

REPORT OF THE INDEPENDENT REVIEWER  
ON COMPLIANCE  
WITH THE  
SETTLEMENT AGREEMENT  
UNITED STATES V. COMMONWEALTH OF VIRGINIA

United States District Court for  
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 7, 2013 – April 6, 2014

Respectfully Submitted By

A handwritten signature in blue ink, appearing to read "Donald J. Fletcher", written in a cursive style.

Donald J. Fletcher  
Independent Reviewer  
June 6, 2014

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## EXECUTIVE SUMMARY

This is the Independent Reviewer's fourth report on the status of compliance in the Settlement Agreement (Agreement) between the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This report documents and discusses the Commonwealth's efforts and the status of its compliance with the obligations, as of April 6, 2014. A Summary of Compliance is included.

The Parties acknowledged in the Settlement Agreement that successfully implementing its provisions would take time. Due dates exist annually through 2021 to create 4,170 new waiver slots to afford members of the target population access to, and funding for, an array of community-based services. The Agreement provisions that were due during the first two years are critical elements for the development of a system that is truly responsive to the needs of individuals with intellectual and developmental disabilities. These provisions include the creation of waiver slots, increased case management and licensing oversight, discharge planning and transition services with a post-move monitoring process, regional crisis services and crisis stabilization programs, offering practicable non-work integrated day activities and supported employment, the development of increased community living options, and the beginning stages of systems to collect and analyze data about safety and quality.

The Commonwealth has achieved compliance with many provisions of the Agreement. At the end of the review period, it had created and distributed more than the minimum required number of waiver slots; more than 1445 slots to allow services for individuals with ID and DD who were on waiting lists, often for many years, and in urgent need. Receiving these services has significantly improved the quality of life for these individuals and their families. More than 310 individuals had transitioned from the Training Centers to live in community homes. Individual reviews of the services and circumstances of individuals who moved from the Training Centers concluded that, overall, they have adjusted well to their new homes, live in typical neighborhoods, and have experienced positive life outcomes. The Independent Reviewer previously reported that the Commonwealth developed, by June 2012, and improved over time, a discharge planning and transition process and a post-move monitoring process. Both have been well organized and effectively implemented to comply with many provisions of the Agreement. Case Management and Licensing Services have been increased. This period's Individual Review study confirmed that all individuals sampled during the past two review periods received case management services; and during the most recent period, all eligible individuals received monthly face-to-face visits. An independent consultant also verified that the frequency of oversight and regular unannounced licensing inspections occurred as required. For adults with ID/DD, in each Region, the Commonwealth provided mobile crisis teams, crisis support, and crisis stabilization services with trained staff. The Commonwealth's Department of Behavioral Health and Developmental Services (DBHDS) is building a quality and risk management system. Several workgroups are meeting regularly, planning, problem solving, and implementing new, or reforming existing, systems. To strengthen its ability to provide quality community-based services for individuals with complex medical and behavioral needs moving out of facilities, the Commonwealth has created new interim tools (i.e. Bridge Funds, Exceptional Rates), until its HCBS waivers and rates are restructured.

The Commonwealth has again demonstrated good faith in its efforts to implement the provisions due to be completed by April 6, 2014, the end of the review period covered by this report. Despite these efforts, the Commonwealth is significantly behind schedule with repeated delays in complying with certain obligations. It is essential that the Commonwealth redouble its efforts and expedite its plans to meet its commitments.

At the recent meeting with the Court, the Commonwealth's new leadership team made a sincere commitment to the principles and goals of the Agreement and described several positive new initiatives, especially regarding housing and non-work integrated day activities. Appointed since the Governor was elected last November, DBHDS Commissioner, Dr. Debra Ferguson; DBHDS Assistant Commissioner for Developmental Services, Connie Cochran; Settlement Agreement Advisor, Peggy Balak; and Deputy Secretary for Health and Human Resources, Suzanne Gore, were joined by the long serving Director of the Virginia Department of Housing and Community Development, William Shelton, in pledging a coordinated and collaborative effort to fulfill the Commonwealth's commitments.

The Commonwealth acknowledges that additional work is needed with respect to crisis services for children, integrated day opportunities, community living options, and transitioning children from nursing facilities and large intermediate care facilities. DBHDS and DMAS have each recently added new staff in leadership roles to oversee implementation. Regular meetings are being held amongst state agencies to facilitate collaboration and problem solving in planning and implementation in areas of non-compliance. DBHDS has also recently planned changes to the individual support planning process in response to the Independent Reviewer's reported concerns and recommendations.

Based on many sources of information available to the Independent Reviewer and his expert consultants, it is clear that a majority of the provisions due in the second half of year two have been met. It is equally clear that there remain significant areas of non-compliance. It is this Reviewer's opinion that the Commonwealth's recent actions and future plans to increase resources and expertise devoted to areas of non-compliance is required to achieve desired outcomes and compliance. The recent increase in interagency collaboration and problem solving is also essential to making needed progress. At this stage of program and system development, the Independent Reviewer determined compliance for many provisions based on quantitative measures, i.e. whether the required program components, the building blocks of the community service system, have been developed and are operating. To determine compliance in future review periods, the Independent Reviewer will increasingly review qualitative measures, such as whether the new and reformed programs are delivered effectively and achieve needed outcomes.

In the Agreement, the Parties agreed to many vitally important Quality and Risk Management provisions (Section V). Complying with these provisions involves the development of new systems and the reform of existing ones. The Parties did not include the dates when the Commonwealth would comply with these provisions. During the third review period, the Independent Reviewer retained a consultant with expertise in quality management to provide a baseline assessment of, and feedback to, the Commonwealth about its planning and development efforts for many of these provisions. The Independent Reviewer will determine the Commonwealth's compliance with the Quality and Risk Management provisions without due dates as of October 6, 2014 and will report the status of compliance in his December 6, 2014, report to the Court. For this report the Independent Reviewer defers determining the Commonwealth's compliance with these provisions.

The implementation of the Agreement has been advanced by the Commonwealth's good faith efforts. During the transition to the new administration, reform efforts were continued and the pace of implementation was maintained. Implementation with some initiatives has been expedited. Throughout the review period, DBHDS leadership and staff, as well as the VA Attorney General's attorneys, have been accessible, forthright, and responsive to the many requests of the Independent Reviewer. The DOJ attorneys have assisted effective implementation by gathering information, by providing consultation on the requirements of the Agreement, and by working with the Commonwealth to build shared understanding of the provisions. The Parties have maintained a collaborative working relationship and reached reasonable solutions when sharing and discussing the issues and concerns that naturally arise when implementing new programs and reforming statewide systems of support. The involvement and contribution of the stakeholders are vitally important aspects of effective planning and implementation. My appreciation is given to the individuals and the families, providers and CSBs, for their assistance with visits to families and to community residential and day programs, and for their responsiveness to requests for information.

## SUMMARY OF COMPLIANCE: YEAR TWO, SECOND HALF

Settlement Agreement Reference	Provision	Rating	Comments
<b>III</b>	<b>Serving Individuals with Developmental Disabilities In the Most Integrated Setting</b>		
<b>III.C.1.a.i-iii.</b>	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community according to the following schedule: In State Fiscal Year 2014, 160 waiver slots.	<b>Compliance</b>	The Commonwealth created 220 waiver slots during FY 12 and 13, and an additional 160 in FY 14 for a total of 380 waiver slots, as required.
<b>III.C.1.b.i-iii</b>	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities). In State Fiscal Year 2014, 225 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs.	<b>Compliance</b>	The Commonwealth created 575 waiver slots during FY 12 and 13, and an additional 575 in FY 14 for a total of 1150 waiver slots, 425 more than the minimum the Agreement required.
<b>III.C.1.c.i-iii.</b>	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities). In State Fiscal Year 2014, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs	<b>Compliance</b>	The Commonwealth created 215 waiver slots during FY 12 and 13, and an additional 130 in FY 14 for a total of 345 waiver slots, 145 more than the minimum the Agreement required.
<b>III.C.2.a-b</b>	The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2014, a minimum of 1000 individuals supported.	<b>Compliance</b>	The Commonwealth met the quantitative requirements by supporting 1294 Individuals in FY 2014; 693 for individuals on the urgent wait list, 373 on the non-urgent wait list, and 228 on the DD wait list. The Independent Reviewer has not determined whether the current program fulfills the qualitative requirements for this program, as defined in Section II.D.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.C.5.a</b>	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	<b>Compliance</b>	<ul style="list-style-type: none"> <li>• 55 (100%) of the individuals studied during the past year were receiving case management.</li> <li>• 53 (93.4%) of 55 had current ISPs.</li> </ul>
<b>III.C.5.b.</b>	For the purpose of this agreement, case management shall mean:		
<b>III.C.5.b.i.</b>	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans (“ISP”) that are individualized, person-centered, and meet the individual’s needs.	<b>Non-Compliance</b>	<p>Of individuals studied:</p> <ul style="list-style-type: none"> <li>• 7 (63.6%) of 11 had not had ISPs modified in response to a major event for the individuals.</li> <li>• 7 (87.5%) of 8 individuals who engaged in aggressive, dangerous, and disruptive behaviors were not receiving needed behavioral support services.</li> </ul>
<b>III.C.5.b.ii</b>	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.	<b>Non-Compliance</b>	<p>Individuals studied did not have the following services:</p> <ul style="list-style-type: none"> <li>• 5 (29.4%) of 17 day/employment;</li> <li>• 7 (25.9%) of 27 dental; and</li> <li>• 5 (45.5%) of 11 communication /assistive technology.</li> </ul>
<b>III.C.5.b.iii</b>	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	<b>Non-Compliance</b>	Same as two comments above.
<b>III.C.5.c</b>	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board (“CSB”) Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	<b>Compliance</b>	There was no evidence that the case managers of the individuals sampled provided direct services, other than case management. A provision has been added to the “FY 2013 and FY 2014 Community Services Performance Contract” with the requirement to offer choice.
<b>III.C.5.d</b>	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	<b>Non-Compliance</b>	The DBHDS Office of Licensing’s monitoring protocols do not align with the Agreement’s requirements and its review process is not adequate to determine compliance.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.C.6.a.</b>	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities.	<b>Non-Compliance</b>	Crisis services were not developed for children and adolescents. DBHDS projects services will be operational by August 31, 2104.
<b>III.C.6.b.i.A</b>	The Commonwealth shall utilize existing CSB Emergency Service, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	<b>Compliance</b>	All regions' REACH crisis response services are available 24 hours per day. Referrals occur during business, evening and weekend hours. 16 (17%) of reported referrals were from CSB ES Teams.
<b>III.C.6.b.i.B</b>	By June 30, 2012, the Commonwealth shall train CSB Emergency Services personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.	<b>Compliance</b>	All Regions trained CSB Emergency Services personnel during this period. To maintain compliance DBHDS must fulfill the Independent Reviewer's previous recommendation to provide a plan by June 30, 2014, to train all ES staff.
<b>III.C.6.b.ii.A.</b>	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.	<b>Compliance</b>	Evidence based training was provided to all regions' REACH programs by the University of New Hampshire's START staff.
<b>III.C.6.b.ii.B</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.	<b>Compliance</b>	REACH Teams continue to provide the following components: crisis response, crisis intervention, and crisis planning. Expert review determined that REACH teams responded appropriately to requests. The vast majority of the individuals served remained in their homes. For the few that received an out of home placement, most were able to return and REACH stayed involved with them.
<b>III.C.6.b.ii.C</b>	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with ID/DD comes into contact with law enforcement.	<b>Non-Compliance</b>	The Commonwealth's crisis system has not developed a plan, training, or other guidance for work with law enforcement personnel to resolve crises and prevent unnecessary institutionalization.



