corrective actions can be taken to achieve the planned, expected and desired outcomes of the development an analysis of the linkages between hospitals and CSB ES programs of REACH crisis services.

The qualitative review study of a small sample of individuals found that REACH had consistently responded to crises and had maintained contact with individuals during their hospitalizations, but that some of these individuals, particularly the adults may have been diverted. REACH staff develops and implements plans and provide families with links to community resources. More families than may have been expected did not accept REACH services. The data reported by REACH indicate that the majority of those who did participate in REACH services generally had their needs for short-term crisis intervention and family training met. However, we were only able to interview four family members of children who were served by the Children's REACH Program. Two of these parents were highly satisfied with REACH, one was dissatisfied. The fourth could not remember the REACH involvement.

DBHDS has put significant effort into increasing the number of behavioral specialists. It must still be determined, however, whether the plans underway will provide sufficient capacity to meet the level of need that exists. DBHDS has not concentrated its efforts on developing residential providers, which can support individuals with co-occurring conditions. Doing so will be critical to the success of the system in reducing unnecessary hospitalizations and transitioning individuals in a timely way from crisis stabilization and psychiatric hospitalizations. I recommend DBHDS provide written reports regarding these efforts and the outcomes in future reporting periods.

ATTACHMENT 1

Qualitative Reviews of Individuals Referred to REACH During the Tenth and Eleventh Review Periods

The Independent Reviewer and Expert Reviewer designed a two-phase study that began in the tenth reporting period and is completed in the eleventh reporting period. The purpose of this study is to collect qualitative data that compliments the quantitative review process to determine:

- The impact and value of REACH services for the target population
- The community capacity in the different Regions of the Commonwealth to successfully support individuals with I/DD who have behavioral challenges, and who may have a mental health diagnosis, and
- Whether psychiatric hospitalizations that occur are necessary, or could be avoided, or the length of stay (LOS) reduced with appropriate and timely crisis prevention and stabilization services

Phase 1 of the qualitative review focused on twenty adults who were referred to REACH between October 1 and December 31, 2016. Phase 2 of the study focused on sixteen children referred to REACH between April 1 2017 and June 30, 2017. DBHDS provided the names of all individuals referred and I randomly selected ten adults from the lists in Regions II, IV and V who had been hospitalized during the time period, and ten individuals who had not been hospitalized. DBHDS provided a list of all of the children referred and I randomly selected eight children from the lists in Regions II and V who had been hospitalized during the time period and eight who had not been hospitalized. All were referred to REACH for crisis services. DBHDS provided REACH records for all individuals selected for the sample and the contact information for the Case Manager, provider and REACH staff for adults. DBHDS provided the names of the parent and REACH staff for children. Only a few children had a case manager. We interviewed all case managers and provider staff by phone and met with each of the adult REACH teams to conduct in-person interviews. We asked for and were provided information about behavioral specialists. Only one of the individuals had a behavioral specialist assigned and we interviewed that person. We interviewed four parents who accepted our calls, and conducted telephone interviews with members of the REACH Children's teams. We reviewed all REACH records and the records that the case managers provided.

I greatly appreciate the time that staff devoted to be interviewed. The REACH Coordinators in Regions II, IV and V assisted us greatly with scheduling the interviews we conducted on-site and by telephone. They made all of the staff available who had some involvement with the individuals.

Summary of Adult Individual Reviews

Refusing REACH services- five of the twenty individuals reviewed refused REACH services. Four of these individuals were hospitalized. REACH did the intake, developed either an interim plan or the full CEPP for the individuals while they were in the hospital, and followed them throughout the time they were hospitalized. In all of these situations REACH staff set up one or more visits to provide mobile supports, but the families either were not available for the appointments after confirming them, or directly communicated that they did not feel the need for REACH in-home supports. The fifth individual was a resident of a group home. The group home staff requested the assistance of REACH and incorporated the elements of the CEPP into the provider's behavioral plan but did not want any training or further consultation from REACH. Four of the five individuals who refused REACH services lived in Region IV. It is useful to have data regarding the number of individuals that either refuse REACH services or fail to follow up to participate in these services but these individuals should not be included in the stratified sample for the eleventh reporting period. DBHDS will identify on the client list for the eleventh period whether REACH services have been accepted or refused so that the sample can be selected to exclude anyone who refused. It will be a more thorough review and analysis of the impact of REACH services with the removal of anyone who did not actually receive the services planned. REACH is to be commended for making repeated attempts with each of the families to provide crisis support.

Crisis Response including hospitalization screenings- REACH responded timely to nineteen of the twenty requests for crisis screening. In one case the REACH program was not notified of the hospitalization until after it occurred. Because the admission was of a short duration, REACH staff did not provide support to the individual while he was hospitalized but became involved after the discharge from the hospital. We selected ten individuals from the REACH program lists who were identified as hospitalized. However, there were actually eleven individuals who experienced a hospitalization during the review period. One person was only hospitalized for two days and had not been identified on the original list as someone who was hospitalized during the review period. With the exception of the one individual mentioned above who was not referred to REACH for the hospital screening, REACH participated in all screenings and followed individuals consistently during their hospitalizations. This included three individuals who refused REACH services after discharge from the hospital.

REACH responded to requests for crisis assistance at family homes when the crisis did not result in a hospital screening. There is evidence of REACH staff providing face-to-face assessment during evening hours at both the hospitals and family homes.

Hospitalizations- Eleven of the individuals reviewed experienced a psychiatric hospitalization during the review period and the vast majority of them had a history of previous hospitalizations. One of them was only hospitalized for two days and refused REACH at the time of hospitalization but later accepted in-home supports which have been beneficial to help him more positively stabilize his living situation with a relative. A twelfth

individual was able to use the CTH in Region II as a diversion from a psychiatric admission. Nine of the individuals hospitalized experienced stays of thirty days or less.

The four individuals who were hospitalized in the Region II sample could have potentially been diverted from a psychiatric admission. One refused REACH services at the time of the hospital screening. The other three were appropriate for crisis stabilization at the CTH. One did not have updated medication orders and could not be admitted and the CTH was at capacity and could not accommodate the other two at the time of the hospital screening. A fourth person in Region II was diverted from hospitalization admission instead using the CTH in Region II.

Five of the individuals in the Region IV sample were hospitalized, all for stays of less than 30 days. Three of these individuals refused REACH services at the time of hospital admission. One of them was hospitalized for only two days and then used REACH mobile support. One has substance use issues and seeks hospitalization frequently. The third individual was hospitalized for physical assault. She had used the CTH in the past as a step-down service but did not accept assistance from REACH this time until after she was discharged from the hospital.

A fourth person was hospitalized for making suicide threats. She was hospitalized for six days and in-home supports were offered but the family never produced a psychological assessment so REACH closed her case. The fifth individual was hospitalized for medication review after assaulting his parents. He was able to use the CTH after his hospitalization for planned crisis prevention.

Only two individuals in the Region V sample were hospitalized. One individual was hospitalized without REACH being notified. She lives with a relative in a chaotic situation in which she has no bedroom and becomes anxious with the activity of the children in the home. REACH staff report she seeks hospitalization as a respite when she is experiencing anxiety. The CTH setting would have been appropriate for her if REACH had been made aware of the hospital screening. The second person who was hospitalized from Region V experienced suicidal ideation and severe aggression. He had a severe impaction, which was causing him pain and may have contributed to his aggression. He experienced his first seizures while in the hospital. As a result, he has stayed for medication review and adjustment of his psychiatric medications.

Two individuals remained hospitalized in April having been in the hospital for several months. One is the individual admitted due to impaction, which was thought to be the result of medication side effects. He lives in a group home and his provider remains committed to continuing his residential support once he is discharged. REACH is involved with the hospital treatment team and the residential provider.

The second person who remains hospitalized has experienced a particularly heartbreaking situation. She was in her late teens when she was hospitalized last fall after receiving social services that ended at age eighteen. After that she lived unsuccessfully with her sister and found herself homeless. She was hospitalized because of her inability to care for herself and her physical aggression. She had no case manager at the time. REACH in Region II did not have an available bed for diversion although she could have most likely been appropriately

supported in the CTH while community support services were arranged. REACH has maintained involvement but has not had a CTH bed available for her to use as a step down. She has been given waiver resources and a residential sponsored home has been located. She now has a case manager and CSB involvement. However, REACH was informed in mid-April that she is pregnant. This may mean that she is unable to transition to the sponsored home. She has become pregnant in the hospital and may never have needed to be hospitalized if the CTH or other crisis stabilization programs could have supported her.

Eleven individuals were hospitalized who were in the stratified sample. Four of these individuals refused REACH services at the time of the hospital screening. Four of the remaining seven individuals could have been diverted if REACH had been notified of the screening (1) or if there had been available capacity at a CTH (3). The majority of hospitalizations were short-term. REACH was actively involved with all but one individual while in the hospital, and offered appropriate in-home supports. All planned in-home supports were delivered unless the individual or family refused REACH services.

Case Management-There was four individuals reviewed who did not have a case manager assigned. One additional individual was assigned a case manager during her hospitalization and another individual only had administrative case management, which was provided intermittently because the assigned case manager was on leave and a temporary case manager was not assigned to her. Individuals on Medicaid are eligible for Targeted Case Management and those who are waiver participants are assigned a case manager through the CSB. It is not known why these three individuals did not have a case manager assigned. Three of the individuals without case managers were added to the waiver waiting list during the reporting period. Four of these six individuals with either no or intermittent support from case managers were admitted to psychiatric hospitals during the reporting period. Two of these individuals were still hospitalized at the end of April 2017.

Case managers were actively involved with the other fourteen individuals reviewed. With the exception of one case manager, REACH and the case managers reported good communication and close coordination during the time the individuals received REACH services. Case managers were actively assisted individuals who needed to secure residential or day providers, or change providers. Case managers report that REACH is beneficial to the individuals on their caseloads, and that the training REACH staff offer providers and families has contributed to a more stable situation for each individual.

It is apparent that case managers have an integral role to play in coordinating services in general and assisting individuals who experience crises to access REACH crisis support. It appears that the lack of active case management and community services may contribute to the need for hospitalization since there is no coordination of community mental health, residential and day supports for these individuals, which may address their needs and help stabilize their living situations so hospitalization may be unnecessary.

Mobile Support- REACH offered crisis mobile supports to seventeen individuals in the sample. Of these individuals five refused all REACH services and one other individual chose to only use the CTH program. Three individuals were not offered in-home supports. Two of them remain hospitalized at the end of the review period and one individual had an extended stay of eighty-nine days in the CTH while awaiting placement in a group home. His family had moved to Florida and the one remaining relative was unable to adequately care for him at home.

Generally, the provision of in-home supports to both families and providers is successful. The REACH staff implement the crisis plans, train parents and other caregivers, and provide follow up and monitoring after the in-home support has been successfully delivered to ensure that the situation remains stabilized or will re-initiate in-home services. There is evidence that many participants and family members benefit from learning new coping skills and better strategies for interacting with each other. There is extensive documentation of numerous visits, follow up phone calls with families, and good communication with case managers. Some cases in the sample were successfully closed during the reporting period because the situation had stabilized for a period of time.

CTH Support- The need for the CTH program and its unavailability for hospital diversion has been discussed in previous sections of this interim report. Thirteen of the individuals in this sample would have accepted, used and benefitted from the CTH. Only six of the thirteen were able to use the program, and one of them who needed it at the time of her hospitalization could not access it but was able to use it later to transition to the community before returning home. Case managers are positive about the outcomes for the individuals who are able to use the CTH program. The records for the individuals who were able to use the CTH program provide evidence of positive visits that contribute to crisis stabilization and prevention. The complaint is that the CTH is often unavailable for diversion, step-down or for crisis prevention. This supports the findings in the Crisis Services Report for the Tenth Reporting Period. Individuals experience extended stays in the CTH because of a lack of community residential support. These extended stays for some people result in a lack of availability for others who need the programs for hospital diversion, timely step-down from hospitals, or prevention and respite. Two of the six individuals in this sample had extended stays in the CTH while waiting to transition to new residential providers. One person who was already mentioned was in the CTH for eight-nine days. The other individual, a woman in Region V was still in the CTH as of April 14, 2017. She was admitted in October 2016. A provider has been located for her and the transition process started in mid-April. The CTH program is an essential element of the crisis prevention and stabilization service delivery system Virginia is developing but it is not readily available to the number of individuals with I/DD who need it.

CEPP- REACH staff are required to develop a Crisis Education and Prevention Plan (CEPP) for every individual referred to and accepted by REACH for crisis services. Every individual, with the exception of three of the five individuals who refused support from REACH had a CEPP. REACH developed the plans for the other two before they or their family refused to participate in REACH services. The CEPPs include a thorough review of medication, previous hospitalizations, family and provider dynamics, and presenting issues. The plans

are comprehensive and provide detailed crisis intervention and stabilization strategies which include training caregivers.

Providers- The twenty individuals in this sample give some insight to the capacity of providers in the I/DD community in Virginia. Only seven of the twenty individuals had appropriate supports including day services while living at home, or had a provider who could meet the individual's behavioral challenges. This inadequacy is exacerbated by the severe lack of behavioral support professionals in the Commonwealth. Ten individuals did not have residential support when they were referred for crisis stabilization and three additional individuals had either lost their day program and needed alternative day or employment support (2) or didn't have a day program. Five of the individuals who need out-of-home residential support were approved for the waiver during the review period and three others received funding and transitioned to a provider. Some individuals in the sample had a history of losing providers because of their behavioral needs. It appears that DBHDS needs to continue to address the behavioral capacity of its provide community.

Only 35% of the individuals in this sample had appropriate supports from providers. Many of the families of the individuals still living at home were not able to continue to have them in the home setting and were in desperate need of residential services. It is positive that DBHDS was able to authorize waiver services for an additional eight individuals after the referral to REACH for crisis intervention was made and acted upon.

Behavioral Support Professionals and Behavioral Support Plans (BSP)- In terms of the adequacy of community capacity the specialty most needed and lacking is Behavioral Support Professionals or Board Certified Behavior Analysts (BCBAs). Thirteen individuals from the stratified sample were identified as needing a BSP. Only three of them received this level of professional behavioral support. Only one had an active BSP identified at the time of the study. The lack of BSPs for individuals in the sample is supported by the feedback of the stakeholders who participated in the Focus Groups in Regions II and V. The lack of behavioral support has been identified in previous review periods and was a finding of the qualitative case study done in 2015. DBHDS continues to implement its plan to develop this capacity. It has implemented the amendments to the HCBS waivers, effective October 2016, that adds the BSP service with a reimbursement rate set to attract these providers to become qualified waiver providers. The REACH programs are sending their Coordinators to BSP training. DBHDS plans to complete this training for all REACH Coordinators by 2019. This will enhance the expertise and capacity of the REACH program to develop behavioral plans for REACH participants. However, it is equally if not more essential for the provider community and families to have access to BSPs to develop, train and implement consistent programming and support to hopefully lessen the need for external crisis stabilization services for individuals with challenging behaviors.

Psychiatrists (PSY)- Most of the individuals have a psychiatrist or have a Primary Care Physician (PCP) who prescribes and monitors the individual's psychiatric medication. The family of one individual in Region IV pursued the referral to REACH primarily to be able to use the REACH psychiatrist because they did not believe there was a suitable psychiatrist in the community.

Summary- Table A summarizes the services available to the twenty individuals in the sample including REACH services and needed community supports from providers, psychiatrists and behavior support professionals. A number and their region of affiliation designate the individuals in the sample.

Table A-Summary of Crisis and Community Services for Adults

IND	REACH Crisis Response	Hospital Support	Mobile Support	CTH	CEPP	Refused REACH	PSY	BSP	Provider Meets Needs
II1	Yes	N/A	Yes	Yes	Yes	No	Yes	N/A	Yes
II2	Yes	Yes	N/A	N/A	Yes	Yes	Yes	No	No-1
II3	Yes	Yes	Yes	Y- 2	Yes	No	Yes	No	No-5
II4*	Yes	Yes	N/A	N-3	Yes	No	No	No	No-5
II5	Yes	N/A	Yes	Y-4	Yes	No	Yes	Yes	Yes-6
II6	Yes	N/A	Yes	N- 7	Yes	No	No	No	Yes
II7	Yes	Yes	Yes	N-8	Yes	No	Yes	Yes	Yes-6
IV8	Yes	Yes	Yes	N/A	Yes	No	Yes	N/A	No-9
IV9	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No-5
IV10	Yes	N/A	N/A	N/A	N/A	Yes	Yes	No	Yes
IV11	Yes	N/A	N/A	N/A	Yes	Yes	No	No	No-9
IV12	Yes	Yes	N/A	N/A	N/A	Yes	N11	N/A	No-5
IV13	Yes	Yes	N/A- refused	Yes	Yes	No	Yes	Yes	Yes-6
IV14	Yes	Yes	N/A	N/A	N/A	Yes	Ink	Unk	No-12
V15	Yes	N/A	Yes	Yes	Yes	No	Yes	No	No-5
V16	Yes	N/A	Yes	No	Yes	No	Yes	No	No
V17	Yes	N/A	Yes	No	Yes	No	No	N/A	No-9
V18	No-10	No	Yes	N-10	Yes	No	Yes	N/A	No (day)
V19*	Yes	Yes	N/A	N/A	Yes	No	Yes	No	Yes
V20	Yes	N/A	Yes	No	Yes	No	No- 11	N/A	No (day)
%	95%	91%	100%	46%	100 %	25%	79 %	15%	35%

- 1- Has no supports because family refuses
- 2- CTH was appropriate for a diversion from hospitalization but was unavailable. It was used as a step-down when a bed at the CTH became available.
- 3- This individual may have been diverted from her hospitalization if the CTH had an opening
- 4- The CTH was used as a diversion service to prevent psychiatric hospitalization
- 5- Provider identified during the review period, or approved for the waiver and selecting provider
- 6- Transitioned to new residential provider during the review period
- 7- Offered use of the CTH but did not use because of a medical issue: medications outdated
- 8- The CTH was requested but there was not a bed available at the time
- 9- Lives at home, needs a new day program, continuing education or employment support, and would benefit from out of home support

- 10- REACH was not notified at time of hospitalization. CTH might have been appropriate for diversion. Short hospital stay so REACH was unable to be involved
- 11- PCP prescribes and monitors medications
- 12- On the DD waiver waiting list

*- Individual remains hospitalized

CONCLUSIONS

The review suggests that REACH in large part is meeting its mission and participating in hospital screenings, responding to family crises, providing crisis planning, and implementing in-home support and provider consultation. REACH is not able to consistently offer its CTH program for diversion, step-down or crisis prevention, in large part because of the unavailability of beds. This lack of capacity is primarily attributed to prolonged stays at the CTH due to a lack of timely residential support development or availability for individuals who use the CTH and do not have a disposition at the time of the admission. The development of transition homes should in part ease this systemic problem. It is also necessary to have funding available when someone needs a residential alternative and to have the expertise and capacity among residential, employment and community engagement providers to address the needs of individuals with I/DD and behavioral challenges.

The adult REACH programs participated in the hospital evaluation process for almost all individuals who were known to REACH and who were admitted to psychiatric facilities. The REACH staff remained involved with these individuals during their hospital stays. The REACH staff provided evaluation, consultation, and training; developed a comprehensive crisis prevention plan; and provided mobile crisis services. Because the crisis stabilization homes (CTH programs) did not have beds available during key times, the CTHs were used only intermittently compared with the ongoing provision of mobile crisis support services. Many of the individuals who were selected to have their crisis services studied were not able to return to their previous residences. It took an extended period to arrange a new home in the community with support services for these individuals. The CSBs and the Commonwealth facilitated these individuals to be approved as HCBS waiver participants after they were referred to REACH. Prior to the referrals to REACH, few of the individuals had access to a behaviorist or to ongoing behavioral support services. All twenty of the individuals whose services were reviewed had community psychiatrists. One family, however, reported having difficulty securing psychiatric services and having sought REACH services in Region IV solely to gain access to the REACH psychiatrist.

It is important to the review of crises services to be able to include qualitative information. The first phase of this two-phase study has focused on services to adults with I/DD and behavioral challenges. It is positive that REACH is consistently involved with individuals who are hospitalized and that the hospital stays are relatively short, compared with past reviews of psychiatric hospitalizations.

Summary of Children Individual Reviews

Refusing REACH services- A number of adults selected for the qualitative study in the tenth review period had actually refused REACH services. DBHDS agreed to have the regional REACH programs indicate the children whose families had refused REACH services. The criterion used to select the random sample was to exclude these individuals. However, four of the sixteen children who were randomly selected did not use REACH services after the initial screening and three-day follow up. This follow up usually constitutes daily telephone calls to check the status of the individual, not face-to-face contact. It was not noted on the individual list that these children's families had declined REACH services. In each case REACH staff were involved in the initial crisis response, provided the three-day crisis follow up, and continually attempted to contact the family to offer in-home mobile supports. The REACH teams documented many conversations or attempts to reach these families. In some cases, they were able to make recommendations for other community resources that would assist the child or family. The reasons families declined the services varied but included an inability to make appointments with REACH Navigators, a previous history of in-home supports from other providers that the family found to be unsuccessful; and a reluctance to have staff work in the home setting.

In addition to the four children who did not use REACH services after the initial screening and three-day follow up there were five other children where REACH services were terminated after a period of accepting REACH support but only briefly. The reasons these families discontinued REACH services are as follows:

- Two families eventually placed their child residentially.
- One family's child had an extended elopement and the child refused to participate.
- One family stopped returning calls for appointments.
- One family became dissatisfied with REACH services citing inconsistency with personnel who arrived to deliver service, a lack of communication among the REACH and a plan the family found ineffective.

Both Regions sent their full list of REACH referrals for FY17Q4. Region II received seventy-eight referrals, of which twenty-four (31%) declined services. Region V received sixty-four referrals, of which seventeen (27%) declined services. However, with the exception of one of the families in our qualitative study the other nine were noted as having accepted REACH services.

Crisis Response Including Hospitalization Screenings- REACH staff in both regions consistently responded to crisis calls and participated in hospital screenings. There were two children in Region II for whom this was not the case. In one situation, the child was screened and hospitalized for two days. Neither ES nor the hospital notified REACH at the time of the crisis. REACH became involved on the day the child returned home. The second child was screened at the Emergency Room and sent home with contact information for REACH. The family contacted REACH the next day and REACH staff responded immediately. Two other children's parents refused diversion, as they wanted their children to be hospitalized. One family was afraid to have the child return home because of highly

aggressive physical attacks by the child. The other child needed an evaluation for changes in the medication regime. Both families wanted REACH services during discharge planning and post discharge.

Hospitalizations-One of the children who was screened for a hospital admission could be diverted because REACH was able to put in-home services in place.

As mentioned above two children were hospitalized per parent choice and need. Two other children experienced a hospitalization prior to REACH involvement. One other experienced hospitalization during REACH services. The lengths of stay in hospitals for all five of these children ranged from 3 days to 33 days. None of the lengths of stay seemed inordinately long but hospital and other clinical records were not made available for review.

Case Management- Four of the children had case managers. Three were active and coordinated with REACH.

Mobile Support- REACH staff provided appropriate mobile supports and developed safety plans when warranted. Many of the children who were referred and part of the sample had suicide ideation or had attempted suicide. One of the children experienced homicidal ideation at school. In all cases the mobile supports were beneficial to the children. In some cases, REACH provided support in the school as well as the home setting. Two children were able to successfully transition back to a regular classroom during the period of time REACH was involved in crisis intervention.

Regions report on the disposition when the crisis evaluation is completed. The disposition may be: returns home; returns home with mobile support; is hospitalized; or is placed outside of the family home. One child from Region V was characterized as returning home with mobile support. This was because mobile support was recommended at the time of the hospital screening. However, the family never accepted or participated in REACH services. The report of the disposition was not changed, and Region V's REACH Children's program staff reported they do not change the disposition. Heather Norton assured me that this data entry problem is unique to Region V. It does misrepresent the level of REACH involvement in assisting children who have experienced a crisis.

CEPP- CEPP's were completed for all children in the study who accepted and used REACH services. The CEPPs were timely. They included teaching strategies for the children and interventions for the family members to use. They included a range of mobile supports and also linkages with community resources. REACH staff communicate whenever possible with the child's psychiatrist, counselors, outpatient therapists, and case managers to seek their input in the development of the plans and to assist with service coordination for children who did not have a case manager.

Region II completed five plans. Four of the completed CEPP's were thorough. Families were trained and the CEPPs were being employed successfully. One was boilerplate and lacked specifics and was the subject of a complaint by the parent. She discontinued services due to her dissatisfaction.

Region V completed five plans. Three were well constructed and were being employed successfully. One was completed two days after initial contact, which is not sufficient time to complete a comprehensive assessment. One was not proving to be successful.

Providers- The REACH Children's programs in both regions routinely assist families to link with appropriate community resources. These include outpatient clinics, in-home intensive supports, mentoring and family training, psychologists, youth development services and schools. In many cases REACH staff made or assisted the family to make these referrals. The provider capacity to support children with co-occurring conditions seems stronger than the adult community service system. A few individuals had to be placed on waiting lists for a service they needed. One family is still on the waiting list for mentoring services. One parent pointed out that she was not supplied with any psychiatric linkages and was left to find one on her own.

Behavioral Support Professionals and Behavior Support Plans (BSP)- None of the children in the study had a behavioral plan that was submitted for review. One child was referred for behavioral support and was still on a waiting list at the time of this review. Other children were referred for mental health support and counseling. Five of the children were receiving behavioral support. While no behavioral support plans were submitted for chart review the providers were identified in the REACH records. REACH staff reported that with the other children did not need a BCBA or BSP and were appropriately treated in the community by mental health professionals. This fits the needs of many of these children who were either suicidal or homicidal at the time of the referrals for crisis services.

Psychiatrists (PSY)- Eleven of the children had a psychiatrist. REACH was able to refer another child for tele-psychiatry but the family declined the service preferring to contact a developmental pediatrician. This family was interviewed and confirmed that this offer was made by REACH and the family had declined. The REACH record noted one other child had a psychiatrist but the family confirmed it is a Nurse Practitioner who oversees the child's medications. Another family had to locate a psychiatrist on their own without a referral from REACH. REACH did not know if psychiatrists were treating all of the children whose families declined services. It seems that psychiatric and medical management care is generally available for children based on the individuals reviewed

Table B-Summary of Crisis and Community Services for Children

IND	REACH Crisis Response	Hospital Support	Mobile Support	CEPP	Refused REACH	PSY	BSP	Provider Meets Needs
II1	NO-1	N/A	YES	YES	NO	N/A	No	NO-1
II2	NO-2	NO-2	Yes	Yes	No	YES	N/A	YES
II3	YES	YES	N/A	N/A	Yes	Unk	Unk	Unk
II4	NO-5	YES	YES	YES	NO	YES	YES	YES
II5	YES-6	YES	YES	YES	NO	YES	N/A	YES
II6	NO-7	NO	YES	N/A	YES	NO	YES	UNK
II7	NO-8	N/A	YES	NO	YES	YES	NO	NO
II8	YES	NO	YES	N/A	YES	YES	NO	UNK
V9	YES	N/A	YES	YES	NO	YES	N/A	NO-3
V10	YES	N/A	N/A	N/A	YES	YES	N/A	YES
V11	YES-4	N/A	N/A	N/A	YES	Unk	Unk	Unk
V12	YES-9	N/A	N/A	N/A	YES	YES	NO	UNK
V13	YES-10	YES	YES	YES	NO	YES	YES	YES
V14	YES-11	YES	YES	NO	YES	NO	NO	UNK
V15	YES-12	YES	YES	YES	YES	YES	YES	NO
V16	YES	YES	YES	NO	NO	YES	YES	YES
%	69%	70%	100%	70%	56%	85%	50%	60%

1: This young woman was seen at the ER on 5/1/17. REACH was not contacted to participate. Hospital staff gave the family the contact information for REACH. REACH contacted the family on 5/2/17. She received a psycho-educational assessment and was referred for behavioral health counseling, ABA and tele-psychiatry. The family rejected the tele-psychiatrist. She is on the waiting list for applied behavioral analysis (ABA)

2: This young man was hospitalized for suicide threats from 4/12-4/14/17. The emergency screener or the hospital did not contact REACH. REACH became involved on 4/18/17 when he returned to his family's home

3: All supports were in place for him except his parents are on a waiting list for mentoring. He has a psychiatrist and outpatient counseling as well as a case manager. The need for intensive support for the parents is a priority.

4: This individual was referred for suicide ideation. She does not have a diagnosis of ID or DD so is not eligible for REACH. REACH did offer in-home supports but the family rejected these services.

5: The call regarding this young man was a non-crisis call. Initial appointment was for assessment where he escalated to the point where police were called. Police had training and were able to de-escalate situation to the degree that young man was easily transported to Manassas Hospital and then sent to CCCA. Reach staff accompanied him to both hospitals. Hospitalized at CCCA from 4/19/17 to 5/7/17. REACH involved in discharge planning and linkages for follow up services and in-home support.

6: Crisis response to 4/21/call immediate. The reason for call was homicidal ideation and threats to School Assistant Principal and teachers at the school. Hospitalized at Dominion from 4/21/17 to 4/24/17. REACH continued with in-home support and linkages through

his residential placement, which began in early August. Parents wanted residential placement. Residential facility is 20 minutes from parent home and REACH contacted parents recently to check on progress.

7: Recorded as non-crisis call on 5/10/17. Navigator did follow up on 5/16/17 and conducted assessment and developed Safety Plan and provided training. Hospitalization was result of PCP visit on 5/24/17. PCP initiated hospitalization from his office transport directly to Children's National. Navigator attempted daily contact with mother who did not respond until 6/7/17 and refused further REACH involvement.

8: Crisis call on 5/25/17 but response took 5 days. REACH involvement through mid-June according to mother when she stopped REACH services as due to being ineffectual and inconsistent.

9: Crisis response time on 5/11/17 under 1 hour. REACH unable to complete follow up appointments as young woman eloped every time appt. was scheduled from 5/14 through 6/28/17. Parent reports three hospitalizations due to suicidal ideation and aggressive behavior. No dates made available.

10: Parents refused REACH services to divert daughter from hospitalization. Reach services accepted to work with hospitals and participate in discharge plan and after care for in-home and linkages.

11: REACH involvement from crisis call through the 5/9/17 ED visit. ED visit resulted in transport to CCCA for medication evaluation. Stepmother does not follow up on linkages and becomes non-responsive to calls. Last attempt to contact was August 2017.

12: REACH involved from initial crisis call from Chesapeake Regional Hospital on 1/5/17 through ECO to Riverside Regional on 5/5/17. Mother refused to give consent for involvement from this point.

Conclusions

The REACH Children Services in Regions II and V have a number of families who after initially engaging with REACH, either did not accept crisis services or stopped them early in the process. Only nine of the sixteen children who were randomly selected for this study continued services from REACH. These nine children did well and REACH both offered viable crisis supports in the home and school when appropriate but provided the necessary community linkages for the child and family. We were only able to speak to four of these families. One was dissatisfied with the services from REACH; one was an aunt who could not remember the services provided in her mother's home to her niece; and the other two were highly satisfied with all REACH staff. REACH staff was not consistently notified of emergency service screenings, which will hopefully improve as more screeners become aware of the REACH children's programs.

We do not have information from the families who refused REACH services; three of the families who had children hospitalized were among the families who refused REACH services. REACH has assisted individuals during hospitalization and after the child's return home, helped the family to stabilize the situation. However, REACH is one component of an effective community-based crisis response system. This small study indicates there are more community resources for children than for adults and REACH helps make these linkages for the families. However, some families and children remain on waiting lists for behavior support services and the sample is too small to draw conclusions about the adequacy of the system.

In the sample reviewed in this study, many of the children who were hospitalized were diagnosed as being either suicidal or homicidal. These children would have been hospitalized regardless of the availability of REACH CTHs. It is critical that REACH staff have appropriate training to address the needs of children with these diagnoses working in partnership with community mental health providers.

DBHDS should do further analysis of the psychiatric hospitalizations to determine the reason for hospitalizations; the children's diagnoses at the time of crisis; the length of stay; the resources that were available to the child and family both prior to and after the hospitalization; and the adequacy of the provider system to address the needs of these children with co-occurring condition.

APPENDIX E.

INTEGRATED DAY – SUPPORTED EMPLOYMENT

By: Kathryn du Pree MPS

**2017 REVIEW OF THE INTEGRATED DAY AND EMPLOYMENT
SERVICES REQUIREMENTS OF THE US v COMMONWEALTH OF
VIRGINIA'S SETTLEMENT AGREEMENT**

REVIEW PERIOD: APRIL 1, 2017– SEPTEMBER 30, 2017

**SUBMITTED TO DONALD FLETCHER
INDEPENDENT REVIEWER**

**BY: KATHRYN DU PREE, MPS
EXPERT REVIEWER
November 1, 2017**

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I. OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the employment services requirements of the Settlement Agreement for the time period 4/01/17 – 9/30/17. The review is the second phase of a two-phase study. The report from this phase will include data and findings of the Commonwealth of Virginia's progress toward achieving the following requirements:

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

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.

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

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

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

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

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

II. PURPOSE OF THE REVIEW

This review will build off the first phase review, which this consultant completed last spring for the tenth review period (10/01/16 through 3/30/17) and the related recommendations the Independent Reviewer made in his last Report to the Court (12/23/16). The report of the review of phase I of this study, which was completed during the tenth reporting period, included findings related to each of the employment requirements of the Settlement Agreement, but did not include conclusions, recommendations or determinations of compliance. This phase II review will include analysis of the findings from the phase I and phase II and will include conclusions, determinations of compliance, and recommendations.

This review will cover all areas of compliance related to employment services to make sure that the Commonwealth has sustained compliance in areas achieved during the previous reporting period. This review's focus will be on:

- The refinement of the implementation plan to increase integrated day activities for members of the target population including the strategies, goals, action plans, interim milestones, resources, responsibilities, and a timeline for statewide implementation;
- The expectation that individuals in the target population are offered employment as the first option by Case Managers and their teams during the individual planning process in which they discuss and develop employment goals;
- The Commonwealth's success meeting the FY 2017 targets it set for the number of people, members of the target population, who are in supported employment, the number who remain employed for at least twelve months, and the average earnings for those in supported employment;
- The exchange of information regarding employment accomplishments and barriers between the RQCs and the E1AG; and
- The Commonwealth's progress to offer community engagement and community coaching to individuals who do not work or as a supplement to employment.

III. REVIEW PROCESS

To complete this review and determine compliance with the requirements of the Settlement Agreement, I reviewed relevant documents and interviewed key administrative staff of DBHDS, and members of the Employment First Advisory Group (E1AG), previously known as the SELN-Virginia. In June 2017, prior to initiating this review, a kickoff meeting was held with the Independent Reviewer, the Expert Reviewer, Heather Norton, Peggy Balak, Jae Benz and Anita Mundy to review the process and to clarify any components. The Commonwealth was also asked to suggest ways the methodology of the planned review could be improved and to provide any additional documents that it maintains to demonstrate that it is properly implementing the Settlement Agreement's provisions related to integrated day and employment services.

Document Review: Documents reviewed include:

1. VA DBHDS Employment First Plan: FY 2016-2018, updated through FY18 Q1
2. DBHDS Semiannual report on Employment (draft): 09/24/17
3. SELN Work Group meeting minutes relevant to the areas of focus for this review. The SELN now includes two advisory groups: the Employment First Advisory Group (E1AG) and the Community Engagement Advisory Group (CEAG). E1AG Minutes 08/16/17, CEAG Minutes 05/26/17, 07/28/17 and 09/22/17. E1AG Interagency Sub-committee minutes 08/12/17
4. Regional Quality Council (RQC) meeting minutes and recommendations for implementing Employment First-
5. Statewide Quality Improvement Committee Meeting Minutes: 06/01/17
6. Community Engagement Plan FY2016-2018, updated through FY18 Q1
7. Community Engagement Best Practice Manual (draft)

Interviews: The Expert Reviewer interviewed members of the E1AG; Heather Norton, Director of Community Support Services, DBHDS; and Anita Mundy, Employment Services Coordinator, DBHDS

IV. THE EMPLOYMENT IMPLEMENTATION PLAN

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

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

DBHDS with the input of the E1AG (formerly the SELN-VA Advisory Committee) has revised the FY16-FY18 plan to increase employment opportunities. I was provided with the Status Report as of 9/30/17, which is listed as Document 1 above. The Plan includes five goal areas each of which has sub-goals.

Goal 1: Align licensing, certification, accreditation, data collection, and other activities between state agencies that facilitate employment for individuals with disabilities.

Status: The DBHDS, DARS and DOE efforts continue to be in the planning stages. DBHDS, DMAS, DARS (Department for Aging and Rehabilitative Services), and DOE have still not developed a Memorandum of Agreement (MOA) between them. The MOA was anticipated by 5/1/17. The goals for the Interagency Workgroup and the identification of interagency projects were not accomplished by June 2017 as projected during phase I of this review. These groups met to re-establish the interagency work group. As steps toward implementing future employment related services, State staff were offered financial empowerment training and the Interagency Work Group created a plan to develop a Benefit Planning service.

Goal 2: Education and training of stakeholders, providers and state agency staff.

Status: DBHDS has delayed the development and implementation of Benefits Planning service referenced above. DBHDS has not yet updated its “Employment Success” website; it has contracted with a new Webmaster. The DBHDS Training Subgroup is describing the process for students who will be transitioning from school to adult employment services to help connect individuals and families to employment resources. The Subgroup established target dates for the development of a benefits planning service fact sheet and access to training resources, but these have not yet been achieved

Heather Norton and Anita Mundy discussed employment training during their interview with me. They report that other DBHDS staff has offered employment training, but they have not been personally involved during this review period. The focus for DBHDS was Community Engagement (CE) training for families, individuals, providers and case managers. DBHDS has provided technical assistance for ESOs.

DBHDS has also not yet completed the planned Employment First Video. Originally projected to be available in September 2017, DBHDS now plans to complete the video in December 2017. DBHDS expects to begin using the video to train case managers in calendar year 2018.

Goal 3: Service delivery system that supports and incentivizes integrated community-based employment.

Status: The Action Plan lists:

- ♦ developing regional strategies;
- ♦ creating process maps to avoid employment disruptions;
- ♦ using data to drive future employment decisions;
- ♦ identifying service delivery gaps; creating practice standards; and
- ♦ developing mechanisms to use existing quality indicators.

The timelines for completing these actions range from 12/30/17-6/30/18. The policy work group of the E1AG is reviewing DARS documents to develop the fact sheets.

Goal 4: Virginia will have a system wide data collection and performance measurement system and procedures for employment data for people in supported employment.

Status: To identify service gaps, the E1AG data subgroup is developing surveys that will be used to collect data on provider capacity and transportation needs. The survey tools were expected by 4/19/17, but were only completed for provider capacity, not for transportation.

Work and activities of the E1AG are delayed. DBHDS now plans to combine and issue a unified survey for providers after November 2017. It is critical that the surveys about transportation and the need for Medicaid workarounds be completed, disseminated, and returned expeditiously. The DBHDS and E1AG will then need to undertake a timely analysis so that recommendations can be made that will support achievement of the targets and related goals.

DBHDS has analyzed and summarized the results of the provider capacity survey. The survey results, which include information about the current locations and types of day services that each provider offers, is available online to individuals, families and case managers. The survey results include what is currently provided, not information about the provider's actual capacity to provide additional day services. DBHDS reports that providers can always provide Individual Supported Employment (ISE), whereas some providers maintain a waiting list for Group Supported Employment (GSE) while waiting for an appropriate group situation to be available for a new participant.

Goal 5: Virginia's Employment First Advisory Group will have a formalized structure with clearly defined roles and responsibilities for members.

Status: The Employment First Advisory Group continues to meet regularly and has applications for new members to fill vacancies. Existing E1AE members have been reappointed.

Conclusion and Recommendations: DBHDS is in compliance with provision 7.b.i.A. DBHDS provided significant community engagement training during this reporting period, as is reported later in this report. Some Employment First training has occurred, but it has not been significant this period because of DBHDS's focus on providing CE training. Technical assistance has been given to ESOs. DBHDS does plan to hold town meetings throughout Virginia in the spring of 2018 for families and individuals. DBHDS staff hopes to discuss attitudinal, cultural and environmental barriers to employment from the perspective of the individual. I fully support this initiative.

This is a critical time in the Commonwealth's implementation of its employment first initiative. The Commonwealth, with the contributions of many stakeholders, completed much of the work that is necessary to reach its employment targets: rate changes, service definitions, provider incentives, meaningful and consistent data reporting, initial training, and interagency collaboration, especially between DBHDS and DARS. These changes were all intended, at least in part to contribute to significant increases in the number of HCBS waiver-funded participants in SE. This occurred during the first half of FY 17, yet there was virtually no change in the number of participants in ISE and the number participating in GSE decreased during the second half of FY 17. The reasons for this are presented in the section about employment targets. These data point to the need for renewed engagement of the E1AG and the state departments to ensure individuals, families and case managers are trained and fully educated about benefits, transportation options, and the availability of supported employment. They also point to the importance of case managers "developing and discussing employment goals" annually during the individual service planning process. The E1AG has diverse membership. The combined expertise and knowledge of the E1AG members should be used to help analyze the case manager and employment provider performance for this review period and develop strategies to improve the Commonwealth's focus and effort to meet the targets.

DBHDS continues to make progress executing its employment implementation action plan. I continue to recommend that the reporting format of the plan should be modified to provide actual updated information and specifics regarding implementation of each recommended action. The current updates do not report the status of each activity, the extent of planned accomplishments, or adjust timelines when necessary.

7.b.i.B.1.a-e: The Commonwealth is to develop an employment implementation plan to increase integrated day opportunities for individuals in the target population including supported employment, community volunteer activities, and other integrated day activities. The plan shall establish, for individuals receiving services through the HCBS waivers: Annual baseline information regarding:

- a. The number of individuals receiving supported employment;*
- b. The length of time individuals maintain employment in integrated work settings;*
- c. The amount of earning from supported employment;*
- d. The number of individuals in pre-vocational services; and*
- e. The lengths of time individuals remain in pre-vocational services.*

DBHDS has worked in partnership with the Department for Aging and Rehabilitative Services (DARS) to refine its data collection since October 2014. DBHDS had a response rate of 44% at that time. The recent semiannual report includes data through June 2017. It is the third semiannual reporting period in which responses were received from 100% of the Employment Service Organizations (ESOs). It is possible to make comparisons between reporting periods as a result.

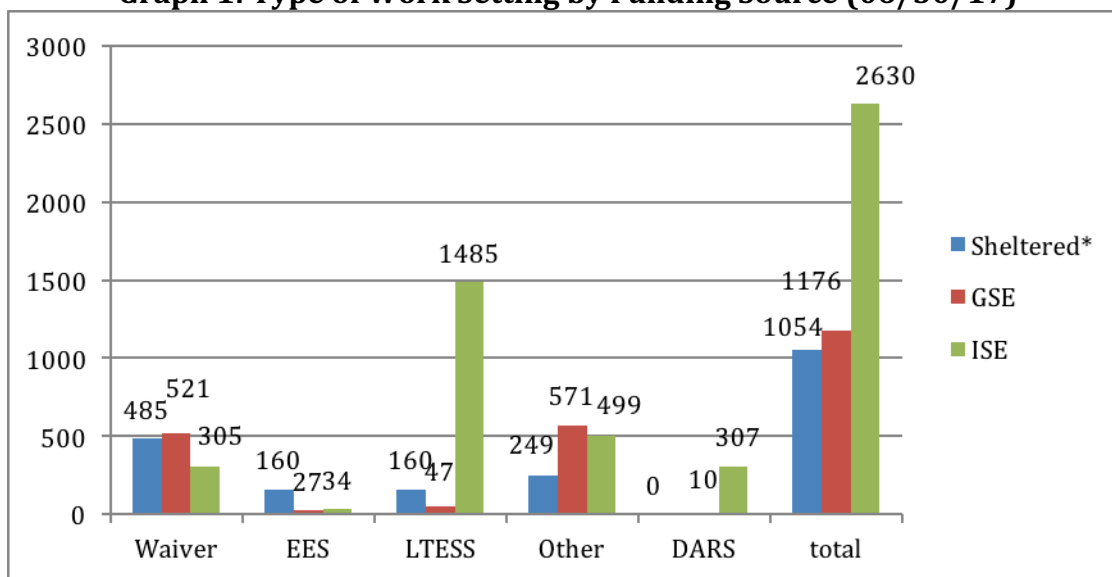
DBHDS also gathers data from a second source for both Employment Reports. DBHDS used its data sharing agreement with DARS to gather data regarding individuals with developmental disabilities who receive Extended Employment Services (EES) and Long-Term Employment Support Services (LTESS). These employment services are funded by DARS.

Statewide Data Analysis-The data in Graph 1 below for June 2017 indicates that 2630 individuals were in Individual Supported Employment (ISE) services and 1,176 were in Group Supported Employment (GSE) services. An additional 1054 people were receiving services in sheltered workshops. The individuals in sheltered workshops are not counted toward the DBHDS employment targets. As of June 2017, the numbers of individuals in these three situations changed when compared to December 2016, as follows:

- 311 more individuals were employed in ISE
- 77 fewer individuals were employed in GSE
- 50 more individuals were in sheltered work, after a reduction of 188 individuals in the previous period

Overall, an additional 234 individuals were in supported employment with the gain evidenced in ISE. These numbers reflect the total number reported as employed across all employment programs including the programs offered by DARS as well as the HCBS waiver employment services.

Graph 1: Type of Work Setting by Funding Source (06/30/17)



3,806 people are employed with supports from ISE and GSE, which is an increase of 234 people from the previous data reported. It also indicates that of the total number of individuals 18-64 on the waivers and the waiver waitlists, 23.38% of people with DD are employed. This is up slightly from the then 22.69% which was rounded to 23% reported in the December 2016 Semiannual Report.

DBHDS reports (6/30/17): 3,806 people are employed with supports from ISE and GSE, which is an increase of 234 people from the previous data reported. It also indicates that of the total number of individuals 18-64 on the waivers and the waiver waitlists, 23.38% of people with DD are employed. This is up slightly from the then 22.69%, which was rounded to 23% reported in the December, 2016 Semiannual Report.

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

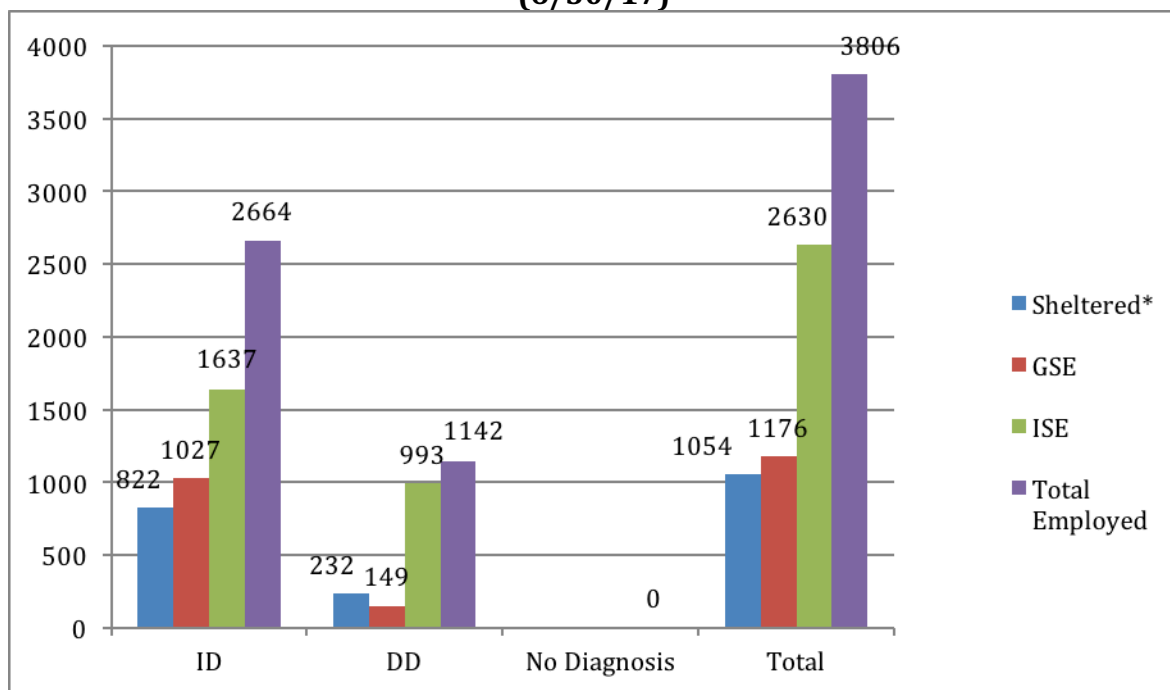
DBHDS continues, as it should, to report on the number of individuals employed in ISE and the number in GSE. The long-term goal of the Settlement Agreement, however, is to have individuals employed through ISE and eventually competitively employed. Overall, of the individuals in supported employment in June 2017, in either ISE or GSE, 69% were employed in ISE. Again, the DARS LTESS program funds the majority of individuals in ISE. Of the total number of individuals in ISE, only 12% are participating in the HCBS waiver-funded employment services. Of individuals in HCBS waiver funded ISE, the number increased by only four individuals between December 2016 and June 2017. This compares to an increase of seventy-six individuals in HCBS waiver ISE from the ninth to tenth reporting periods. During this period, the second half of FY 17, the number of individuals in

GSE decreased by seventy-seven individuals across all of the employment programs including a decrease in the ninety-nine HCBS waiver-funded program participants. It is of concern that sixteen fewer individuals (1311) in the HCBS waiver programs were participating in supported employment in June 2017 (1327) than had been participating in December 2016. This overall decrease resulted from 101 fewer individuals participating in GSE and eighty-one more individuals working in large congregate sheltered workshop participants. It is concerning that for individuals who are in the HCBS waiver program, participation in sheltered workshops has increased, in GSE has decreased, and in ISE remained relatively flat during the recent six-month periods. The number of individuals in the sheltered workshops is not counted by DBHDS towards the employment target goals. However, it is important to track the changes in utilization of the workshops. Fewer individual should be in SWs as a result of the changes DBHDS made in the waiver service definitions. The Commonwealth did not plan to have SWs in the waiver at all by July 2019 to make sure Virginia was fully compliant with the federal Workforce Innovation and Opportunity Act (WIOA). It seems more inexplicable that this number has increased between December 2016 and June 2017.

It is positive that, overall, 311 more individuals (counting individuals with I/DD who are funded by all sources, not only those with HCBS waiver funding). This overall increase was due to a significant increase from participation by individuals in the DARS funded LTSS program and by some increase in the “Other” category. The “other” category includes individuals using CSB funding for supported employment.

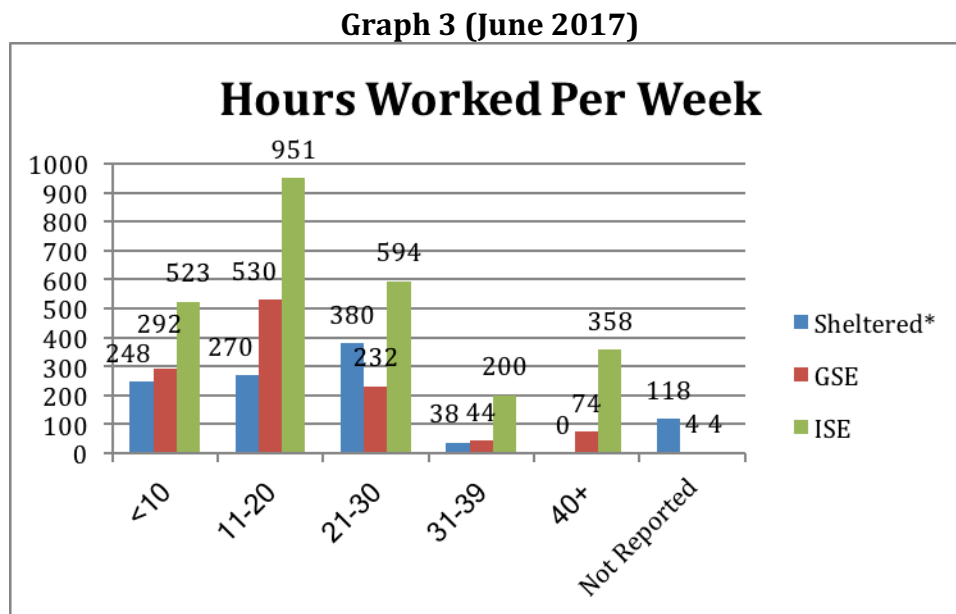
Graph 2 shows the employment involvement of individuals by disability group (i.e. individuals with Intellectual Disabilities (ID) and those with Developmental Disabilities, other than ID).

**Graph 2: Type of Work Setting by Disability
(6/30/17)**



The participation in ISE has increased between December 2016 and June 2017 for individuals with both ID and DD. Participation in GSE increased slightly for individuals with DD (+20), but decreased for individuals with ID (-97). Surprisingly the increase in sheltered work in this reporting period is the result of more individuals with DD using these large congregate segregated settings. Between the tenth and eleventh periods, thirty-seven fewer individuals with ID, but eight-seven more individuals with DD, were working in sheltered workshops. DBHDS should analyze the factors contributing to more individuals with DD being served in segregated sheltered workshops rather than in GSE. The Commonwealth should determine whether the changes to the HCBS waiver programs led to unanticipated consequences when the Commonwealth has implemented disincentives for providing services in segregated settings and incentives for supported employment that occurs in integrated setting.

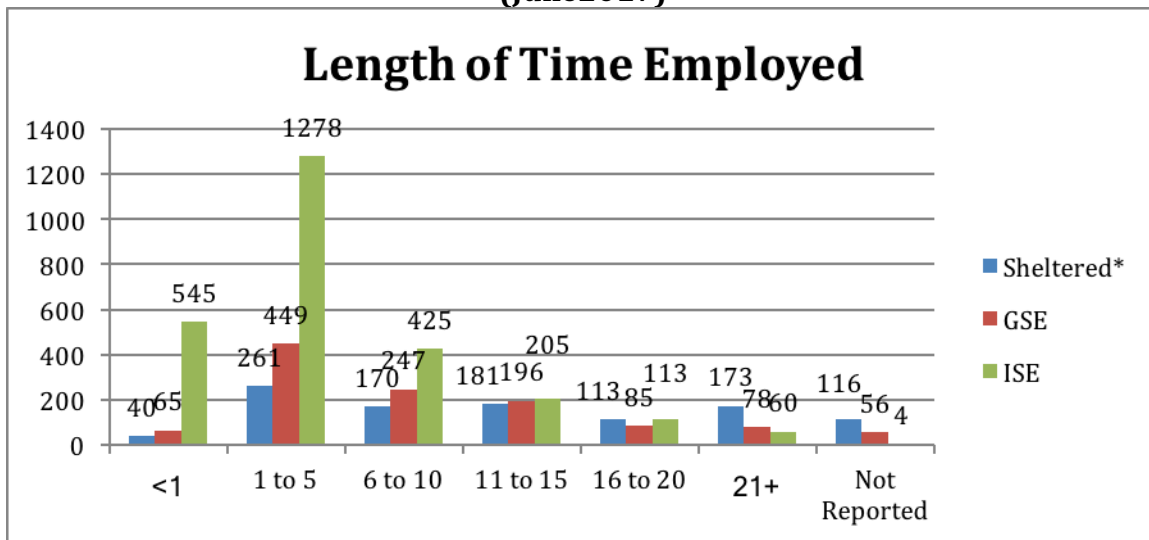
Average hours worked- The Commonwealth no longer reports on these data by ID and DD target groups or by Region. Previously individuals with DD worked more hours on average than did their counterparts with ID. Comparisons of both data sets have been useful in the past as they provide more detailed information about potential areas of under employment and geographic disparities. Graph 3 below details hours worked by service type in the DBHDS semi-annual employment report as of June 2017.



Fifty-six percent of individuals with IDD who receive employment support work twenty hours or less per week in ISE compared to 70% respectively in GSE. Only 21% in ISE and 10% in GSE report working more than thirty hours per week. However, the number of individuals in ISE working forty or more hours per week increased by 174 individuals in the eleventh reporting period which is significant. DBHDS does not report on whether individuals are working the number of hours they want to be employed. Many of the individuals may be underemployed.

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

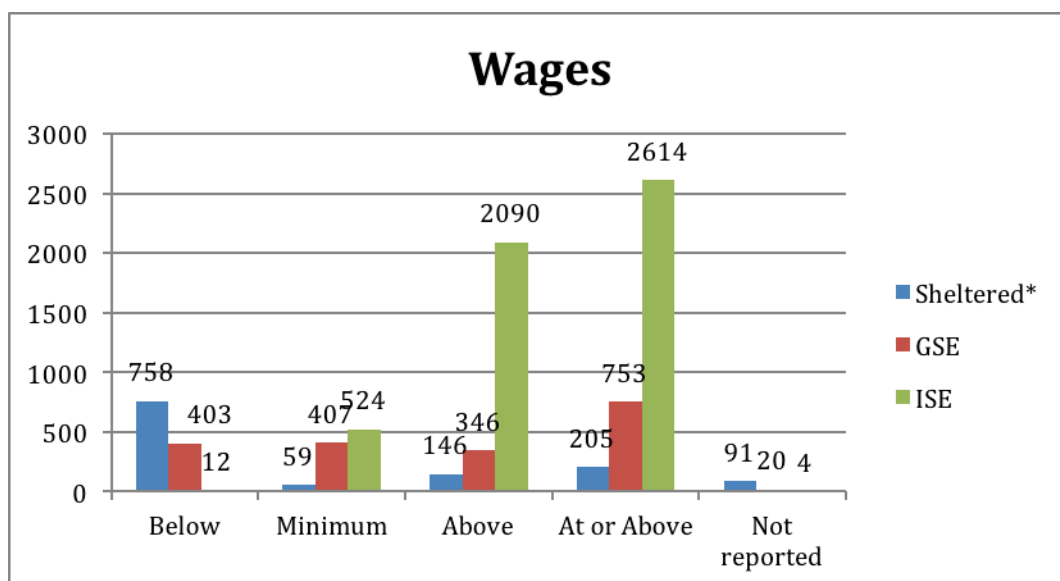
**Graph 4
(June 2017)**



The Commonwealth exceeded this expectation in the tenth reporting period. Eight-seven (87%) worked at their job for one year or more in ISE and 96% held their jobs for one year or more in GSE. This changed, however, in the eleventh reporting period. While 95% of individuals in GSE have been employed in their job for over one year, only 80% of individuals in ISE were so employed. Overall eight-four percent of individuals were continuously employed in the current position. The total number of individuals in ISE and GSE is 3806. Of this number, 610 have been in their position less than twelve months. This does not meet the requirement of the settlement agreement. Graph 4 displays this information.

Earnings from supported employment- DBHDS collected information regarding wages and earnings. The two tables below depict the data in terms of the average hourly wages and the number of individuals that earn above or below minimum wage. All but seven individuals in ISE earn at least minimum wage. However, of the individuals in GSE, 40% earn below minimum wage. Both figures are consistent with previous reporting periods. It is impressive that, of individuals in ISE, 77% are paid more than minimum wage. Graph 5 below depicts the wage information for individuals with I/DD. Table 1 summarizes average wages by program type.

Graph 5



DBHDS reports: Additional detail around wages was also added to gain better understanding of the number of individuals who are earning at or above minimum wage and the number of people earning below minimum wage. Currently there are 415 (11%) people employed who are earning below minimum wage (a 3% reduction from last reporting period) while there are 3,367 (88%) who are earning at/or above minimum wage (a 2% increase from last reporting period). 1 individual in ISE earning below minimum wage is in a tip position. The range of wages is noted in Table 1 below. The range for GSE hourly wages is consistent with the previous reporting period but the lowest and highest hourly wages for ISE are less than previously reported.

Table 1 - Statewide Distribution of Wages

IDD	Lowest hourly wage	Highest hourly wage
Sheltered*	\$0.04	\$18.22
GSE	\$0.22	\$29.91
ISE	\$2.36	\$22.05

Conclusion and Recommendations: The DBHDS is in compliance with 7.b.i.B.1.a, b, c, d, and e. Its data reflects information from 100% of all providers including the providers who offer HCBS waiver funded services and all employment related data from DARS relevant to the I/DD population. It is concerning that the Semi-Annual Employment Report for June 2017 reported that for the previous six-month period, the percent of individuals who maintained their jobs for at least twelve months fell below the expectation 85%.

It is very positive to continue to have data that include all individuals with ID and DD who are employed. DBHDS now has more accurate information about both the ID and DD populations related to employment with complete reporting for three reporting periods. The increase in individuals in ISE is noteworthy in a six-month period.

I repeat my previous recommendation that the Parties decide what if any outcomes are expected and required in the following areas: the amount of earnings; the number of individuals in pre-vocational services; and the length of time individuals are in pre-vocational services. Currently the Agreement only requires that DBHDS report accurately on these data elements

V. SETTING EMPLOYMENT TARGETS

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

DBHDS has set employment targets at two levels. A target was set on June 30, 2015 for 25% of the total number of individuals with I/DD 18-64 years old on the waivers or the waiting list (15,739), to be employed, in both ISE and GSE, by June 30, 2019, for a total of 3,935 individuals. As of June 2017, 3,806 individuals are so employed, which is 24% of the total number of 15,739. This is evidence of steady progress. This is an increase of 234 individuals in ISE and GSE combined since December 2016, and June 2017. The number represents 24% of the total number of 15,739, which is excellent progress over the past three six month periods. The percentages of individuals in ISE and GSE in previous periods was as follows:

- *December 2015: 20% of the total number of individuals on the HCBS waivers or the waiting list*
- *June 2016: 22% of the total number of individuals on the HCBS waivers or the waiting list*
- *December 2016: 23% of the total number of individuals on the HCBS waivers or the waiting list*

The second goal is to increase the number of individuals who are employed through waiver programs. DBHDS has slowed its progress toward the employment targets it has adopted for increases in employment for individuals in the HCBS waiver in this reporting period. The targets depicted in **Table 2** are for the total number of individuals in ISE for each of the next five fiscal years. These goals were set by DBHDS and the SELN in March 2014.

Table 2

Employment Targets in HCBS Waiver Programs: FY16 – FY20			
End of FY	ISE	GSE	Total
16	211	597	808
17	301	631	932
18	566	731	1297
19	830	831	1661
20	1095	931	2026
Total Increase FY'16- '20	884	334	1218

Comparison of the Targets- As of June 2017, 826 individuals were participating in ISE and GSE waiver-funded services. This is 106 fewer individuals than the target of 932 that DBHDS had set for that date. As of December 2016, more individuals were employed than the Commonwealth's targets for June 2017, however, by June 2017 there were nearly 100 fewer individuals in SE. Whereas, the number of individuals participating in ISE had increased slightly, from 301 to 305, the number of participants in waiver-funded GSE services had decreased substantially, from 622 to 521. DBHDS has not met its target that 932 individuals. with waiver funded services would be employed by the end of FY17.

Individuals in Supported Employment -the Commonwealth's current goal is to reach 85% of the total number of individuals who are in ISE to remain employed for 12 or more months. The Commonwealth had surpassed this expectation for the six-month period of the ninth reporting period, and has again for the year-long, combined tenth and eleventh review phase I and phase II of this year-long study. It is concerning that during the most recent, the eleventh review period only 84% of individuals had been employed in their current position for at least twelve months and only 80% of those individuals in ISE have been employed for this length of time.

The Commonwealth is reporting that more individuals are employed throughout the Commonwealth's employment programs, which meets the Commonwealth's employment target. However, the Commonwealth has not met the target for employment for individuals with waiver-funded services. There has been a decline in the number of individuals in GSE and a flat number for individuals in ISE compared to December 2016. It appears that the waiver redesign is supporting the employment goals. These employment reports always reflect a point in time but this lack of progress for participation in HCBS waiver-funded ISE and the decline of participation in GSE programs causes concern. In December, all stakeholders reported that the changes in the waiver design were demonstrating positive impact on employment. It will be important to review and analyze the data in the December 2017 employment semi-annual report to determine if there is a trend. DBHDS has set an ambitious goal for the end of FY18 for both ISE and GSE. ISE was to increase from 301 at the end of FY17 to 566 by the end of FY18. The fact that there has been virtually no increase in ISE since December 2016 does not demonstrate the progressive growth that forecasts that

the next target will be met. The number of individuals in GSE as of June 2017 is actually lower than the target of 597 individuals that was set for June 2016.

Of interest is a new table that DBHDS has included in its Semi-Annual Employment Report. The table captures the number of unique individuals who have a service authorization for ISE and GSE. These numbers as of 6/30/17 are respectively 346 and 674. Both numbers are higher than the number reported as actually in waiver ISE and GSE services. It appears that funding exists to support an increase in the number of individuals who have access to ISE and GSE waiver services. DBHDS does reference this in the semi-annual report and recommends that the E1AG Data Committee follow-up on the significant decrease in GSE participation, in light of the high number of authorizations. DBHDS also notes that the decrease is related to provider restructuring that has happened to respond to new requirements of the Workforce Innovation and Opportunities Act (WIOA) and the CMS Home and Community Based Settings Rule. DBHDS also credits the advent of community engagement (CE) and some individuals shifting from employment to CE. CE was designed to provide inclusive community options for individuals who were not ready or interested in employment and to enhance the lives of individuals with part time employment. It was not intended to replace employment for individuals capable of and interested in working. This data will need further analysis in future reporting periods to determine if there are trends and unintended consequences on employment growth by offering this new service option. In order for the Commonwealth to reach its employment targets in future fiscal years, especially in ISE for individuals in the HCBS waivers, the DBHDS will need to concentrate on increasing provider capacity. Provider capacity remains critical to Region I, II, III and V, which continue to have a preponderance of large congregate sheltered work settings, especially Region III.