<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.C.6.b.ii.D</b>	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	<b>Compliance</b>	All Regions' REACH mobile crisis teams operate at all hours. REACH programs report the time of day of referrals and the time of response. All programs respond on-site to crises.
<b>III.C.6.b.ii.E</b>	Mobile crisis teams shall provide local and timely in home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	<b>Non-Compliance</b>	The Commonwealth has not provided sufficient documentation that this requirement is being properly met. Available data indicate that four of the five Regions may not be offering support for up to three days. See Section IX.C below.
<b>III.C.6.b.ii.G</b>	By June 30, 2013, the Commonwealth shall have at least two mobile crisis teams in each Region that shall respond to on-site crises within two hours.	<b>Non-Compliance</b>	Regions have added staff to existing teams to improve response time. Response time exceeded two hours for 8 (53%) of 15 recent crisis interventions.
<b>III.C.6.b.ii.H</b>	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.	<b>Not due</b>	
<b>III.C.6.b.iii.A.</b>	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services	<b>Compliance</b>	All Regions now have crisis stabilization programs that are providing short-term alternatives.
<b>III.C.6.b.iii.B.</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.	<b>Compliance</b>	Crisis stabilization programs are used as last resort; teams attempt to resolve crises and avoid out-of home placements. Vacancies in homes of other individuals are not pursued (see below).
<b>III.C.6.b.iii.C.</b>	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 the placement if the provider is willing and has capacity 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.	<b>Deferred</b>	The Parties will be asked to determine if this provision should remain. Placing individuals who are in crises into the homes of other individuals with ID/DD is not a recommended practice.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.C.6.b.iii.D.</b>	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	<b>Compliance</b>	All five Regions' crisis stabilization programs comply.
<b>III.C.6.b.iii.E.</b>	With the exception of the Pathways Program at SWVTC ... crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds.	<b>Substantial Compliance</b>	Four Regions' stabilization programs are not located on institution grounds and are in compliance. The Commonwealth reports that the other Region has located and will move to a permanent community-based setting.
<b>III.C.6.b.iii.F.</b>	By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.	<b>Compliance</b>	Each Region now has a crisis stabilization program.
<b>III.C.6.b.iii.G.</b>	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	<b>Compliance</b>	Each Region's existing crisis stabilization program has beds available to meet the needs of the individuals currently receiving crisis services. At least 17% of the available bed-day capacity was not being used .
<b>III.C.7.a</b>	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.	<b>Non-Compliance</b>	Of individuals studied: 17 (85%) of 20 were not offered integrated activities, 20 (95.2%) of 21 did not have employment goals developed and discussed.
<b>III.C.7.b</b>	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy.	<b>Compliance</b>	The Commonwealth has maintained membership in SELN, established an Employment First policy, included the policy as a requirement in its Performance Contracts with CSBs (e.9. page 5.a), and has an employment service coordinator.
<b>III.C.7.b.i.</b>	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreational opportunities, and other integrated day activities.	<b>Non-Compliance</b>	The Commonwealth provided a preliminary plan, but has not developed an implementation plan for integrated day activities.
<b>III.C.7.b.i.A.</b>	Provide regional training on the Employment First policy and strategies through the Commonwealth.	<b>Compliance</b>	The employment services coordinator provided 28 trainings to more than 500 individuals.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.C.7.b.i.B.1.</b>	Establish, for individuals receiving services through the HCBS waivers annual baseline information re:		
<b>III.C.7.b.i.B.1. a.</b>	The number of individuals who are receiving supported employment	<b>Compliance</b>	The Commonwealth provided annual baseline information.
<b>III.C.7.b.i.B.1. b.</b>	The length of time individuals maintain employment in integrated work settings.	<b>Compliance</b>	The Commonwealth provided annual baseline information.
<b>III.C.7.b.i.B.1. c.</b>	Amount of earnings from supported employment;	<b>Non-Compliance</b>	The Commonwealth did <u>not</u> provide annual information.
<b>III.C.7.b.i.B.1. d.</b>	The number of individuals in pre-vocational services	<b>Compliance</b>	The Commonwealth provided annual baseline information.
<b>III.C.7.b.i.B.1. e.</b>	The length of time individuals remain in pre-vocational services.	<b>Compliance</b>	The Commonwealth provided annual baseline information.
<b>III.C.7.b.i.B.2. a.</b>	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year	<b>Compliance</b>	The Commonwealth has set targets to meaningfully increase by 5% annually for five years, from 204 currently enrolled to 2026 in 2019.
<b>III.C.7.b.i.B.2. b.</b>	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	<b>Compliance</b>	The Commonwealth has set the target of 85% of the number of individuals in supported employment to remain employed for at least 12 months is a meaningful increase.
<b>III.C.7.c.</b>	Regional Quality Councils (RQC), described in V.D.5. ... shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly ... Regional Quality Councils shall consult with those providers with the SELN regarding the need to take additional measures to further enhance these services.	<b>Deferred</b>	The employment target data were reviewed by the SELN Advisory Group. The RQCs are now established and shall begin reviewing data during the State Fiscal Year 4 <sup>th</sup> quarter.
<b>III.C.7.d</b>	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.	<b>Deferred</b>	The RQCs were not developed to be able to review the new targets prior to implementation on April 1, 2014.
<b>III.C.8.a.</b>	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	<b>Compliance</b>	Of the Individuals studied, 24 (96%) of 25 were receiving transportation services.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.C.8.b.</b>	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.	<b>Non-Compliance</b>	The Commonwealth completed draft guidelines in June 2013. There is no evidence that the guidelines were published or provided to appropriate agencies. A committee has been formed to update the guidelines.
<b>III.D.1.</b>	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	<b>Non-Compliance</b>	Individuals are primarily offered congregate settings. The plan developed will not meaningfully increase living options that offer most integrated settings. None (0%) of the 30 individuals who moved from Training Centers and were studied in the two recent review periods were referred for rental assistance.
<b>III.D.2.</b>	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 ...	<b>Non-Compliance</b>	The Commonwealth has not facilitated individuals receiving waivers to live in leased apartments or made referrals for rental assistance.
<b>III.D.3.</b>	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	<b>Non-Compliance</b>	The Commonwealth developed a plan, but it will not meaningfully increase access to independent living options. Commonwealth officials have recently described promising housing initiatives to add to the plan.
<b>III.D.3.a.</b>	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations as determined appropriate by DBHDS.	<b>Compliance</b>	A DBHDS housing service coordinator developed the plan with these representatives, and others.

Settlement Agreement Reference	Provision	Rating	Comments
III.D.3.b.i-ii	The plan will establish, for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and Recommendations to provide access to these settings during each year of this Agreement.	<b>Non-Compliance</b>	The Commonwealth's plan estimated through FY15 the number of individuals who would choose independent living options. Recommendations to provide access to these settings each year were not provided.
III.D.4	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing, from a one-time fund of \$800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii,	<b>Non-Compliance</b>	The Commonwealth has established and is prepared to distribute the one-time funds. Distribution of the funds, however, did not begin during the review period. No individuals applied due primarily to the time-limited availability of the assistance.
III.D.5	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	<b>Non-Compliance</b>	Studies during the past year found that 27 (90%) of 30 individuals who moved from Training Centers to placements that were consistent with the individual's, or if applicable the authorized representatives, choice after receiving options. The Independent Reviewer has determined that options received were not consistent with the terms of Section IV.B.9.b.
III.D.6	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant and, under circumstances described in Section III.E below, by the Regional Support Team.	<b>Compliance</b>	The individuals reviewed who moved to congregate settings that were consistent with the individuals' needs and informed choice. For many individuals who chose larger congregate settings, barriers were identified to less integrated setting.
III.D.7	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home (and, if relevant, to their authorized representative or guardian).	<b>Compliance</b>	This term has been included in the Commonwealth's "FY 2013 and FY 2014 Community Services Performance Contract."

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.E.1</b>	The Commonwealth shall utilize Community Resource Consultant (“CRC”) positions located in each Region to provide oversight and guidance to CBSs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office... The CRCs shall be a member of the Regional Support Team in the appropriate Region.	<b>Compliance</b>	Community Resource Consultant positions are located in and are members of the Regional Support Team in each Region and are utilized for these functions.
<b>III.E.2</b>	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.	<b>Non-Compliance</b>	The CRC’s referred 37 individuals in the second quarter of FY 2014. The RST’s did not resolve identified barriers to living in most integrated settings or to receiving integrated day opportunities. Reasons for choosing less integrated residential options include: the lack of needed services, the lack of availability in the area, the lack of safety equipment (i.e. fence), and the severity of individuals’ needs for medical and behavioral supports. Integrated day opportunities are not available.
<b>III.E.3.a-d</b>	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met)	<b>Compliance</b>	DBHDS established the RSTs, which met monthly since March 2013. The CRCs are referring cases to the RSTs regularly. CRCs referred 37 individuals in the second quarter of FY 2014. RSTs frequently recommend more integrated options. See III.E.2. above regarding the RST’s ability to resolve barriers.
<b>IV</b>	<b>Discharge Planning and Transition</b>		
<b>IV.</b>	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	<b>Compliance</b>	Discharge planning and transition processes were implemented by July 2012. Improvements have occurred in response to concerns identified and to the Independent Reviewer’s recommendations.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.A</b>	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	<b>Non-Compliance</b>	Most integrated settings that meet the needs of individuals with complex medical and behavioral concerns are often not available. A sponsored home that meets an individual's needs is often not offered in most regions. Referrals for rental assistance have not occurred.
<b>IV.B.3.</b>	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	<b>Compliance</b>	Individual Review studies during the past year show that 30 (100%) of individuals and their authorized representatives participated. Staff is trained to present information and a support staff, familiar with the individual and their means of communication, provides communication support during discharge planning meetings.
<b>IV.B.4.</b>	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, well being, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	<b>Non-Compliance</b>	Individual Review studies during the past year found that the treatment goals in the support plans for 54 individuals, 39 (72%) and 19 (35%) respectively did not include outcomes that lead to skill development and outcomes that relate to the individuals' talents, preferences and needs. Integrated settings were not provided in most domains of the individuals' lives.
<b>IV.B.5.</b>	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan (developed within 30 days prior to discharge) will include:	<b>Compliance</b>	All 30 (100%) of the individuals studied during the two previous review periods had discharge plans. DBHDS tracks this information and reports that all residents of Training Centers have discharge plans.
<b>IV.B.5.a.</b>	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	<b>Compliance</b>	Documentation of information provided was present in the discharge records for 27 (90%) of 30 individuals studied during the two recent review periods.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.B.5.b.</b>	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	<b>Compliance</b>	The discharge plans continue to include this information.
<b>IV.B.5.c.</b>	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	<b>Compliance</b>	DBHDS refined its discharge planning guidance to ensure that assessments of supports and services needed are included regardless of availability. The discharge records for both individuals reviewed this period included the assessments.
<b>IV.B.5.d.</b>	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	<b>Compliance</b>	Specific providers are listed that can provide identified supports and services.
<b>IV.B.5.e.</b>	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	<b>Compliance</b>	Barriers are documented on the Regional Support Team data collection sheet.
<b>IV.B.5.e.i.</b>	Such barriers shall not include the individual's disability or the severity of the disability.	<b>Compliance</b>	No evidence has been found that an individual's disability or the severity of the disability is a barrier. The availability of providers, housing options, and services that can meet the needs of individuals with severe disabilities in most integrated settings remain barriers.
<b>IV.B.5.e.ii.</b>	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	<b>Deferred</b>	Since October 2011, five individuals were each readmitted once to a Training Center.
<b>IV.B.6</b>	Discharge planning will be done by the individual's PST... Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	<b>Deferred</b>	The facts regarding this provision are inconclusive. Further review will be conducted for the next report to the Court.
<b>IV.B.7</b>	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	<b>Compliance</b>	Individual review studies have not found evidence that complex needs are considered barriers to living in an integrated setting.



<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.B.9.</b>	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	<b>Compliance</b>	Individual reviews during the past 6 months found that 28 (93%) of 30 individuals and their ARs were provided with information regarding community options and the opportunity to discuss them with the PST.
<b>IV.B.9.a.</b>	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	<b>Compliance</b>	Discharge records of individuals reviewed included evidence that a choice of providers was offered.
<b>IV.B.9.b.</b>	PSTs and the CSB case manager shall coordinate with the specific type of community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	<b>Non-Compliance</b>	Individual reviews during the past year found that 28 (93%) of 30 individuals and their ARs did not have an opportunity to speak with individuals currently living in their communities and their families. DBHDS has developed a family-to-family program, but conversations for the individuals studied had not occurred. A peer program does not currently exist, but is being developed.
<b>IV.B.9.c.</b>	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	<b>Compliance</b>	Discharge records indicate that individuals and their authorized representative were assisted and that providers were identified and engaged. For 29 (97%) of 30 individuals studied, the provider staff was trained in support plan protocols that were transferred to the community.
<b>IV.B.11.</b>	The Commonwealth shall ensure that Training Center PST's have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	<b>Compliance</b>	During the past year, studies of individual services found that 28 (93%) of 30 individuals who moved were provided with information regarding community options.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.B.11.a.</b>	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	<b>Compliance</b>	At all Training Centers, training has been provided via regular orientation, monthly, and ad hoc events, and ongoing information sharing.
<b>IV.B.11.b.</b>	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meeting and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches throughout the state will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers	<b>Compliance</b>	All staff receives person centered training during orientation and receives annual refresher training. All Training Centers have person-centered coaches. DBHDS reports that regularly scheduled conferences provide opportunities to meet with mentors.
<b>IV.B.15</b>	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 ...	<b>Deferred</b>	Data about barriers are reportedly submitted and aggregated quarterly, and have been used by DBHDS to develop plans to overcome barriers (e.g. Bridge Funding, enhanced rates) The Regional Quality Councils will begin to review these data this quarter.
<b>IV.C.1</b>	Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.	<b>Compliance</b>	For 29 (97%) of 30 individuals studied during the past year, the residential provider staff was trained in support plan protocols that were transferred to the community and participated in the pre-move ISP meeting.
<b>IV.C.2</b>	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	<b>Compliance</b>	Reviews found that 28 (93%) of 30 individuals moved within 6 weeks, or reasons were documented and new time frames developed.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.C.3</b>	The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	<b>Compliance</b>	The Commonwealth has developed and documented a well organized post move monitoring process. The schedule includes more visits, especially during the first weeks after individual transitions. Post Move Monitors were adequately trained. During the year, individual review studies found that for 29 (100%) individuals Post Move Monitoring visits had occurred and monitoring checklists were used.  Maintaining a compliance rating will require a functioning look-behind process that utilizes a reasonable sample to validate reliability of the PMM process.
<b>IV.C.4</b>	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	<b>Compliance</b>	The Commonwealth had updated the discharge plans within the required 30 days for all 30 (100%) individuals whose services were reviewed during the past year.
<b>IV.C.5</b>	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge from the Training Center.	<b>Compliance</b>	All of the 30 (100%) individuals whose services were studied during the past year had essential supports documented in their discharge plans.
<b>IV.C.6</b>	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.	<b>Compliance</b>	The discharge records reviewed indicated that individuals who moved to settings of five or more did so based on their informed choice after receiving options.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.C.7</b>	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	<b>Compliance</b>	Documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred.
<b>IV.D.1</b>	The Commonwealth will create Community Integration Manager (“CIM”) positions at each operating Training Center.	<b>Compliance</b>	Community Integration Managers are working at each Training Center.
<b>IV.D.2.a</b>	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals;	<b>Compliance</b>	CIMs have reviewed PST recommendations for individuals to be transferred to settings of five or more.
<b>IV.D.3</b>	The Commonwealth will create five Regional Support Teams ...	<b>Compliance</b>	The Commonwealth has created five Regional Support Teams. All RSTs are operating and receiving referrals. The Independent Reviewer has not monitored the ability of the RST’s to resolve barriers or the Commonwealth’s compliance with IV.D.3.a-c.
<b>IV.D.4.</b>	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed ...	<b>Compliance</b>	The CIMs provide such monthly reports and the Commonwealth provides the aggregated information to the Reviewer and the US DOJ.
<b>V.</b>	<b>Quality and Risk Management</b>		
<b>V.B.1</b>	The Commonwealth’s Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals’ needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	<b>Deferred</b>	The Commonwealth made progress during this review period. Planning documents, however, continue to indicate that providers will not be required to report a complete list of risks of harm. A future determination of compliance depends, in part, on identifying, reporting, and addressing risks of harm.
<b>V.C.1</b>	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	<b>Deferred</b>	The Independent Reviewer recommended in his last report that the required list of risk and triggers must include all significant harm and risks of harm.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.C.2</b>	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	<b>Compliance</b>	A web based incident reporting system and reporting protocol was implemented. The Independent Reviewer recommended in his last report that “all allegations of abuse, neglect...serious injuries, and deaths be reported, including for individuals in DD waiver funded services.”
<b>V.C.3</b>	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.	<b>Deferred</b>	The Commonwealth has established a reporting and investigative process. Information about serious injuries and critical incidents are reported and promptly shared with the Reviewer. This process will be reviewed for the next report to the court.
<b>V.C.4</b>	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.	<b>Deferred</b>	The Commonwealth is developing trainings to offer providers in the investigative process and root cause analysis. In his last report, the Independent Reviewer recommended the development of standards for investigators, the investigation process and investigation reports.
<b>V.C.5</b>	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system.	<b>Deferred</b>	A Mortality Review Committee was established under the direction of the DBHDS medical director. It met monthly and completed mortality reviews of unexpected and unexplained deaths reported through its incident reporting system. Information flow has improved, but remains a significant limitation to an effective process. Limited reporting requirements undermine the ability of the Commonwealth to identify trends and to determine corrective actions to reduce mortality rates.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.C.6</b>	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.	<b>Deferred</b>	The Commonwealth's process of investigating reports of harm, of timely reporting, and of implementing corrective actions will be reviewed for the December 2014 report to the Court.
<b>V.D.1</b>	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety.	<b>Deferred</b>	The Commonwealth is restructuring its HCBS waivers and its CMS quality improvement plan. The Independent Reviewer will determine how to evaluate compliance during the transition process.
<b>V.D.2.a-d</b>	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.	<b>Deferred</b>	The Independent Reviewer will determine status of compliance for the next report to the Court.
<b>V.D.3.a-h</b>	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	<b>Deferred</b>	The Commonwealth began collecting and analyzing information in State Fiscal Year 2012. A workgroup is developing the plan to meet the June 30, 2014 due date.
<b>V.D.4</b>	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in ... (specified sections of the Agreement).	<b>Deferred</b>	The Independent Reviewer will determine the status of compliance for the next report to the Court.
<b>V.D.5.a-b</b>	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.	<b>Deferred</b>	Regional Quality Councils were implemented beginning in March 2013 and have met quarterly. An evaluation of the Commonwealth's compliance with this provision will be determined for the next report to the Court.
<b>V.D.6</b>	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability ... and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	<b>Deferred</b>	The Commonwealth has not yet reported publicly on the availability, quality, and gaps in services, or made recommendations for improvement.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.E.1</b>	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement (“QI”) program ...	<b>Deferred</b>	The Independent Reviewer will determine the status of compliance for the next report to the Court.
<b>V.E.2</b>	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.	<b>Deferred</b>	Measures were developed and reported in the Independent Reviewer’s second report to the Court. Regional Quality Councils are being developed and will be reviewed for compliance during the next reporting period.
<b>V.E.3</b>	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.	<b>Deferred</b>	Since the Reviewer’s last report to the Court, the Commonwealth evaluated and modified its implementation plan to comply with the Agreement’s requirements. It will be reviewed for the next report.
<b>V.F.1</b>	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.	<b>Compliance</b>	Of the individuals studied during the past year 55 (100%) were receiving case management services.
<b>V.F.2</b>	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 documents its resolution.	<b>Non-Compliance</b>	The individual study this review period found that 7 (64%) of 11 individuals did not have an individual support plan modified as necessary, and 8 (100%) individuals with mal adaptive behaviors with significant negative consequences did not have needed behavioral support services.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.F.3.a-f</b>	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	<b>Compliance</b>	The individual review study of 27 individuals this period found that all 19 individuals (100%) who met the eligibility criteria for enhanced case management were receiving the required monthly face-to-face meetings.
<b>V.F.4</b>	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	<b>Compliance</b>	The Commonwealth collects and aggregates this information. An expert reviewer determined for this Reviewer's previous report to the court that the DBHDS Dashboard appears to be a valid accountability tool.
<b>V.F.5</b>	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in Section V.D.3.	<b>Deferred</b>	The provision became effective one month prior to the end of the review period for this report. Compliance will be determined during the next review period.
<b>V.F.6</b>	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	<b>Compliance</b>	The Commonwealth developed the curriculum with training modules that include the principles of self-determination.
<b>V.G.1</b>	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	<b>Compliance</b>	DBHDS unannounced licensing inspections occur regularly.
<b>V.G.2.a-f</b>	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.	<b>Compliance</b>	DBHDS established and implemented a licensing inspection process with more frequent inspections.



<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.G.3</b>	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.	<b>Non-Compliance</b>	The DBHDS Licensing protocol does not align with the Agreement’s requirements. Its review process is not adequate to ensure provision of reliable data.
<b>V.H.1</b>	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.	<b>Deferred</b>	The Commonwealth has provided extensive training related to person-centered practices. A core curriculum and the competencies in the required elements of service training have not been developed, nor has the method for determining competency.
<b>V.H.2</b>	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	<b>Deferred</b>	The Commonwealth utilizes coaching and supervision to train staff. It has not developed the curriculum for the statewide training program of the coaches and supervisors.
<b>V.I.1.a-b</b>	The Commonwealth shall use Quality Service Reviews (“QSRs”) to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals’ needs and choice.	<b>Deferred</b>	The Commonwealth redesigned and is implementing its revised plan for QSR to address concerns identified in the Independent Reviewer’s report on December 6, 2013.
<b>V.I.2</b>	QSRs shall evaluate whether individuals’ needs are being identified and met through person-centered planning and thinking (including building on individuals’ strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals’ needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals).	<b>Deferred</b>	The Independent Reviewer will determine the status of compliance for the next report to the Court.
<b>V.I.3</b>	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.	<b>Deferred</b>	The Independent Reviewer will determine the status of compliance for the next report to the Court.
<b>V.I.4</b>	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	<b>Deferred</b>	The Independent Reviewer will determine the status of compliance for the next report to the Court.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>VI</b>	<b>Independent Reviewer</b>		
<b>VI.D.</b>	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with the Parties ... shared with Intervenor's counsel.	<b>Compliance</b>	The DHBDS promptly reports to the Independent Reviewer all deaths and serious injuries, upon receipt of notification. This period, the Reviewer, in collaboration with a nurse, reviewed and submitted seven reports to the Court with copies provided to the Parties.
<b>IX</b>	<b>Implementation of the Agreement</b>		
<b>IX.C.</b>	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented ...	<b>Non-Compliance</b>	Sufficient records were not maintained to document compliance with crisis services, supported employment, or case management.

Notes:

1. The independent Reviewer does not monitor services provided in the Training Centers. During this review period the following provisions related to internal operations of Training Centers were not monitored: III.C.9, IV.B.1, IV.B.2, IV.B.8, IV.B.12, IV.B.13, IV.D.2.b.c.d.e.f. and IV.D.3.a-c.
2. For the Independent Reviewer's next report to the Court, due December 6, 2014, monitoring will be prioritized for the obligations in Quality and Risk Management, Licensing Investigations, Integrated Day Activities, Crisis Services for children, and an individual review study of individuals who have transitioned from Training Centers to the community.

## **DISCUSSION OF COMPLIANCE FINDINGS**

### **A. Methodology:**

The Independent Reviewer requested that the Commonwealth provide data and documentation related to its progress in meeting the provisions of the Settlement Agreement. Throughout the review period, the Commonwealth's progress was reviewed in Parties' meetings and work sessions; through discussions with providers and community stakeholders; through examination and evaluation of prioritized areas; and through site visits to community residential and day programs.

During this fourth review period, the second half of year two of implementation, the Reviewer prioritized the following areas for examination and evaluation:

- New services for individuals with behavioral challenges residing in Region IV or V;
- Integrated Day Activities and Supported Employment;
- Crisis Services;
- Licensing,
- Community Living Options
- Mortality Review

The Reviewer worked with five independent consultants, including four clinical consultants, and utilized a monitoring questionnaire to review the status of services for individuals. Twenty-seven individuals were randomly selected from forty-two individuals residing in Regions IV (Greater Capitol) or V (Tidewater). These individuals had received new waiver-funded community-based services since July 1, 2013. Their prior annual Supplemental Intensity Scale evaluations indicated a need for behavioral support. Of the twenty-seven randomly selected individuals, two had moved from the Southside Virginia Training Center. A new section of the Monitoring Questionnaire was developed to review the planning and delivery of behavior support services. Two-person teams reviewed the services for each individual. One member of each team was a clinician, either a registered nurse with extensive experience serving individuals with ID/DD or a doctoral level Board Certified Behavioral Analyst. The Behavioral Analyst reviewed the services of eight individuals, selected from the twenty-seven individuals due to their histories of aggressive, assaultive or destructive behaviors. Each review included studying service planning and case management records, visiting and observing the individuals (usually in their homes), and interviewing those providing services.