Conclusions and Recommendations: the Commonwealth is not in compliance with Section 7.b.i.B.2.a. The Commonwealth has set targets to meaningfully increase the number of individuals receiving services through the waivers. The Commonwealth has not achieved its target for June 2017; and the number of individuals with HCBS in SE declined during the most recent semi-annual report. This decline appears to be evidence of a systemic obstacle to the Commonwealth's ability to sustain the progress needed to significantly increase the number of individuals with waiver funded employment services. The Commonwealth is in compliance with 7.b.i.B.2.b.

I support the recommendations the DBHDS made in the Semiannual Employment Report draft. These recommendations, however, have not changed since the previous semi-annual report; and, there is little indication of concerted action or progress. Implementation of these recommendations would further DBHDS's efforts to achieve its employment goals. Recommendations include:

1. *DBHDS needs to continue collaborating with CSBs to ensure that accurate information about the different employment options is discussed with individuals in the target population and that these discussions are documented.*
 - a. *Work with the SELN to develop a video that shows the conversation between a case manager and individual and their family to show how to have a better conversation. (9/30/2017)*
(Update: Postponed until 12/31/17)
2. *Increase the capacity of the Commonwealth's provider community to provide Individual Supported Employment services to persons with intellectual and developmental disabilities by providing technical assistance and training to existing and potential new providers.*
 - a. *Report the number of waiver providers offering Individual Supported Employment and Group Supported Employment. (6/2017)*
(Update: 42 ESO's offering ISE and GSE; 36 offer GSE only)
 - b. *Training for providers to support people with more significant disabilities. (6/30/2018)*
 - c. *Competency development (6/30/2018)*
 - d. *Find out from ESO's additional services offered/sub contracted with to identify potential combination of services that would help providers be better able to support people with specialized needs (6/30/2018)*
3. *Increase capacity in parts of the Commonwealth that have less providers and employment options. Create a map of the service providers in each of the Regions and the services provided so we can track increase in capacity. (Provider Survey complete)*
4. *Continue to collaborate with DARS, Employment Service Organizations, and DMAS to collect and report on employment data. (Semi- Annually)*
(Update: on schedule)
5. *Do a comparison in future reports of employment discussions and employment goals to evaluate the impact on the percent of people employed per region. (Start once data reporting is consistent and accurate)*
 - a. *DBHDS will follow up with the CSBs who have data reporting concerns around the discussion of employment and goals to address barriers to employment.*
6. *Create data tables around the waiver data according to old slots, new slots, and training center slots. (Next semiannual report)*
7. *Implement recommendations from the Regional Quality Councils. (6/30/2018)*
 - a. *Create success stories of employment that identify individuals according to the current support level as indicated by their supports intensity scores.*
 - b. *Develop tools/training for individuals and families*
 - c. *Gather transportation data*
 - d. *Improve communication with DOE around transition age youth and employment services and supports*

8. *Monitor the number of transition age youth entering non-integrated work settings to determine potential future intervention. (Semiannually)*
(Update: DARS is collecting this data to be used to target career counseling under WIOA)
9. *Develop additional detail regarding individuals who are earning subminimum wage by age and job type to determine if any trends exist. (6/2017) Use current data to establish baseline data and present to Advisory Group for refinement.*

It would be helpful if DBHDS could report on the impact new waiver funding has in each fiscal year on increasing its waiver opportunities for ISE and GSE to analyze the impact of new resources on the targets. There are 12,621 waiver slots, of which 9,802 are currently held by someone between the ages of 22 and 65. Approximately 900 slots are held by youth between 18-21 years of age. DBHDS did get new waiver slots in the current fiscal year. There are 12,108 individuals on the waiting list, as referenced in the DBHDS Semiannual Report on Employment (draft) of which 9,242 (68%) are under the age of 21. The new waiver slots are allocated to individuals based on the urgency of their need. Older individuals or youth with behavioral challenges may need many of the available slots. Unlike other states, none of these new slots are targeted for employment, particularly for school graduates. If new funding is not sufficient to achieve the targets set for each fiscal year, changes will need to focus on transitioning individuals in sheltered workshops and group day programs toward employment supports. This will require re-education of families and case managers and more vigorous implementation of the Commonwealth's Employment First Policy.

I continue to recommend that the Commonwealth further refine these targets by indicating the number of individuals it hopes to provide ISE to from the following groups: individuals currently participating in GSE or pre-vocational programs; individuals in the target population who are leaving the Training Centers; and individuals newly enrolled in the waivers during the implementation of the Settlement Agreement. I am pleased that the E1AG has also made this recommendation. The E1AG committed to start to set these sub-goals in the tenth reporting period, but this activity has been postponed. Creating these sub-groups with specific goals for increased employment for each will assist DBHDS to set measurable and achievable goals within the overall target and make the undertaking more manageable and strategic. Realistic and successful marketing and training approaches to target these specific groups can be developed through discussions between the DBHDS and the E1AG. A collaborative out-reach effort to families, case managers, CSBs, Training Center staff, and ESOs will assist the DBHDS to achieve its overall targets in each of the next three fiscal years.

VI. The Plan for Increasing Opportunities for Integrated Day Activities

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

Waiver Redesign: The Commonwealth is implementing the redesign of its HCBS waivers serving individuals with I/DD. The redesigned HCBS waivers include a definition for integrated day activities, which DBHDS now refers to as Community Engagement. The Commonwealth submitted its HCBS waiver amendments to CMS in March 2016. The Commonwealth's amendments were approved for implementation in FY17. The Commonwealth's General Assembly delayed implementation of two employment related services until FY18: benefits planning and non-medical transportation. Heather Norton confirmed that DBHDS would submit amendments to initiate transportation, community guide and benefits planning. DBHDS anticipated these would be available in October 2017. These amendments, however, have not been submitted as of October 28, 2017. DBHDS plans to now submit the waiver amendment by December 2017 and projects the services will be available before the end of this fiscal year. The actual date of availability will depend when the application is submitted the application and the length of time required to secure CMS approval.

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

Since the Commonwealth of Virginia entered into the Settlement Agreement with the US DOJ, DBHDS focused its work and activities on increasing employment opportunities for individuals with ID and DD. The Independent Reviewer directed DBHDS to develop a plan by March 31, 2014 to describe its approach to create integrated day activity capacity throughout its provider community and ensure that individuals in the target population can participate in these integrated activities as the foundation of their day programs. During this review period, DBHDS submitted the revised Community Engagement Plan FY2016-FY2018, which includes updates through FY18Q1. The foundation for community engagement is the CMS waiver as redesigned to offer community engagement, community coaching, and related services with reasonable rates.

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

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

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

The DBHDS Community Engagement Plan, as revised December 29, 2105, was updated to reflect the status of achieving the six goals as of September 30, 2017.

1. There is an overall goal to develop a common understanding and philosophy among stakeholders, providers, and state agencies of Community Engagement (CE) based on accepted national standards and in compliance with federal regulations.

STATUS- DBHDS has created the CEAG with broad stakeholder membership. All of the original actions have been completed. During this review period providers and case managers were trained. A family training was provided to fifty families, individuals with disabilities and providers. DBHDS trained an additional fifty professionals at the annual Collaborations Conference. Heather Norton also reported training in Henrico, Portsmouth and Southwest Virginia for families, providers and case managers. DBHDS reports a total of 600 stakeholders were trained during the eleventh reporting period.

2. Establish Policies to promote and encourage CE Activities.

STATUS- a monitoring process is to be in place by 7/1/16. No update on this activity. The CEAG completed the draft of the Best Practice Manual. It is comprehensive and sets the Commonwealth's philosophy about the value of community engagement for adults with developmental disabilities.

3. Develop funding sources that promote and encourage implementation of CE.

STATUS- Feedback from providers regarding provider concerns about staffing and the need to clarify the expectations for service delivery is being shared with the CEAG. Technical assistance is provided to CE providers to help meet waiver expectations.

4. Ensure that structures, at both the state and provider level, will support delivery of CE in the least restrictive and most integrated settings that are appropriate to the specific needs of the individual as identified through the person-centered planning process.

STATUS- The RFP awardees continue to meet to discuss successes and challenges. The experiences these providers have are being used as examples for the Best Practice manual.

4. Ensure CE services are being offered and provided to individuals across the state in the most integrated community settings based on the needs of the individual as determined through the person-centered planning process.

STATUS- There are currently 183 licensed provider locations of community engagement (non-center based day) services, an increase of eleven since the previous reporting period. There are 1,588 approved authorizations for individuals to receive CE and 120 approved authorizations for Community Coaching (CC). CE authorizations have increased by 62. The authorizations for CC coaching have increased by ten from the number in the tenth reporting period. These data are as of 6/30/17.

Although not yet official for FY18 Q1, DBHDS indicates the combined number of individuals engaged in CE or CC is 1969. This, an increase of 24% participants in a three-month period, is evidence of considerable interest in this new program among individuals and families and an ability of providers to respond to this increased level of interest.

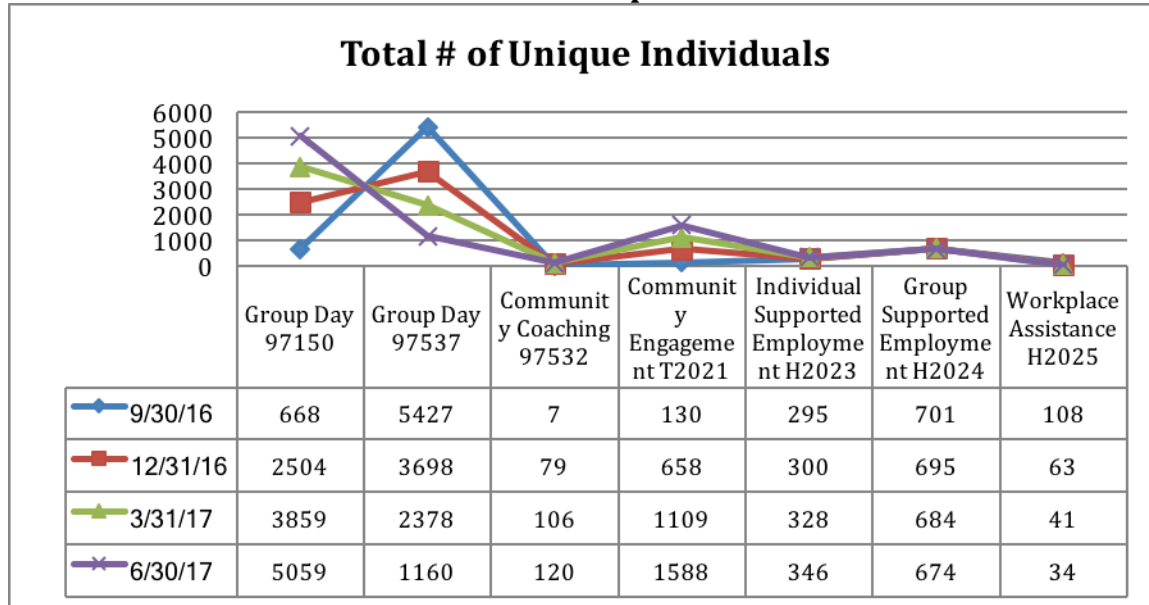
5. Ensure that there is an increase in meaningful CE for each individual. Virginia's vision is to have an array of integrated service opportunities available for individuals with disabilities and wants individuals to be able to choose to have services delivered to them in the least restrictive and most integrated setting.

STATUS – DBHDS and the CEAG are reviewing provider's practices on collecting data and plan to use NCI and QSR data on CE activities by 7/1/17. No specific activities occurred related to this goal during this reporting period. The CEAG continues to collect data. This activity becomes even more important as the participation in CE and CC increases substantially over a short period of time. DBHDS needs data that provide information on the hours of involvement and the type of activities offered. It is essential that the DBHDS can monitor the effectiveness of this program and the satisfaction of its participants.

Individuals Participating in Day Service Options

DBHDS has provided data, which is depicted in Graph 6 below that allows for comparison and growth of CE and CC from 9/30/16 through 6/30/17. This information reflects the number of individuals authorized for each service type.

Graph 6



In the nine-month period, 9/30/16 and 6/30/17, there was an increase of 113 individuals in Community Coaching (CC) and of 151 individuals in Individual Supported Employment (ISE). The involvement of individuals in Community Engagement (CE) grew dramatically in this nine-month period from 130 to a total of 1588. There was an increase of 124 individuals in Group Day, over the nine-month period (6,219 vs. 6,095). This increase is somewhat surprising in light of the reported disincentives to maintain congregate non-integrated day programs.

Participation in Group Supported Employment (GSE) reduced by twenty-five individuals. Participation in Workplace Assistance supports declined by seventy-four individuals. Heather, Norton explained that the data for Workplace Assistance from 9/30/16 reflected people with authorizations for pre-vocational programs because both services have used the same code. She believes there were not more than ten individuals using actual Workplace Assistance in 9/16. DBHDS staff will review the service type for the current number of 108 individuals to confirm the coding duplication has been corrected. These employment and day support programs had 7,336 participants as of 9/30/16 compared to 8,981 as of 6/30/17. The percentage of individuals participating in CC, CS and ISE increased from 6% in June 2016 to 23% of the individuals receiving some type of day support service. This results primarily from the dramatic increase in the number of participants in CE.

Conclusion and Recommendations: The DBHDS and the CEAG have developed a robust definition of Integrated Day Activities, which it now calls Community Engagement. These services have been approved by CMS and offered to waiver participants since September 2016. There is a total of 8,981 individuals authorized for waiver day services including center based day services. As of 6/30/17, 1,708 (19%) of these individuals are authorized for CE and community coaching. This compares to a total of 1,092 individuals authorized for these same services in the tenth reporting period. If the increase to 1,969 is confirmed in the next report, then 22% of individuals in waiver day programs are in CE. This is a significant increase and illustrates a strong interest among individuals and families. It is clear from the number of providers that have become licensed for these services that the provider community is responding to the direction set by DBHDS to transition its system of day supports away from segregated center based programs to services that support individuals with I/DD in inclusive community opportunities. Transportation, which is included, but not yet available, will be a key element to successfully offering these services. DBHDS expects to produce quarterly reports summarizing demographic data, successes, barriers and the average hours of participation in CE and community coaching by urban and rural areas. I recommend that DBHDS initiate this during the next reporting period so there are specific data to better determine the success of this initiative longitudinally. The Commonwealth will not achieve compliance with *III.C.7.a* until it achieves compliance with the sub-provisions of *III.C.7* regarding integrated day, including supported employment, are in compliance. To be determined to have provided integrated day and supported employment services “to the greatest extent possible” will requires the Commonwealth to be in compliance with the sub-provisions of this overarching provision.

The Commonwealth is newly in compliance with *III.C.7.b.i*. DBHDS and the CEAG have continued to do considerable work during this reporting period including significant training and information distribution. During the tenth and eleventh review periods, DBHDS improved its plan and implemented new community engagement services for hundreds of individuals. It will be helpful for the Commonwealth to establish baseline data, to develop targets, to articulate its expectations for hours of participation, and to determine how it will monitor the provision of these services to assure they are meaningful for the individuals.

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

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

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

Virginia has maintained its membership in the SELN and issued a policy on Employment First. DBHDS employed the Employment Services Coordinator until his resignation in January 2016. The DBHDS hired Anita Mundy as the new Coordinator who started in October 2016.

The Settlement Agreement requires the Commonwealth to ensure that individuals in the target population are offered employment as the first day service option. DBHDS included this requirement expectation in its Performance Contracts with the CSBs starting in FY15. The CSB Performance Contract requires the CSBs to monitor and collect data and report on these performance measures:

I.C. The number of employment aged adults receiving case management services from the CSB whose case manager discussed integrated, community-based employment with them during their annual ISP meeting, and

I.D. The percentage of employment-aged adults in the DOJ Settlement Agreement population whose ISP included employment-related or employment-readiness goals.

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

Employment Discussion with Individuals- DBHDS reports that a total of 6,945 adults whose case managers conducted annual ISP meetings or updates in this semi-annual report period. However, 10,288 individuals between the ages of 18-64 receive case management, most of whom should have annual ISP meetings. This indicates that ISP meetings were reported to have only been conducted for 67.5% of the total number of individuals who should had an ISP meeting. DBHDS believes this is an issue of data inaccuracy rather than an indication that CSBs are not convening teams annually for many individuals' ISP meetings. Of these 6,945 individuals, their case managers checked a box that indicated that a total of 5,932 individuals had discussed integrated, community-based employment during their annual ISP meetings. To ensure that these discussions are meaningful and include development of possible goals for exploring employment options or the steps to gaining employment, the Settlement Agreement requires that Employment Services goals be developed and discussed annually. The results of the Individual Services Review study and the Case Management study found that development and discussions of service goals are rarely documented; available documentation indicates that many of these discussions are cursory and do not meet the requirements of the Agreement. DBHDS reports that the data supplied by CSBs indicate that 85 % of individuals had a discussion of integrated employment when their ISP was reviewed. This reporting period has much better reporting from the CSBs. The number of individuals about whom the CSBs reported has significantly increased. CSBs reported on 6945 individuals with ISP meetings during the eleventh period compared 3,103 in the tenth reporting period. The higher recent numbers continue to appear to represent significant underreporting by the CSBs since the data report in Attachment 1 is for the entire FY17 year.

It is important to look at the data specific to each of the 40 CSBs. The following table provides a breakdown of the percentage of individuals that the CSB's reported discussed employment

Table 3- Tracking Employment Conversations

Number of CSBs	Percentage of Employment Discussion
5	100%
20	90-99%
5	80-89%
2	70-79%
0	60-69%
2	50-59%
1	40-49%
2	30-39%
1	20-29%
0	10-19%
2	0%

Only 12.5% of the CSBs reported that case managers discussed employment with all of their waiver participants. Whereas, 25% of CSBs reported such discussion with 100% in the tenth reporting period.

CSBs also reported that 2,212 of 6,945, a statewide average of 32% of individuals who had an annual ISP review in this reporting period, had an employment or an employment-related goal in their ISP. This would represent an increase of 2% from last reporting period. Only thirteen CSBs met the DBHDS expectation to have employment goals for 35% of their consumers, which is an increase over the ten CSBs that reported meeting this expectation in the tenth reporting period. Four CSBs did not report employment goals for any waiver participants and another reported employment goals for 15% or less.

The twenty CSBs reported having discussed employment with 95% or more of individuals having ISP meetings are: Alexandria, Alleghany, Arlington, Colonial, Crossroads, Cumberland Mountain, Eastern Shore, Fairfax-Falls Church, Goochland-Powhatan, Hampton/ Newport News, Hanover, Harrisonburg-Rockingham, Henrico, Highlands, Horizon, Mount Roger, Board, Rappahannock, Rappahannock-Rapidan, and Rockbridge. Thirteen CSBs reported including employment goals for at least 35% of the individuals who had ISP meetings. These are: Alexandria, Arlington, Chesterfield, Colonial, Goochland-Powhatan, Hanover, Harrisonburg-Rockingham, Henrico, Horizon, Prince Williams County, Rappahannock, Rockbridge, and Virginia Beach. The full DBHDS report of the CSB effort to meet these two target goals is detailed in Attachment 1.

This issue is of concern to the statewide Quality Improvement Council and has been minimally discussed by some of the Regional Quality Councils. It has not been discussed by the E1AG. The DBHDS efforts to date are still focused on improving the accuracy of the reporting, but not on how to monitor that the employment discussions occur and employment goals are established for individuals in their plans.

DBHDS reports that it has worked with the Case Management Coordinator and Performance contracting staff to retrain all CSB case managers on these data elements and will continue to meet with the CSBs to develop a plan to address the discrepancies in meeting these targets. However similar information was reported in the tenth reporting period. I recommend that the Independent Reviewer request a written plan of the actions that will be taken and the timeline to implement them from DBHDS. This should include the department's plans to use agency quality monitoring and enhancement staff to review a sample of ISPs to determine the meaningfulness of the employment conversations and the suitability of the employment goal.

The Commonwealth is not in compliance with *III.C.7.b*. The Commonwealth is not meeting the requirement to have employment addressed in the individual planning process through meaningful discussion and goal setting. The Commonwealth has not yet demonstrated effective and sustained implementation of its Employment First policy by the CSBs. The Commonwealth has also not demonstrated that it has the ability through its performance contract to require CSBs to take effective corrective actions that address and resolve repeated performance below acceptable standards. For example, Case Managers and Support Coordinators are not consistently:

- offering individual supported employment in integrated work settings as the first and priority service option, or
- developing and discussing employment service goals annually.

The Engagement of the SELN - The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, to set the targets for the number of individuals in the target population who will be employed, and to provide ongoing assistance to implement the plan and the Employment First Policy. The SELN Advisory Group was renamed the Employment First Advisory Group. Its members were appointed for two-year terms: August 2015- July 2017. Members report they have been formally reappointed. The EFAG has twenty-six members. It includes self-advocates, family members, advocacy organization representatives, CSB staff, state agency administrators, educators, employment providers, and representatives of the following state agencies: DBHDS, DMAS, DARS, and VDOE. This Advisory Group has several sub-committees: membership, training and education, policy, data, and interagency collaboration. I reviewed the E1AG meeting minutes from 08/16/17. The meeting was well attended. A previous meeting was cancelled. DBHDS shared the minutes of the Interagency Sub-committee meeting of 08/12/17. No other sub-committee meeting minutes were provided for review.

DBHDS has formalized the work of the Community Engagement Advisory Group (CEAG). It has a membership of twenty-three individuals, which includes representatives of all of the stakeholder groups. Members have also been appointed for two-year terms. Two sub-committees, policy and training, continue to operate. DBHDS provided minutes from the meetings held during the review period, the last of which was September 22, 2017. The CEAG continues to review and have input into the Best Practice Manual and to review provider concerns that effect implementation of CE.

The two Advisory Groups remain active in their advisory capacities to DBHDS regarding its employment initiatives. I interviewed six members of the E1AG for this reporting period to gain perspective on the work of the advisory group and the progress the Commonwealth is making to meet the Settlement Agreement requirements for employment.

- 1. *The operation of the SELN and the opportunity afforded its members to have input into the planning process*** -all members who I interviewed continue to report that the E1AG is active and has a diverse and effective membership. Members report that they have opportunity for meaningful input. They appreciate the structure of the sub-committees for policy, training and data. They report that the sub-committees function effectively. The structure is for the full E1AG to meet bimonthly and for both sub-committees to meet during alternate months. This has created more meaningful and efficient E1AG meetings. The agenda and discussion of topics is now driven by the recommendations of the sub-committees. Members are pleased that decisions are more data driven and that the committee is involved with DBHDS in making data that are understandable, usable, and available to individuals and families.
- 2. *Review of the Employment Targets***- Members appreciate the continued progress to increase the number of individuals overall who are employed, but are concerned with the most recent semi-annual employment report. Some feel the families need much more information and that their CSB case managers must more fully understand and embrace employment as the first and priority service option, articulate its value for individuals, and allay families' concerns. Members hope that DARS can develop the capacity to continue to respond to greater numbers of individuals with I/DD who are seeking employment support. Members are hopeful that employment participation will increase once non-medical transport is available as a waiver service. Members do advocate that the E1AG focus its attention to analyze and strategize how to best increase the number of waiver participants in ISE and GSE.
- 3. *Review of CSB Targets***- DBHDS has not reviewed the CSB data with the E1AG. The E1AG training sub-committee is revising the employment training modules for case managers. Members think that case managers will benefit from continued training on employment to fully embrace the principles, intent, and the policy direction; and to understand their role in the ISP planning to assist families and individuals to seriously consider employment as the first and priority option.

- 4. Provider Capacity and Training-** Members report positively about the ESO survey that provides information for families, individuals and case managers to help them locate employment providers in their areas of the state. Members are involved with the DBHDS to further survey providers to determine their interest in becoming waiver providers and to identify barriers that exist among the ESOs to the participation by individuals with HCBS waivers. Members hope to use the responses to determine what policy changes may be needed. Sheltered Workshops are closing. One recently transitioned to become a supported employment provider. DARS is working with their providers to become HCBS waiver providers. The E1AG has developed a flow sheet for Vocational Rehabilitation (VR) providers to simplify the process of becoming a qualified waiver provider. Some members recommend that provider training be enhanced and be offered in the more highly populated areas that have a greater density of individuals with I/DD. A significant amount of the employment training for providers has been offered in rural areas according to the members. There is agreement among the members who were interviewed that the training initiative needs to become a priority again.
- 6. Review of the RQC Recommendations-** The members of the E1AG do not report receiving many recommendations from the RQCs. They note low participation in the RQC meetings and recommend the RQCs craft their group discussions to be more solution-oriented.
- 7. Interagency Initiatives-** the members of the E1AG who I interviewed were positive about the interagency cooperation between DBHDS and DARS, and about the newly appointed member representing DOE, the state's education agency, which members report as positive. The representative from DMAS has worked for DARS previously and brings knowledge of this initiative. These state agencies, however, have still not developed a MOA, which been a long-standing goal.
- 8. Transportation-** The lack of available transportation continues to be a significant concern by many stakeholders. Members are hopeful that adding non-medical transportation as a waiver service will be an enhancement to employment support.

Conclusion and Recommendation: The DBHDS continues to meet the Settlement Agreement requirements to maintain the SELN, has set goals for the CSBs in the performance contracts, and has a full time Employment Services Coordinator, but is not in overall compliance with *III.C.7.b*. The CSBs have not consistently offered employment as the first and priority option or developed and discussed employment service goals annually.

VIII. Regional Quality Councils

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

III.C.7d. 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.

Quality Improvement Meetings

There is a statewide Quality Improvement Council. It convened June 1, 2017 when seventeen members of thirty-nine members attended including only one Regional Quality Committee liaison from Region IV. During this meeting, the members discussed the employment targets after a presentation by DBHDS.

Committee members discussed the December 2016 Semi-Annual Employment Report that had responses from 100% of the Employment Services Organizations (ESO). The Commonwealth had met its target for June, 2017 at that time. The QIC discussed the targets and the tracking data of employment first conversations by SPTs with individuals. The targets for employment discussions and designing employment goals were not met. It was reported by DBHDS that there were some coding inaccuracies. The committee discussed strategies to bring the CSBs into compliance including providing guidance to Case Managers and making data corrections. DBHDS is committed to training CMs and working with CM Supervisors to better oversee the achievement of this expectation through improved data tracking. The QIC members want to review this data again at the October 2017 meeting. The QIC reviewed the progress on provider service mapping. The purpose of this project is to ensure that services are available in terms of quality, quantity and accessibility. Providers are completing self-surveys. Responses have been received from 1109 locations. This includes existing and planned locations. This project is providing the data that will inform the DBHDS' analysis of where there are gaps in service availability. The DBHDS hopes to include data on provider competency and specialized services in future reports.

RQC Regional Meetings

The minutes for the Regional Quality Councils (RQC) were shared for all five Councils. These meeting occurred between May 24, 2017 and June 15, 2017. Heather Norton discussed employment targets with each RQC highlighting that:

- The ISE target set for FY17 301 was met in December (six months early)
- The GSE target set for FY17 is 631. DBHDS believes this will be met by June 2017 since there are 622 individuals in GSE as of December
- 90% of individuals employed have held their job for 12 months or more
- 86% of individuals employed are paid at or above minimum wage

Each of the RQCs also met during FY18 Q1. DBHDS staff provided updates on employment for each Council meeting but again no discussion occurred.

The RQCs' meeting minutes reflect that DBHDS consistently made presentations about employment in both quarters of the eleventh review period. However, there was not any significant discussion about the targets nor did the RQCs make recommendations, with the exception of Region I that did discuss the targets in FY17 Q4. The other RQCs did not discuss the employment first discussion goal except to note data problems. None of the RQCs offered ideas for strategies that might improve the performance of CSBs. None of committees had all of their members attend. All of the RQCs were missing one or more of their employment representatives, with the exception of RI in the August 2017 meeting. Most of the committees did not have any member attend who represented an employment provider. Many were missing some or all of their individual and family representatives. The RQCs were missing the input and expertise of the members who could offer substantive recommendations to the DBHDS and E1AG that would reflect the perspective of stakeholders.

I recommend that the Commonwealth be found to be in compliance with the requirement of involving the RQCs because the meetings were held and employment was at least presented. Targets need to be reviewed on an annual basis and were reviewed during the tenth reporting period which meets this annual review requirement. Additionally, the statewide QIC had a meaningful discussion about the employment targets at their meeting in June and made recommendations that were shared with the EFAG. I do recommend that the DBHDS converse with the regional committees to determine the reasons for the lack of engagement of individuals, families and employment providers in committee meetings. Their attendance is important to ensure local and regional concerns and recommendations for quality improvement are being brought to the attention of the state.

Conclusions and Recommendations: DBHDS is in compliance with III.C.7.d because the employment target for sustaining employment for twelve months was reviewed by the five RQCs in the reporting period. DBHDS is in compliance with III.C.7.c because there were quarterly reviews of employment data. All five regions held meetings in both FY17 Q4 and FY18Q1 and all of the minutes were shared. However, there was not meaningful discussion so there were no substantive recommendations to share with the E1AG. I recommend the role of the RQCs to review employment data quarterly and make recommendations for improvement be analyzed to determine whether such frequent review adds value. If this requirement is maintained the RQC members need to fulfill their role more consistently.

IX. SUMMARY

DBHDS has made significant gains during this reporting period in its data collection and in its efforts to implement integrated day activities, which DBHDS refers to as “community engagement”. Its progress towards achieving its multi-year employment goals is mixed. DBHDS has improved its plan to create integrated day activities and participation in community engagement has increased significantly. The Commonwealth has increased the number of individuals who are employed, although more in the DARS-funded programs than for individuals with waiver-funded services, in which participation in GSE decreased significantly during the recent six-month period. The Commonwealth has not reported identifying the systemic obstacle that contributed to a 16% decline in the number of individuals with waiver funded services participating in GSE during the recent quarter

DBHDS achieved compliance with one additional requirement of the Settlement Agreement by improving and implementing its plan for community engagement. The Commonwealth sustained compliance with nine other provisions that were previously met.

DBHDS is not in compliance with three of the Settlement Agreement’s provisions related to integrated day and supported employment. It has newly achieved compliance with one provision and lost a determination of compliance for two provisions. The lost determinations of compliance are related to the targets for employment not being achieved for participation in GSE by individuals with HCBS waiver-funded services. In addition, the recent reversal of progress, a significant decline in the number of participants working in integrated settings and an approximate corresponding increase in the number of individuals served in large congregate settings. This decline appears to be a symptom of new systemic obstacles that, if unaddressed, will interfere with the Commonwealth’s ability to continue to increase participation in supported employment. The Commonwealth continues to not achieve the targets set for the CSBs to hold employment conversations and set employment goals for individuals. The overall progress, especially in community engagement and the sustained efforts to work collaboratively with stakeholders is noteworthy.

Attachment 1

Tracking Employment First Conversations

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

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

The results of the data collection are presented below for the entire fiscal year of FY2017 (7/1/16-06/30/2017).

CSB	Receiv ing Case Manage ment	Annual ISP Meeting Data	Employment Discussion at Annual ISP Meeting		Employment Goals in ISP	
		F-T-F Meeting: Individua ls with Annual ISP Meeting	#	%	#	%
Alexandria	73	70	69	99%	47	67%
Alleghany- Highland	49	41	39	95%	13	32%
Arlington County	116	79	76	96%	30	38%
Blue Ridge Behavioral Healthcare	347	242	212	88%	49	20%
Chesapeake	184	52	0	0%	10	19%
Chesterfield	734	467	434	93%	180	39%
Colonial	130	74	74	100%	26	35%
Crossroads	110	1	1	100%		0%
Cumberland Mountain	137	106	105	99%	26	25%
Danville- Pittsylvania	277	222	173	78%	33	15%

Dickenson County Behavioral Health Services	19		0	0%		0%
District 19 Community Services Board	311	143	81	57%	39	27%
Eastern Shore	102	93	93	100%	11	12%
Fairfax-Falls Church	837	632	607	96%	163	26%
Goochland-Powhatan	55	34	33	97%	13	38%
Hampton-Newport News	406	228	227	100%		0%
Hanover County Community Services Board	152	56	53	95%	23	41%
Harrisonburg-Rockingham Community Services Board	145	99	95	96%	64	65%
Henrico Area	462	295	288	98%	107	36%
Highlands	118	84	77	92%	16	19%
Horizon	472	301	291	97%	276	92%
Loudoun County Community Services Board	186	142	70	49%	41	29%
Middle Peninsula-Northern Neck	205	158	55	35%	30	19%
Mount Rogers	217	204	197	97%		0%
New River Valley	215	152	42	28%	71	47%
Norfolk Community Services Board	349	277	275	99%	72	26%
Northwestern	305	227	197	87%	71	31%
Piedmont	235	187	166	89%	20	11%

Planning District I	152	74	58	78%	4	5%
Portsmouth	212	193	160	83%	40	21%
Prince William County Community Services Board	348	111	99	89%	69	62%
Rappahannock Area Community Services Board	456	274	259	95%	211	77%
Rappahannock -Rapidan Community Services Board	184	107	104	97%	32	30%
Region Ten Community Services Board	294	251	231	92%	60	24%
Richmond	370	325	96	30%	47	14%
Rockbridge Area Community Services	39	33	33	100%	15	45%
Southside Community Services Board	180	160	149	93%	49	31%
Valley Community Services Board	242	128	125	98%	23	18%
Virginia Beach Community Services Board	686	589	570	97%	227	39%
Western Tidewater Community Services Board	177	34	18	53%	4	12%
State Total	10288	6945	5932	85%	2212	32%

APPENDIX F.