The Independent Reviewer's consultant, Kathryn du Pree, completed two studies. For the fourth time, she reviewed the status of the Commonwealth's compliance with Crisis Service requirements of the Agreement. For the third time, she reviewed the status of the Commonwealth's progress toward meeting the Integrated Day Activities and Supported Employment provisions of the Agreement. Both studies review the status of planning and program development for provisions of the Agreement that the Reviewer had recently determined to be non-compliant and confirm that compliance has been sustained with other requirements. These studies involved reviews of related data and documents and interviews with Commonwealth officials, SELN – VA members, providers, families of individuals served, and other stakeholders.

Patrick Rafter, an independent consultant with extensive expertise in developing community-based housing options for individuals with ID and DD, was retained to review the status of Virginia's "*Plan to Increase Independent Living Options*" and associated progress. His study involved reviewing relevant progress reports and work group minutes, as well as visiting with and engaging in candid discussions with many of those involved at both the state and local levels.

The Independent Reviewer's consultant, Ric Zaharia Ph.D., who previously completed a base line evaluation of the Commonwealth's Case Management services, was retained to complete a study of the Commonwealth's status of compliance with licensing requirements of the Agreement. Dr. Zaharia's evaluation consisted of reviewing documents, including licensing standards and regulations, licensing tools/protocols, licensing survey reports and corrective action plans, and complaint investigations as well as interviewing Licensing Specialists, the Director of Licensing, and a sample of nine service providers selected by the consultant.

The Independent Reviewer examined the Commonwealth's mortality review process. The Commonwealth informed the Reviewer of all deaths of individuals served in the community, including deaths of individuals who had moved from the Training Centers. The Reviewer collaborated with a consultant nurse in reviewing and reporting on four deaths during this review period. The study of the mortality review process was comprised of reviewing the membership, meeting minutes, operating procedures and other organizing documents of the Mortality Review Committee; the system of tracking and reviewing deaths; the data collected; and the Medical Director's mortality reviews. The Reviewer also interviewed three members of the Mortality Review Committee including its chairperson, the DBHDS Medical Director. This review, at this time, did not include the study of whether the findings and recommendations of the MRC were effectively implemented.

Recommendations from these reports/reviews are included at the end of this Report.

Finally, as provided in the Settlement Agreement, the Independent Reviewer provided this report in draft form to the Parties for review and comment prior to submission to the Court.

## **B. Compliance Findings**

### **1. Providing Waivers**

The Commonwealth has created more waiver slots than the minimum required by the Agreement. As detailed in the Summary of Compliance chart (page 4), the Commonwealth has approved funds for these waivers during a challenging fiscal period. These waiver slots were provided to prevent the institutionalization of individuals with intellectual and developmental disabilities who had been on waitlists for services, usually with urgent needs. Waiver slots were also provided to enable members of the target population, children with ID/DD who reside in nursing homes and individuals with ID/DD who reside in Training Centers, to transition to living in the community.

To facilitate the transition of individuals from Training Centers, the Commonwealth advanced a detailed plan. It involved a multiple-step transition process to develop a plan of support for each individual. The plan included a schedule for engaging each individual and his or her family. Staff resources were initially assigned to implement the process and were gradually increased, as needed.

Feedback from post-move monitors and others, including this Reviewer, was used to adjust and improve the process. Since October 2011 through April 6, 2014, more than 300 individuals transitioned from Training Centers to homes in the community. Overall, studies by the Independent Reviewer have concluded that these individuals have adjusted well to their new community homes, live in typical neighborhoods, and had positive life outcomes.

The Commonwealth has not yet implemented plans to facilitate children with ID and DD living in nursing homes and the largest Intermediate Care Facilities to transition to community homes. Although children continue to be admitted to, and discharged from, these facilities, the Commonwealth's work group initiatives have not yet increased the number of children who have transitioned. Authorized representatives of children living in nursing facilities have expressed reservations about transferring their children to community homes because of the lack of nursing and other support services needed to support individuals with complex medical needs in community homes. A revision of the initial plan was reported to be nearly complete when the Reviewer submitted his last report to the Court on December 6, 2013. The Commonwealth received significant feedback with concerns from multiple stakeholders. After distributing the draft of the revised plan, the Commonwealth has further revised the plan to address these concerns. The revised plan will reportedly include initiatives to prevent the unnecessary institutionalization of children. This will be accomplished by identifying those at risk of being admitted to these large facilities; by resolving both short and long term barriers; and by providing needed supports in their homes or least isolated, most integrated setting. By September 30, 2014, for specific children currently residing in nursing homes and other large facilities, waiver slots should be prioritized to enable them to live in, rather than be separated from their communities. The Commonwealth has the benefit of its Training Center discharge planning and transition process to offer effective elements of a transition planning and post-move monitoring processes. The success of the plan will be increased if the range of supports available to individuals transferring from Training Centers is available for children transitioning from nursing facilities. These include Bridge Funds, enhanced rates, 24-hour nursing, customized community programs developed for a specific group of children, and housing supports.

The Commonwealth has provided more than 1300 new waiver slots for individuals, who had been on waitlists for services in the community, to gain access to a menu of needed services. Based on a sample of these individuals' services, a common theme for them and their families is their improved quality of life since receiving services. Reviews confirmed that some needed services are not necessarily available, especially for individuals with complex medical and behavioral needs.

The Commonwealth has taken steps to improve the capacity of community programs to support individuals with complex needs. It has approved Bridge Funds to assist those moving out of the Training Centers. It has requested and, after a lengthy review, received approval from the Centers for Medicare and Medicaid Services to pay enhanced rates to congregate residential providers who serve individuals with complex medical and/or complex behavioral needs. In addition, a national consulting firm is currently reviewing the Commonwealth's waiver structure and rates. It will recommend reforms with the goal of increasing and strengthening the Commonwealth's services for people with complex needs. The Commonwealth also used an RFP process to select providers to work directly with individuals who reside at SVTC and their families. They are developing programs for these specific individuals to facilitate their transition to the community.

With new financial tools, and two years of successfully enabling individuals to transition from Training Centers to the community, the Commonwealth is better prepared to assist children with complex medical needs to move from nursing facilities to integrated settings in their communities.

## 2. Individual Reviews

By the second half of year two, the Settlement Agreement expects individuals with ID/DD to receive HCBS services in the most integrated setting consistent with their informed choice and needs. The Agreement envisioned these individuals receiving core services including case management, integrated day opportunities, and referrals for rental and housing assistance.

The Independent Reviewer's study focused on the new services provided for individuals needing behavioral supports who reside in Region IV (greater Capitol) or Region V (Tidewater). The Reviewer randomly selected twenty-seven individuals (from a cohort of forty-two) with histories of challenging behaviors, who had received new HCBS services since July 1, 2013. The Independent Reviewer expanded the monitoring questionnaire used in studies during three previous review periods. Questions were added to review the planning and use of structured behavioral services and to determine the extent to which each individual's maladaptive behavior impacted their lives. Finally, the Independent Reviewer's consultant, a doctoral level Board Certified Behavior Analyst, visited with eight selected individuals and reviewed their individual service records to contribute to the findings of the study. Although there were individual exceptions, the Independent Reviewer's study of individual services found the following themes and examples of positive outcomes and areas of concern.

**a. New waiver services significantly improved the quality of life for individuals with urgent needs and their families.** The families demonstrated strengths, often making incredible efforts, while providing loving support for their family members.

Among the positive outcomes, all individuals were receiving case management services, including monthly face-to-face visits, as required. Each individual's support plan listed his or her essential needs. Each had a physical examination within the past twelve months and was receiving the medical supports identified in the plan. Twenty-five (92%) of the twenty-seven individuals had a support plan that was current and received the supports identified in his/her plan.

Areas of concern included that seven (25.9%) of the twenty-seven individuals had not been examined by a dentist within the last twelve months and eight (29.6%) individuals needed assessments that were not recommended. Twenty (74.1%) of twenty-seven individual support plans lacked specific outcomes and activities that lead to skill development or other meaningful outcomes.

**b. Structured behavioral supports were not provided to individuals whose aggressive, dangerous, and disruptive behaviors negatively impacted their ability to learn new skills, impeded their ability to participate in their communities, and reduced their quality of life and independence.** Language assessments were not offered to individuals for whom communication aid may reduce problematic behaviors. The behavior supports that were provided lacked essential elements of

behavioral intervention programs, including a Functional Behavior Analysis, objectives to acquire new skills, and data collection to measure progress.

**c. Restrictions were imposed on individuals with challenging behaviors without evidence of external review or approval.** Restrictions (i.e. locked clothing and food) appeared justified to protect individuals from harm, but were not accompanied by plans to teach skills to reduce the need for the restrictions.

**d. Case managers and residential providers did not provide guidance to increase opportunities for integrated activities.** Case managers did not develop and discuss supported employment services and goals or make referrals for rental and housing assistance.

The Independent Reviewer has provided the Individual Review reports to the Commonwealth so that it will review the issues identified for each individual. The Independent Reviewer has asked the Commonwealth to share the reports with the individual's residential or in-home provider and CSB, and to provide updates, by September 30, 2014, on actions taken with regard to the issues identified.

Selected tables with the Individual Review study's findings and the Behavior Analyst's report are attached at Appendix A. The Independent Reviewer has separated findings from the study into tables focusing on positive outcomes and areas of concern. The findings from the Individual Review study are also cited in the Independent Reviewer's comments in the Summary of Compliance.

### 3. Crisis Services

The Independent Reviewer's consultant, whose report is attached at Appendix B, found that the Commonwealth has complied in each Region with the requirements that the crisis service system include the following components: trained mobile crisis teams, CSB emergency services personnel, and crisis stabilization programs. Crisis Services are an important building block of a community-based service system. At the current stage of program and system development, the Independent Reviewer determined compliance for crisis services based primarily on quantitative measures, such as whether the required program components of a crisis system have been developed and are operating in each region. During future review periods qualitative aspects of these program components will be reviewed to determine compliance based on whether the programs are effectively delivered and achieve needed outcomes. During the recent review period, each Region was providing the required program components including crisis response, crisis intervention, and crisis planning for adults. The Commonwealth's crisis system is on a pace to serve more than 600 individuals with ID/DD during Fiscal Year 2014. This is comparable to the number served during Fiscal Year 2013. CSBs and case managers were more aware of REACH crisis services and had worked proactively with individuals with dual diagnoses and their families. During the most recent quarter, case managers were the main referral source for crisis services, an indication that more referrals occurred that were not specific to an emergency, a pattern of a more planful approach to referrals.

The Commonwealth has again not complied with the requirements to provide crisis services for children or to respond to each crisis call within two hours. Data were not available to determine the impacts of the lack of crisis services for children or the delayed responses to crisis calls.

On January 6, 2014, the Commonwealth provided a plan, “My Life, My Community: A Road Map to Creating a Community Infrastructure,” to restructure the operations of its statewide crisis services program. This plan also outlined components of a crisis response system for children. A more detailed plan to develop a crisis service system for children was issued on February 4, 2014. It is positive that the Commonwealth plans to provide crisis services to children using evidence-based models and practices and that it plans to build on existing services and supports through the strengthening of community partnerships. DBHDS requested and received specific proposals from each of the five Regions. The consultant determined that the elements proposed by DBHDS are necessary for effective services, but that each of the five Regions’ plans lacked one, or more, key program component. The missing components that are required by the Agreement include: mobile crisis response, in-home services, and short-term alternatives to institutionalization.

The consultant again found that few individuals with DD, not ID, have utilized crisis services and that the Commonwealth has not planned outreach to individuals with DD and their families.

During the recent period, the Commonwealth continued to make progress with crisis services. It maintained all compliance ratings from previous reporting periods and achieved compliance with other provisions by providing crisis stabilization programs and training CSB Emergency Service personnel in all Regions. For the provisions that have not yet been met, the Commonwealth is embarking on an important transition period. DBHDS is creating standards for its statewide crisis services. It is also developing a monitoring tool and process to ensure that the standards are met. In addition, the Commonwealth will implement a Crisis Response system for children. To help it achieve these important goals and Agreement requirements, the DBHDS is creating a new team to oversee crisis and day services to advance clinical practice.

#### 4. Integrated Day Activities and Supported Employment

The Independent Reviewer’s consultant found that the Commonwealth provided extensive training related to Employment First and that a training module for case managers was developed by the SELN Advisory Group. The Commonwealth gathered baseline annual data and reported it, as required, with the exception of wage information. The Commonwealth has now established meaningful targets to increase the number of individuals in supported employment programs and to track how long they remain employed. It has not yet achieved the very modest targets that were established in March 2013.

The Commonwealth is undertaking a significant redesign of its HCBS waivers for integrated day services, including supported employment. The Commonwealth developed and submitted new service definitions in the recent ID waiver renewal process. With the assistance of a national consulting firm, it is restructuring the rates for services that the Commonwealth will, if approved by the General Assembly, implement in Fiscal Year 2016. There is broad recognition that the waiver structure, definitions, and rates will set the direction and the financial incentives for future program approaches. The training module for case managers will be especially important because both the consultant’s review and the Individual Review Study determined that case managers are not currently implementing and do not appear to understand the Agreement’s requirement to develop and discuss supported employment services and goals annually.



In addition to providing supported employment services, the Agreement requires DBHDS to provide integrated day activities for members of the target population. To date, it has focused on increasing employment opportunities. With rare exception, providers do not offer individuals who are not employed other types of integrated day activities. The Independent Reviewer asked the Commonwealth to develop an implementation plan by March 31, 2014. Such a plan was due during the first year of implementation. DBHDS provided a preliminary plan that described “strategies and activities.” These include creating a vision, definition, a common understanding and aligning policies, procedures, and funding. The plan lacked specificity and depth about how to achieve these goals, which themselves are preliminary. The Commonwealth agreed to provide day opportunities for individuals served “to the greatest extent possible” so they can enjoy the benefits of being part of a community. The preliminary plan pushes the promise of providing non-work integrated day activities two years away, at best. The Independent Reviewer recommends that the Commonwealth expedite its efforts and actions to offer non-work integrated day activities to individuals in the target population and to report quarterly on the number of individuals who have been offered, and have subsequently received, integrated day activities.

## 5. Licensing

The Independent Reviewer’s consultant evaluated the Commonwealth’s compliance with the case management requirement (III.C.5.d.) to establish a mechanism to monitor compliance with performance standards and the licensing provisions (V.G.1.-2.) that require both regular unannounced inspections of all providers and more frequent inspections of providers who meet specific criteria. A copy of the consultant’s report is attached at Appendix E.

The DBHDS licensing system is the primary compliance mechanism for Community Service Board (CSB) case management performance under contracts with the Commonwealth. If the licensing system continues as the primary compliance mechanism, its effective functioning, in accordance with the requirements of the Agreement, is critical to the goal of improving the lives of people with I/DD and to achieving compliance. In recent years, the Commonwealth significantly increased the DBHDS Licensing staff to strengthen its oversight of services, including implementing a mechanism to monitor compliance with the provisions of the Agreement.

The consultant reports several positive findings from his review of the DBHDS monitoring mechanism. The six Licensing Specialists that he selected and interviewed appeared mission driven, well trained, and appropriately qualified to review case management compliance. Among the nine providers selected by the consultant, there was a high regard for Licensing Specialists. Exceptions focused on contested citations and “fair” application of a regulation. The consultant reported that to support the Licensing Specialists, DBHDS has made available sufficient resources with in depth clinical, healthcare and medical consultation. The Licensing Specialist reviews that the consultant examined included appropriate attention to detail and fact gathering, and included clear statements of provider problems that appropriately evolved to corrective action plans. The consultant concluded that providers respected the work of the Licensing Specialists and the Office of Licensing, and, for the most part, agreed in retrospect with the validity of problems identified by Licensing at their agencies. Licensing also contributes to the alerts and system guidances that are generated by DBHDS for individuals, families, case managers, and care givers to increase awareness of risks and problems that may occur while someone is receiving services.

The consultant's evaluation reports several concerns with the DBHDS mechanism to monitor case management compliance with performance standards. The licensing protocols for monitoring case management compliance involve confirming compliance with DBHDS Licensing regulations. Although, the DBHDS regulations align generally, they do not align specifically, with the expectations of the Agreement. The Licensing protocol for reviewing case management involves a review of a small sample of individuals and only the review of documentation from the case managers' records. The consultant concluded that the licensing protocol for reviewing case management services is "not adequate to determine compliance with performance standards and may result in substandard performance not being discovered and opportunities for improvement being missed." In addition, results of licensing reviews are not regularly compiled into a report on trends related to compliance patterns across CSBs.

The consultant determined that the frequency and number of unannounced licensing inspections have significantly increased and are in compliance with the Agreement. The protocols for these licensing inspections, however, do not align the Supports and Services area of the regulations with the requirements of the Agreement. This gap leaves assessment up to Licensing Specialists to interpret, which contributes to reliability problems. Services providers have expressed concerns about a lack of consistent and reliable interpretations of regulations. Under the direction of the Assistant Commissioner for Quality, DBHDS has formed the "Licensing Stakeholder's Workgroup," in part, to study and to respond to these concerns.

The consultant's review also discovered examples of problems experienced by individuals, families and other stakeholders. On the DBHDS website, the list of ID providers with provisional status licenses was incorrect, not all completed investigations and corrective action plans were posted, and the "Submit a Complaint about a Licensed Provider" was not functioning.

## 6. Community Living Options

The Independent Reviewer's consultant, Patrick Rafter, was retained to review the Commonwealth's "Plan to Increase Independent Living Options." Specifically, the Reviewer asked the consultant to determine the connection between the development of accessible and affordable units and the individuals with ID/DD who are receiving waivers; specifically, how did the Commonwealth plan to fulfill its obligation to "facilitate individuals receiving HCBS waivers ... to live in their own home or apartment."

The Commonwealth complied with the Agreement when it developed its "Plan to Increase Independent Living" in coordination with the appropriate agencies and when it submitted the plan on March 6, 2013. This Plan provides a thorough analysis of the challenges to increase housing capacity to meet the needs of the target population. The Plan includes two elements that involve clear deliverables for providing housing units on a schedule: a pilot rental assistance project and the provision of 150 units of accessible/affordable units annually through the LIHTC (Low Income Housing Tax Credit). The consultant determined that both initiatives have problematic elements.

The Commonwealth developed a thoughtful implementation plan for the rental assistance pilot. The consultant concluded, however, that by starting a "pilot project," the Commonwealth has taken off the table, for at least two years, "the option of expanding a rent subsidy program that could be used quickly to access the existing housing market and be directed to specific areas where individuals in the target population choose to locate." He also concluded that the Commonwealth had completed

several important preliminary steps to implementation: an operations manual, an interagency Memorandum of Understanding, and performance agreements with two CSBs. The Commonwealth has monitored implementation of the pilot and adjusted its eligibility criteria. Unfortunately, at the end of this review period, no individuals had applied for the pilot rental assistance program, reportedly because there is no assurance of on-going funding once the pilot project ends. To provide on-going funding for the rental assistance program, DBHDS has recently submitted a budget request, which is subject to the approval of the Secretary, Governor, and General Assembly.

The consultant also determined that the plan to develop 150 accessible/affordable units annually “has no direct linkage to the individuals who will receive the waiver slots” being created. The LIHTC program should be eliminated from the plan, unless the Commonwealth can facilitate individuals receiving waivers to live in the LIHTC units. These units will be accessible to individuals with ID/DD if units are located where needed, if arrangements allow for the time to implement support plans and the resources to ensure that rent is paid. To effectively address this challenge typically requires that units are set-aside for the target population and that active coordination occurs at both the state and local levels. The Commonwealth acknowledges that it has more work to do and has pledged a coordinated and collaborative effort.

It is positive that the Commonwealth prepared and submitted an application for HUD 811 funding to provide housing options for people with disabilities. Development of the application required agencies that have historically not worked together to collaborate. If successful, the development of new housing units through the HUD 811 program, however, will take one to three years.

## 7. Serious Injuries and Mortalities

### A. Mortality Reviews

The Independent Reviewer found that, in December of 2012, the Commissioner of DBHDS established the Mortality Review Committee (MRC), under the direction of its Medical Director. As required by the Agreement, the MRC membership includes the Assistant Commissioner for Quality Improvement and others who possess appropriate experience, knowledge and skills. The MRC has met monthly to review deaths. It implemented a data collection process; began to identify trends, patterns and problems; and took actions to reduce mortality rates statewide. These actions include developing and issuing Safety Alerts and system guidances related to risks identified in reviews. The Mortality Review Committee operating procedures were developed and implemented over several months. Improved performance was evident between the beginning and end of the period reviewed.

The Independent Reviewer determined that the Commonwealth implemented a statewide mortality review process with the basic elements expected of such systems. The DBHDS Mortality Review Committee:

- screens deaths with standard information,
- reviews unexpected and unanticipated deaths,
- includes medical professionals as Committee members,
- reviews and uses mortality review information to address quality of care;
- aggregates data over time to identify trends, and
- takes statewide actions to address problems.

The MRC operating procedures required that information be provided and organized for its reviews. Difficulty in obtaining needed information resulted in the Medical Director and MRC's reviews being based on limited information that significantly reduced the extent of the review possible. As the mortality review procedures were implemented, improvements were made: additional data elements now are collected and a tracking system was implemented to organize the data collected and to monitor the completion of tasks. During the year, DBHDS took statewide action to improve care and safety by posting Safety Alerts related to concerns that have been identified. These include alerts about constipation, choking, psychotropic medications, and holiday season safety. The MRC has not yet determined whether posting Safety Alerts has been effective at improving care related to the identified concerns or at reducing mortality rates.

The elements of the current systems are in the early stage of development. The MRC members described planned improvements. These include gathering and providing more information to allow more thorough reviews. Furthermore, a nurse will be designated to screen all deaths and to serve as an additional MRC member with clinical training and experience.

The Commonwealth has not made significant progress in being notified of the deaths of individuals with ID receiving services under the Agreement who are residing in private homes, unlicensed programs, nursing facilities or in hospitals. As a result, the Medical Director frequently did not have adequate information to complete an informed review; therefore, the information for the MRC to review and analyze about these deaths has been insufficient.

The MRC committee members agree that the implementation of the existing elements of the mortality review process can and should be improved. The provision of more information for the reviews will improve the thoroughness of the Medical Director's and the Mortality Review Committee's reports and the value of their respective findings in determining the priority areas for statewide actions to reduce mortality rates.

B. Independent Reviewer's reviews of serious injuries and deaths of former Training Center residents (V.I.D.). The Commonwealth promptly forwards to the Independent Reviewer all reports of deaths of all individuals with ID living in the community and reports of serious injuries to individuals who moved from Training Centers. Between October 2011 and April 6, 2014, DBHDS has reported the deaths of thirteen individuals who moved from the Training Centers, five of whom died during this review period. The Independent Reviewer, in collaboration with a consultant nurse, has reviewed the deaths of seven individuals. The Commonwealth has provided the Reviewer additional resources to complete the remaining reviews and to keep pace with the reviews of serious injuries and deaths as more individuals transition to the community from the Training Centers. The reports from the completed reviews have been submitted to the Court with copies provided to the Parties and shared with the Intervenor's counsel.

These completed reviews generally found that the Commonwealth's Licensing Specialists initiated timely reviews of reported deaths and that the investigations were opened and investigated within a reasonable period. If, during these investigations, Licensing Specialists identified violations of regulations, the responsible providers were notified and Corrective Action Plans were developed. In the reviews of deaths, the findings and conclusions were consistent with those of the Mortality Review Committee and the Licensing Specialists' investigations.

The Independent Reviewer's reviews of deaths also found individual examples of the reporting and investigation processes not working as expected. Examples include: reports that private providers submitted late and incomplete, investigations that DBHDS Licensing staff did not implement as expected, and corrective action plans which service providers did not complete on schedule. In such cases, the Independent Reviewer has recommended improvements.