INDEPENDENT HOUSING

By: Patrick Rafter, CEO, Creative Housing Inc

MEMORANDUM

Date: November 1, 2017

To: Donald Fletcher, Independent Reviewer

From: Patrick Rafter, CEO, Creative Housing Inc.

Re: Virginia Housing Plan Review

Subsequent to my June 4, 2017 review of *Virginia's Plan to Increase Independent Living Options*, I am submitting a Phase 2 follow up report of issues noted over the time of my visit.

During the visit, as noted in my June 2017 report, "I reviewed training materials on independent living that DBHDS utilized to orient its own staff, the provider community, direct consumers and their families. I also visited Region IV (Richmond Area) and Region I (Charlottesville Area) where I met with Regional Implementation Teams which had a cross section of DBHDS staff, Community Service Board staff, providers and family members. I had additional meetings with involved family members to assess how the process was working for them and their relatives".

My October Phase 2 activities involved reviewing updated DBHDS reports and having discussions with DBHDS lead staff. I have the following observations:

Independent Housing Development: With 553 housing options created, the DBHDS Outcome Timeline Report shows development almost a year ahead of its projected path to achieve 847 new options by FY2021. In past reports (November 2013, 2014), I had been critical of the lack of progress in the actual development of housing options during those review periods. It should be noted now that DBHDS progress in this area over the last two years is both substantial and commendable. DBHDS appears well on its way to meeting its projected development targets.

LIHTC Development Monitoring: DBHDS currently has a monitoring system in place, capable of tracking availability of units with a DD housing preference as they come on line. This system makes the units available to members of the Settlement Agreement in a timely manner. The 2015 LIHTC allocation has set aside 95 units with a leasing preference for individuals with DD. The 2016 LIHTC allocation has a set aside preference of 53 units. To date, 7 individuals in the Settlement Agreement have been able to access LIHTC units which are just beginning to become available as the two-year development cycle reaches the point of actual unit production. It should be noted that some Settlement Agreement members may choose other locations in which to live with the support of a rent subsidy. As I mentioned in previous reports, the matching of individuals, their supports and available apartments is a complex choreography. DBHDS needs to continue closely monitoring this process as it has moved from unit production to occupancy of individuals who would benefit from the apartments.

Provider Development/Geographic Service Disparity: DBHDS staff provided me with “working draft” of an *Integrated Living Plan (FY 2017 – FY 2019)*. Primary projected long-term outcomes of the plan include a 3% annual increase in the number of providers who support individuals in independent housing statewide. The plan notes a number of initial activities intended to achieve long-term stated outcomes.

As this plan matures, I would expect for a more detailed baseline measurement tool be developed which would clearly delineate areas and services around the Commonwealth that are struggling with capacity problems. The tool will assist in ascertaining the impact that proposed independent housing development activities are having in noted problem geographic areas. Once this aspect of reporting is firmed up, there will be a clearer and more comprehensive picture as to how the Commonwealth is responding to the provider development/geographic service disparity.

As always, I have appreciated the courtesies and assistance given to me by DBHDS staff during my review. I am available to answer questions they may have.

APPENDIX G.

TRANSPORTATION

By: Ric Zaharia Ph.D.



Consortium on Innovative Practices

October 15, 2017

TO: Donald Fletcher
Independent Reviewer

FROM: Ric Zaharia, Ph.D.

RE: Brief Review & Report on Transportation Services
in *US v Commonwealth of Virginia*

I telephone interviewed DMAS leadership on transportation services to establish the status of recommendations from previous reports and planned changes at DMAS. These interviews occurred in late September 2017.

The original RFP for transportation services was withdrawn and cancelled due to procurement issues earlier this year. The new RFP was issued on 9/25/17 and is expected to be awarded in December 2017 for July 2018 implementation. It includes specifically the language:

"The DOJ agreement requires an Independent Reviewer to determine if the Commonwealth is in compliance with the terms of the Agreement.... the Independent Reviewer determined that the Commonwealth was in noncompliance with qualitative aspects of transportation that address concerns related to the quality of transportation services for individuals with ID/DD. While the report outlined recommendations for the current broker, DMAS, under this RFP, shall require the Contractor to adhere to the following specific to NEMT services for the ID/DD populations: 1. Separate out ID/DD Waiver users in data collection and reporting, and the quality improvement processes, to ensure that transportation services are being properly implemented for the members of the target population; 2. Encourage more users, including ID/DD Waiver users and/or their representatives, to participate in the Advisory Board process; 3. Periodically sample survey transportation users to assess user satisfaction and to identify problems; and 4. Conduct focus groups with the ID/DD Waiver population, in order to identify problems. Until completion of the waiver redesign, the Contractor shall provide NEMT services to waiver services for these members. It is anticipated that transportation to waiver services for CL/FIS (formerly ID/DD) members, as provided under this contract, will transition to the managed care organizations beginning July 2019 but no later than July 2020. ..however, DMAS anticipates that there will continue to be a specialized population of fee-for-service membership that will access transportation."

DMAS indicates it now meets weekly with Logisticare staff to troubleshoot problems. DMAS reports that Logisticare continues to analyze utilization and complaint trends for the distinct IDD user population and sample surveys IDD users who may have satisfaction issues; and that Logisticare has also implemented a) a member mobile application, b) new dispatching software for providers, c) a new automated telephone short survey in which members receive an automated telephone call asking six service satisfaction questions, and d) updates to the website for users that permit easier access and trip confirmation/updates.

Reportedly Logisticare has not conducted focus groups or had focused conversations with users in the IDD Waivers and has not delegated additional authorities to Logisticare 'case managers' at the local level to effect solutions to continuing problems. DMAS has made no further improvements to the mileage reimbursement form/process.

Finally, I did have the unplanned opportunity to evaluate an alleged sexual assault that occurred on a Logisticare trip earlier this year. An adult woman, who is competent and her own guardian, reported to day program staff that she was "groped" by a peer during a transport in a Logisticare vehicle. Day program administrative provider staff reported notifying Logisticare about the allegation. It is encouraging in follow-up that DMAS was able to report that Logisticare logged the complaint and reported the allegation to APS, which declined to investigate the matter. After a Logisticare investigation, the company determined the accused passenger would have to henceforth sit in the front seat; they had no previous reports about this individual.

Conclusion

The Commonwealth is not yet in compliance with the Settlement Agreement (Sec. III.C.8.a). The next review of Transportation Services should occur after the July implementation date.

Recommendations toward achieving compliance:

DMAS should complete the award process and implementation of *RFP 2018-01* for Transportation Services for users in the IDD Waiver-funded services.

DMAS should continue its focus on improvements in transportation services through its current broker, Logisticare; if another broker is selected, this focus on Logisticare should continue until that broker is in place.

APPENDIX H.

REGIONAL SUPPORT TEAMS

by: Ric Zaharia, Ph.D.



Consortium on Innovative Practices

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

Regional Support Teams
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

November 1, 2017

Executive Summary

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a Phase II review, a follow-up to our Phase I review (April 2017), of the Regional Support Team (RST) requirements of the Agreement.

There are several themes in the Settlement Agreement that guide Regional Support Teams: a) diverting individuals prior to being placed in nursing homes, intermediate care facilities and other larger congregate settings (five+), b) identifying and resolving barriers and ensuring placement in the most integrated setting, and c) ongoing quality improvements in discharge planning and development of community-based services. In order to meet the RST expectations of the Agreement, Community Resource Consultants (CRC), who staff the RSTs, operate at the micro level of individual situations and then generate insights and actions at the macro level.

This study found that the RSTs are not effectively reviewing all individuals prior to non-emergency placement in large congregate settings. Effective reviews by the RST did not occur due to a) late RST involvement in placements originating in the community and b) non-responsiveness by case managers/support coordinators (CM/SCs). The problem of late referrals (after or concurrent with an individual's move) has improved but fluctuated over the years; further, lasting improvements are needed. The RST were not able to divert individuals from placement in large congregate facilities because they frequently did not receive the referral with adequate time to identify and address barriers and because of gaps in the needed services for individuals in their home communities, especially those with intense needs.

The quality of the operating data collection and analysis system that DBHDS uses to determine actions to improve the quality and effectiveness of RST performance has matured. Trending analyses are more reliable now; definitions have been clarified for the field and reporting formats have been improved.

The CRCs and the RSTs are involved with individuals who are referred to large congregate facilities or nursing facilities when an appropriate service cannot be found that are the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. However, there are breakdowns in the referral system and process.

Community Resource Consultant functioning is still missing the formalized dimension of 'ongoing planning and development of community-based services'.

Methodology of Phase II Report

- Reviewed RST Annual, Quarterly Reports 2017;
- Reviewed the RST 2017 Survey Report, 9/19/17;
- Reviewed RST minutes from all regions for the period April – July 2017;
- Reviewed 1/12/16 report of the OSIG (Office of the State Inspector General) on CCCA (Commonwealth Center for Children and Adolescents);
- Reviewed Department of Behavioral Health & Developmental Services (DBHDS) Retrospective Study (11/16/16) in response to OSIG Report on CCCA;
- Reviewed Critical Case Consultation Team (CCCT) process description, 10/6/14, CCCT updates;
- Interviewed DBHDS leadership responsible for RSTs.

Phase I Findings Recap

As we found two year ago, the quality improvement processes used for RSTs are still in a developmental phase. RST staff had drafted formalized protocols/procedures for processes and quality assurance in 2015, but they had not yet been finalized or approved by DBHDS.

The quality of the DBHDS operating data collection and analysis system has matured. DBHDS plans to use this system to determine actions to improve the quality and effectiveness of RST performance. The RST Quarterly Reports illustrate referral patterns, barrier frequency, and the potential for identifying geographic density of existing and needed services.

DBHDS has developed the WaMS System for use in waiver slot management, service plan storage, and pre-authorizations. The previous RST Coordinator did not acquire the technical expertise to take maximum benefit of access to this system. This expertise is critical to early identification of potential placement events that CRCs could plan for and anticipate.

The lack of timely referrals by case managers/support coordinator and therefore timely reviews by the RST were problems identified in our previous review. RST members were unanimous in reporting improvements in the receipt of timely referral information, but it is not a resolved problem. In the Phase I sample of referrals which we reviewed from three regions, 6 of 14 cases (43%) moved to placements prior to the referral. However, the aggregate data in RST Quarterly Reports show that during April-May-June 2016, 17 cases out of a total of 47 community cases (36%) statewide moved prior to the referral to RST; the Quarterly Report for October-November-December 2016 shows 9 cases out of a total of 57 cases (16%) moved prior to the referral.

Based on this Phase I review, supporting emergency or crisis placements was becoming a core function of RSTs. The minutes of two regions for the six-month periods July-December, 2016, indicated more than half the situations reviewed (37 of 64 or 58%) were emergencies or crises (homeless, in jail, etc.).

The CRCs and the RSTs are involved with some individuals who are referred to large congregate nursing facilities. However, at least one problematic case involving a very young child (RST #65916) suggests that there are still system gaps and hence avenues for admission to congregate settings that bypass RSTs. Youths and adults with intellectual and developmental disabilities (IDD) are also admitted to state hospitals and other facilities, regularly without using the RST process.

RST members were unanimous in reporting that they consider the RST's effective at identifying and resolving barriers in some individual cases. For example, during the nine-month period April-December 2016, seventeen (17) individuals reviewed by RSTs were diverted from placement in large group homes, or other congregate settings, and into integrated, smaller settings.

Community Resource Consultant (CRC) functioning is still missing the formalized aspects of the 'ongoing planning and development of community-based services'. The CRC's continue to perceive this planning and development role as one that exists in their area, but not one for which they have a direct responsibility. CRCs, RSTs and managers in the Provider Development Section at DBHDS all generally perceive that service system gaps and local needs are well known from the CSB level up to the state level. The Commonwealth, however, did not provide documentation that it has identified these gaps.

Phase II Findings

The Provider Development Section's 2017 survey of RST members (9/19/17) was thorough and informative. In the RSTs, the DBHDS has a committed cadre of volunteer individuals with thoughtful insights on the needs of the system. DBHDS has committed to annual resurveys of RST members and to make several changes that would improve the training provided to RST members and to provide feedback on the effectiveness of their work. Although not explicitly surveyed, one underlying theme of the survey feedback was the need for the RST process to allow for the identification of options "that may not exist in the system and what would be needed or developed".

The DBHDS Provider Development Section's analysis of RST referrals for all of FY17 suggests that timeliness by case managers/support coordinators worsened over the 12 months (46% were late in the 4th Quarter FY17, up from 18% late in the 1st Quarter FY17). Table 1 illustrates the recent pattern.

Table 1

PLACEMENTS MADE BEFORE OR CONCURRENT WITH RST REVIEW*						
	SAMPLE, CY16	Q4, FY16	Q1, FY17	Q2, FY17	Q3, FY17	Q4, FY17
Late referrals	43%	36%	18%	19%	30%	48%

*based on RST annual and quarterly reports

In response to fewer timely referrals, the Section reports that it has increased outreach activity to CSBs and case managers/support coordinators who have demonstrated difficulty in making timely referrals to the RST. In addition, as part of its redesign of its HCBS waiver program, the Commonwealth has established CSBs as the single point of entry into the case management/support coordination system for all individuals with IDD. DBHDS expects that this change will enhance its ability to oversee case management/support coordination functioning, improve the timeliness of referrals, and identify alternatives to admissions to congregate facilities.

The DBHDS analysis of RST FY17 data also suggests that the most frequent barrier to a placement in the most integrated setting was the absence of “residential setting in the desired area” (cited in 134 RST referrals). DBHDS has not yet drafted a Network Development Plan to address service gaps, but provider surveys have been completed by the Section, and DBHDS has public presentations planned to share the results of current provider deployment and provider interest in future expansion.

In Phase I we raised the findings of the Inspector General’s 1/12/16 report on the DBHDS facility, Commonwealth Center for Children and Adolescents (CCCA – a 48-bed facility on the grounds of Western State Hospital in Staunton). The Department subsequently conducted a retrospective study of those admitted to the facility in FY15. According to the Department 139 unique children and adolescents with IDD utilized 31% of the days of service at the facility. These individuals, who are identified in the Settlement Agreement’s target population, are admitted by a CSB pursuant to an Involuntary Temporary Detention Order from a magistrate requiring inpatient hospitalization. Of those IDD admissions in FY15, 90% were admitted by their CSB from their own or a foster home. DBHDS believes preadmission diversion is now handled by REACH staff at the time of the prescreening assessment. Concurrently, DBHDS reported that overall 269 individuals with IDD were admitted in FY15 to all state psychiatric facilities, which included CCCA.

These involuntary commitment facility admissions are considered by the Department as crisis situations that, once the individual is stable will return to the existing home placement, are, therefore, not generally required to be reviewed by RSTs. Instead of the RST process, the DBHDS REACH crisis services programs offer stays in its crisis stabilization homes as a last alternative to placement in a psychiatric facility.

Finally, we have previously raised the connections between the Critical Case Consultation Team (CCCT) and the RSTs. This Team originally managed a flexible crisis fund to support individuals for whom the RSTs had no solutions and other individuals in crisis mode. In FY17 \$687,000 of one-time funding was approved for medical and/or behavioral supports for 27 individuals in crisis. Now that fund is managed by the administrators of the DD Crisis System, and the CCCT is apparently non-functional, since it has not been convened for over one year.

Conclusion

DBHDS is not in compliance with the requirements of III.D.6., regarding RST review of admissions to congregate facilities with five or more.

DBHDS is in compliance with the requirements of III.E.1., regarding the utilization and role of the CRCs

DBHDS is not in compliance with the requirements of III.E.2., regarding CRCs referrals to the RST to ensure that an available placement is offered in the most integrated setting appropriate to the individual’s needs.

DBHDS is in compliance with the requirements of III.E.3, regarding the role of the CRCs.

The Commonwealth is in non compliance with the requirements of IV.B.15. See the explanation for IV.D.3 below. DBHDS is in non-compliance with the requirements of IV.D.3. Although adhering to the requirements regarding the creation, composition, authority, and role of the five RSTs, the RST cannot be in compliance with their responsibilities to “work with”, to “identify”, and to “resolve” unless referrals are received with sufficient lead time to fulfill these responsibilities.

Recommendations toward Achieving Full Compliance

DBHDS should encourage CRCs to use their access to WaMS to get “in the loop” in the service authorization process, when a CSB first assigns an individual to a slot. The point is to provide technical assistance efforts earlier to case managers/support coordinators, 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). At the very least, placements that are considered true “emergencies” should not be delayed to process a referral to the RST. These emergency placements, however, should be sorted differently and be distinguishable in the data analytics for RST.

DBHDS should create annually updated 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/support coordinators and providers about the system goal of offering and facilitating placement in smaller and more integrated residential settings.

DBHDS should ensure that RSTs are aware of changes to the crisis funding process, including the defunct status of the CCCT, and should update the website references.

Summary of Findings

Findings from this review indicated that the implementation of the RST process has had positive impacts on the system and on some individual cases, especially those referred with sufficient time for barrier identification and resolution. Overall individuals were referred to the RST were regularly placed in more integrated settings when the RSTs and CRCs had adequate notice to be able to complete an effective review process.

The RSTs are carrying out functions that support the goal of placements in the most integrated setting possible for individuals with HCBS waiver funded services. The impact of the RST process continues to be limited by the oversight or the inadvertent delay by case manager/support coordinators in making timely referrals for individuals who reside in the community. The RSTs effectiveness in fulfilling this role depended largely on the timeliness of referrals. The continuing most frequent reason larger congregate settings are chosen by individuals and their Authorized Representatives is the absence of more integrated settings that include needed supports and services, especially for individuals with intense medical and behavioral needs, that are in the geographic area of the individual’s family/AR. Only a clear plan for development and needed expansion in services can begin to redress this core problem.

Attachment A

RST Settlement Requirements

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.

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.

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.

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.*

APPENDIX I.

QUALITY AND RISK MANAGEMENT

By: Maria Laurence and Chris Adams

Report on Quality and Risk Management

United States v. Commonwealth of Virginia

Submitted by: Maria Laurence, and Chris Adams
Independent Consultants
November 10, 2017

INTRODUCTION

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

At the request of the Independent Reviewer, this is the fifth Report that assessed the Commonwealth’s progress in meeting these terms of the Settlement Agreement. Maria Laurence previously reviewed and submitted reports that included findings and recommendations related to the Quality and Risk Management systems. These reports were included with the Independent Reviewer’s Reports to the Court, which were submitted on December 6, 2013, December 8, 2014, December 6, 2015, and December 23, 2016. Using information from these reviews, and from other sources, the Independent Reviewer made previous determinations of compliance. This report includes references to previous reports, as relevant to recent findings. This consultant’s most recent previous report is referred to as the “last Report.” Chris Adams joined Maria Laurence in conducting the current review.

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

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

At the outset, the consultants would like to thank the Department of Behavioral Health and Developmental Services (DBHDS) staff for their time and input. The assistance given throughout the review period by the Assistant Commissioner of Quality Management and Development (QM&D) and the Community Quality Management Director is greatly appreciated. In addition, a number of other Commonwealth staff, staff from the Delmarva Foundation, staff from two Community Services Boards (CSBs), as well as staff from three community provider agencies participated in interviews and provided documentation. Their candid assessments of the progress made, as well as the challenges ahead, were very helpful, and are an indication of their commitment to future progress. The organizational assistance provided by the Senior DD Administrative and Policy Analyst also was of significant help.

METHODOLOGY

The fact-finding for this Report was conducted through a combination of interviews and document review. Between August and October 2017, interviews were held with staff from the DBHDS, Delmarva Foundation, CSBs, and provider agencies. (Appendix A includes a list of the people interviewed and the documents reviewed.) It is important to note that many of the Commonwealth's Quality and Risk Management System initiatives are in the process of development and implementation. As a result, a number of draft documents formed the basis for this Report.

FINDINGS AND RECOMMENDATIONS

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

V.C.1. The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risk of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.

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

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

At the time of the last Report, the Commonwealth remained in the process of developing a list of triggers and thresholds. Some triggers and thresholds the Commonwealth developed were event-based (i.e., events that already occurred), and some provided ways to identify the potential for risk. In approximately July 2016, the Commonwealth recognized the need to develop a process that placed more responsibility at the CSB and private provider level. At the time of the previous onsite review in early October 2016, such a process was still under development.

Since that time, the Commonwealth stopped the development of lists of specific triggers and thresholds, and decided to pursue different options for identifying individuals at risk of or who experienced harm, as well as providers that might place individuals at risk of harm, and potentially require attention. One of the major reasons for the shift was that the system under development at the time of the last review was a reactive one that relied heavily on the Commonwealth to identify that a problem had occurred and notify CSBs and/or providers. Commonwealth staff recognized the need for a more proactive approach that combined efforts on the part of the CSBs and providers, as well as Commonwealth staff to proactively identify risk and potential for risk, as well as to retroactively address harm that occurred to prevent its recurrence to the extent possible. The Commonwealth staff drafted a framework for this new approach, but the staff recognize that significantly more work is needed to finalize and implement the framework. The Assistant Commissioner of QM&D indicated that DBHDS has requested funding to hire a consultant to assist them in finalizing the risk management system, and leveraging their resources to ensure CSBs and providers implement robust risk management systems. The Assistant Commissioner hoped to show more progress with this system at the time of the next review.

DBHDS's Draft Community-Based Risk Management Framework incorporated a number of important components, including:

- 1) Serious incident reports (SIRs) and human rights complaints review: The document describes steps that are needed to harness the information that these existing processes generate, including identifying individuals at risk, as well as providers that require attention; triaging them so that highest priority issues are addressed first; following up on identified issues; and identifying issues that repeat themselves for further analysis and action;
- 2) Mortality review: To review and follow up on mortality information at the provider level, the process would be similar to that the Commonwealth proposes for SIRs;
- 3) Health risk assessment: DBHDS proposes identifying one health risk assessment and/or common elements of a risk assessment that all six managed care organizations (MCOs) would use to determine individuals' risks in key health areas on an annual basis. Once such a tool is implemented across the MCOs, DBHDS could utilize the data for risk management purposes, and work with providers in the development of plans to mitigate identified risks to the extent possible;
- 4) Provider competency and capacity: Data for this component would come from a variety of sources, including the Office of Licensing Services (OLS) and Department of Medical Assistance Services (DMAS) citations, completion of Service Coordinator/Case Manager training and competencies, and information about direct support professional and supervisor completion of training and competencies; and
- 5) Provider quality improvement and risk management framework: The first step listed to obtain relevant data for this component is the development of a QI/risk management framework, which the Commonwealth has just begun. The specific actions the Commonwealth has undertaken are discussed below in the section of this report that addresses providers' quality improvement systems. Once completed and implemented, the Commonwealth proposes monitoring providers and CSBs' implementation, and then reporting on specified metrics.

Given the size and structure of the Virginia intellectual and developmental disabilities (IDD) system and the need to develop a sustainable risk management system, the Commonwealth's plan to work with CSBs and providers to structure their risk management systems, and then develop mechanisms to ensure those systems are working correctly is a reasonable one. The general framework and components that the Commonwealth outlined has the potential to generate useful data to identify potential risk of harm and realized harm. For example, the framework necessarily incorporates data that retroactively identifies harm that occurred (e.g., SIRS, complaints, and mortalities), and much of this data already is available. The framework also anticipates the development of other data that could be used proactively, including annual health risk assessments that should allow interdisciplinary teams to develop and implement plans to mitigate risks to the extent possible. Tracking provider capacity and intervening when capacity does not align with individuals' needs also would potentially serve a proactive risk management role. Finally, assisting CSBs and providers to develop or bolster their risk management systems, and then developing monitoring systems or look-behinds to ensure such systems are working correctly appears to be a good way to utilize DBHDS' limited QM&D staffing.

That being said, the outline the Commonwealth shared with the Consultants included limited details, and the details will be important to ensure that the system has the necessary data, and the analysis processes, to proactively, as well as retroactively identify areas of risk and/or harm; to utilize that data efficiently and effectively to identify the need for interventions; and to provide sufficient oversight to ensure that when CSBs or providers need to take action, they do and those actions are effective.

The Commonwealth QM&D staff reported that they already began working with their Data Warehouse and data analysts to identify existing data with which to employ predictive modeling techniques to identify providers and individuals with highest numbers/percentages of issues, as well as providers with few or no issues, which might indicate underreporting. The plan is then to utilize the Commonwealth's Regional staff, Office of Integrated Health (OIH) staff, OLS staff, etc. to follow-up. The QM&D staff estimate that within the next few months, they will complete work on identifying the components they want included in the model (e.g., falls, bowel obstructions, etc.). The data analysts would then need to build and generate the reports, which would take several additional months.

The Commonwealth's Risk Management Review Committee (RMRC) continues to meet approximately every two months. According to the minutes for the meeting held on 7/27/17, the group agreed that it needed a charter to define the purpose, membership, responsibilities (e.g., reports/data it should review, follow-up it should undertake, etc.), and the group's relationship to other committees, such as the Quality Improvement Committee (QIC), and Mortality Review Committee (MRC). As of the meeting held on 9/6/17, the charter remains in the development phase. The minutes indicated that the Community Quality Management Director is first gathering feedback from stakeholders on the Risk Management Framework.

At this juncture, the RMRC has played a role in discussing the overall risk management framework that is under development, including, for example, the risk assessment tools available, as well as planning for a second quality improvement/risk management survey of providers. The group also regularly reviews and tracks completion of recommendations from the Independent Reviewer's SIR review report recommendations.

As past Reports indicated, the Commonwealth's regulations provided significant obstacles related to implementing a system-wide risk management and quality improvement system, because of what they did not require from private providers. On a positive note, the Community Quality Management Director had undertaken a project to identify the regulations that do include related requirements, which should then assist in identifying missing components.

As the Commonwealth moves forward in adding detail to its Draft Community-Based Risk Management Framework, some of the recommendations from previous Reports apply and new ones are offered:

- As additional data elements are identified and/or developed, it will be important for Commonwealth staff to focus on measurability and definitions of terms, as needed. For example, as the Consultants discuss in their report on training, a continuing challenge with the training competencies is the lack of measurability. Given that one way the Commonwealth has proposed measuring provider capacity and competence is providers' compliance with the training competencies, it will be essential that the Commonwealth improve the measurability of the competencies, and for the system to integrate an inter-rater reliability component into the process that it will use to measure providers' compliance with the competencies. Similarly, as the Commonwealth works with the MCOs to develop a common health risk assessment tool, it will be essential to agree upon identical criteria for risk ratings, and ensure that definitions of terms are agreed upon as well.
- The Settlement Agreement provides an inclusive definition of harm (i.e., "Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes"). The framework that the Commonwealth has proposed has the potential to encompass a wide variety of harm and risk of harm. As the Commonwealth staff add detail to the framework, they should take care to ensure that it covers the wide breadth of potential areas of harm. As one example, the information provided does not make clear whether or not the health risk assessment will include risks related to behavioral health, but if not, the system will need to incorporate such risks through some other mechanism. The RMRC identified some concerns related to the system's current ability to track decubitus ulcers, which often indicate inadequate health and physical care. It will be important to solve this tracking problem and to continue to identify such gaps, as well as solutions.
- The Mortality Review Committee identified eight conditions that uniquely contribute to the deaths of individuals with IDD (i.e., urinary tract infection, constipation/bowel obstruction, aspiration pneumonia, decubitus ulcers, sepsis, seizures, falls, and dehydration). As Commonwealth staff recognize, the early indicators of these conditions should be included in individuals' ISPs, and incorporated into the triggers and thresholds providers and CSBs track for individuals with IDD. Highly sensitive

“triggers” should be included for individuals who are older (i.e., over age 45) and who are considered medically complex based on their Support Intensity Scale (SIS) assessments.

- The Commonwealth should consider specifically identifying 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.)
- The Commonwealth should further define how health risk assessment, and then related planning, will contribute to its risk management model. For example, it will be important for the Commonwealth to determine whether individuals have risk-reduction plans, but also whether the plans include the basic elements of a quality risk-reduction plans (i.e., provide a clinically relevant and achievable goal by which to measure an individual’s progress or lack thereof, include actions steps sufficient to minimize to the extent possible the individual’s risk, and provide mechanisms to monitor the implementation of the plan), and the staff competencies in the delivery of this element of an individual’s services.
- Although annual health risk assessment is an important place to start, a proactive system also will require mechanisms to identify and respond to individuals’ changes of status. For example, CSBs and providers’ risk management systems should be sensitive enough to identify changes in status, such as excessive weight loss and/or gain, or increases in, for example, falls, swallowing issues, seizures, both minor and serious injuries, emesis, pneumonia, behaviors placing the individual at risk, etc.
- As noted in previous reports, if changes to licensing regulations are necessary to require providers to fully implement risk management systems, and/or provide the Commonwealth with necessary and reliable data, then the Commonwealth should effectuate such changes.
- As noted in previous Reports, it will be important for the Commonwealth to identify mechanisms to gather data from providers not licensed by DBHDS to provide IDD services or DBHDS-operated Training Centers, including nursing homes, private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and private homes.

As discussed in further detail below, based on the Consultants’ interviews with CSBs and private providers, they continue to be largely unfamiliar with the concept of risk triggers and thresholds, and/or the Commonwealth’s work on developing a risk management framework or system. For the most part, they also were unfamiliar with the resources the Commonwealth posted on its website related to, for example, root cause analysis. Therefore, the next phase of soliciting stakeholder feedback, finalizing the framework, and implementing it will be substantial.

Based on documentation provided and interview, the Community Quality Management Director developed a presentation entitled: Guided Discussion on Development of a Community-Based Quality Improvement and Risk Management Framework. The presentation provided some information about why such systems are necessary, and provided a forum for DBHDS staff to seek information about providers’ and CSBs’ current systems. It also set forth some of the basic components of quality improvement and risk

management systems. As of the time of the Consultants' review, the Community Quality Management Director had begun using the presentation to guide discussions about the framework with Regional Quality Councils (RQCs). Moving forward, the plan is to incorporate relevant feedback into the draft framework.

QM&D staff also recognize that once the framework is finalized, the roll-out of the requirements and related training and monitoring will be keys to its success. Some options that they are considering include working with the Quality Leadership Council for the CSBs, which meets every two months and includes representatives from the quality departments of all 40 CSBs; using regular Roundtables in the various regions to communicate changes and expectations; and partnering with private provider associations, including any quality forums they might sponsor.

As has been discussed in previous Reports, it is a challenge for the Commonwealth to implement an effective multi-level quality and risk management system when attendance is optional at current training options related to risk management creates. This is an area that the Commonwealth needs to address. It appears that CSBs and providers are not using, and in many cases, are not even aware of the quality resources and tools that DBHDS has "offered" by posting them on its website. Moving forward, the Commonwealth should offer classroom training on risk management systems, as well as online training, including the equivalent of experiential-based learning, such as role-plays and discussion.

In summary, since the last review, the Commonwealth began charting a new course to address the Settlement Agreement requirements related to tracking of risk triggers and thresholds. This effort includes a component that brings in CSB and providers' risk management systems. Specifically, the Commonwealth's QM&D staff developed a Draft Community-Based Risk Management Framework that generally sets forth the skeleton for a reasonable risk management system. However, once finalized, a number of factors will determine its success, including: the details of the system, which remain under development; training and technical assistance for CSBs and providers; consistent implementation across providers, which have varying levels of understanding and capacity to implement risk management systems; the Commonwealth's oversight of CSBs and providers; as well as the Commonwealth's use of the data generated from a number of sources. Commonwealth staff recognize that they have considerably more work to complete in order to address these elements of the Settlement Agreement.

V.D.1-6

- 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 medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status);*
 - c. Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);*
 - d. Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);*
 - e. Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);*
 - f. Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);*
 - g. Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services*

geographically, cultural and linguistic competency); and

- h. Provider capacity (e.g., caseloads, training, staff turnover, provider competency)...*
- 4. The Commonwealth shall collect and analyze data from available sources, including, the risk management system described in Section V.C. above, those sources described in Sections V.E-G and I below (e.g., providers, case managers, Quality Service Reviews, and licensing), Quality Management Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.*
- 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:

- a) Obtain status of any modifications to the Centers for Medicare and Medicaid Services (CMS)-approved Quality Improvement (QI) plan and implementation efforts (i.e., Section V.D.1).
- b) Obtain updates on the Commonwealth's efforts to identify the data to be collected and to collect valid and reliable data for the eight domains (i.e., as listed in Section V.D.3, a through h).
- c) Determine status of the validity of the measures and reliability of the data (V.D.2, a through d) and the status of data analyses (i.e., Section V.D.4).
- d) Obtain updates on the status of CSBs' and providers' review of data (i.e., V.D.1.), as well as of the review processes of data at CSB's and by DBHDS/DMAS' review of CSBs' and providers' data review processes.
- e) Obtain updates on the status of the Regional Quality Councils (i.e., Section V.D.5a. and b) and the status of assessments of relevant data, review of trends, and recommendations by the Quality Councils.

- f) Obtain updates on the Commonwealth website designed to report publicly on the availability, quality and gaps in services, and recommendations made for improvement (i.e., Section V.D.6)

Section V.D.1: CMS approved Virginia's waiver amendments for the Community Living, the Family and Individual Support, and the Building Independence waivers on 9/1/16, and emergency regulations regarding these waivers were approved for the period 9/1/16 through 2/28/18. Final regulations are under review and are expected to be approved for implementation in advance of the 2/28/18 expiration date for the emergency regulations. Appendix H, Quality Improvement Strategy, outlines the basic assurances the Commonwealth agreed to provide to CMS to measure the quality provision of protections, services, and supports through the implementation of the Waivers. These assurances include data and information regarding (1) Case Management; (2) the inter-agency Quality Review Team; (3) the DBHDS Quality Improvement Committee and Regional Quality Councils; (4) Quality Services Reviews; and (5) the DBHDS Mortality Review Committee. This description included many of the requirements of the Settlement Agreement relating to quality improvement and is consistent with and not in contradiction to the provisions and these requirements.

Staff report that two of the waivers are scheduled for renewal in 2018. The renewal applications are scheduled for submission in March. According to DBHDS staff, the applications will incorporate a description of numerous changes in the Commonwealth's quality assurance system and will reflect revised and expanded data measurements. During the twelfth review period, the Consultants recommend review of the Waiver renewal information and status of its review and approval by CMS.

The Commonwealth provided a copy of the most recent iteration of the DBHDS Quality Management Plan, updated 10/20/16. The plan, in its current iteration, presents a comprehensive, high-level description of how the agency structures its Quality Management program. The Consultants found that DBHDS is not using its Quality Management Plan as its central repository of efforts to advance the structure and implementation of a data-driven quality improvement system. The plan does not provide a roadmap for DBHDS to expand and improve its ability to collect and analyze data to measure improvement in both quantity and quality of its services for individuals in the target population. The plan has also not been updated to incorporate some of the more recent modifications made to the way in which DBHDS collects and analyzes data (e.g., the addition of the Quality Review Panel described in a later section of this report). The Consultants recommend that DBHDS consider incorporating a roadmap (e.g., annual plan) as well as this greater level of detail as an attachment to the Quality Management Plan and assure that the plan is kept up-to-date to reflect its most current plans and initiatives.

Section V.D.2: DBHDS continues to expand and improve its ability to collect and analyze consistent, reliable data to measure availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services. To date, the primary focus on measure identification has been on data that is currently available through a variety of existing data sources.

DBHDS has used a thoughtful approach to begin evaluation of identified data elements to determine if the data are accurate and complete and to ascertain how well the data, once analyzed, will be useful to measure the quality and quantity of services being provided. As described in the previous Report and discussed in more detail below, the Data Quality and Analytics Coordinator worked closely with a group of subject matter experts to develop initial measures for each of the eight domains. DBHDS staff reported that this initial process helped to solidify the relationships needed to move forward, and particularly, helped subject matter experts to gain an understanding of the development of valid and reliable measures with the assistance of data experts.

DBHDS staff recognize that their development of these initial measures was the first step in a much larger project. Data analysis staff report that the primary means to accomplish this expansion is through an expanded role for subject matter experts well-versed in the programs that make up the service delivery system. The subject matter experts, working with data analysts, will continue to develop measures, evaluate the accuracy and completeness of the data and, through analysis, further evaluate the efficacy and utility of the data measures.

On a positive note, data available through the OneSource Data Warehouse continues to expand. The Director of the Business Analytics Center of Excellence described data that they have incorporated since the last review, including, for example, REACH data, as well as data his team is actively working to incorporate, such as additional death information, hospitalization data, and forensic data.

Current efforts to identify, analyze and expand the use of data are appropriate first steps; however, DBHDS has not developed a structured plan that includes specific goals, objectives, tasks and timelines to guide the efforts necessary to identify, define, collect, analyze, report, and effectively use relevant data to evaluate and improve services. Without a formal plan to establish the parameters, objectives and timelines for the project, it is difficult to determine if the significant efforts and resources being dedicated to this initiative are making meaningful progress. It is recommended that DBHDS formulate a formal plan that captures current and future goals, objectives, and timelines to expand and improve effective use of data, and maintain it as an attachment to the DBHDS Quality Management Plan. Reporting on status of goal, objective, and milestone achievement should then flow from this plan.

Section V.D.3: During the ninth review period, DBHDS indicated plans to produce a data-based report to measure progress in each of eight domains set out in Section V.D.3 of the Settlement Agreement. DBHDS anticipated one measure in each domain with data collection to begin on 1/1/17. DBHDS produced its most recent “Report on the Eight Domains” in 10/17. The report includes a greatly expanded set of 26 data measures with the following number of measures for each Domain:

- Domain 1, Safety and Freedom from Harm – 4 measures
- Domain 2, Physical, Mental and Behavioral Health and Well-being – 4 measures
- Domain 3, Avoiding Crises – 5 measures
- Domain 4, Stability – 4 measures
- Domain 5, Choice and Self-determination – 2 measures
- Domain 6, Community Inclusion – 2 measures
- Domain 7, Access to Services – 3 measures
- Domain 8, Number of In-Home Licensed Service Locations – 2 measures

With the goal of providing more useful data to assist the Quality Improvement Committee (QIC) and Regional Quality Councils (RQCs) in evaluating services on a broad scale throughout the Commonwealth, this ground work to expand and refine data measures is both necessary and appropriate.

This initial work shows great promise. More specifically, the Report on the Eight Domains shows solid work in defining relevant measures, while recognizing some of the limitations of the data currently available. The group took care to develop definitions, as needed, to allow a common and clear understanding of terms. The report also includes some metrics, charts, and graphs to allow visualization of the data in easy-to-understand formats that also place the data in context (e.g., the growth of the numbers of individuals DBHDS supports). The clear involvement of subject matter experts also assisted DBHDS in providing context to the information based on current standards or limitations in the field of IDD. The group also did a nice job of conducting some analysis/discussion of the data, and identifying some questions for future analysis and additional data sources, which might help complete the picture.

DBHDS Staff report that these efforts to produce reports based on the indicators in the eight domains are in their infancy at the present time. Given the expanding set of data measures, it was positive to find that data analysis efforts are now beginning to include cross-referencing of data to verify its consistency/accuracy and to identify inter-relationships between processes and outcomes.

The Department recently implemented a new structure to more effectively group and evaluate the various data indicators under each domain. These new more broadly defined categories are characterized as Key Performance Areas (KPA's). The table below describes the structure of KPA's and sub-category Domain areas currently being used in this revised

organizational structure, although DBHDS indicated this is a work in progress that will understandably change with experience:

Key Performance Area	Domains Assigned	Reports Reviewed
Provider Capacity / Competency	8. Provider Capacity	Delmarva QSRs
		National Core Indicators
		DBHDS/DMAS Quality Review Team (CMS Quality Assurances) Report
		Provider Capacity Report
	7. Access to Services	Provider Networks
		Access to Services Report
Person-Centered Services	5. Choice and Self-Determination	Choice & Self-Determination Report
Health & Well-being	1. Safety/Freedom from Harm	Licensing Report
		Human Rights Report
		Mortality Review Committee Report
	2. Health & Well-being	Post-Move Monitoring Report
		Enhanced Case Management Report
	3. Avoiding Crises	Avoiding Crises Report
		REACH Crisis Reports
Integrated Setting / Community Inclusion	4. Stability	Regional Support Team Report
	6. Community Inclusion	Training Center Discharges Report
		Housing Report
		Employment Report
		Community Inclusion Report
		Case Management/Community Engagement/Coaching Reports
Other	RQC Reports	Regional Quality Council Reports
	Quality Management and Development	QI Plan

DBHDS uses the QIC to organize, direct, and evaluate efforts to expand and improve its use of consistent, valid and reliable data to measure the improvement in availability, quality, and accessibility of services. The QIC also directs the work of the RQCs. The QIC meets monthly. The DBHDS Commissioner chairs the Committee, and its membership includes senior department administrators, a representative from each of the RQCs, and several at-large members who represent the community provider network, individuals, families, and/or other stakeholders. Staff from the Department's Data and Analytics area also participate in the meetings.

To assure that the QIC consistently reviews data related to each KPA/Domain area throughout the year, DBHDS developed and implemented a schedule matrix that assigns presentation of data and follow-up on previous data analysis discussions for each KPA/Domain by month across the year. The matrix structure continues to evolve as data measures and KPAs are expanded and refined. Currently, the KPAs are not referenced in the DBHDS Quality Management Plan. A description of this revised structure should be added to the Quality Management Plan in Appendix D, Developmental Disabilities Eight Domains of Quality.

In January 2017, DBHDS established a Quality Review Panel (QRP) of subject matter experts and experienced data analysts to streamline and improve the quality of data reports and to structure the reports to more efficiently and effectively tell a clear story. DBHDS staff shared several examples of improved data reporting to both the QIC and RQCs resulting from the work of the QRP over recent months. This addition appears to be a successful process improvement to help the Commonwealth advance its efforts to become more data driven in planning, structuring, delivering, and evaluating its IDD services.

With the initiation of the work of the QRP, DBHDS established a uniform flow of data and information used for measurement. That flow begins with various departments and subject matter experts submitting draft reports to the QRP in accordance with the annual schedule of report. Authors of reports attend the QRP meetings at which their reports are discussed. A collaboration occurs between the authors of reports and the QRP, which results in improved reports then flowing from the QRP to the QIC for review and analysis at the statewide level, and finally to the RQCs whose primary role is to assess relevant data, identify trends and recommend responsive actions in their respective regions, as well as make recommendations back to the QIC.

Section V.D.5: RQCs are operational and they consistently hold meetings each quarter in each of the five Regions. Over time, membership in the RQCs has been incomplete, but improvements have been made to secure a full membership roster for each Council. One challenge was due to the appointment of initial members all at one time, which resulted in terms expiring all at once. The membership terms for each member now have been staggered to ensure consistency as members' terms expire.

In looking at meeting participation over the past three quarters, percentage attendance appears variable within and across regions with most meetings attended by an average of 60% of the membership or less. It is a concern that less than 40% of the members of the Region 5 RQC attended any of its three most recent quarterly meetings.

RQC use consistent agendas to guide the structure and discussion of each meeting. Minutes reflect that some discussion items focus specifically on data review. The use of data as the primary focus of discussion in these meetings continues to be in its infancy, but continuing focus on structuring the meetings around data analysis presentations will enhance the capabilities of each RQC to identify trends and to recommend responsive actions to identified issues. This will also improve the ability of each RQC to provide substantive and

meaningful response to DBHDS regarding regional impacts of various new initiatives and process changes that DBHDS implements or is considering to improve the service delivery system. The format and content of the meeting minutes is clear and efficient; however, the minutes continue to reflect considerable variability in identifying specific feedback and recommendations from the regional participants, and often, the minutes do not reflect that the RQCs offered any recommendations.

As the use of data continues to evolve, DBHDS should identify data measures/reports that allow comparative presentation of information across regions and over time. Multiple times during the past three quarters, RQC members commented that the presented data appeared to represent trends. Often, the Department's response was that the data are inconsistent and that they frequently represent a "snapshot in time." To be truly effective in meeting both the stated requirements in Section V.D.4 of the agreement and to facilitate use of these meetings as a primary source of regional review and feedback on service delivery system metrics across the Commonwealth, DBHDS should consider focusing attention in the RQC meetings on a small number of key measures that lend themselves to comparability and measurement over time. Through a narrower initial focus, the process of data review within the RQC structure can evolve and mature more rapidly.

Feedback from interviews with staff at four Community Services Boards and five community-based private providers indicated they are not familiar with specific data measures that the Commonwealth is using to measure quantity and quality of services, nor of processes DBHDS is developing, or considering expanding, to improve data reporting and analysis. The Commonwealth continues to be challenged by the absence of a uniform means for reporting key operational data across the provider system. To advance its efforts to establish meaningful data measures of its service delivery system, DBHDS should direct considerable effort. It should clearly define each data element; and it should ensure both that each data element can be objectively measured and that an electronic data reporting system exists that will allow providers to consistently, and accurately report data without taking excessive staff time and effort.

Section V.D.6: At least annually, the Commonwealth is required to report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in the Agreement) and quality of supports and services in the community and gaps in services, and make recommendations for improvement. As a framework to satisfy this requirement, DBHDS established 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; however, information contained under this tab is not current, it does not identify an analysis of available data to identify gaps in services nor does it identify recommendations for address of identified gaps. The information currently available under this tab includes ID Waiver 2014 Service Data, DD Waiver 2014 Service Data, Day Support Waiver 2014 Service Data and the Virginia State Rehabilitation Council 2015 Annual Report. The Annual Report is not referenced in the DBHDS Quality Management Communication Plan (Appendix C to the DBHDS Quality Management Plan) nor does the Communication Plan identify other means to satisfy this requirement from the Agreement.

The Settlement Agreement Coordinator explained that due to changes with the DBHDS website, reports that the website previously included were deleted. In the next month, a new web site will come on line, and DBHDS plans to add to what was there. By March 2018, DBHDS anticipated that the annual report will be up and running.

It is important that summary information be provided to the public about the Commonwealth's analysis of these data and recommendations to address concerns. This public reporting also can serve as a basis for expanded and improved provider and other stakeholder feedback to DBHDS regarding its service planning and delivery across the Commonwealth. The Consultants look forward to reviewing the revised website.

In conclusion, DBHDS continues to expand and improve use of data to guide its assessment of necessary service delivery improvements. The expanded number of measures that DBHDS has established over the past year is evidence of considerable progress. It is critical that DBHDS create a comprehensive data quality improvement plan that provides a roadmap and specific milestones to guide its ongoing efforts to expand and improve the quantity and quality of data to measure performance, provide a structure for greater accountability of effort, and assist in appropriate allocation of resources to develop better data reporting systems, better analysis of data and to support the Department's effective use of data in its performance measurement.

V.E.1-3

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

Goals for this Review included to determine whether or not:

- a) DBHDS has established a baseline regarding existing QI practices;
- b) DBHDS has established expectations, as of December 2015, for providers' and CSBs' quality improvement systems (i.e., Section V.E.1);
- c) DBHDS requires providers and CSBs to report on key indicators that address both positive and negative outcomes for health and safety and community integration per Section V.E.2;
- d) DBHDS Quality Improvement Committee has begun to review and to address these measures;
- e) Providers and CSBs have begun implementing root cause analysis, as appropriate, and if so, have implemented action plans to address identified causes that have either resulted in desired outcomes, or if not, have been modified; and
- f) DBHDS is aware of the extent to which providers and CSBs are meeting its expectations.

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

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

The Commonwealth's oversight of community providers' Quality Improvement programs remains a work in progress. As stated in the 2015 Report, the Commonwealth conducted a survey of all 40 CSBs. As expected, CSBs were found to have different levels of sophistication regarding their quality improvement processes. DBHDS's next step was to survey a sample of the 900 community providers to ascertain a baseline with regard to quality improvement practices. In September 2016, the Commonwealth sent out a survey to CSBs as well as private providers asking foundational questions about their quality assurance/improvement programs. According to a summary of the results that the Commonwealth provided, of the 800 providers that the Commonwealth forwarded a link to participate in the on-line survey, 149 responded (19%). The 18 questions were largely formatted for yes/no responses, and addressed topics, such as whether or not the provider has policies related to quality improvement and risk management, conducts mortality reviews, trains staff on completing incident reports, collects risk trigger and threshold information, conducts root cause analyses, completes satisfaction surveys, etc.

In reviewing the results of the survey, Commonwealth staff concluded that most respondents have some form of quality improvement/risk management planning occurring. Although the results provided some insights, the DBHDS staff determined that they should conduct another survey with more clearly-stated questions.

According to the July and September 2017 RMRC minutes as well as information gained through interview, DBHDS still plans to complete an additional survey adding more questions to address the scope and breadth of provider quality improvement/risk management programs and plans to better identify additional DBHDS guidance and training recommendations. As discussed above, the Community Quality Management Director is in the process of reviewing the Draft Community-Based Risk Management Framework, which also included quality improvement components, with RQCs. DBHDS plans to incorporate feedback from these sessions into the survey. In addition, using information from its Provider Quality Reviews, Delmarva completed an ad hoc report on provider quality improvement/risk management programs. DBHDS might also incorporate some of this information into the survey.

Although at the time of this current review, some work was underway, the Commonwealth has not yet established expectations for CSBs' and private providers' quality improvement programs. The Agreement's provision requiring formal training and technical assistance to CSBs and private providers had also not yet begun.

As noted in the sections above, the Commonwealth has made some progress, but is still in the process of finalizing drafts of the data that it intends to collect. The Commonwealth has identified some of the data CSBs and providers need to collect and report (e.g., SIR data, CCS3 extract specifications, REACH data). In order to address the requirements of the Settlement Agreement, however, additional data will likely be required. In some cases, improvements also are needed in the reliability of the data that are currently being collected. In other cases, mechanisms and methodologies for collecting the data need to be developed.

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

Based on the Consultant's meetings with two CSBs in different Regions of the Commonwealth and with three private providers, the impressions, albeit limited, gained from these quality improvement staff, were identical to those garnered from last year's similar review with a different group of providers and CSBs:

- The various CSBs and private providers each allotted different levels of resources to the quality assurance/improvement functions, even when taking into consideration the size and scope of the services they provide. This disparity clearly impacts the ability of the agencies to develop fully working quality improvement programs, as the Agreement requires.
- The activities in which the CSB and private provider QI staff were involved varied from making sure basic functions occurred timely and completely, to more advanced quality improvement activities. The basic functions included submitting CHRIS reports and following-up to ensure corrective action was taken, completing investigations, conducting environmental safety checks, and addressing licensing report citations and human rights complaints. The more advanced quality improvement activities included completing internal audits, providing technical assistance to programmatic areas to make improvements and/or reduce risk, developing reports on data with varying levels of sophistication, conducting satisfaction surveys, and developing and implementing outcome and performance measures, including goals for improvement.
- Some of the CSBs had Quality Councils or leadership meetings at which quality improvement information was presented and discussed. In these cases, staff provided examples of improvements made as a result of the analysis of information, and the resulting recommendations for changes.
- In discussing the Commonwealth's requests for data, CSB staff cited CHRIS reports as the main data request. Case Management extract data and REACH data also were identified as data they regularly submitted. As noted above, none of the staff interviewed were familiar with or had knowledge of risk triggers and thresholds.
- A common theme for CSBs and providers was that current record-keeping practices (i.e., various EHRs, combinations of paper and electronic systems) presented challenges in terms of easy extraction of specific data points.
- The CSB and provider staff involved with quality improvement had no or limited knowledge of the resources, information, or training that the Commonwealth has offered regarding quality improvement. Some examples of offerings with which they were familiar involved the medical/health risk Safety Alerts and training on investigations.

The Commonwealth's Quality Improvement Committee continues to meet quarterly. Since the last review, the QIC modified its agenda to align with four key performance areas (KPA's) in which the eight Domains were subsumed:

- Provider Capacity/Competency, including the Domains #8 related to provider capacity, and Domain #7 related to access to services;
- Person-Centered, including Domain #5 on choice and self-determination;
- Health and Well-Being, including Domain #1 on Safety/freedom from harm, Domain #2 on health and well-being, and Domain #3 on avoiding crisis; and
- Integrated Setting/Community Inclusion, including Domain #4 related to stability, and Domain #6 on community inclusion.

The QIC continues to work towards determining which data reports staff present at each of the quarterly meetings. However, based on a review of minutes since the last review, the content was becoming more data-driven. Some of the data that CSBs and providers were collecting and reporting are now being provided to the QIC, as well as the RQCs. For example, at the 8/3/17 meeting, under the heading of "avoiding crises", the QIC heard a presentation on, and then discussed, REACH data. Findings included, for example, that the use of crisis prevention services had increased at a much higher rate than had crisis mobile services. Similarly, on 6/1/17, the QIC reviewed the semi-annual employment report. The group discussed some of the findings, but also some problems with the data that required correction before its use in decision-making could be fully realized. Some of the issues that needed to be addressed required DBHDS to work with the CSBs to correct coding in their electronic health records. These examples show some good initial use of data, as well as the need to critically evaluate the quality of the data, and make adjustments, as necessary.

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

V.I.1-4

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

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

As noted in this Consultant’s previous two Reports, on 5/18/15, the Commonwealth’s contract with the Delmarva Foundation to conduct the QSR reviews went into effect. On 5/31/17, the Commonwealth renewed its contract with Delmarva for another year. As also described in those Reports, according to its contract, Delmarva uses a multi-tiered approach to conduct the Quality Service Reviews, including:

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

As part of this review, Maria Laurence met by telephone with members of the contractor's staff. As indicated in last year's Report, they clearly are a dedicated group with a strong person-centered philosophy. It was helpful to again hear directly from them about their process and procedures.

Staff positions remained the same as described in the last report. Since then, however, some turnover in the people filling the positions occurred. Specifically, a Project Director is responsible for coordination with DBHDS and for overall oversight of the project, and a Project Manager is located in Virginia. In addition to a Team Lead who also conducts reviews, Delmarva employs five other Field Reviewers for the QSR project, subcontractors from Virginia Commonwealth University complete individual and family interviews, and a Senior Scientist and Data Analyst provide support to the team. As discussed below, none of the reviewers have clinical backgrounds. The turnover occurred in the Project Director position, as well as the Field Reviewer positions. Since May 2017, the team had been fully staffed.

As described in previous Reports, the contract requires Delmarva to complete 400 individual and family interviews, and 50 provider reviews. Delmarva selected the sample using a regional approach in an attempt to ensure that large enough numbers of individuals are surveyed to allow statistically valid conclusions to be drawn. As noted in the previous Reports, one concern regarding the sample was the small number of providers included in the reviews (i.e., 50 out of 900). For the Year 2 QSRs, DBHDS made the decision to select 50 providers of day supports for review. Reportedly, this was due to the fact that the small number of providers made it difficult to draw conclusions, and with the new Waiver and further emphasis on day supports, this area seemed a good one on which to focus. The plan for Year 3 is to focus on residential providers, including in-home support, supported living, sponsored residential, and independent living.

Based on interview and document review, DBHDS completed a review of Delmarva's Year 1 work. DBHDS subsequently decided to focus on realigning some of Delmarva's indicators for the key performance areas (i.e., Provider Capacity/ Competency, Person-Centered, Health and Well-Being, and Integrated Setting/Community Inclusion). This caused a significant delay in Delmarva's initiation of Year 2 work. However, in the interim, DBHDS and Delmarva staff worked together to review the driver indicators within the audit tools to link them to these key performance indicators. After this process was finalized, Delmarva began conducting audits, and DBHDS granted an extension to complete them. By August 15, 2017, Delmarva completed all 400 PCRs and 50 PQRs with a focus on day programs.

Delmarva issued a preliminary report on October 16, 2017, which the Commonwealth shared with the Consultants.

For Year 2, the major changes that Delmarva reported making in conjunction with DBHDS staff included:

- Deleting, editing, and adding standards;
- Defining certain standards as driver indicators; and
- Scoring some driver indicator on a Likert scale of: almost always, frequently, sometimes, or rarely (as opposed to yes/no); and
- Results of the driver indicators are aggregated into a score, which is then converted into a final rating for each key performance area, as follows: developing ($\leq 50\%$), emerging ($>50\% - \leq 75\%$), achieving ($>75\% - \leq 90\%$), or innovating ($>90\% - 100\%$).

Based on both document review and interview with DBHDS and Delmarva staff, it is clear that staff expended considerable time, thought, and effort to attempt to address concerns raised in the last Report about the audit tools and reports that Delmarva generates. Although some limited progress was made in defining measurable drivers and the relationship of the measures to DBHDS' key performance areas, overall, it is not evident the current QSR process generates valid and reliable results. Part of the issue appears to be that Delmarva has attempted to measure too much too quickly without adequate development of the underlying infrastructure. This includes the lack of sufficiently qualified staff or valid audit tools that are designed to collect reliable information. Another major issue is that the audit tools do not offer CSBs or providers with a roadmap of what Delmarva will assess, or the standards by which Delmarva will evaluate their performance. In addition, the audit tools do not lend themselves to the production of reports that are concise, and that clearly identify findings, including areas of strength and specific information about needed actions to make improvements on an individual, provider, and aggregate level.

With regard to the audit process itself, all of the problems the Independent Reviewer (initially in an email, dated 8/5/15) and this Consultant identified previously continue to persist. For example:

- **Lack of Definition of Standards/Terms** – Standards need to be well defined in audit tools in order to ensure inter-rater reliability, as well as to clearly articulate expectations for providers and CSBs. 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., “Person does not show signs of adverse drug interactions/reactions” without defining adverse drug reaction, or “The provider advocates to ensure the person is afforded preventive health care based on age and gender” without defining the standards for preventive health). Broad statements such as these frequently result in varied interpretations by both auditors and providers. If specific licensing regulations or policies drive the expectations, then they should be cited. If not, then, clear standards should be set forth.

- **Lack of Definition of Methodology** – Similarly, the audit tools do not consistently identify the methodology that auditors would use to answer questions. For example, at times, indicators on observation tools appear to require additional document review (e.g., “Person requires adaptive equipment and it is available” without indicating which documents the auditor will reference to determine which equipment the individual requires, or “Person is free from abuse” without defining the documentation needed to confirm such a finding). Record review audit tools do not identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation).

- **Lack of Criteria for Compliance** – The contractor provides reports that indicate whether or not providers have “met” or “not met” requirements, and now has added a Likert-like scale for some driver indicators. Although for the latter, work was done to define somewhat the expectations for the sliding scale scores, auditors continue to use met/not met as the scoring mechanism for many indicators. The audit tools, however, do not explain how this is determined. This calls into question the validity of the findings. These tools generally have numerous indicators, with several that overlap in content. Most of the tools continue to include columns with “suggested protocols” and “standards,” but no explanation is provided regarding, which of these columns contains the actual requirement, how the two are connected, or how a provider will “meet” the requirements.

- **Scope of Review without Definition of Auditor Qualifications** – The audit tools and resulting reports cover a wide variety of topics, including, for example, healthcare and use of psychotropic medication. However, based on an interview with contractor staff, none of the reviewers have clinical qualifications, and the Project Director indicated that it is not within their contract’s scope to complete clinical reviews. This is problematic for a number of reasons, including:
 - Firstly, the QSR process needs to entail a clinical review to address the requirements of the Settlement Agreement. If Delmarva is not responsible for this component, then the Commonwealth will need to define who will conduct the clinical portions of the QSRs. The Settlement Agreement specifically requires the staff conducting the QSRs to “interview professional staff,” to “review treatment records,” and “to evaluate whether the individual’s needs have been met.”
 - Secondly, judgments of the adequacy and appropriateness of behavior support plans, nursing care, clinical and medical supports, etc. would generally require an auditor with specific qualifications, such as a psychologist/Board Certified Behavioral Analyst (BCBA), a nurse, and/or physical and nutritional management experts. A number of the protocols and standards in the audit tools require auditors to make judgements about individuals’ healthcare and clinical services, and the Settlement Agreement requires that these staff be adequately trained” to make these judgments. For example, the Provider Record Review Guide includes the following standards that auditors are expected to score, but would appear to require input from a nurse: “The provider assists the person to access care from medical

specialists when applicable; e.g. Psychiatry, Neurology, Endocrinology,” “Provider ensures risk protocols are in place to mitigate risk, if applicable,” and “Provider reviews health risks and refers to medical personnel as needed.” In order to judge the quality versus the mere presence of the following standard, a psychologist or BCBA would need to conduct the audit: “Develops or has behavioral support plans in place.” The lack of staff auditors who are qualified to make these assessments calls into question the accuracy of the findings.

- Finally, Delmarva’s reports include key performance areas that read, for example: “2.a. Needs are met,” “2.b. Health needs are met,” and “2.c Safety needs are met.” Similarly, some specific findings in the most recent report indicate: “Person receives needed services (92.9% Individual Interview, 94.7% Observation),” “Person has Adaptive Equipment necessary for safe mobility and/or eating (96.1% Individual Interview, 100% Observation),” or “Person does not show signs of adverse drug reaction (96.0% Observation).” Summary findings included statements such as “Health needs were addressed,” or “Safety needs were mostly met and individuals were free from harm.” The broad findings made in the contractor’s reports provide the impression that individuals’ clinical needs, as well as other needs are assessed as part of the QSR review process.
- **Missing Components** – Particularly with regard to clinical services, the audit tools do not comprehensively address services and supports to meet individuals’ needs. For example, indicators to assess the quality of clinical assessments, as well as service provision, are not evident. This calls into question the validity of the findings.

In the last Report, the Consultant identified questions and concerns related to the reliability of Delmarva’s data, which in part, could be attributed to a weak inter-rater reliability testing and remediation system. Since the last review, Delmarva made progress in instituting a formal inter-rater reliability process that is more consistent with standard practice. In a document entitled: “Delmarva Foundation Rater Reliability Process Virginia Quality Service Reviews,” dated 3/10/17, Delmarva describes informal as well as formal means for ensuring the reliability of the QSR audit data.

The document describes the informal methods as:

- Initial training of new auditors that occurs prior to review activities, “which includes an overview of all tools, processes and procedures, and training on the interpretation of standards according to provider manuals and Department of Behavioral Health and Developmental Services (DBHDS) expectations. Reviewers are taught to use the content of the tool to lead questioning and drive documentation review efforts. Training occurs on scoring methodologies (yes/no, met/not met, Likert Scale), interpreting information from interviews and documentation review, linking findings to specific scores, and requirements associated with proper data collection and data entry.”;

- New auditors shadowing of experienced auditors, described as: “Once the new [auditor] is prepared to participate in a review, the Program Manager or Team Lead shadows them at least once post orientation training and before formal reliability testing begins. This shadowing process helps ensure each [auditor] follows the proper protocols and makes determinations based on appropriate documentation and information gathered during the review. The Program Manager and Team Lead provide coaching as needed.”; and
- Ongoing training for all auditors, which occurs through bi-weekly conference calls to address questions and provide clarifications, Program Manager and Team Leader participation in some reviews, and an annual in-person training.

The document also describes formal reliability testing as:

- “The Program Manager... is established as the ‘Gold Standard’ to which all other reviewers are compared. Via research, regulation review, and interpretation discussions with DBHDS staff as well as the DF [Delmarva Foundation] Team Lead and Project Director, the Program Manager creates the accepted interpretation and determination for each standard, applicable to each component of our reliability process. All [auditors] are then held to that interpretation as they are observed and evaluated during reliability activities.”
- Reviewer-to-reviewer reliability occurs when auditors score scenarios that the Program Manager and Team Lead develop, and determine the correct scores or “gold standard.” Auditors complete the scoring independently. The Program Manager then enters the responses into a spreadsheet to determine the level of agreement in comparison with the “gold standard.” Depending on the level of agreement or disagreement, disagreements are then discussed in a group setting or with individual reviewers.
- Field reliability occurs for new auditors, and then annually for all auditors. New auditor must “pass” within six months of hire and prior to conducting reviews independently. The Program Manager accompanies the auditor on a review, and completes the audit tools without offering any assistance of coaching to the auditor. Each then scores the tools independently. Once scoring is complete, the scores are compared. The Program Manager asks for justification for scores, particularly when there is a discrepancy in scores or it was a difficult determination to make. Subsequently, the Program Manager provides coaching and feedback to the auditor.
- For field reliability, a “passing score” is 85%. If an auditor does not meet this requirement, coaching commences, and she/he does not conduct reviews independently until obtaining a passing score.

Based on this description, Delmarva now has in place a system that generally should enable it to better confirm the reliability of the data its audits generate. Based on the summary inter-rater score spreadsheet shared with the Consultant, Delmarva had identified issues with inter-rater reliability, and subsequently completed re-testing.