DBHDS forwards reports of the deaths of individuals with ID to the US Department of Justice. The DOJ has notified the Commonwealth that its review of the data indicates potential trends in the causes of accidental deaths of individuals with ID in Virginia.

The Independent Reviewer suggests that the DBHDS Mortality Review Committee consider the transparency and accountability benefits of publicly reporting its annual mortality statistics and its annual report with findings, trends and recommendations. It should also consider adding a second external stakeholder; so that at least one external member is present when each mortality review is conducted.

The Independent Reviewer has included mortality review recommendations at the end of this report.

## **CONCLUSION**

The Commonwealth of Virginia, through its Department of Behavioral Health and Developmental Services and sister agencies, has made significant progress implementing key building blocks of a community-based service system for individuals with intellectual and developmental disabilities. It has met, and exceeded, its obligations to create new waiver slots. Since Fiscal Year 2012, the services that resulted from awarding these new slots have significantly improved the quality of life for more than 1400 individuals with intellectual and developmental disabilities and their families. Most have been waiting with urgent needs for many years. The Commonwealth has also developed and implemented a successful discharge planning and transition process and a post-move monitoring program. More than 300 individuals have received needed supports to move from Training Centers and to live in integrated community settings. Although there have been individual exceptions, independent reviews of their services have documented that they now live in typical neighborhoods, have adjusted well, and have had overall positive life outcomes.

At this phase of implementing the Settlement Agreement's obligations, the Commonwealth has achieved compliance with a majority of provisions that were due by this point in time. By developing and operating new required programs during the recent review period, it has newly achieved compliance. Nonetheless, progress toward achieving compliance with other major provisions of the Agreement has not been what was expected or needed by individuals with ID/DD and their families. During the next six months, it is critical that the Commonwealth make major strides in several areas of non-compliance. These areas of systemic reform include developing and effectively implementing plans to develop a statewide crisis service systems for children; increasing community living options; offering integrated day activities; and providing opportunities for children to transition from living in nursing facilities to integrated community settings with needed supports.

As these needed developments occur, the Commonwealth must continue to take deliberate action to build and comply with the Quality and Risk management systems called for in the Settlement Agreement. As these plans are finalized and implemented, the Commonwealth must pay careful

attention to gathering needed data and information, including a complete list of risks of harm, so its quality and risk management system is able to “ensure that all services for individuals receiving services ... 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 ...”

With the change of administrations in the Commonwealth, there are many new leaders in the effort to implement the reforms in the Settlement Agreement. They, and their longer-serving staff and partners in sister agencies, have expressed strong commitment to fulfill the obligations of the Settlement Agreement. With new tools, with lessons learned from two years of implementation, and with new ideas of concrete steps to move forward, the Commonwealth is positioned to make significant progress. The year ahead should be characterized by implementation of strategies to create opportunities for meaningful community integration, to improve the teaching of skills to increase independence, implement a statewide core competency-based training curriculum for all staff, and to develop quality measures to guide future improvements in services and outcomes for individuals with ID/DD and their families.

## **RECOMMENDATIONS**

### Case Management

1. The Commonwealth should report by September 30, 2014, its plan to align its monitoring protocols, and sampling methodology, to document that the case management requirements of the Agreement are being properly implemented.

### Licensing

2. DBHDS should report by September 30, 2014, its plan to fulfill the requirement that the licensure process assesses the “adequacy of individualized supports and services” and to report these data and assessments.

### Community Living Options

3. The Commonwealth should report by August 31, 2014 its revised plan to increase community living options for the target population, including the use of available rental assistance funds.

4. The Commonwealth should report by August 31, 2014, its plan to facilitate individuals receiving waivers to live in leased LIHTC units. The plan should include actions to be taken to ensure careful coordination at the state and local level so that barriers are resolved and access is provided.

### Integrated Day Activities and Supported Employment

5. The Commonwealth should report by September 30, 2014, its plan to provide guidance that ensures that CSB’s and ID and DD case managers, understand and fulfill their responsibility to implement the Employment First Policy. These responsibilities include that employment services and goals must be developed and discussed at least annually and included in the Individual Support Plan.

6. The Commonwealth should report its implementation plan by August 31, 2014, to provide individuals in the target population with non-work integrated day activities to the greatest extent practicable. The plan should include more specific objectives, an implementation schedule, measurable interim milestones, and an indication of the resources it will use to complete the implementation plan.

#### Crisis Services

7. The Commonwealth should report by September 30, 2014, the standards for all Regions' crisis services for children, including each crisis service requirement of the Agreement, . and what it will document to demonstrate that the requirements have been properly implemented.

8. The Commonwealth should report by September 30, 2014, its plan to provide guidelines to appropriate agencies for use in directing individuals with DD to the point of entry to access the Regional crisis services.

#### Behavior Supports

9. The Commonwealth should report by September 30, 2014, its plan to ensure access to quality behavior specialists and supports, and for case management and licensing services' monitoring protocols to include guidance as how to identify risks associated with an individual's aggressive, dangerous, and disruptive behaviors. These includes monitoring if the individual's mal adaptive behaviors negatively impacts on his or her:

- ability to learn new skills
- participate in their communities;
- quality of life and independence; and
- safety (the risk of harm to self, or others)

When provided, the monitoring protocol should confirm that behavior support services include the elements that are considered necessary for good quality assessment, services, staff training, and to measure progress. If restrictions are imposed, such restrictions should be monitored to ensure that they receive required external review and approval, and that the plans include teaching skills to reduce the need for the restrictions.

#### Mortality Reviews

10. The Commonwealth should report by August 31, 2014, its assessment of data about the causes of accidental deaths for 2012 and 2013 and actions taken, or planned, to address areas of concern.

11. The Commonwealth should report by September 30, 2014, its plan to gather and provide to the MRC information related to the deaths of individuals receiving services under the Agreement who die in nursing facilities, hospitals, or non-licensed locations.

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**APPENDIX A**

**INDIVIDUAL REVIEWS  
October 7, 2013 – April 6, 2014**

**Completed by:  
Donald Fletcher, Independent Reviewer  
Elizabeth Jones, Team Leader  
Marisa Brown MSN  
Barbara Pilarcik RN  
Shirley Roth MSN  
Patrick Heick Ph.D.**

## Demographic Information

<b>Sex</b>	<b>n</b>	<b>%</b>
Male	17	63.0%
Female	10	37.0%

<b>Age ranges</b>	<b>n</b>	<b>%</b>
Under 21	13	48.1%
21 to 30	10	37.0%
31 to 40	2	7.4%
41 to 50	1	3.7%
51 to 60	1	3.7%

<b>Levels of Mobility</b>	<b>n</b>	<b>%</b>
Ambulatory without support	24	88.9%
Uses wheelchair	1	3.7%
Total assistance	2	7.4%

<b>Authorized Representative</b>	<b>n</b>	<b>%</b>
Guardian	20	74.1%
Authorized Representative	7	25.9%

<b>Type of Residence</b>	<b>n</b>	<b>%</b>
Group home	9	33.3%
Family home	16	59.3%
Sponsored home	2	7.4%
Nursing home	0	0%

<b>Highest Level of Communication</b>	<b>n</b>	<b>%</b>
Spoken language, fully articulates without assistance	7	25.9%
Limited spoken language, needs some staff support	7	25.9%
Communication device	2	7.4%
Gestures	9	33.3%
Vocalizations	2	7.4%

Below are the positive outcomes and areas of concern related the individuals' healthcare.

<b>Healthcare Items - positive outcomes</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	27	100.0%	0.0%	0.0%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	27	92.6%	7.4%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	26	92.3%	7.7%	0.0%
Is lab work completed as ordered by the physician?	27	100.0%	0.0%	0.0%
If applicable per the physician's orders, Does the provider monitor fluid intake?	11	90.9%	9.1%	0.0%
Does the provider monitor food intake?	19	100.0%	0.0%	0.0%
Does the provider monitor seizures?	12	100.0%	0.0%	0.0%
Does the provider monitor positioning protocols?	16	100.0%	0.0%	0.0%
Does the provider monitor bowel movements?	20	100.0%	0.0%	0.0%
Were appointments with medical practitioners for essential supports scheduled for and, did they occur within 30 days of discharge?	6	100.0%	0.0%	0.0%
If ordered by a physician, was there a current psychological assessment?	9	88.9%	0.0%	11.1%
If ordered by a physician, was there a current speech and language assessment?	8	87.5%	12.5%	0.0%

<b>Healthcare Items - areas of concern</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	27	74.1%	25.9%	0.0%
Are there needed assessments that were not recommended?	27	29.6%	70.4%	0.0%
Does the provider monitor weight fluctuations, if applicable per the physician's orders?	24	83.3%	16.7%	0.0%
If weight fluctuations occurred, were necessary changes made, as appropriate?	18	77.8%	22.2%	0.0%
If applicable, is there documentation that caregivers/clinicians Did a review of bowel movements?	10	80.0%	10.0%	10.0%
Made necessary changes, as appropriate?	7	71.4%	28.6%	0.0%
If applicable, is the dining plan followed?	6	83.3%	16.7%	0.0%
Is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	16	50.0%	43.8%	6.3%
If the individual receives psychotropic medication is there documentation of the intended effects and side effects of the medication?	16	37.5%	43.8%	18.8%

Below are the positive outcomes and areas of concern related the individuals' support plans.

<b>Individual Support Plan Items – positive outcomes</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Is the individual's support plan current?	27	92.6%	7.4%	0.0%
Is there evidence of person-centered (i.e. individualized) planning?	27	96.3%	3.7%	0.0%
Are essential supports listed?	27	100.0%	0.0%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	25	92.0%	8.0%	0.0%
Medical	27	100.0%	0.0%	0.0%
Recreation	27	96.3%	3.7%	0.0%
Mental Health	15	100.0%	0.0%	0.0%
Transportation	25	96.0%	4.0%	0.0%

<b>Individual Support Plan Items – areas of concern</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Has the individual's support plan been modified as necessary in response to a major event for the person, if one has occurred?	11	36.4%	63.6%	0.0%
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her individual support plan?	27	81.5%	18.5%	0.0%
Does the individual's support plan have specific outcomes and support activities that lead to skill development or other meaningful outcomes?	27	25.9%	74.1%	0.0%
Does the individual's support plan address barriers that may limit the achievement of the individual's desired outcomes?	27	14.8%	85.2%	0.0%
If applicable, were employment goals and supports developed and discussed?	21	4.8%	95.2%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Day/Employment	17	70.6%	29.4%	0.0%
Dental	27	71.4%	28.6%	0.0%
Communication/Assistive Technology	11	45.5%	54.5%	0.0%
Has the individual's support plan been modified as necessary in response to a major event for the person, if one has occurred?	11	36.4%	63.6%	0.0%

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

<b>COMPARISON – Case Management</b>			
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.			
<b>1<sup>st</sup> review period 2012</b>	<b>3<sup>rd</sup> review period 2013</b>	<b>4<sup>th</sup> review period 2014</b>	<b>% change +, (-)</b>
46.9% (15 of 32)	88.9% (24 of 27)	100% (19 of 19)	+53.1%

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

<b>Integration items – areas of concern</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Were employment goals and supports developed and discussed?	21	4.8%	95.2%	0.0%
If no, were integrated job opportunities offered?	20	15.0%	85.5%	0.0%
Does typical day include regular integrated activities?	20	10.0%	90.0%	0.0%
Have you met your neighbors?	27	48.1	48.1%	3.7%
Do you belong to any community clubs or organizations?	27	18.5	81.5%	0.0%
Do you participate in integrated community volunteer activities?	27	7.4%	88.9%	3.7%
Do you participate in integrated community recreational activities?	27	22.2%	77.8%	0.0%

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

<b>Residential Staff – positive outcomes Items</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Is there evidence the staff has been trained on the desired outcome and support activities of the individual’s support plan?	26	96.2%	3.8%	0.0%
Is the staff working with the individual as detailed (consider the individual’s Behavior Support Plan or ISP regarding the level of support needed)?	26	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?	26	96.2%	3.8%	0.0%

<b>Residential Environment Items – positive outcomes</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Is the individual’s residence clean?	16	93.8%	6.3%	0.0%
Does the individual appear well kempt?	27	100.0%	0.0%	0.0%

<b>Residential Environment Items – areas of concern</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Are food and supplies adequate?	9	66.7%	33.3%	0.0%
Is the residence free of any safety issues?	9	55.6%	44.4%	0.0%
Is there evidence of personal décor in the individual’s room and other personal space?	9	44.4%	44.4%	11.1%

Below are descriptions of the behavior support needs of the twenty-seven individuals who were studied.