One consideration, though, is that the “passing score” appears to provide an overall picture of inter-rater reliability. Another important way to look at the data is to assess the occurrence and nonoccurrence rates. In other words, if 10 questions are assessed and 80% overall inter-rater agreement is noted, it is important to look at the occurrence and nonoccurrence rates, which might show a different picture. For example, if the “gold standard” reviewer scored four out of the ten questions as “no” (i.e., nonoccurrence), and the other reviewer only scored “no” for two of the four that the “gold reviewer” scored as “no,” then the nonoccurrence reliability rate is 50%. Although this would require further analysis, it might provide further insight into the need for training or clarification of standards/expectations.

On October 2016, Delmarva issued a preliminary Virginia Quality Service Reviews Annual Report, which represented its second annual report. It clearly showed an intense amount of work. Like the previous report, in summarizing the results of the PCRs, the newest report made broad statements, such as: “Individuals’ basic needs were consistently met... Over 90 percent of individuals received needed services... Safety needs were mostly met and individuals were free from harm...” Unfortunately, due to the problems identified above with regard to validity of the tools and process, questions about the reliability of data collected, and the lack of clinical qualifications of reviewers, it remained unclear whether these findings were accurate. Moreover, findings within the report sometimes appeared contradictory. For example, in comparison with the findings quoted above, the following finding appeared to paint a different picture: “Provider ensures services are implemented per the person’s ISP/Part V Plan of Supports (67.1% Provider Record).” The narrative of the report appeared to indicate that these findings came from different review tools. However, it is important when making overall findings not to make generalizations that the data do not support, and to reconcile differences in findings.

Overall, the report was difficult to follow, and raised many questions in relation to the procedures used to gather the information to make the findings. For example, often interview or observation data were cited as the source of a finding, when such a finding would have required confirmation through document review, as well as observation and/or interview.

In order for the process to progress to one that is valid and reliable, the following recommendations are offered:

- Given that the current process is unwieldy and continues to need substantial revision, it is recommended that the Commonwealth work with Delmarva to define priority areas that it would like to initially measure using the QSR process. Scaling back the scope is important to provide a solid footing on which to build the QSR system. DBHDS and the contractor could then build upon this initial group of priority areas over time until a full set of QSR topics is implemented to meet the requirements of the Settlement Agreement.
 - In determining these topics, it is recommended that DBHDS use the key performance areas and the corresponding domains to structure its decision-making and planning process for building out the QSR model. For example, DBHDS might consider prioritizing one or two topics from each of the key performance areas to start to rebuild the QSR process.
 - DBHDS should consider topics about which it wants/needs information, but on which other sources (e.g., licensing) do not currently provide data.
 - A plan should be set forth for at least the next couple of years that shows a listing of priority topics, and when they will roll out.
- Prior to building the audit tools, DBHDS and Delmarva should determine if specific expertise is required to audit the areas identified. For example, if DBHDS determines that it is important to review behavioral and crisis intervention supports, then psychologists/BCBAs should participate in the tool development (as well as the auditing). If community integration is a topic agreed-upon as a priority issue, then staff with experience and understanding of this topic should participate.
- As a method for organizing the audit tools, it might be beneficial for DBHDS to work with Delmarva on the development of audit tools that address each topic, as opposed to the current format that arranges audit tools according to methodology of review (i.e., interviews, record reviews, etc.). This will assist in connecting the dots with regard to how a topic is assessed, and make it clear how providers and CSBs will be assessed. The tools should include:
 - Indicators that are measurable, and to the extent possible, measure only one item at a time;
 - Define for each indicator the methodology (e.g., document review, including when possible, specific documents; observation; interview; or some combination). If this is done carefully, it will allow audit worksheet development, as needed, to break up the audit tools into tasks (e.g., Service Coordinator interview, record review, observation);
 - Defining the data source, whenever possible;
 - As necessary, interpretive guidelines to facilitate the collection of reliable data. This section can define terms, if necessary, reference specific regulations, standards, etc.; and

- Formulas or calculations, if necessary, particularly, if data from more than one indicator or sub-indicator will be used to make a finding.

At this juncture, the audit tool that shows the most promise is the ISP/QA Checklist. DBHDS and Delmarva would need to do substantial work to ensure it addresses the five bullets above, but it offers a good start. Examples of changes needed include:

- Making sure indicators are clearly measurable or standards are stated. For example, Indicator #2: “The ISP is current,” but does not state how the currency of an ISP is defined – annually, whenever a change of status occurs, etc.; and Indicator #13 reads: “The ISP describes active medical and behavioral support needs that include what was identified in the assessment. At a minimum, each medical or behavioral support need identified on the Annual Risk Assessment is addressed.” This measure addresses both medical and support needs. It also is unclear whether it is measuring presence as well as quality of the supports. In sum, it is too much to measure in one indicator;
- Defining methodology, including, for example, which indicators will rely solely on review of documents, and which require interview with the Case Manager, the individual, etc. (e.g., Indicator #22: “The Life I Want describes the person’s ideal life from the perspective of the person and those who know him best.”);
- Defining the data source. For example, in order to answer Indicator #6: “The ISP describes the person’s communication and sensory support needs,” an auditor would need to know how he/she will determine what the individual’s needs are, for example, by reviewing the most recent speech or communication assessment and comparing it to the ISP;
- Including interpretive guidance. For example, Indicator #8 states: “The ISP contains health information and at a minimum describes the following: a) advanced directive status, b) Informed consent for psychotropic medications..., and c) medications, including prescribing physician, dosage, route, frequency, reason prescribed and location of potential side effect medication.” Interpretive guidance might be needed to ensure that sufficient information is included in the ISP for the first two items. The third one specifies exactly what is expected.
- Setting forth formulas, when necessary. Using Indicator #8 as an example again, given that the options for responses are listed and yes/no/NA, a score likely should be calculated for each of the subparts, and then it should be clear whether all three need to score yes for the auditor to assign a yes score overall, or if some percentage is acceptable for the assignment of a yes score.
-
- All tools should be piloted prior to full implementation. Piloting provides an opportunity to conduct inter-rater reliability testing. It also provides an opportunity to obtain feedback from the auditors who will use the tools, as well as the recipients of the auditing and resulting reports (e.g., individuals, providers, CSBs, family members).

- As tool development progresses, DBHDS should work with Delmarva on report formats.
 - As is currently the case, reports should be available at the following levels:
 - Individual;
 - CSB and/or Provider;
 - By topic; and
 - Aggregate.
 - Findings in reports should largely have a one-to-one correlation with the identified indicators. In other words, if a provider or CSB were to review the audit tools, it should be clear to them what the Commonwealth expects of them, and the report format should not include any surprises. The report format should simply show the findings for each indicator for which that provider or CSB is responsible.
 - Similarly, aggregate reports should provide succinct findings that are clearly connected to the audit tools, and have a close to one-to-one relationship with the indicators.
 - A possible format for any of the individual, CSB and/or Provider, and Aggregate Reports would be as follows (with some sample topic areas included just for discussion's sake):
 - Key Performance Area #1 - Provider Capacity/Competency
 - Direct Support Professional Person-Specific Training Competencies
 - Indicator #1 findings
 - Indicator #2 findings, etc.
 - Key Performance Area #2 - Person-Centered
 - Case managers and providers' role in educating individuals and their representatives about the ISP process and their roles in it
 - Indicator #1 findings
 - Indicator #2 findings, etc.
 - Quality of ISPs
 - Indicator #1 findings
 - Indicator #2 findings, etc.
 - Key Performance Area #3 - Health and Well-Being
 - Quality and implementation of positive behavior support plans
 - Indicator #1 findings
 - Indicator #2 findings, etc.
 - Quality and implementation of nursing care plans
 - Indicator #1 findings
 - Indicator #2 findings, etc.
 - Key Performance Area #4 - Integrated Setting/Community Inclusion
 - Individuals' and families' satisfaction with community inclusion options
 - Indicator #1 findings
 - Indicator #2 findings, etc.

- Case managers' role in educating individuals about and identifying vocational options that meet individuals' preferences
 - Indicator #1 findings
 - Indicator #2 findings, etc.
- Narrative sections of the report should provide information that assists the reader to interpret data, and highlights and provides insight into both best practice and areas needing improvement. Within each key performance area section of aggregate reports, drilldowns of data to show regional differences could be included, as appropriate to assist in telling the story. Similarly, individual reports should/could include narrative within these sections to tell the individual's story (e.g., what is working, what is not working). Providers should have a good sense of what the concerns were when they did not meet expectations, including specific examples or recommendations for improvement.

In summary, although it is clear that the Commonwealth staff and Delmarva staff have worked diligently to make changes to and complete the QSR process, the quality of the reviews completed is highly questionable. Additional work is needed to improve the audit tools that the contractor uses, as well as the resulting reports. An important missing piece continues to be clinical review of individuals' physical, therapeutic, and behavioral health supports and outcomes. Specific and detailed recommendations are offered to rework the entire QSR process.

APPENDIX A – Interviews and Documents Reviewed

Interviews:

- Dev Nair, DBHDS, Assistant Commissioner, QM&D
- Peggy Balak, DOJ Settlement Advisor
- Jodi Kuhn, Director, Office of Data Quality and Visualization
- Allen Watts, Director of the Business Analytics Center of Excellence
- Challis Smith, Community Quality Management Director
- Britt Welch, Quality Improvement Program Specialist
- Kathy Starling, Quality Improvement Program Specialist
- Marion Oliver, Project Director; and LaDonna Walker, Program Manager, Delmarva Foundation
- Amber Allen, Director of Residential Services; Gary Willburn, Vice-President of Developmental Disability Services; Linda Hinchell, Chief Operating Officer; Dan Jenkins, Assistant Director of Residential Services; Tina Ring, Day Programs Director; and Kate Means, Quality Assurance Director, from DePaul Community Resources, Roanoke, Region 3
- Nancy Eisele, Chief Operating Officer; Tom Palermo, Chief Program Officer; Mycie Lubin, Director of Residential Services; Sharonda Bradley, Executive Assistant/Human Resources Support; Joan Henry, Program Coordinator; and Tammy Holt, Assistant Coordinator for Day Programs, from Chimes Virginia, Inc., Fairfax, Region 2
- Donna Hayes, Director of Intellectual and Developmental Disability Services; Jan Donovan, Compliance Officer; and Vicky Wheeler, Chief Program Manager from Northwest Community Services Board, Winchester, Region 1
- Sharon Taylor, Community Support Services Director; Donna Blankenship, Case Management Supervisor; Christy Denman, Case Management Supervisor; Regina Lawson, Director of Developmental Disability Services; Susan Chandler, Supervisor of In-Home Programs; and Diane Bowen, Quality Assurance/Compliance Officer, from Planning District 1 (Frontier Health), Norton, Region 3
- Chris Greene, Training Coordinator, from Community Alternatives, Inc., Norfolk, Region 5

Documents Reviewed:

- Draft Community-Based Risk Management Framework
- Educational Risk Assessment Tool Follow-up Survey
- Draft QI Risk Management Framework
- Draft RMRC Minutes, for meeting on September 6, 2017
- Final RMRC Minutes, for meetings on July 27, 2017, and May 1, 2017
- Independent Reviewer Consultant Serious Incident Review Recommendation RMRC Follow-up spreadsheet
- Results of Risk and Quality Management Survey, dated 10/24/16
- PowerPoint presentation entitled Guided Discussion on Development of a Community-Based Quality Improvement and Risk Management Framework
- An Introduction to Commonwealth Coordinated Care Plus: A Managed Long Term Services Supports Program
- Virginia's Medicaid Regional Map for Commonwealth Coordinated Care Plus
- Health Plan Comparison Chart for Commonwealth Coordinated Care Plus
- Notice of Award for Commonwealth Coordinated Care Plus, dated 2/9/17

- Community Consumer Submission (CCS) 3 Extract Specifications Version 7.3.3, dated 7/1/17, and DBHDS' email to CSBs regarding these specifications, dated 5/25/17
- DBHDS email to CSBs regarding contract renewals, dated 5/15/17
- Appendix H: Quality Improvement Strategy
- Quality Management Plan, revised 10/20/16
- Virginia Quality Management Services monthly reports, for January through August 2017
- Virginia Quality Service Reviews Year 2 Annual Report June 2016 to June 2017 Preliminary Report on PCR Results
- Delmarva contract modification/renewal, dated 5/31/17
- Virginia Quality Service Review Ad Hoc Report Findings and Recommendations based on Results of Support Coordination Components, June 2015 to June 2016
- Sample PCR and PQR reports
- Delmarva Foundation Rater Reliability Process Virginia Quality Service Reviews, dated 3/10/17
- Year 3 Delmarva Rater Reliability spreadsheet
- Delmarva QSR Operational Manual, dated 9/15/15
- Virginia Quality Management System Training – Richmond, 8/10/16 to 8/11/16
- Quality Service Review Sampling Process FY17
- Quality Services Review Quarterly Report, dated 3/15/17
- PCR ISP QA Checklist – Year 2
- PCR Family Member Guardian Interview – Year 2
- PCR Support Coordinator Interview Tool – Year 2
- PCR Support Coordinator Record Review Tool – Year 2
- PCR-PQR Individual Interview Tool – Year 2
- PCR-PQR Observation Review Checklist – Year 2
- PCR-PQR Provider Interview – Year 2
- PCR-PQR Provider Record Review Guide – Year 2
- Virginia Quality Management System PCR Key Performance Areas status grid - Final
- “Report on the Eight Domains”, Released 10/17
- “The Redesigned Waivers for Persons with Developmental Disabilities & The HCBS Settings Requirements” PowerPoint dated 9/7/16
- “The State of Developmental Disability Services” dated 8/29/17
- Gap Analysis Sample dated 8/29/17
- FY18 Community Services Performance Contract Renewal and Revision documents distributed 5/15/17
- QIC meeting agendas, handouts and minutes for three meetings held during Quarter 3, FY17
- QIC meeting agendas, handouts and minutes for three meetings held during Quarter 4, FY17
- QIC meeting agendas, handouts and minutes for three meetings held during Quarter 1, FY18
- QIC Action Item Tracker FY18 – Quarter 1, Updated 9/14/17
- Working QIC Report Calendar, Revised 9/13/17
- RQC meeting agendas, handouts and minutes for each regional meeting held during Quarter 3, FY17
- RQC meeting agendas, handouts and minutes for each regional meeting held during Quarter 4, FY17
- RQC meeting agendas, handouts and minutes for each regional meeting held during Quarter 1, FY18

APPENDIX J.

OFFICE OF LICENSING SERVICES – OFFICE OF HUMAN RIGHTS

by: Ric Zaharia, Ph.D.

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

Licensing and Human Rights
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

November 1, 2017

Executive Summary

At the request of the Independent Reviewer, we conducted a two-phase review of the Office of Licensing Services (OLS) and the Office of Human Rights (OHR); Phase I was completed in April 2017. These entities represent the Commonwealth's primary system for regulating the conduct of provider agencies. Therefore, the effective functioning of OLS and OHR in accordance with the requirements of the Settlement Agreement (SA) is central to the goal of improving the lives of people with intellectual and developmental disabilities in Virginia.

The first phase of this study found that the newly established Regional Manager positions in OLS have been incorporated into the functioning of OLS and into the current version of the OLS *Office Protocol*. They are having a positive qualitative impact on the work of Licensing Specialists.

The draft revision of the OLS Rules and Regulation reviewed for this cycle (dated 7/17/17) shows an improved alignment with the provisions of the Settlement Agreement, including a clarification of expectations around root cause analysis, risk triggers and thresholds, risk management programs, and quality improvement programs. This most recent draft, however, does not include criteria that align with the Settlement Agreement's requirements for enhanced case management, case manager/support coordinator responsibilities at face-to-face meetings, and an assessment of the 'adequacy of individualized supports and services'.

The OLS system is the primary compliance mechanism for Community Service Board (CSB) performance under their contracts with the Commonwealth for the case management/support coordination function. The trend found during Phase I (April 2017) of an increase in CSB (Community Service Board) citations and corrective actions by OLS for case management/support coordination problems continued into FY17.

OLS now regularly compiles the results of licensing reviews into statistical reports related to compliance patterns across CSBs and other provider agencies. The Department's QIC (Quality Improvement Committee) minutes reflect regular review and periodic actions towards system improvements indicated by the analytics.

OLS postings indicate that six IDD (intellectual and developmental disability) provider settings were placed on provisional status during FY17. Phase I Interviews with OLS staff confirmed previous findings of a continued systemic reluctance by OLS to pursue use of these other tools, including provisional status, because of the due process burdens on Licensing staff. DBHDS occasional use of Service Agreements between with problematic providers is potentially a quasi-legal vehicle for leveraging provider improvements, if OLS monitoring is frequent and strict during the period of the agreement.

The OHR Abuse Allegation Report database has improved due to the implementation of the retrospective look-behind process. Additional focus studies by OHR have yielded useful information that enabled OHR to generate both targeted and general educational and technical assistance efforts to improve the quality of provider investigations. Two such provider investigations were reviewed and found to be consistent with best practices.

This review, however, identified a potential weakness in the protection from harm system for which OHR is responsible. DBHDS regulatory language and/or interpretation has determined that sexual assaults by peers are outside of both the provider's and OHR's investigatory purview, because they are not perpetrated by employees; in fact, both redirect such matters to Adult or Child Protective Services and/or local law enforcement, who, it appears, give such allegations low or no priority.

This reviewer is encouraged by the actions undertaken by DBHDS over the last few years to improve the effectiveness of both the Office of Licensing Services and the Office of Human Rights.

Office of Licensing Services

Methodology:

- Reviewed current OLS *Office Protocol* (9/17);
- Reviewed OLS guidance memorandum re Internal Quality Checks Tool, 8/31/17;
- Reviewed CSB and other surveys for 2016 where compliance problems with case management requirements were identified;
- Reviewed FY16 and FY17 Data Warehouse reports for CSB licensing results around case management requirements;
- Reviewed Quality Improvement Committee (QIC) minutes and actions taken in 2017;
- Reviewed Quality Management's Regional Resource Team (R2 Team) process description (5/3/17);
- Reviewed provider surveys for 2017 in which DBHDS identified compliance problems;
- Reviewed OLS Quarterly Trend Report April 2017;
- Reviewed OLS use of provisional licensing, 'Service Agreements';
- Reviewed proposed draft of revised *Rules and Regulations for Licensing Providers* (7/7/17);
- Reviewed OLS at a Glance, Spring 2017, Fall 2017, Winter 2017; Office of Licensing FAQs, (6/17); Office of Licensing: Serious Incident Reporting-Online Resource Guide, (6/17);
- Reviewed OLS Managers Meeting agendas, March-June 2017; OLS All Staffing Meeting agendas & minutes, March-August 2017;
- Reviewed all investigations-inspections-complaints closed with a CAP during April 2017;
- Reviewed proposed Waiver Regulations for support coordination/case management services (12VAC30-50-440);
- Interviewed two investigators regarding sexual abuse cases at their two agencies;
- Interviewed OLS leadership.

Phase I Findings Recap:

OLS updated their *Office Protocol*, which guides Licensing Specialists in their conduct of the work of Licensing. The newly established OLS Regional Manager positions were incorporated into the *Protocol*.

Licensing regulations (12VAC35-105-10 to 105-1410) continue to undergo editing and draft revisions. The draft that we reviewed last year cleaned up language, clarified licensing statuses, updated DD and ID definitions, and added requirements for providers regarding: data sharing, risk management programs include monitoring reports and conducting death reviews, quality improvement programs including root cause analysis, and ISP requirements and reviews.

OLS now regularly compiles the results of licensing reviews into statistical reports related to compliance patterns across provider agencies. The DBHDS Data Warehouse capability gives OLS the ability to pinpoint difficult areas in the compliance patterns across the state.

OLS trend reports suggest that timely reporting (i.e. within 24 hours) of SIRs has remained at about 86-88% during most of 2016. Reports on deaths appear to be more timely reported to OLS at 92% of the time.

Among the positive developments that were identified in OLS is the creation of a supervisory evaluation tool to review the work of Licensing Specialists, such as investigations, inspections, etc., and the development of a *Mortality Review Guidance Document* for use by Licensing Specialists.

The OLS system is the primary compliance monitoring mechanism for Community Service Board (CSB) performance under their contracts with the Commonwealth for the case management/support coordination function. Reports for 2016 indicate an increased frequency of OLS citing CSBs for case management service violations, particularly in the area of ISP requirements.

Reports supplied by OLS, including on their provider search web page, suggest that two ID provider settings were placed on provisional status during the second half of 2016, and two new provider settings were placed on provisional status during the first three months of 2017. As reported previously, OLS appears to have the necessary regulatory tools to force improvements among substandard providers and to eliminate substandard providers who have demonstrated a refusal or inability to improve their services. Interviews with OLS staff continue to confirm a continued systemic reluctance by DBHDS to pursue use of these other tools, and provisional status, because of the due process burdens on Licensing staff.

The case management checklist used by OLS to operationalize the expectations of the Agreement does not include assessment of the “adequacy of individualized supports and services”. The current checklist is documentation-focused rather than outcome-focused and does not include specific probes of: identifying risks to the individual, offering choice among providers (including for case management), assembling professionals and non-professionals who provide supports, and amendments to the ISP when needed.

OLS data for 2016 continues to show a significant voluntary closure rate of about twenty (20) agencies/services/settings per quarter. This is a positive byproduct of system oversight in that many marginal agencies will self-select to surrender a license.

The first phase of this study again found that DBHDS does not have evidence at the policy level that OLS is identifying systemic patterns of compliance problems with the Agreement, including its “data and assessments” across the eight (8) domains described in Section V.D.3.

Phase II Findings

The complaint form on the OLS webpage is now a fillable form. OLS reports extensive use of the web-based complaint system.

OLS staff received root cause analysis training and training in risk triggers/thresholds. OLS reports that Licensing Specialists responded positively to the training. OLS Regional Managers are directing an increasing share of quality control over the work of Licensing Specialists.

Trend reports suggest that timely reporting of SIRs has remained at about 87% during most of FY2017. In the review sample of 55 investigations that were closed with a CAP during April 2017, 16 (29%) providers were cited and required to submit CAPs for late reporting (160C.2)

A deeper analysis of one randomly selected investigation/corrective action plan suggests that Regional Managers may be relieving enforcement frustrations at the Licensing Specialist level. The review of this particular case confirmed that a 45-day follow-up review health and safety CAP was carried out. Following review by the Regional Manager, the Licensing Specialists had looped back to review and cite the case managers/support coordinator's handling of challenging cases for which the residential provider may have originally been cited. The addition of OLS Regional Managers and an increased number of Licensing Specialists, and changed or additional citations following 45-day reviews, will likely contribute to changes in the patterns and trends reflected by increased activity and refocused attention encouraged by the use of new monitoring tools (e.g. *Mortality Review Guidance Document*) by Licensing Specialists.

OLS trend reports to the QIC show citations for neglect and abuse have been among the most frequent in recent quarters. The QIC is evaluating the issue in advance of taking action system-wide to address it. The QIC has organized its work, and the data it receives from OLS and others, around the eight domains of the Agreement (V.D.3.). The OLS Regional Managers have begun attending Regional Quality Councils (RQC) to participate and share information regarding OLS's work in their respective regions.

DBHDS reported that its attempted collaboration between OLS and the Virginia Department of Health (VDH) regarding overlapping service recipients in hospitals, nursing homes, etc., was unsuccessful due to the Commonwealth's HIPAA policy constraints. Reportedly, VDH is not allowed to disclose information to DBHDS due to HIPAA protections against disclosing personal health information. As this was a request that emerged from the Mortality Review Committee, DBHDS reports that it intends to begin situationally filing formal complaints on behalf of individuals served in VDH regulated facilities, in order to surface or identify quality outcome concerns. VDH has indicated they would be responsive to these complaints.

Because CHRIS incident reports are not required for medication errors that do not cause injury or harm, providers must keep logs and review quarterly the patterns and trends of the medication errors occurring at their agency. OLS indicates that Licensing Specialists review and verify the quarterly review and medication error logs when they conduct inspections.

OLS participated in a national benchmarking study being conducted by the National Association of State Directors of Developmental Disability Services (NASDDDS). The NASDDDS study is being conducted as a result of studies elsewhere in the country by the Federal Inspector General which have suggested state developmental disability authorities are not receiving all serious incidents report occurring in their systems. The results of this study should help OLS understand the extent of under reporting in Virginia.

OLS and OHR have engaged a national firm, LRA (Labor Relations Alternatives), to conduct investigation training for their and other DBHDS staff. This training is not similarly planned for a rollout to the private or CSB sectors.

The trend noted in Phase I of an increase in CSB citations and required corrective actions by OLS for case management/support coordination problems continued into FY17. There may be an increase in the use of the dispute resolution process in connection with this increase.

The DBHDS process of drafting planned revisions to the OLS regulations has continued. The most recent draft (version dated 7/7/17) includes emphasis on root cause analysis, risk triggers and thresholds, risk management programs, and quality improvement programs. It does not include detailed requirements for enhanced case management, case manager/support coordinator responsibilities at face-to-face meetings, an assessment of the 'adequacy of individualized supports and services', and direct support staff core competencies (these competencies are apparently in the new Waiver regulations). DBHDS is finalizing its new HCBS Waiver Regulations (12VAC30-50-440 to 490) for case management/support coordination, which show alignment with the Agreement. However, it still appears OLS is the primary monitoring entity for DBHDS regulations.

Conclusions:

The Commonwealth is not currently in compliance with III.C.5.d, the requirement to have a mechanism to monitor CSB compliance with case management performance standards.

DBHDS continues to be in compliance with Section V.G.1. and 2.

DBHDS is not currently in compliance with the requirements of Section V.G.3. Based on this review, DBHDS is moving towards, but does not have evidence yet at the policy level, that OLS is identifying systemic patterns of compliance problems with the Agreement, including its "data and assessments" across the eight (8) domains at Section V.D.3.

The Commonwealth is also not currently in compliance with Section IX.C, which requires that there be "...sufficient records to document that the requirements of the Agreement are being properly implemented..."

Recommendations to achieve compliance:

DBHDS should complete and publish needed revisions to its Licensing Regulations to ensure that they align with the all related requirements of the Settlement Agreement and to ensure that it can and does take appropriate actions as needed.

OLS should modify their Individual Served Record Review Form checklist to specifically include probes identifying risks to the individual, offering choice among providers, assembling professionals and non-professionals who provide supports, amending the ISP when needed, and determining the adequacy of individual supports and services.

OLS should compile an annual narrative trend report on licensing results for case management/support coordination, using information now available in the Data Warehouse.

Suggestions for Departmental consideration:

OLS should consider a mini-study comparing DMAS hospitalization data with CHRIS incident reports to ensure complete CHRIS incident reporting.

OLS might consider a formal, annual inter-rater reliability check for each Licensing Specialist's annual performance appraisal. This would help identify areas of the regulations that need interpretive guidelines. It may also inspire increased confidence among providers who are skeptical about the "fair" application of the regulations.

OLS should evaluate other non-statutory interventions to deal with providers who are not performing well.

OLS should develop a method of verifying the implementation of CAPs for non-health and safety citations, perhaps by a provider affirmation statement.

OLS should develop an outcomes-focused checklist for interviews with staff and clients.

Office of Human Rights

Methodology:

- Reviewed OHR Retrospective Review (8/8/17) of provider investigations where sexual abuse or neglect was alleged in CY2017;
- Reviewed summary of all CHRIS incident reports of sexual abuse for FY17;
- Reviewed OHR Protocol #106-2016, Guidelines for Investigation of Human Rights Issues;
- Reviewed OHR Guidance (6/15/17) regarding Peer-to-Peer Reportable Incidents;
- Reviewed revised DBHDS/VDSS (Virginia Department of Social Services) Protocol, 7/16/17 (unsigned);
- Reviewed contract for investigation training (Labor Relations Alternatives), #720-4582;
- Interviewed two agency's (one CSB, one private provider) investigators re: two allegations of sexual abuse from FY17;
- Interviewed OHR leadership.

Phase I Findings Recap:

OHR receives all initial reports of abuse or neglect injury through the CHRIS electronic reporting system. Most investigations are carried out by the originating provider, but OHR triages for whether an outside investigation of abuse and neglect is needed. Provider investigations are submitted to OHR for review and closure.

As a quality improvement strategy OHR has initiated a retrospective look-behind of a sample of provider investigations from closed cases from 2016. OHR has learned from these reviews and was able to generate targeted and general educational and technical assistance efforts to improve the quality of provider investigations. However, the fact that these are retrospective reviews, which in many cases will be 6-12 months following an investigation, suggests that the information and feedback to the provider agency may have been stale, investigative personnel may have changed, or direct support staff may have turned over.

Phase II Findings:

During the period 7/1/16 to 12/31/16 there were twenty (20) allegations of sexual abuse identified by OHR across seventeen (17) provider agencies. We expressed concerns about the finding that only one was substantiated by the provider agency investigation. Subsequently, OHR undertook a retrospective review of sexual abuse allegation investigations between 7/1/16 and 12/31/16 and between 4/1/16 and 6/30/17. OHR identified 37 investigations of such allegations across disabilities during this nine month period. OHR's review determined that more than 20 (54%) of the allegations did not correctly meet the definition of sexual abuse ("performed knowingly, recklessly or intentionally by an employee or other person responsible for the care of an individual"). OHR concluded that 89% (33/37) of the investigations were timely and that 67% (22/37) had documentation on file of their investigations, which included and went beyond the facts through CHRIS. Only 51% (19/37) of these providers were able to supply evidence of investigation training for their staff who completed the investigation. The OHR review report suggests that in a number of these substantiated cases providers failed to report as required to the Virginia Department of Social Services (VDSS), whose protective services are responsible for investigating abuse and neglect. The OHR report did not address the issue of subsequent notification and involvement of law enforcement.

Finally, telephone interviews were held with investigators at a CSB and a private provider regarding two sexual allegation cases from FY17. These investigators were recommended by OHR as representative of best practice.

The first case (an adult woman who is competent and her own guardian and who reported to staff being "groped" by a peer during a transport in a Logisticare vehicle) demonstrates several systemic problems created by a) defining peer-to-peer sexual assaults as neglect, b) assuming the active involvement of VDSS in this arena, and c) the rejection by law enforcement of the legitimacy of a claim of sexual assault by a woman with an intellectual disability who is her own guardian. Because of DBHDS definitional constraints on sexual assaults (they must be perpetrated by an agency employee), the agency investigator could not interview the alleged perpetrator or the vehicle driver. Because VDSS said they would not investigate the allegation, this protection safety net for individuals with IDD has flaws. Because law enforcement immediately responded that they would not investigate, she is denied the rights afforded to non-disabled women to be able to report to law enforcement and be taken seriously. Because of the limits on agency investigators and the disinterest of VDSS and law enforcement, there is no way for the woman to know or investigators to know the disposition of the peer's alleged behavior. (DMAS reports that Logisticare logged the complaint, reported the allegation to APS, which declined to investigate the matter, and, then, after a Logisticare investigation, determined the accused passenger would have to henceforth sit in the front seat; they had no previous reports about this individual

The second case revolved around an unfounded allegation which the investigator examined from all aspects and concluded it was unsubstantiated. Both of the two cases were competently investigated within the confines of DBHDS policy. Immediate actions were taken to protect individuals, investigators have extensive training and experience, appropriate parties were interviewed and statements taken as warranted, a formal disposition process was used to conclude the case, written summaries were distributed per the investigators to the involved parties as a formal recap of findings, the substantiation/non-substantiated decision,

and actions the agency will take. Both investigators welcomed additional investigator training for themselves and their staff. One had received and one had not received the certificate of completion offered by DBHDS.

The OHR retrospective review was a well-done focus review that resulted in and included Action Plans based on OHR findings. The issue raised in this internal OHR review, but not resolved, is the DBHDS definition of peer-to-peer sex assault (non-consenting) as “neglect”. Eleven (11) cases in this study fell into this area. The disposition of those cases by VDSS and/or law enforcement was not addressed in this study.

DBHDS has contracted with a well-known national vendor of investigator training, Labor Relations Alternatives (LRA). The contract is limited at this time to OLS, OHR and other state staff. There is no plan for private sector or CSB provider investigator training, where most abuse and neglect investigations occur.

Conclusions:

DBHDS is in compliance with V.C.2.

DBHDS is not in compliance with V.C.3, but DBHDS is making progress toward compliance with implementing requirements that its Licensing Specialists verify the implementation of corrective actions that have to do with “health and safety”.

DBHDS is not in compliance with V.C.6., but DBHDS is making progress toward compliance by increasingly taking “appropriate action” with agencies which fail to timely report.

Recommendations to achieve compliance:

OHR should initiate contemporaneous look-behinds that occur after case closure in order to provide timely feedback, once a full cycle of retrospective reviews have been completed.