<b>Behavioral Supports Needs</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others?	27	59.3%	40.7%	0.0%
Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment?	27	51.9%	48.1%	0.0%
Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)?	27	44.4%	55.6%	0.0%
Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills?	27	29.6%	70.4%	0.0%
Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence?	27	51.9%	48.1%	0.0%

Heick Ph.D. BCBA-D reviewed the services of eight of the 27 individuals in the study. These eight individuals were selected because their annual Support Intensity Scale assessments indicated the need for behavioral support services. A copy of Dr. Heick's report is follows at Appendix A.1.

<b>Behavioral Supports Needs</b>				
<b>Item</b>	<b>n</b>	<b>Y</b>	<b>N</b>	<b>CND</b>
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?	8	100%	0.0%	0.0%
Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment?	8	87.5%	12.5%	0.0%
Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)?	8	87.5%	12.5%	0.0%
Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills?	8	50.0%	50.0%	0.0%
Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence?	8	87.5%	12.5%	0.0%

7 (87.5%) of the 8 individuals were engaging in aggressive and destructive behaviors. These behaviors impeded these individuals' ability to access a wide range of environments and negatively impacted their quality of life and greater independence. The chart below indicates the previous and current planning for behavior support. One of the eight individuals had a current Behavior Support Plan.

<b>Behavior Support Planning</b>				
<b>Name (see confidential addendum)</b>	<b>Previous Functional Behavior Assessment</b>	<b>Previous Behavior Support Plan</b>	<b>Current Functional Behavior Assessment</b>	<b>Current Behavior Support Plan</b>
1			N	N
2			N	N
3			N	N
4	Y	Y	N	N
5			not provided	not provided
6	Y	Y	N	N
7	Y	Y	Y	Y
8			in development	in development

**APPENDIX A.1.**

**Behavioral Support Summary**

**Completed by:  
Patrick F. Heick, Ph.D., BCBA-D**



To: Donald J. Fletcher, Independent Reviewer  
From: Patrick F. Heck, Ph.D., BCBA-D, Manager, PFHConsulting, LLC  
RE: UNITED STATES v. VIRGINIA, CIVIL ACTION NO. 3:12cv59-JAG  
Date: May 2, 2014

The following *Behavioral Supports Summary* and *Confidential Addendum* were prepared and submitted in response to Donald Fletcher's request to summarize a small sample of reviews completed as part of his larger Individual Review Study. More specifically, the following summary is based upon the reviews of eight individuals, a sample selected from a larger sample (n=27) by Mr. Fletcher, which included visits to each of their homes or residential programs, completed with Elizabeth Jones, on March 8-10, 2014. This summary is submitted in addition to previously submitted Monitoring Questionnaires completed for each of the eight individuals reviewed. As detailed in the Addendum, items on the Monitoring Questionnaires were scored based on information obtained through on-site interviews, brief observations, and/or chart reviews as well as off-site phone interviews and/or reviews of provided documentation (see Confidential Addendum for more specific information). It should be noted that, although items within other sections of the Monitoring Questionnaire were completed (e.g., Section 8 Supplemental Questions as well as Section 9: Supplemental Questions), items within Section 9: Behavioral Interventions were only completed for one individual (#7 in Confidential Addendum) as a currently implemented behavior support plan was only provided for one of the eight individuals sampled.

## **Summary**

### Findings

1. Based on a review of the individuals' service records and other provided documentation, on-site observations, and interviews, it appeared that most of the individuals sampled would likely benefit from formal behavioral programming, or other therapeutic supports, implemented within their homes or residential programs. More specifically, of those sampled, eight (100%), seven (88%), and seven (88%) engaged in behaviors that could result in injury to self or others, that disrupted the environment, and that impeded his/her ability to access a wide range of environments, respectively. However, only two (25%) of the individuals sampled were reportedly receiving formal behavioral programming at the time of the on-site visit (see below for more specific information). A third individual was identified as receiving behavioral supports at the time of the on-site visit, however a formal behavior support plan was not yet in place. Overall, all (100%) of the individuals sampled appeared to demonstrate maladaptive behavior and/or evidenced skill deficits that negatively impacted their quality of life and greater independence. Consequently, it appeared that all of these individuals would likely benefit from positive behavioral or other therapeutic supports. Indeed, in lieu of these types of supports, some families appeared to be designing and implementing programs (e.g., behavior strategies, communication systems) without expert support and guidance.

2. Based on a review of the individuals' service records and other provided documentation, on-site observations, and interviews, it appeared that two (25%) of the individuals sampled (#5, #7) were currently receiving formal behavioral programming. However, evidence of systematic behavioral programming (e.g., current functional behavior assessment, behavior support plan, and/or data collection and regular data review), although reported to be completed and/or in place, was not provided for one of the two individuals. More specifically, verbal reports indicated that a functional behavioral assessment was completed and documentation (i.e., 'Client/Family Service Plan') indicated that a "Behavioral plan will be developed" and "Safety plan will be developed" (i.e., with an expected date of completion of 8/30/13) for one of the individuals (#57) sampled; however, evidence that these were completed and in place was not provided. When evidence of current systematic behavioral interventions was provided (i.e. for #7), current behavioral programming appeared inadequate. A third individual (#8) appeared to require significant behavioral supports, however, although planning was underway, a formal behavior support plan had not yet been implemented. Overall, of the individuals sampled, zero (0%) appeared to have adequate behavioral programming in place.
3. Based on a review of the individuals' service records and other provided documentation, on-site observations, and interviews, it appeared that all of the individuals living in residential programs experienced rights restrictions that were not identified by the residential provider as restrictive and/or necessitating the review by an independent human rights committee. More specifically, of the three individuals sampled living in residential programs (#4, #6, #7), all (100%) experienced restrictive strategies that limited their access to clothing, food, or other items (e.g., sharps). And, although these restrictions might be necessary to ensure their or others' safety or quality of life, these restrictions did not appear to be reviewed and/or approved by a human rights committee (HRC) for any (0%) of the individuals reviewed. It should be noted that evidence suggested that one of the individual's teams (i.e. #4) pursued HRC review for a behavior support plan that had been previously in place. It was unclear if this review included a discussion of the identified restriction.

## **Conclusions**

1. It appeared that most of the sampled individuals were not receiving behavioral supports and/or other therapeutic services that could address unsafe and disruptive as well as skill deficits that would likely improve their independence and quality of life. It was unknown whether or not case managers identified the need for these additional supports, communicated the potential benefits of these supports, and/or facilitated access to these support and services for families.
2. It appeared that, for those few individuals currently identified as receiving formal behavioral supports or behavioral therapy, behavioral programming was inadequate.
3. It appeared that individuals receiving services in residential programs experienced rights restrictions that were not adequately reviewed and/or approved by an independent human rights committee.

## **Recommendations/Suggestions**

1. Consistent with Section V.5 of the Settlement Agreement, the Commonwealth shall “ ... ensure that appropriate services are available and accessible for individuals in the target population ...”. It appears that, in some cases, additional services, such as those provided by behavioral analysts or speech language pathologists, should be available and known to individuals and their families. Consequently, it is recommended that case managers assist families in identifying the need for and, when appropriate, accessing necessary behavioral services or supports (or other).
2. Consistent with Section V.5 of the Settlement Agreement, the Commonwealth shall “ ... ensure that all services for individuals receiving services under this Agreement are of good quality ...”. That is, those individuals receiving behavior supports should receive quality supports. Consequently, it is recommended that the Commonwealth, through the work of their case managers or others, critically examine and ensure the quality of the behavioral supports being provided to individuals receiving those services.
3. Consistent with Section V.5 of the Settlement Agreement, the Commonwealth shall ensure “ ... increased integration, independence, and self-determination in all life domains ...”. That is, individuals should have the ability to independently access items without undue restriction or dependence on staff. Consequently, it is suggested that any potential rights restriction be reviewed and approved by an independent human rights committee prior to their implementation. When rights restrictions are restricted, behavioral programming should be implemented in an effort to reduce the future need for such restrictions.

Respectfully submitted by,

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

**APPENDIX B**

**CRISIS SERVICES REQUIREMENTS**

**By: Kathryn du Pree MPS**

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

***PREPARED BY KATHRYN DU PREE, MPS  
EXPERT REVIEWER  
MAY 6, 2014***

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## **SECTION 1: OVERVIEW OF REQUIREMENTS**

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the crisis services requirements of the Settlement Agreement for the time period 10/7/13-4/6/14. The review will determine the Commonwealth of Virginia's compliance with the following requirements:

The Commonwealth shall develop a statewide crisis system for individuals with ID and DD; provide timely and accessible supports to individuals who are experiencing a crisis; provide services focused on crisis prevention and proactive planning to avoid potential crises; and provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current setting whenever practicable. This will be the fourth review of crisis services and prevention and will focus on the recommendations made by the Independent Reviewer in his report of December 6, 2013.

## **SECTION 2: PURPOSE OF THE REVIEW**

This review will build off the review completed last fall for the review period through 10/6/13 and the recommendations the Independent Reviewer made in his last Report as a result of the conclusions and findings of that review. It will focus on those areas that were not in compliance and the Independent Reviewer's related recommendations. This focus will be on:

- The Commonwealth's ability to serve adults with developmental disabilities in terms of crisis prevention and intervention services ensuring this target population, including those on the waiting list, has case management services to facilitate full access to crisis services and stabilization programs, and access to community supports to prevent future crises
- Outreach strategies to ensure families of individuals with DD are aware of and can access crisis prevention and intervention services
- The Commonwealth's ability to provide crisis prevention and intervention services to children with either intellectual or developmental disabilities. A plan to address this population is to be provided to the Independent Reviewer by 3/31/14. It is to include outreach, education of case managers, referral process, CSB involvement, community supports, a methodology to track the need for out-of-home placement, and placement outcomes for children who are placed out of home.
- The DBHDS' methodology to track training for Case Managers in CSBs serving individuals with intellectual disabilities and actions to train all DD Case Managers by 3/31/14.
- The status of training of CSB Emergency Services workers to be completed by 6/14.
- The Commonwealth's plan to reach out to law enforcement and criminal justice personnel to link individuals with intellectual and developmental disabilities (I/DD) to crisis intervention services to prevent unnecessary arrests or incarceration
- The number of individuals who were removed from their homes to an out-of-home placement during a crisis, the duration of the placement and the number of individuals who were not able to return to their original home or residence.
- The status of establishing the crisis stabilization units (crisis therapeutic homes) in Regions IV and V.

- The impact of changes in the practices of the crisis services and crisis stabilization units on the Commonwealth’s compliance with the prevention, timely response, and in-home service aspects of the crisis system.
- The satisfaction of the families who have used the crisis intervention service system, now called REACH.

**SECTION 3: REVIEW PROCESS**

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

**Document Review:** Documents reviewed included:

1. The DD Crisis Response System: “My Life, My Community”
2. Crisis Response System for Children and Adolescents with ID/D
3. The regional implementation proposals for children and adolescent crisis services
4. The National START Center Semi-Annual Report: 7/1/13-12/31/13
5. State and Regional Quarterly reports for 10/7/13-12/31/14 and 1/1/14-3/31/14

**Interviews:** The Expert Reviewer interviewed the Assistant Commissioner for Developmental Services, Crisis Services State Coordinator, a REACH Program Manager, a Regional REACH Coordinator, and the State Director of the *arc*. I also participated in one meeting of all of the REACH Coordinators. The Expert Reviewer interviewed seven families randomly selected who have used Crisis Services to determine their level of satisfaction and elicit any recommendations they have for improvement. I appreciate 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 individuals with either intellectual or developmental disabilities as part of its obligation under Section 6.a. of the Settlement Agreement that states:

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

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



## **A. REVIEW OF THE CRISIS SERVICES PLAN TO SERVE CHILDREN AND ADOLESCENTS**

The Commonwealth focused on developing these services for adults to date and has not had them available for children and adolescents with ID/D in any coordinated and consistent fashion although there are various supports available in different parts of Virginia to respond to children and adolescents in crisis that may include young people with ID/D.