OHR should regularly conduct focus studies on topics of interest, such as it did for sexual assaults.

DBHDS should review the required training on investigations which is provided by provider agencies to their ‘investigators’ to ensure it is comparable to the LRA training.

Suggestions for DBHDS consideration:

DBHDS should evaluate its handling of peer-to-peer sexual assaults, which it categorizes as neglect, not sexual assault. Peer-to-peer sexual assaults can be severely traumatizing, so the flagging of ‘neglect reports’ of sexual assaults should have a high priority with both providers and the Commonwealth, particularly as regards reliable referral to VDSS and law enforcement.

OHR should consider conducting a ‘deeper dive’ into its sexual assault study to answer these questions: What happened with the substantiated sexual assault case/reports at the VDSS and law enforcement level? What happened with the substantiated cases/reports of ‘neglect’ involving a peer-to-peer sexual assault?

Attachment A
Settlement Agreement Requirements for OLS and OHR

III.C. 5. Case Management

d. The Commonwealth shall establish a mechanism to monitor compliance with performance standards.

V.C.3 & 6

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

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

V.G.1-3

G. Licensing

- 1. The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.*
- 2. Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals under this Agreement, including:*
 - a. Providers who have a conditional or provisional license;*
 - b. Providers who serve individuals with intensive medical and behavioral needs as defined by the SIS category representing the highest level of risk to individuals;*
 - c. Providers who serve individuals who have an interruption of service greater than 30 days;*
 - d. Providers who serve individuals who encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;*
 - e. Providers who serve individuals who have transitioned from a Training Center within the previous 12 months; and*
 - f. Providers who serve individuals in congregate settings of 5 or more individuals.*
- 3. Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.*

APPENDIX K.

MORTALITY REVIEW

By: Wayne Zwick M.D.

To: Donald Fletcher, Independent Reviewer

From: Wayne Zwick, MD

Re: Mortality Review

Date: 11/1/17

**Re: Review of the Mortality Review requirements in the Settlement Agreement,
U.S. vs. Commonwealth of Virginia**

This is the second phase of a two-phase review to assess the status of the Commonwealth's planning, development, and implementation of the mortality review committee membership, process, documentation, reports, and quality improvement initiatives to comply with the mortality review provisions of the Settlement Agreement.

Methodology

The findings and conclusions of this review are based on information obtained during interviews with administration and staff from DBHDS: Dev Nair, PhD, Assistant Commissioner for Quality Management and Development; Marion Greenfield, MA, MHA, Director Facility Quality Management, Risk Management, Health Information Management; Renay Durham, LPN, nurse reviewer (staff support); Jodi Kuhn, Director Data Quality and Visualization; Ariel Unser, Data Reporting Specialist (staff support); Susan Moon, RN, BS, Care Consultant, Integrated Health Services; and Cleopatra Booker PsyD, Director of Licensing. Additionally, the following documents were submitted for review since the first phase of this review period:

Mortality Review Committee Meeting Minutes:

4/18/17, 4/26/17, 5/10/17, 5/24/17, 6/7/17, 6/14/17, 6/28/17, 7/19/17, 7/26/17, 8/9/17, 8/17/17, 8/23/17, 9/13/17, and 9/27/17.

Mortality Review Committee: Quality Improvement Plan: CY 2017

Mortality Review Committee: Master Document Posting Process (undated)

Recommendations Status 3/14/17

Action Tracking Report FY 18 (in testing): Mortality Review Committee Action Tracking Report July-Sept 2017

Copy of Master Schedule July 2017 (in testing): MRC Master Document Posting Schedule (MDPS) Posting Period July 2017; Date Master Schedule Posted August 2017

Mortality Review Presentation Form (Final) Form MRC #001, 08/11/17

MRC Master Document Posting Schedule (MDPS) with drop downs

DI (Department Instruction) 315 Reporting and Reviewing Deaths. Draft. Field Review
10/3/17: DI 315 (QM) 13 Attachment B: (Name of Facility) Mortality Review Worksheet

MRC Meeting Minutes Shell 10/16/17

Office of Licensing DBHDS: IDD Death Mortality Review Committee Required
documents/reviews

Quality Improvement Committee Meeting Minutes 7/6/17

2017 SFY Mortality Tracker (as of October 2017)

Alerts: Type II Diabetes, Type I Diabetes, Sepsis Awareness, Scalding, Preventing Falls,
Breast Cancer Screening, Aspiration Pneumonia – Critical Risk, 5/19/17 Drug Recall Alert

2017 Progress Report: Office of Integrated health

Training Data (Skin Integrity Training)

MRC: Action tracking Log: Sept 2017 - Dec 2018 Plus Outstanding Recommendations from
Previous Tracker

Excerpt from the Office of Integrative Health Annual Report: Data ending April 30, 2017
report published June 2017

Note: Documents submitted during prior review periods, which were used as baseline and
reference information in interpreting the content of the above, are included at Attachment
A.

Settlement Agreement Requirement

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

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

Findings

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

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

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

The role of the Mortality Review Committee is to:

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

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

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

The Mortality Review Committee then gives these outcomes (findings, recommendations, etc.) to the Quality Management Committee and to the Commissioner for review and action.

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

The following review of submitted documents and summary of meetings with DBHDS administrative staff provides an evidence based synopsis of the quality, scope, and completeness of this process, as of October 2017.

The following data is derived from the contents of several years of Mortality Review Committee minutes:

Mortality Review Committee Cases - Outcomes - Pending					
Calendar Year	# cases reviewed	Outcome pending	Outcome blank	Pending resolved	Action steps/alerts, etc.
2015	307	48	15	31	75
2016	295	9	57	4	80
2017* (Jan-Mar)	50	2	9	0	23
2017 (Apr-Sep)	91	8	3	5	52

Currently, a nurse reviewer completes a clinical review and summarizes findings on a standardized form, and then presents this information to the MRC. Since the information obtained from this review is sufficiently complete, when the requested documents are submitted and reviewed, this clinical review process has contributed to a trend of the MRC having fewer pending cases. The current MRC process is focused on gathering a standard packet of information and completing a quality review of this information in a timely manner (discussed in more detail later in this report). This is a much-improved review process from what was found during the 2016 review. At that time, the MRC routinely closed cases without sufficient information, which resulted in limiting the quality of the MRC reviews and undermining its ability to fulfill both its purpose and the requirements of the Agreement. Overall, the MRC is completing reviews with more complete information. Fewer of their cases are now closed when there is insufficient information.

The MRC process continues to lack a structure or process to rapidly review unexpected deaths. A rapid review of unexpected deaths by staff with the clinical training and experience can identify safety issues that require action to reduce the risk of future adverse events. The Office of Licensing staff are involved timely, but Licensing Specialists do not have the clinical expertise to complete a quality mortality review.

DBHDS was provided legal counsel, which indicated only the DBHDS Office of Licensing has the authority to review another individual's records in the home. The Action Tracking Report July –Sept 2017 reflected this information. The 7/19/17 MRC minutes indicated the need to discuss criteria for Licensing Specialists to use to determine if medical consultation is needed "to determine if other individuals in the home may be at risk." Although, providing clinical consultation rapidly to Licensing Specialists, when needed, could provide a rapid review that ensures the health and safety of housemates, there was no documentation that any action has been taken on to implement this recommendation.

Settlement Agreement Requirement

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

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

Expected vs Unexpected Deaths				
Year	Total	Expected deaths	Unexpected deaths	Blank/pending
2013*	179	56	123 (68.7%)	
2014	226	75	151 (67.8%)	
2015	290	92	198 (68.3%)	
2016	325	109	212 (65.2%)	4
2017 (Jan-Mar)	50	17	28 (56%)	6
2017 (Apr-Sep)	91	25	61 (69%)	5

*From 2014 Annual MRC Report DRAFT

This table reviews the decisions by the Mortality Review Committee as to the categorization of each death reviewed as expected or unexpected. The average of unexpected deaths as a percentage of total deaths during 2017 has been similar to data for the years 2013-2016.

Mortality Review Committee Meetings		
Year	# meetings	Months without meeting
2015	12	Jan, Aug, Sept
2016	19	Apr, May
2017 (Jan – March)	5	None (all months had meetings)
2017 (April-Sept)	14	None (all months had meetings)

DBHDS held at least one Mortality Review Committee meeting each month since June 2016.

Mortality Review Committee Meeting Attendance		
Year	Attendance range at meetings	Average attendance
2015	5-10	7.4
2016	6-12	7.5
2017 (Jan – March)	8-11	9.0
2017 (April – Sept)	7-10	8.5

Attendance at the Mortality Review Committee remained stable. The average attendance rate increased in the first quarter of 2017, which continued through the second and third quarters.

Mortality Review Committee Member Expertise and Affiliations									
Year	MD	Clinical nurse	Admin nurse	Psych / beh/ mental health	Data analyst	QA/QI/ risk mgmt.	Licensing	Other	No information
2015	2	2		2	2	2		1	6
2016	1	4	2	1	2	3	2	2	3
2017*	1	2	2	1	2	2	1	2	1
2017*	1	4	2	1	2	4	2	5	0

* January – March

** April- September

The MRC meeting minutes now include the name of each attendee, along with the affiliation and the department which they represent. In the past, this important clarification was located in a separate document entitled ‘Mortality Review Committee, membership/participation’. This information is now located in each MRC minutes document for ready reference if needed. This improvement is reflected in the above table, as there was information concerning degree, title/department designee for each participant. During the past two quarters of 2017, this information was available for each attendee.

DBHDS reported that the MRC has not recruited “at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State.” This position and role remains vacant. DBHDS administration indicated there may be an RN recruited to complete this task. It is the opinion of this reviewer that a “clinician with the clinical experience to conduct mortality reviews” would be a clinician who has the role and training of advanced practice nurses, physician assistants and physicians. i.e., those qualified to practice medicine (those who have been trained in diagnosis and treatment and have prescription authority).

Additionally, the MRC continues to discuss other possible members who may be beneficial to the work of the MRC. A 7/19/17 MRC meeting minutes indicated there was consensus that a representative of the OHR (Office of Human Rights) was to be invited to participate in meeting when an individual's history included an abuse or neglect investigation.

Settlement Agreement Requirement

V. Quality and Risk Management System, C. Risk Management 5.

Within ninety days of a death, the monthly mortality review team shall:

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

Mortality Reviews Completed within 90 days			
Year	Within 90 days	Exceeds 90 days	% compliance
2014	123	103	54%
2015	71	216	24%
1/1/2016-6/30/2016	37	127	23%
7/1/2016-12/31/2016	1	107	1%
1/1/2017-3/31/2017	1	72	1%
4/1/2017-9/30/2017	1	64	2%

The process for timely completion of the mortality reviews remains a challenge. At the time of interviewing the DBHDS staff, the nurse (LPN) reviewer was completing reviews for the deaths that occurred in April. However, this nurse reviewer had only been in the position for a few months; DBHDS anticipates that the MRC backlog will be resolved over the next few months. There was a second nurse reviewer (RN.MSN, behavioral health RN consultant) listed on the MRC attendance roster. It was unclear if the backlog of cases needed additional nurse reviewer hours temporarily or permanently to meet compliance in this area.

Mortality Review Committee Information Reviewed											
YR	# case s	Med rec	Drs' notes	Nurses notes	IRs	IPP	Mal tx data	PE re- cord	Death cert	Autopsy	interview
2014	226	0	0	0	0	0	0	0	4	1	0
2015	289	1	1	1	289	3	40	0	2	1	0
2016*	164	1	1	2	161	2	39	1	15	7	3
2017**	108	17	15	6	93	23	29	14	6	1	4
2017** *	138	58	29	36	137	76	4	44	21	4	0

*1/1/2016-6/30/2016, **7/1/16-12/31/16, ***1/1/17-6/27/17

There has been much progress in this the to improve the quality and completeness of the review.

Previous reviews found that the content of the database for all years reviewed in the Mortality Tracker indicated significant gaps in the availability of important information. Many of the columns were blank. The 2014 Mortality Tracker did not enter that Incident Reports were reviewed, when it would be difficult to review deaths without this essential information. It was likely this Mortality Tracker did not reflect this information was available within DBHDS. DBHDS also had access to the majority of the documents listed in the tracker for deaths at the Virginia Training Centers, as well as some information obtained through licensing reviews, but the MRC tracker database indicated that this information was not available for the MRC reviews. In 2015, an Incident Report was submitted for every death, but this 100% compliance then declined to 86% during the first quarter of 2017. A further key was needed in the MRC Tracker to understand the availability of maltreatment data. For this subject category, it was not clear whether the correct interpretation of the entry “no” meant that no data were collected, or that data were collected but indicated no maltreatment, two very different interpretations. This review found significant improvement. DBHDS data analysts have created systems to review the data for completeness, accuracy, and consistency. To improve the completeness and integrity of the data available, DBHDS limited the number of staff with privileges to enter/edit data to improve consistency, streamlined the review process, and added a layer of review to check data reliability. The need for definitions for each data field, however, remains unaddressed and a challenge.

The MRC is continuing to make further improvements in data collection. Currently DBHDS is working toward capturing death certificate information electronically.

DBHDS has created a list of documents needed for the review of unexplained or unexpected IDD deaths. The Office of Licensing Services obtains these documents for their own reviews and forwards copies to the MRC nurse reviewer. This list is entitled ‘Office of Licensing – DBHDS IDD Death Mortality Review Committee Required Documents/Reviews.’ The list includes 10 document categories (medical records for the 3 months preceding the death, physician case notes for 3 months preceding the death, nurse notes for 3 months preceding

the death, most recent ISP, PCP assessment, quarterlies, other daily documentation, MARs, discharge summary, most recent physical exam, case management notes, any evidence of maltreatment related to the death, and, if available, autopsy reports and death certificates. Additionally, brief information as to any licensing issues is requested (i.e., whether provider staff read related DBHDS Safety and Quality Alerts, any OLS findings that a provider had violated regulations, corrective action plans, and licensing investigation summary report). To collect complete documentation in a timely manner, MRC established posting periods (i.e., dates when documents must be posted), and shared information regarding the meeting date when the MRC review is scheduled and the deadline for documentation to be available. The MRC posting schedule template included the nurse reviewer assigned, special status (individual resided in a state facility, SNF, etc.), and any offices that will potentially contribute to the document collection (i.e., licensing, community integration, integrated health services, etc.).

The notification that the template is available for review is forwarded to the MRC member offices which are collecting the information. When all documents are collected, the MRC staff identify any additional documents that are needed and track receipt of these documents through the posting process. The MRC has created an MRC Coordinator (a new ½ time position filled on 10/16/17), who is responsible to ensure that the process remains on track, sends follow up notices of documents that were not posted in a timely manner. Every two weeks, the MRC Coordinator reviews the contents of the folder system to identify any documents that had not yet been received for a mortality review. A standard notification message is forwarded to the MRC Reviewer by the MRC Coordinator when the documents are available for review.

The headings in the “Information Reviewed” table above identify some of the documents that are required for review by the nurse reviewer. For the first 6 months of 2017, the 2017 Mortality Review Tracker shows significant improvement in availability for the documents needed to complete a quality mortality review.

An LPN with experience in IDD and MH, as well as in overseeing medical records, has recently joined the DBHDS staff, and has been methodically conducting reviews and completing a new form entitled ‘Mortality Review Presentation Form’. This new form has gone through several drafts, with the most recent draft being dated 8/11/17. The nurse reviewer is able to consult an RN or NP in the Office of Integrated Health Services, as needed. The Mortality Review Presentation Form was created to ensure that all essential components are reviewed and succinctly documented. Such areas include determining whether the death included any of the fatal 8 diagnoses identified by DBHDS, screening to determine whether a full MRC review is needed, providing a narrative/ timeline of events, listing pertinent diagnoses and medications prescribed, completing a checklist of concerns/issues identified by the nurse reviewer, and determining whether required/requested documents were received, and separately whether these same documents were reviewed. The instructions to the form are precise and clear in order to provide consistency and completeness of the review in preparation for the presentation to the MRC.

The minutes of MRC meetings are recorded in the MRC folder. When the MRC makes recommendations, these are posted through a separate step identified in the MRC process

flow chart, as “Follow up Action Documentation and Reporting Process.” The recommendations are placed in a template/chart entitled ‘Mortality Review Committee: Action Tracking Report’ for that quarter of the calendar year. This process includes specific tracking of each recommendation. This tracking includes identification of the lead office assigned to each recommendation, the completion date, and any actions taken. The information in this form has been rolled in to another “MRC: Action Tracking Log: Sept 2017 –Dec 2018 Plus Outstanding Recommendations from Previous Tracker” to reflect the status of all recommendations made by the MRC in the prior months. The contents are categorized by recommendations assigned to the lead offices. This specific document was produced in response to the request by this consultant to determine the status of all outstanding recommendations, not just those made by the MRC during the current calendar quarter. This document, which reports on the status of MRC recommendations, and which is discussed later in this report, may not be part of the MRC’s ongoing tracking system for its recommendation.

The MRC has significantly improved its process, which has positively impacted the quality and completeness of required documentation and data integrity, and the quality of the MRC reviews. These improvements have allowed the MRC to discuss and determine findings more effectively and efficiently, to improve the accuracy of its categorization of each death, and to make needed recommendations. The few pending MRC cases are often due to insufficient information or the need for additional follow-up by various departments under DBHDS. During this reviewer’s onsite visit during phase I of this study, DBHDS staff were discussing options for streamlining and reducing the volume of documents that needed to be reviewed. The current list of documents that the MRC seeks for its mortality reviews, however, continues to include those required by the Agreement; and, the MRC has been able to significantly increase its ability to obtain and to review these documents given the increased staff support that has been provided to the MRC. The current MRC process appears to be a much more effective and efficient process and improving the quality of the mortality review process and outcomes.

Settlement Agreement Requirement

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

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

DBHDS finalized and published the annual report ‘Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 – June 30, 2016. This report would have been forwarded to the office of the DBHDS Commissioner. This “Annual Report”, which included an eighteen-month period, included a review of available MRC data, analysis and a summary of findings. The Report included were several recommendations that were based on MRC findings and which provide direction for future endeavors by the MRC.

The MRC, however, did not include information in its “Annual Report” or in the Mortality Review Committee Tracking document to indicate what action steps have been taken (the Safety Alerts, the assistance/action steps taken in response to deaths in the provider agencies, etc.) to implement MRC’s recommendations. The “Annual Report” did not prioritize needs that the DBHDS Commissioner should consider to facilitate implementation and completion of the MRC recommendations.

The “Annual Report” for the period January 1, 2015 – June 30, 2016, is the MRC’s most recent report. A DBHDS Annual Mortality Report for July 1, 2016 – June 30, 2017 was not expected to be completed at the time of this review.

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

The Quality Improvement Committee (DBHDS) reviews the MRC recommendations every 6 months. At its July 6, 2017 meeting, the QIC, an update on MRC progress and recommendations was provided. There QIC did not identify any action steps that it would take or recommend based on the submitted information.

Settlement Agreement Requirement

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

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

The Office of Integrated Health Services continues to create Safety Alerts, which are distributed via email to service providers and are posted on the DBHDS website. An RN BSN Care Consult for the Office of Integrated Health Services indicated there were several additional alerts that were finalized, and/or updated, since phase I of this review in May 2017. These alerts included the following topics: Type II Diabetes, Type I Diabetes, Sepsis Awareness, Scalding, Preventing Falls, Breast Cancer Screening, Aspiration Pneumonia Critical Risk, and a Drug Recall Alert. These alerts were of high quality, were written for easy understanding by the lay public, and included source references. The Office of Integrated Health Services also created one page, “in a nutshell”, summaries of these alerts.

Only one of the alerts was dated, the Drug Recall Alert 5/19/17. This reviewer could not determine whether these were new or updated versions of previous documents. The revised Alerts, however, are an indication of a quality improvement approach: the periodic review of the whether the implementation of policies and practices that address complex issue can be improved, and, if so to make needed revisions. It will be important to continue to review these Alerts periodically (i.e., every 2 to 3 years). Without a date of initial implementation or publication, and the dates of revisions (i.e., created xx/yy, revised xx/yy), it could not be determined whether the contents were current. There was no information whether there was an established time interval for review of the Safety Alerts. This consultant was informed by the Director of QM/RM/HIM that both the drug recall alert and the hot water scalding alert were posted since the first phase of this review in May 2017.

The Office of Integrated Health Services (OIHS) also provided ongoing technical assistance to the community service providers. Submitted was a roster of training topics, dates of training, and number of attendees. OIHS provided 22 training events across 5 Regions of the state. The most frequently trained topics during the prior calendar year (October 2016 -17) were skin integrity training, DSP oral care training, oral health training (Professionals). There were occasional other topics lists that were trained. Attendance varied from 4 – 35. Upcoming training dates and locations were provided for November 2017 through April 2018. Additionally, the Office of Integrated Health staff attended 100 regional nurses meetings.

One of the ‘next steps’ listed in the 2014 draft annual report was to “establish a process for evaluating the impact of Safety and Quality Alerts and other risk reduction strategies developed by the Mortality Review Committee.” There was no documentation provided for this review that indicated that this had occurred.

The Office of Integrative Health Services also has organized Mobile Rehab Engineering in which safety assessments, repairs and sanitation are scheduled at the state Training Centers. From the 6/26/17 Progress Report of the Office of Integrated Health, 1291 repairs were made, 830 safety assessments were completed. 86% of repairs were for wheelchairs. It was not readily apparent from the submitted document the time period in which this activity occurred.

Settlement Agreement Requirement

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

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

Mortality Review Committee						
Cause of Death						
Year	2014	2015	2016	7/1/16 - 12/31/16	1/1/17 - 3/31/17	4/1/17 - 6/30/17
Total deaths	226	289	164	109	73	65
Pneumonia	32(14.2%)	21 (7.3%)	17 (10.4%)	6 (5.6%)	17(23%)	
Cancer	24 (10.6%)	30 (10.4%)	28 (17.1%)	8 (7.4%)	1	1
Aspiration	17 (7.5%)	19 (6.6%)	4 (2.4%)	6 (5.6%)	1	
Sepsis	20 (8.8%)	21 (7.3%)	18 (11%)	6 (5.6%)	1	3
GI	8 (3.5%)	8 (2.8%)	4 (2.4%)	2 (1.9%)	0	
Respiratory	5 (2.2%)	19 (6.6%)	3 (1.8%)	7 (6.5%)	7(9.6%)	
Other	19 (8.4%)	19 (6.6%)	14 (8.5%)	8 (7.4%)	14 (19%)	1
Unknown	47 (20.8%)	58 (20.1%)	22 (13.4%)	12 (11.1%)	11(15%)	2
Respiratory/ pneumonia	37 (16.4%)	40 (13.8%)	20 (12.2%)	13 (12.0%)	24 (33%)	
Cardiovascular	-	-	-	-	13(17.8%)	
Neurological	-	-	-	-	6(8.2%)	

The ‘Mortality Tracker’ included valuable data, such as the above information concerning the most common causes. The categories being tracked had been expanded to include, “DD related deaths” and “unknown due to multiple medical conditions”. This review found positive results from the work that is evident in this area. These results are due, in part, to access to autopsies, death certificates, and improved documentation availability, as well as to the MRC’s documentation of information it received. The percentage of deaths from pneumonia and combined respiratory/pneumonia had increased significantly from prior time periods, as noted in the above chart. This may in part be related to the breakdown in quarterly information. This was to allow for evidence of much improved availability of specific document types (physical exams, nurses notes, etc.). The first quarter of the year is often marked by increased respiratory illness (flu, etc.). The second quarter of 2017 had gaps in the Mortality Tracker as DBHDS remained several months behind schedule in

completing mortality reviews. However, the backlog is expected to reduce with many changes that are underway in the mortality review process.

Of concern, on review of the MRC minutes, there were 3 suicides reviewed during these meetings from April through September 2017. One of these occurred out of state. Of the two which occurred locally, there was identification of the responsible agency, but the documentation did not reflect the need for urgent review, identification of root cause, and steps implemented in a timely manner as preventive action. There was no documentation of feedback information from the responsible state agency.

Recommendation follow-through

As mentioned earlier, when the MRC makes recommendations, these are posted through a separate step identified in the process flow chart as “Follow up Action Documentation and Reporting Process.” This process was reviewed earlier in this document. However, the quarterly review template entitled ‘Mortality Review Committee Action Tracking Report July-Sept 2017’, which was being tested in the second month of development as of October 2017, indicates all recommendations were being tracked until completion. This template allows the committee members to view which responsibilities have been assigned to them, and enter their updates on a monthly basis. This consultant requested information concerning closure of recommendations prior to the current quarter of the Action Tracking template. In response, a submitted document included this information which was then rolled in to another “MRC: Action Tracking Log: Sept 2017 –Dec 2018 Plus Outstanding Recommendations from Previous Tracker” to reflect the closure status of all outstanding recommendations in the prior months. The contents are categorized by recommendations assigned to the lead offices. Documentation (as of the date of 10/18/17, indicated the following. The Office of Community Integration completed 3 of 3 recommendations. The Licensing Office completed 4 of 4 recommendations. Office of Integrated Health Services completed 2 of 13 recommendations. Facility QM/RM completed 4 of 8 recommendations, the Medical Director completed 1 of 2 recommendations, and Community QM/RM completed 1 of 3 recommendations. There were additional actions taken that were documented for various recommendations, which had not been closed. This information indicated the recommendations were continuing to be tracked to completion.

Summary Bullets

Advances

- MRC occurs monthly or twice monthly on a consistent basis.
- Names of attendees with titles and department/ institution affiliation were now documented as part of the MRC minutes.
- Data accuracy and integrity is reviewed by data analysts.
- There has been significant progress in the required documentation being received for review. A list of documents that providers are required to submit to DBHDS licensing surveyors has been developed and implemented. Tracking included when the documents were received by MRC administrative staff. Timely inventory of received documents at periodic intervals was part of the tracking process by an MRC Coordinator.

- According to the MRC minutes, the administrative staff with a major role in mortality review includes two nurse reviewers.
- A standardized format for mortality reviews has been finalized and is providing a rich source of information. This has extended the length of time of the meetings in some instances to accommodate this information and the subsequent discussions.
- The quality of the clinical reviews brought to the MRC appear to be complete and of sufficient quality to allow the MRC to complete its duties. Standardization of data presented to the MRC has been successfully implemented.
- The MRC protocol appears to be back on track in attempting to ensure quality mortality reviews when adequate documentation is available. Closing mortality reviews with insufficient data no longer occurred, according to the MRC minutes.
- The process of database management in populating the Mortality Tracker spreadsheets has been reorganized and is now streamlined to allow only 3 staff to enter information.
- There was now a tracking system to follow MRC recommendations to closure.

Challenges

- The DBHDS Mortality Review Committee did not include the required member identified with clinical experience in mortality reviews who was independent of the State.
- The deadline of review within 90 days of death has not been attainable in most cases due to the backlog of cases to be reviewed by the nurse reviewer(s).
- The MRC was developing a trigger tool to guide licensing specialists in determining when they need to seek consultation with an RN. This appeared to remain an outstanding concern.
- The Safety Alerts continue to be developed. However, the submitted examples generally did not have dates when they were created or when they were revised.
- The OIHS tracked information concerning technical assistance that it provided. It does not yet track whether training has achieved the expected and desired outcome.
- Based on the MRC Annual Report, a Quality Improvement Plan had been created for 2017. An updated version indicated many outstanding areas needing completion dates.
- The mortality review process did not include a review of potential risk of other individuals in the provider home; DBHDS reports that only its OLS has the authority to review such cases. The recommendation has not yet been implemented to provide Licensing Specialists access to staff with the clinical training and experience to review identify immediate safety issues ... requiring action ... to prevent deaths, poor health outcomes, injury, or disability in other individuals served

Attachment A

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

2015: 2/11/15, 2/24/15, 3/11/15, 4/15/15, 4/17/15(2), 5/27/15, 6/10/15, 6/29/15, 7/10/15, 7/22/15, 10/14/15, 11/23/15, 12/2/15, 12/9/15, and 12/29/15.

2016: 1/27/16, 2/10/16, 3/9/16, 3/28/16, 6/8/16, 6/22/16, 6/30/16, 7/7/16, 7/13/16, 8/10/16, 8/24/16, 9/14/16, 9/21/16, 10/12/16, 11/9/16, 12/5/16, 12/9/16, 12/14/16, and 12/21/16.

2017: 1/11/17, 1/18/17, 2/15/17, 3/8/17. 3/22/17

2016 Mortality Tracker

Draft Community DD Mortality Review Worksheet

'Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 –June 30, 2016'

Departmental Instruction 315 (QM)13 Reporting and Reviewing Deaths (draft)

Mortality Review Committee Operating Procedures 2017

Responses to Recommendations from the Independent Reviewer Report to the Court 12-23-16

Mortality Review Committee Membership/Participation (undated)

Numbered Recommendation Status Tracker

Mortality Review Committee tracking 3/15/17

Safety and Quality Alerts of the Office of Integrated Health Services

Mortality Review Committee Interventions to Address Concerns

Form letter to Office of Vital Records for copy of death certificate (draft)

Form letter to provider organization requesting specific documents for review (draft)

DBHDS ID/DD Mortality 2013 Annual Report (May 2014 Draft)

DBHDS 2014 Annual Mortality Report (August 2015 draft): 'Mortality Among Individuals with an Intellectual Disability'

DBHDS Mortality Review Letter to Medical Practitioners (October 2015): "Reminding Medical Practitioners of High Risk Conditions"

Mortality Review Committee data tracking documents: 2014 Mortality Tracker, 2015 Mortality Tracker, and 2016 Mortality Tracker (to 6/30/16)

DBHDS Instruction (July 2016 Draft): Mortality Review

DBHDS Safety Alert: Recognizing Constipation

APPENDIX L.

Provider Training

By: Maria Laurence and Chris Adams

Report on Competency-Based Training
United States v. Commonwealth of Virginia

Submitted by: Maria Laurence,
Independent Consultant

Chris Adams,
Independent Consultant

November 10, 2017

INTRODUCTION

The Settlement Agreement provides specific direction to the Commonwealth regarding the provision of core competency-based training for all staff who provide services under the Agreement. It states: “(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 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.” (V.H)

Additionally, other sections of the Settlement Agreement establish requirements relating to staff training. Other consultants of the Independent Reviewer address these components of the Settlement Agreement, so they are not the focus of this report.

REVIEW PROCESS

In November 2014, and November 2015, Maria Laurence provided the Independent Reviewer with a report that assessed the planning, development, and status of a number of the Commonwealth’s Quality and Risk Management systems, including the requirements related to competency-based training. On 12/8/14, and 12/6/15, using information from these reviews, the Independent Reviewer submitted reports to the Court that included findings and recommendations related to competency-based training. At the request of the Independent Reviewer, from May to October 2017, Chris Adams and Maria Laurence (the Consultants) conducted a two-phase study to assesses the Commonwealth’s progress in meeting the terms of the Settlement Agreement relating to core competency-based staff training during the 10th and the 11th review periods. This report summarizes their findings.

The methodology and review process utilized to conduct this review included review of documents, in-person and telephone interviews with staff at the Department of Behavioral Health and Developmental Services (DBHDS), in-person interviews of staff at two Community Services Boards (CSBs), telephone interviews with staff at two CSBs, in-person interviews with staff at three community-based IDD services providers, telephone interviews with staff at two additional community-based IDD services providers, and one follow-up telephone interview with a community-based IDD services provider.

DBHDS provided extensive documentation in response to the document request made in advance of the consultants’ onsite review in May and again in response to the follow-up review in October. These documents provided evidence of the major milestones and tasks that have been completed to date in DBHDS’ Provider Training Plan. The training plan comprises six strategy areas. In December 2015, DBHDS began work to implement the plan. Following is a brief description and status report for each of the strategy efforts DBHDS reported as of October 2017:

- 1) Strategy 1.1 – Develop competency-based training materials that include knowledge-based testing, observational competency checks and that address intensive medical and behavioral needs. DBHDS reported that it began work on this strategy in December 2015, and completed it in May 2016.
- 2) Strategy 1.2 – Incorporate content related to basic and advanced health and behavioral risks into the established risk assessment and Individual Support Plan (ISP) processes. DBHDS reported that it began work on this strategy in March 2016, and completed it in June 2016.
- 3) Strategy 1.3 – Provide online access to providers for Direct Support Professional orientation and health risk training materials and related ISP changes. DBHDS reported that it began work on this strategy in March 2016, and completed it in September 2016.
- 4) Strategy 2.1 – Implement a provider rating system that serves as a self-evaluation process for providers of DD services. DBHDS reported that it began work on this strategy in July 2016 and the project is ongoing at this time.
- 5) Strategy 3.1 – Survey providers and identify gaps in services statewide. DBHDS reported that it began work on this strategy in February 2016, and completed it in October 2016. Further work has been done in this area over the past year with specific information planned for publication before the end of calendar year 2017.
- 6) Strategy 3.2 – Publish online results of provider surveys and self-reported standing. DBHDS reported it began work on this strategy in March 2017, with a projected completion date in January 2018. DBHDS reports that funding for the effort has been approved and that its collection and analysis of initial survey results has been initiated and is progressing.

The consultants' interviews with DBHDS staff focused on learning more about the processes and procedures for planning, implementing, and monitoring the delivery of competency-based training for staff working directly with individuals and their supervisors consistent with the requirements set out in Section V.H of the Settlement Agreement. Specific focus areas of the interviews included:

- 1) How DBHDS operationalized the requirements for competency-based training in the Settlement Agreement;
- 2) How DBHDS engaged and continues to engage stakeholders - including but not limited to CSBs and community-based providers - in the planning, development, implementation, evaluation, and revision phases of the training initiative;
- 3) The identification the major topics covered in the competency-based training curriculum;
- 4) The degree of prescriptiveness that DBHDS required of the provider and/or CSB to deliver the competency-based training and to continuously assess each staff member's competency going forward;
- 5) The resources DBHDS made available to providers and CSBs to comply with the training requirements;
- 6) The procedures DBHDS employed to measure compliance of each provider and CSB to meet the competency-based training requirements, and to enforce compliance, when necessary; and
- 7) The status of the DBHDS training project including what has been completed, what is currently underway, and what is planned for the future.

The interviews with CSBs and community-based providers focused on ascertaining their knowledge of the training provisions in the Settlement Agreement, DBHDS' training requirements, and these agencies' organizational planning, implementation, and evaluation of the delivery of competency-based training as set out in DBHDS' plan. Specific focus areas in the interviews included:

- 1) The major functions of the organization, including identification of specific services and supports provided for individuals with IDD;
- 2) The structure and content of their organization's policies, procedures, and practices relating to staff training and their measurement of staff competency to carry out their job responsibilities;
- 3) Their knowledge of DBHDS' requirements relating to core competency-based training of staff providing elements of services directly to individuals with intellectual/developmental disabilities and their supervisors;
- 4) How the organization operationalizes the initial and ongoing competency assessment and coaching processes in their staff training program;
- 5) How the organization records and maintains records of the delivery and successful completion of competency-based training, follow-up assessment, and coaching supervisors provide; and
- 6) The organization's quality assurance processes and procedures that measure the effectiveness of its staff training program and the methods by which these quality assurance processes inform changes needed in individual and/or corporate training curricula, and processes.

FINDINGS

DBHDS, through an organized planning and implementation effort, has taken some important steps in the development and implementation of a statewide core competency-based curriculum for staff who provide direct services and supports for individuals in its various programs for persons with intellectual and developmental disabilities. Major initiatives in the effort included:

- DBHDS leadership staff have begun to evolve the role of DBHDS from one of provider training to "provider development." Specific to training initiatives, DBHDS plans to establish expectations, and develop or coordinate the development of some curricula. CSBs and providers are expected to develop additional curricula as needed, and provide or purchase training. This shift in responsibility for training is designed to reduce the amount of human resources within DBHDS engaged in direct delivery of training, a change that appears necessary as the system of community-based services grows larger and more complex across the Commonwealth. Examples of DBHDS-developed video training modules that were shared statewide include a toolkit for shared living and one focusing on processes for Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Feedback from providers continues to center on the need for more face-to-face training provided by the Department in a variety of areas. Potential consideration to help address this consistently identified need would be to further expand "train-the-trainer" instruction that the Department provides for key areas of training identified and prioritized from provider/provider group feedback. The benefits of train-the-trainer model include minimizing the time commitment for DBHDS staff, while expanding training capacity within the service provider community.

- DBHDS developed an orientation training curricula and competency-based measures for direct support professionals and their supervisors, which represented significant revisions to the previous orientation training manual. Initial implementation of this revised curricula and checklists began in Fall 2016 with completion of required training/retraining of staff by 2/28/17. Review and revision of these curricula has continued to evolve with the most recent issuance of revised curricula for behavioral and autism competencies released on 9/25/17. The training curricula DBHDS developed includes the following competencies:
 - Virginia's Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 11/28/16;
 - Virginia's Health Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 1/19/17;
 - Virginia's Behavioral Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 9/1/17; and
 - Virginia's Autism Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 9/1/17.
- DBHDS established mechanisms to obtain input from and participation of providers and other relevant stakeholders in development of the training plan, the training curriculum, and the training manual. This consisted of the Director of Provider Development reaching out to a group of provider agencies, by obtaining input at monthly regional Provider Roundtable meetings, and through the Department of Medical Assistance Services (DMAS) stakeholder group. Based on interviews with DBHDS and provider staff, DBHDS has continued to solicit information from stakeholders about the training curriculum and implementation plans, and it continues to revise the curricula and the implementation requirements to more effectively ensure that staff working with individuals have the competencies necessary to be successful in delivering each individual's service elements. On 9/1/17, DBHDS released revised curricula and competency checklists for behavioral competencies and autism competencies.
- DBHDS also implemented a communication plan to provide information to its network of impacted community-based providers and CSBs about the training plan, the providers' responsibilities to ensure effective use of the revised training curricula for both new and incumbent staff, and the requirements for providers to measure competency of staff initially and on an ongoing basis. As part of the HCBS waiver redesign process, the Department of Medical Assistance Services (DMAS) officially notified CSBs and community providers of the requirements to complete competency-based training. On 9/1/16, the Director of DMAS sent a memo to all ID providers informing them of the updated training requirements, including the due date for completion of initial training/retraining by 2/28/17. The Commonwealth also utilized other forms of notification. These included, for example, Provider Roundtable meetings, My Life My Community stakeholder calls, postings on the DBHDS website, etc. Providers and CSB staff interviewed indicated increasing familiarity with the various information sharing mechanisms that the Department has established and shared examples of their use at the local level.

- DBHDS reports devoting considerable effort to share information with provider organizations through its ListServe. Consultant interviews found that providers and CSB staff were aware of this information source and, as the revised core competency-based training processes have evolved, they shared increasing references to and familiarity with the information promulgated by the Department through this information source. Providers interviewed consistently identified that DBHDS and DMAS do not provide notice of training opportunities and requested provider process changes through the ListServe or other information early enough to allow them to plan staff participation in external training or complete the requested internal changes in processes and procedures. While always a challenge, DBHDS should consider establishing a minimum window of time of at least four to six weeks for notices to be posted prior to the scheduled training or process change implementation date.
- The Commonwealth made emergency modifications to regulatory requirements to establish an initial mechanism for review and enforcement, if necessary, of providers' adherence to the training requirements. Emergency regulations (i.e., 12VAC30-120-515) related to the Waiver implementation, which are in effect from 9/1/16 through 2/28/18, set forth the requirements for competency-based training. DBHDS staff report the final regulations continue to be in the approval process and they anticipate approval in advance of the 2/28/18 expiration date of the emergency regulations. The emergency regulations include the following requirements:
 - "Providers shall ensure that DSPs and DSP supervisors providing services to individuals with developmental disabilities receive training on the following core competencies:
 - The characteristics of developmental disabilities and Virginia's DD waivers;
 - Person-centeredness, positive behavioral supports, effective communication;
 - DBHDS-identified health risks and the appropriate interventions; and
 - Best practices in the support of individuals with developmental disabilities...
 - Providers shall ensure that DSPs and DSP supervisors supporting individuals identified as having the most intensive needs, as determined by assignment to Level 5, 6, or 7 (as referenced in 12VAC30-120-570) based on a completed Supports Intensity Scale® assessment, shall receive training specific to the individuals' needs and levels.
 - DSPs and DSP supervisors supporting individuals with extraordinary medical support needs shall receive training on advanced core competencies in the area of medical supports as established by DBHDS.
 - DSPs and DSP supervisors supporting individuals with extraordinary behavioral support needs shall receive training on advanced core competencies in the area of behavioral supports as established by DBHDS.
 - DSPs and DSP supervisors supporting individuals with autism shall receive training on advanced core competencies in the area of characteristics of autism as established by DBHDS."

The Commonwealth has continued to expand and improve its provider and case manager training curricula as evidenced by:

- In response to stakeholder feedback, DBHDS staff recognized the need to streamline two sets of competencies they initially identified as necessary for providers supporting individuals with complex behavioral needs: 1) Virginia's Behavioral Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities revised 9/1/17; and 2) Virginia's Autism Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 9/1/17. The revised curricula and competency checklists for these two areas were released on 9/25/17. DBHDS should continue to focus its attention on simplifying and streamlining its requirements for providers as was done in the two most recent revisions of competency documents as this was a consistent issue identified through provider interviews for this study.
- DBHDS updated the Supervisors' training requirements in April 2017, and have posted those in the Learning Management System for use by providers.
- Although the case management training curriculum has been in place for several years, DBHDS continues its work to develop case management competencies. An initial draft of the competencies was completed in Spring 2017 with feedback currently being solicited from several sources, including case managers themselves. Based upon information received through this feedback, and, upon completion of internal review, DBHDS will pilot the competencies in several Regions. This seems to be a reasonable approach that will allow DBHDS to make necessary changes prior to implementing the competencies statewide.
- DBHDS continues its work to revise the case manager training modules and a resource manual for case managers to use after completing the training.
- An extensive training for case managers was held on 8/30/17, that includes a comprehensive presentation on the purpose of case management and the numerous processes and procedures case managers employ to ensure the needed quantity and quality of service delivery for individuals in the service delivery system. The Office of Integrated Health Services continues to provide training, including in-person training with a current focus on training related to significant health issues and dental services.

As the full implementation of the revised training competencies and supervisory coaching matures, the Department must develop mechanisms for determining whether CSBs and providers are implementing the competency-based training, whether the training results in staff being able to demonstrate competence, and whether the competencies developed are having the intended impact. DBHDS reported that the following areas are under consideration:

- DBHDS utilizes its Office of Licensing Services to provide regulatory oversight of community-based providers. It appears this is a primary means by which DBHDS intends to measure compliance with the newly revised competency-based training requirements for staff. However, it remained to be seen how the licensing process would evaluate providers' compliance with training requirements and remediate any issues identified. Reportedly, if Licensing Specialists found problems, in addition to requiring a corrective

action plan, they also can inform DBHDS Provider Development staff that a provider needs technical assistance to improve their competency-based training system.

- Reportedly, DMAS also is expected to play a role in assessing waiver providers' compliance to meet the system assurances it must make to the federal government regarding the provision of Home and Community-Based Services.
 - The DBHDS Quality and Risk Management Division staff recognize the need to incorporate training and the outcomes of training into the measures they are developing. At the present time, Domain 8 – Provider Capacity – includes reference to staff training, staff turnover and provider competency as example measures; however, definition of data elements to be measured in these areas and the means by which data can be collected consistently throughout the expanding service delivery system has yet to be undertaken.
 - The DBHDS Draft Community-Based Risk Management Framework proposes use of data related to direct support professional and supervisor completion of training and competencies. However, a continuing challenge with the training competencies is the lack of measurability. As discussed in further detail below, it will be essential that the Commonwealth improve the measurability of the competencies, and for the system used to measure providers' compliance with the competencies to integrate an inter-rater reliability process (i.e., all licensing specialists should review providers' training compliance using the same standards).
- In terms of supporting providers, the DBHDS Regional Resource and Response Team development should assist in coordinating the provision of technical assistance. These teams will include Licensing staff, Human Rights staff, nurses, Community Resource Consultants, Regional Support Team staff, etc. Many of the providers with whom the Consultants spoke reported frustration with different DBHDS staff providing different answers to the same question. It will be essential for the Commonwealth to clearly identify staff responsible for technical assistance, and develop mechanisms to ensure they provide accurate and consistent information to CSBs and providers.

Since the November 2015 review of the status of progress toward achieving the core competency-based training requirements of the Settlement Agreement, the Commonwealth staff have made progress in developing and disseminating a set of competencies designed to improve the quality of services and supports provided to individuals with IDD that the system services. However, the following concerns were noted:

- Many of the competencies that the Commonwealth has developed are not measurable. For example, the following competencies included in Virginia's Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 11/28/16, would be difficult to measure reliably:
 - Describes and records new learning about the individuals they support (#1.2.2);
 - Provides guidance to DSPs upon identifying deficiencies in documentation (#2.1.3);
 - Understands their scope of service and when to seek out assistance if a change in the individual's status is outside of that scope (#2.3.3); and

- Communicates the expectations and responsibilities to the DSPs they supervise (#3.2.4).

This lack of measurability negatively impacts both providers' ability to consistently ensure their staff have the necessary competencies, as well as DMAS and DBHDS Office of Licensing staff's ability to reliably measure providers' compliance with, and otherwise hold providers accountable to fulfilling the requirements. Based on interviews with CSBs and providers, some are concerned about whether their training and their determinations that staff are competent will comport with external monitors' expectations. According to the Director of Provider Development, DBHDS recognizes the need to make additional changes to the competencies, but they also recognize that doing so will result in substantial changes on the part of CSBs and providers. Therefore, DBHDS does not plan to make incremental changes, but rather to make a decision about when it is best to roll-out a larger package of needed revisions.

- The Virginia's Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 11/28/16, and Virginia's Health Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, dated 6/10/16 and revised 1/19/17, included a number of basic competencies related to individuals' health and wellness. This was good to see and was identified by several providers as an enhancement over previously defined training/competency requirements. Additional competencies, however, would be necessary for staff to fully support individuals with complex medical needs, including direct support professionals and nurses.
- Regarding training to address elements of needed service as described in individuals' ISPs, requirements were nebulous. Most CSBs and community-based providers reported awareness of DBHDS' Safety Alerts and resources available to them to address the eight high-risk conditions that more commonly lead to the death of individuals with IDD. Each also confirmed and provided some examples of staff training focused on specific elements of an individual's service plan. Several of the community-based providers shared their appreciation for DBHDS' increased focus on how to effectively deliver services and supports for persons with complex healthcare needs in the training curriculum as they have identified a growing complexity of healthcare needs in the individuals they currently serve. Feedback obtained through interview of CSB and provider staff did not identify mechanisms to establish additional competencies that may be necessary to implement individualized components of service plans that are not covered through the competencies the Commonwealth specifically required.
- Providers and CSBs with whom the Consultants spoke consistently expressed concern that they do not receive sufficient notice from the Department regarding new or revised procedural roll-outs and training opportunities available to their staff. Given commitments providers schedule several weeks in advance, they require more than a couple of weeks' notice to add Commonwealth training opportunities to their schedules, or to make changes to their systems.
- Providers interviewed for this study reported that while they met the initial training deadlines the Department established, they struggled to meet those deadlines and to do so in a quality manner. Many of the providers and CSBs described their existing internal

training resources as sufficient at the time the Commonwealth required the additional training requirements, but also recognized the utility of a standardized set of competencies and training curricula to be used across the service delivery system. From this limited review, the Consultants were not able to make definitive findings about providers' ability to assess and modify their staff training curricula as well as the delivery mechanisms to meet the current requirements, and/or to expand staff competencies to effectively address the increasing complexity of the elements of services of individuals their provider organizations support. However, based on some of the descriptions of how CSBs and providers implemented the revised training requirements, it was not clear that supervisors actually assessed staff's competence.

Interviews with the staff of four CSBs and review of information they provided support a finding that they have knowledge of DBHDS' competency-based training requirements, are largely aware of competency-based training information resources that DBHDS provided, and that they regularly take advantage of these resources. Some CSB staff, however, were unfamiliar with training resources that have been available for some time, such as the root cause and investigation training modules.

Interviews with the five community-based private providers also identified evidence of their knowledge of DBHDS' competency-based training requirements, their general awareness of training resources that DBHDS provided, and their participation in information sharing opportunities DBHDS provides on an ongoing basis. These opportunities include the round-table meetings held approximately every two months in each region and chaired by the regionally-based Community Resource Consultants. While providers could articulate specific examples of how they take advantage of DBHDS' information resources, each shared that they also utilize other information sharing mechanisms to maintain up-to-date information about DBHDS' requirements. These include information received through other providers, provider trade organizations, and other informal means. While there appears to be increasing provider familiarity with and use of the Department's electronic notification process available on DBHDS' website (ListServe), providers interviewed expressed frustration with the multiple attempts necessary to identify who within the Commonwealth system can assist them to find the answers to their questions, if not readily identifiable through information on the ListServe.

Regarding general competencies, all CSBs and community-based providers interviewed reported that they had policies and procedures that structure the process and content of their staff training requirements to comport with DBHDS' new competency-based training requirements. Each organization described procedures for competency assessment, coaching, and supervision of employees. That being said, the providers and CSBs all had varying training capacity, and, as noted above, it was not consistently clear that CSBs and providers understood and/or implemented procedures to actually assess staff's competence. While a few had separate training departments to manage the development, delivery and assessment of staff training, most providers and CSBs rely on staff who also have other responsibilities (e.g., Human Resources, supervision). Providers and CSBs were using a variety of mechanisms for training, including on-line training (e.g., provider developed, College of Direct Support, etc.), classroom training, and on-the-job training.

Several of the CSBs and one of the community-based private providers reported employing electronic staff training recordkeeping systems to varying extents within their organizations. These systems, if fully utilized, greatly enhanced these organizations' ability to identify required training competencies for each employee, track each employee's successful completion of

required training, and the delivery of coaching and supervision to assist in ensuring ongoing competency. They also provide documentary evidence of training compliance that reportedly was sufficient to satisfy regulatory requirements. The smaller community-based providers and CSBs reported continued use of paper-based recordkeeping systems for much of their staff training. They also reported that, while cumbersome even in their small organizations, the paper-based record system appeared to assist them in tracking all training provided to staff to meet both their organizational needs and the requirements of the regulatory bodies that oversee their operations.

Each organization interviewed could cite specific processes and procedures that identify operational incidents/issues/areas of concern and that result in procedural changes and/or modifications to staff training/retraining. The examples identified, however, did not provide evidence that the providers were effectively using their incident management system to identify and make changes in processes and procedures relating to direct service delivery within their organizations.

SUMMARY AND NEXT STEPS

Based on this limited review, DBHDS has taken a number of important steps to develop and to begin implementation of a reasonable plan to ensure the competency of all staff who provide services for individuals under the terms of the Settlement Agreement. The Commonwealth developed the plan with input from stakeholders and established milestones to measure the completion of required elements. The plan contains methods to ensure effective communication of plan requirements, implementation efforts, and, to a limited extent, resources available to service providers to deliver effective competency-based training. DBHDS's implementation has continued to demonstrate that its staff have become aware of necessary additions and/or improvements to the plan, and has made some of these revisions as its implementation moves forward. However, DBHDS has not yet implemented mechanisms to fully measure CSBs' and providers' implementation of the training requirements.

In September 2016, the Commonwealth began its initial implementation of the revised core competency-based training curricula and training plan. The Commonwealth established February 2017 as the deadline for providers to retrain all incumbent staff and to initiate using the new curriculum for new staff. Staff interviewed from the CSBs and the community-based private providers consistently identified that the rollout of the training program and the requirement to retrain and re-assess competency of all staff in a period of six months was challenging. Each of the organizations reported that the Commonwealth had informed them of the expectations and provided materials relevant to the training curriculum. During the initial implementation phase of the new curriculum, the Commonwealth provided information, electronically and in face-to-face meetings, and support to clarify issues and to answer questions as they arose. Each provider also reported that they had completed the retraining requirements and initial competency assessments within the specified six-month period.

DBHDS continues to solicit feedback from providers and other relevant stakeholders about the competency-based staff training plan. In response to the feedback received, DBHDS staff described efforts to revise and refine the processes and consideration of other focus areas for development of future training. They have, in response to specific input and direction from relevant stakeholders, revised, and in September 2017, implemented curricula and competency

checklists in the areas of behavioral services and autism services. The future trainings that are currently being considered for development include: dementia care, mental health supports, accessibility needs of individuals, and others.

This review did not assess the quality of the training provided and/or the outcome of the training in terms of the competency of staff. Moreover, at this juncture, the Commonwealth has not identified a set of measurement criteria, data indicators to measure the quality or impact of the revised competency-based training, or specific outcomes to be measured to determine the efficacy of the competency-based training plan. The Commonwealth's current plan is for the Office of Licensing Services, DMAS, and the DBHDS Quality and Risk Management Division to assess various components of CSB and provider training; however, without specific data indicators and measurement criteria, the lack of measurability of both the training requirements and the identified competencies cannot be consistently implemented and will contribute to unreliable reporting. It will also undermine the Commonwealth's ability to hold all CSBs and private providers to the same standards and to ensure a consistent level of competency across staff throughout the system. Given the complexity of the provider system across the Commonwealth, it appears necessary that the Commonwealth identify a small number of measurable data indicators related to training that are common to each provider location and work within that framework to develop reporting mechanisms that each provider is capable of supporting. Some examples of measurable data indicators could include (1) the number and percent of newly hired staff who completed initial training required by DBHDS within 30 days of employment, (2) the number and percent of staff who have **demonstrated** ability to operate adaptive and orthopedic equipment safely. As these initial measurable data indicators are rolled out and deemed successful, more measures can be incrementally added leveraging processes and lessons learned from the initial work.

According to the Director of Provider Development, some providers have different requirements for provider training than those required of the majority of the providers implementing the revised waivers. These include: 1) supported employment providers, who have contracts with the Department of Aging and Rehabilitation Services, are required to obtain accreditation through the Commission on the Accreditation of Rehabilitation Services (CARF); 2) Service Facilitation, for which DMAS sets the requirements; and 3) providers of individuals who receive services through other waivers. DBHDS staff report no updated information or further addressing of training requirements in any of these three regulatory/certification organizations. During these Consultants' next onsite review, more information will be sought to determine the status of the Commonwealth's assurances that such providers meet the requirements of the Settlement Agreement.

Attachment A - List of Interviews:

- 1) On Tuesday May 2, 2017, the Consultants conducted site visits and interviews with:
 - a) Connie Cochran, DBHDS, Assistant Commissioner of Division of DDS
 - b) Eric Williams, DBHDS, Division of DDS, Director Provider Development
 - c) Dev Nair, DBHDS, Assistant Commissioner of Quality and Risk Management, and Challis Smith, Case Management Coordinator
 - d) **Good Neighbor Homes, Inc., Richmond, Region 4**, a community-based provider of in-home, residential and day program services for persons with intellectual disabilities. The interview was with Keelly Perdue, Director of Compliance and Training, and Ly Hayes, Director of Operations.
 - e) **Chesterfield County Community Services Board, Chesterfield, Region 4**. As part of its broad service array, the Chesterfield CSB provides residential, day program, employment support, case management/service coordination and early intervention services for persons with intellectual/developmental disabilities. The interview was conducted with Karyn Carpenter, Director of Human Resources, and David Meadows, Director of Developmental Disability Services.
- 1) On Wednesday May 3, 2017, Chris Adams conducted site visits and interviews with:
 - a) **Noble Care, LLC, Suffolk, Region 5**, a community-based provider of residential and day program services for persons with intellectual disabilities with primary focus on services for persons with complex healthcare issues. The interview was with Felicia Parker, Co-Owner, and Portia Kelly, Day Program Manager.
 - b) **Community Alternatives, Inc., Norfolk, Region 5**, a community-based provider of in-home, supported living, residential, and day program services for persons with intellectual disabilities. The interview was with Chris Greene, Training Coordinator; Andrea Cook, Regional Manager; and Jeanette Young, Regional Manager.
- 2) On Thursday May 4, 2017, Chris Adams conducted a site visit and interview at **Colonial Behavioral Health Community Services Board, Williamsburg, Region 5**. As part of its broad service array, the Colonial Behavioral Health CSB provides in-home, residential, day program, and case management/service coordination services and supports for individuals with intellectual/developmental disabilities. The interview was conducted with a large group of agency staff representing each of the areas of primary service delivery as well as employee supports within the organization. Those participating in the interview included Deborah Townsend-Pittman, Director of Rehabilitative Services; Chaenn Thomas, Human Resources Generalist; Linda Butler, Residential Services Coordinator; Kaitlyn West, ID/DD Services Specialist; Juan Vera, Community Services Coordinator (former Case Management Director); Donna Kastelan, ID Day Services Manager-Documentation; Cynthia Wilkes; ID Day Services Manager-Operations; Elizabeth Erfe-Howard, Community Integration Coordinator; and Rebecca Thornton, I/DD Case Management Services Manager.
- 3) On Thursday September 28, 2017, Maria Laurence and Chris Adams conducted a telephone interview with staff at DePaul Community Resources, Roanoke, Region 3. DePaul is a community-based provider of residential and day program services for persons with intellectual disabilities. Staff participating in the telephone interview included Amber Allen, Director of Residential Services; Gary Willburn, Vice-President of Developmental Disability Services; Linda Hinchell, Chief Operating Officer; Dan Jenkins, Assistant Director of Residential Services; Tina Ring, Day Programs Director; and Kate Means, Quality Assurance Director.

- 4) On Thursday October 12, 2017, Maria Laurence and Chris Adams conducted a telephone interview with DBHDS staff including Eric Williams, DBHDS, Division of DDS, Director Provider Development; Dev Nair, DBHDS, Assistant Commissioner of Quality and Risk Management; Challis Smith, Case Management Coordinator; and Peggy Balak, Settlement Agreement Coordinator.
- 5) On Wednesday, October 18, 2017, Maria Laurence and Chris Adams conducted a telephone interview with staff at Chimes Virginia, Inc., Fairfax, Region 2. Chimes, Inc. is a community-based provider of residential, day support, in-home and respite services for persons with intellectual disabilities. Staff participating in the interview include Nancy Eisele, Chief Operating Officer; Tom Palermo, Chief Program Officer; Mycie Lubin, Director of Residential Services; Sharonda Bradley, Executive Assistant/Human Resources Support; Joan Henry, Program Coordinator; and Tammy Holt, Assistant Coordinator for Day Programs.
- 6) On Friday October 20, 2017, Maria Laurence and Chris Adams conducted a telephone interview with staff at Northwest Community Services Board, Winchester, Region 1. Northwest CSB provides in-home respite and case management services for persons with intellectual disabilities. Staff participating in the interview included Donna Hayes, Director of Intellectual and Developmental Disability Services; Jan Donovan, Compliance Officer; and Vicky Wheeler, Chief Program Manager.
- 7) On Thursday October 26, 2017, Maria Laurence and Chris Adams conducted a telephone interview with staff at Planning District 1 (Frontier Health), a CSB with offices in Norton, Region 3. Through a cooperative relationship with Frontier Health, Planning District 1 CSB provides residential, day program services and case management services for persons with intellectual disabilities. Staff participating in the interview included Sharon Taylor, Community Support Services Director; Donna Blankenship, Case Management Supervisor; Christy Denman, Case Management Supervisor; Regina Lawson, Director of Developmental Disability Services; Susan Chandler, Supervisor of In-Home Programs; and Diane Bowen, Quality Assurance/Compliance Officer.
- 8) On Friday October 27, 2017, Maria Laurence and Chris Adams conducted a telephone interview with staff at Community Alternatives, Inc., Norfolk, Region 5, a community-based provider of in-home, supported living, residential, and day program services for persons with intellectual disabilities. This was a second interview with staff from this provider as a face-to-face interview was conducted in May. Chris Greene, Training Coordinator, was the organization's staff member who participated in this telephone interview.

Attachment B - Documents Reviewed:

DBHDS provided the following documents either in advance of or during the onsite review in May 2017:

- **Provided and discussed during interviews with DBHDS staff in Richmond:**
 - Initial Results of the Provider Survey
 - DBHDS Provider Training Plan
 - DBHDS Provider Self-Assessment Instrument
 - DBHDS Provider Development Process Flow Chart 12-30-16
 - Draft Case Manager Competency Assessment Checklist
 - Draft DBHDS Regional Resource and Rapid Response Team
 - Draft Case Management Quality Improvement Record Audit Tool
- **Relating to the provider training summary:**
 - Training and Competencies Development Contact List 3.21.17.pdf
 - Orientation Requirements/Assurances for DBHDS-Licensed Providers
 - Orientation Requirements/Assurances for Non-DBHDS-Licensed Providers
 - Orientation Manual
 - Orientation Training Slides
 - Orientation Manual Test
 - Initial competency checklists
 - External training site: http://www.partnership.vcu.edu/DSP_orientation/
 - DBHDS training site – see Competencies and Training Tab:
<http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/provider-development>
- **Relating to policies and regulations:**
 - Orientation Requirements Medicaid Memo V1.0 dtd 090116.pdf
 - Emergency Regulations - Training and Comp 2016 12VAC30.pdf
 - DRAFT Permanent Regulations language 2017.pdf
- **Relating to training program implementation:**
 - Updated Basic and Health Competencies Checklists
 - Draft Combined Autism and Behavioral Checklist
 - Draft Advanced Training Topics Guidance
 - Initial DBHDS PowerPoint Information for Supervisors - final 8-23-16
 - Announcements regarding delay in VLC access
 - DSP Supervisors Training Report 3.13.2017.xlsx
 - DRAFT UPDATED DBHDS PowerPoint Information for Supervisors - final 3.13.17
- **Relating to communication with providers and CSBs:**
 - Competencies Communications
 - My Life My Community (MLMC) Communications
 - Competencies Slides - MLMC Series final 6-30-16.pptx
 - MLMC training count Feb to June 16.pdf
 - Provider Network Listserv - full history
 - Provider Development Meeting and Training Schedules
 - MLMC Stakeholder Call Communications
 - MLMC Stakeholder Call Recordings
 - MLMC final combined QAs 3117 final for online.pdf
 - MLMC Integrated Life Definition

- VNPP Provider Questions 1.19.17.pdf
- Other provider communications (i.e. community engagement, health, ISP, regulations, housing, WaMS, MLMC, etc.)
- Trainings Offered to Support Provider Community
- Waiver Experts Contact List
- **Provided in electronic format by staff at the Chesterfield Community Services Board during onsite review at that location:**
 - Service Coordination Modules
 - Service Coordination Mentoring
 - Services Coordination Competency Checklist
 - Residential Orientation Outline
 - Residential Supervisor Training
 - Residential Profiler
 - Residential New Staff Competency Tool
 - Residential New Counselor Training
 - Residential Medication Management
 - Residential College of Direct Supports Curriculum
 - DD Waiver Orientation Competencies
 - Day Support Skill Competencies
 - Day Support Identifying and Responding to Issues
 - Day Support – Health Competency
 - Day Support – Health and Safety Competencies
 - Day Support – Behavior Management
 - Day Support – Autism Competency
 - Day Support – Person-Centered Plan
 - Day Support – Orientation
 - Day Support – Hydration
 - Service Coordination Training

DBHDS provided the following documents relating to the telephone interview on October 12, 2017:

- **DBHDS Provider Training Updates/Competencies:**
 - DBHDS Provider Training Updates Memo dated 9/25/17 (final)
 - DD Advanced Training Topics dated 9/25/17 (final)
 - VA DD Autism Competencies dated 9/1/17 (final)
 - VA DD Behavioral Competencies dated 9/1/17 (final)
- **Service Coordinators Meeting Attendance and Agenda**
 - Support Coordination/Case Management Quality Improvement PowerPoint dated 8/30/17
 - OIH Nursing Meeting Schedule
 - OIH Training Offerings
 - Regional Service Coordinator Meeting numbers 7/16-7/17
 - Scalding Alert – 8/17
 - Statewide 9/16 Regional Support Coordinator/Case Manager and Provider Roundtable Meeting Agenda – All Regions
 - Statewide 11/16 Regional Support Coordinator/Case Manager and Provider Roundtable Meeting Agenda – All Regions

- Statewide 1/17 Regional Support Coordinator/Case Manager and Provider Roundtable Meeting Agenda – All Regions
- Statewide 3/17 Regional Support Coordinator/Case Manager and Provider Roundtable Agenda – All Regions
- Statewide 5/17 Regional Support Coordinator/Case Manager and Provider Roundtable Meeting Agenda – All Regions
- Statewide 7/17 Regional Support Coordinator and Provider Roundtable Meeting Agenda – All Regions
- Regional Provider Roundtable Meeting Attendance Numbers – 7/17
- **Other Documents Relating to Training Requirements**
 - Regional Community Nursing Meetings – September 2017
 - The State of Developmental Disability Services 8/29/17
 - DMAS Draft Rule Revision Project 4614 – Three Waivers (ID, DD, DS) Redesign

APPENDIX M.

LIST OF ACRONYMS

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

HR/OHR	Office of Human Rights
HSN	Health Services Network
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports (“DD” waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
LIHTC	Low Income Housing Tax Credit
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
ODS	Office of Developmental Services
OHR	Office of Human Rights
OLS	Office of Licensure Services
PASSR	Preadmission Screening and Resident Review
PCP	Primary Care Physician
POC	Plan of Care
PMM	Post-Move Monitoring
PST	Personal Support Team
QI	Quality Improvement
QIC	Quality Improvement Committee
QSR	Quality Service Review
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
START	Systemic Therapeutic Assessment Respite and Treatment
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
WDAC	Waiver Design Advisory Group