The Independent Reviewer directed DBHDS to develop a plan for crisis services for children and adolescents with ID/D by March 31, 2014. The plan was to include outreach, education of case managers, referral processes, CSB involvement, community supports, a methodology to track the need for out-of-home placements, and placement outcomes for children who are placed out of home. The DBHDS issued “My Life, My Community: A Road Map to Creating a Community Infrastructure” on January 6, 2014. This document included a section about Children’s Crisis Supports. This plan outlined key components of a crisis response system for children based on the review of children’s crisis programs across the country. These components include:

- ✓ The availability of services 24 hours a day, 7 days per week
- ✓ A multidisciplinary team of staff consisting of clinicians, nurses, case manager, and psychiatrist
- ✓ Mobile Teams trained to assess the crisis, prescribe an appropriate intervention and implement the course of treatment within the family’s home
- ✓ Post crisis time limited supports and services to the individual and/or family
- ✓ Access to hospitalization for stabilization and mental health treatment including health assessments when the child is presenting symptoms indicating s/he is a danger to self or others. The goal is for the child to return home as soon as possible after being stabilized.
- ✓ Access to out-of-home placement in a therapeutic foster home when the crisis cannot be de-escalated in the home, as a last option

The plan defines the role of a Navigator that will be the lead person in each region to coordinate children’s crisis services and will collaborate with an array of stakeholders to develop a regional crisis response system that coordinates existing resources and systems of care to ensure the effective use of existing resources and building upon them as service gaps are identified. Services are to include crisis resolution, comprehensive case management, assistance to families to navigate service systems, demonstrate and train family caregivers and service providers in effective crisis interventions, and observe and enhance these techniques as used by caregivers.

***The Mission of the crisis response system for children is:***

***To assist families and their support systems in developing and maintaining a stable and happy home for children who have been identified as having an intellectual or developmental disability.***

***The Target Population is children and families with children under eighteen years of age who have experienced a crisis event that their family and support system need assistance to resolve.***

DBHDS anticipates that the children's crisis response system will teach caregivers the warning signs of impending crises and strategies to avert the crisis; phone support; crisis de-escalation; development of a short-term crisis support plan; medical screening and referral; family and support system assessment and the development of a comprehensive support plan; training for crisis plan implementation; behavior assessment or functional analysis; parent training; intensive in-home respite services; services and supports linkages; alternative placement in a therapeutic foster home; and referrals to inpatient hospitalization when necessary to insure the safety of the individual, family and support system. DBHDS anticipates the children's crisis response system being developed in four phases beginning with the department's notification of funding (3/14):

**Phase I:** 3 months from notification of funding (3/14)- Hire the Regional Program

Developer/Navigator: 3 months

**Phase II:** 3-6 months- Hire or contract for the Child Coordinator and the Child Community Professional. Launch services in July 2014

**Phase III:** 6 months- possible program expansion based on the needs identified in the first six months of operation. A decision will be made about expansion and cross-training REACH clinical staff in providing or developing supports to enhance the comprehensive system.

**Phase IV:** 2-3 years- program expansions based on documented need for crisis services.

**Timelines:** Timelines are set in the plan for establishing implementation milestones, hiring and training children's staff, developing a communication strategy and doing home modifications. All of this was to be accomplished by 3/31/14. Regions were asked in March to submit their specific proposals and these were due on March 14, 2014. I review these plans and summarize my conclusions in Table 1. None of the timelines set in the January 2014 plan have been met. Full implementation is anticipated for August 31, 2014.

A more detailed planning document, "*Crisis Response System for Children with ID/D*" was issued by Connie Cochran, Assistant Commissioner, Division of Developmental Services, DBHDS, on February 4, 2014. While acknowledging it is not a road map, it describes the purpose of a crisis response system for children, how DBHDS will establish children's crisis operations, and the expectations and timeline for regions submitting proposals to secure funding and departmental approval of individual regional initiatives. Key elements to be addressed in the plans are:

- ✓ Identify the Program Developer
- ✓ Detail the use of evidence based practices or models
- ✓ Detail how resources will be leveraged to reach all parts of the region with evidence based services or treatment
- ✓ Identify how the region will determine which target priority population the program will serve
- ✓ Identify the initial sub-populations to be served through age 17 who may also have co-occurring mental health or behavioral health problems; be involved in the juvenile justice or court systems, have a history of frequent use of emergency services; have required long-term mental health supports; or have a history of hospital admission for mental health treatment.

Funding will be provided to each region through FY15 with a base allocation of \$225,000. Additional funding may be available and each region was to submit budgets through FY16. Examples are provided of the type of services that *may* be included (italics mine). These are mobile crisis response, intensive in-home support, child psychiatry, evidence based treatment team models. This list of services is prefaced that they are examples of services that should be funded.

I will next provide a summary of the regional proposals evaluating them compared to the DBHDS expectations and those articulated by the Independent Reviewer in terms of his expectations of the crisis response system for children. I want to comment on the DBHDS plan before reviewing the regional proposals. It is a positive step that DBHDS is creating a plan to provide crisis services to children and adolescents with ID/D. Expecting the regions to develop a plan that uses evidence-based models and practices and that builds on existing services and supports through the strengthening of community partnerships provides the right direction. However, there is not a consistent message or expectation set for the regional proposals to fulfill the Agreement's Crisis Services requirements for a statewide crisis system with in-home and community based services, mobile response in two hours, and short term alternatives to institutionalization.

The DBHDS expectation of specific services is more detailed in its "My Life, My Community" Plan. All of the supports that are articulated in the plan are not included in the request for proposals used on 2/4/14. This may be due to the foundation of this initiative, which is to build upon the existing supports and services that are available in each region for children with ID and DD who experience a crisis. However the request for proposal does not require regions to identify all that exists currently in their region, who it is available to, if the capacity is sufficient to meet the need and then identify how the region will use the funding from DBHDS to supplement existing services and address gaps so that all the components of the ideal crisis response system will be available over time. Each region proposes to complete a needs assessment as its first phase of development. Four of the five regions include resource identification and a gap analysis as well as a determination of the projected needs of children and adolescents for crisis intervention. Region IV should also complete a gap analysis as part of its needs assessment. Region III needs to conduct a needs assessment.

The DBHDS needs to clarify its expectations of the children's crisis response system so that each region is offering the full range of required crisis services and supports to individuals with an ID/DD diagnosis that are required by the Agreement, realizing that the provider and/or funding sources for these services may differ across regions.

The DBHDS also needs to clarify the expectation that all children and adolescents through age of seventeen will have access to the children's crisis response system. The Development of Child ID/D Crisis Services from the Assistant Commissioner includes conflicting information. It first states that the DOJ Settlement Agreement requires DBHDS to fully fund a crisis stabilization program by FY14 for children under the age of 18. The Development of Child ID/D Crisis Services includes a request that the region determine/narrow down which target populations the program will serve as part of the key elements to address. At least one region plans to serve only adolescents and does not respond to the full age range of children and adolescents. If the narrowing of the population infers that a region can select from among the factors of having a mental health or behavioral problem, being involved with the court system, using emergency response or inpatient services, that is unresponsive to the Settlement Agreement.

**TABLE 1: SUMMARY OF THE REGIONS' PLANS FOR CRISIS SERVICES FOR CHILDREN AND ADOLESCENTS**

PLAN ELEMENT	REGION I	REGION II	REGION III	REGION IV	REGION V
Timelines	Yes	Yes	No	Yes	Yes
Budget	Yes	Yes	No	Yes	Yes
Program Model	Yes	Yes	Yes	No	No
Needs Assessment	Yes	Yes	No	Yes	Yes
Gap Analysis	Yes	Yes	Yes	No	Yes
Community Linkages	Yes	Yes	Yes	Yes	Yes
Formal Agreements	No	No	No	Yes	No
Target Group	Yes	Only 16-18	15-17 Initially	Yes	Yes
Outreach	Yes	No	No	No	No
Referral Process	Yes	Yes	Yes	Yes	Yes
Csb Role	Yes	Yes	Yes	Yes	Yes
Cm Training	No	No	No	No	No
Data Collection	Yes/Not Specific	Yes	Yes	Yes/Not Specific	Yes/Not Specific
Staffing	Yes	Yes	Yes	Yes	No
Training	Yes	Yes	Yes	No	No
Mobile Child Crisis Response	Yes	Yes	Yes	Yes	No
Psychiatric Services	Yes	Yes	Yes	Yes	Yes
In-Home Services	No	No	Yes	Yes	No
Respite Services	No	Yes*	No	Yes	No
Out Of Home Alternatives	Yes	Yes*	No	Yes	No
Hospital Access	Yes	No	No	Yes	No

**Region I** has a fully developed proposal that includes tele-psychiatry in addition to contracting for child psychiatric services. The focus is placed on crisis assessment and coordination of services. The proposal indicates using the START model but does not specifically state whether in-home or respite services will be available.

**Region II** includes a unique plan to provide training about the Autism Spectrum Disorder for providers, families, and health professionals. Region II plans to collect data about children under the age of 17 but currently has no plans to serve or coordinate services for all children in crisis. Region II also notes to limitations of the current budgetary allocation to serve all children with ID or DD in need. Respite services and out of home placement are noted with an asterisk because there is mention of out of home crisis stabilization but no detail to determine how this will be provided and if this includes respite.

**Region III** did not include a budget or a specific timeline but did indicate that funding is requested for staffing. The Region is proposing to fund family crisis support grants to help families with financial hardship. There is no discussion of out-of-home services or access to psychiatric hospitalization. Psychiatric services will be available through tele-psychiatry but no additional psychiatric consultation is included.

**Region IV** does not have an evidenced-based program model. Training is mentioned but is not at all detailed, which is why it is noted in Table 1. It does detail the availability of respite services and also proposes to offer crisis support funding for families.

**Region V** does not include an evidenced-based practice model to serve children and adolescents. The proposal references training but provides no specificity. Services are listed in the budget document in terms of their relationship to funded Medicaid services but the proposal does not specify any or them of how they will be provided. The Region is only requesting funding for one position, the Children's Crisis Program Developer but no other staffing support is proposed.

**Conclusions:** The DBHDS has developed a plan to serve children and adolescents and has set an expectation that services and supports will begin to be implemented by July 2014. However, there is no requirement of the REACH Programs to create standardized crisis services systems for children and adolescents across the regions. The funding available was not determined based on an analysis of the need and regional proposals indicate the need for additional funding. Of particular concern is the lack of outreach to families, no plan to train case managers, and no consistent data collection requirements. The DBHDS is providing initial funding but it is impossible to know if the level of funding is adequate until the needs assessments and gap analyses are completed. The Commonwealth is not in compliance with *Section III.C.6.a.i, ii, and iii* of the Settlement Agreement because crisis services are not systematically in place and available to children and adolescents.

**Recommendations:** The DBHDS has developed a road map to initiate the planning process for serving children and adolescents with I/DD who are in crisis. The elements it proposes are necessary for effective services to be developed. It needs to insure that all of the regions develop and implement a standardized crisis services system for all individuals with a diagnosis of ID or DD. While regional differences exist in terms of the existing capacity and expertise to serve children and adolescents, it is important that the same expectations are set by DBHDS for each regional program and that the regions are monitored to insure consistent implementation. The DBHDS should create standardized requirements for:

- ✓ Serving all children and adolescents up to the age of 18 who have ID/D and experience a crisis
- ✓ The continuum of services to include mobile crisis teams, in-home support, respite and access to crisis stabilization and hospitalization
- ✓ Core staffing
- ✓ Core training for team members, case managers, providers and CSBs
- ✓ Outreach to families
- ✓ The data elements to be tracked to determine if outcomes are being achieved
- ✓ Program evaluation

I remain concerned about the access that children and adolescents with DD will have for crisis services. CSBs are the point of contact for children with ID and children with DD who also have a mental health diagnosis. The needs assessment should include a review of children and adolescents with DD who may be prone to behavioral crisis who may not have a psychiatric diagnosis. The Semi-Annual START Report for July - December 2013 indicates that 29% of adults referred to START do not have a psychiatric diagnosis. If there is a similar referral pattern among children and adolescents DBHDS will need to create referral and access protocols for them.

## **B. REACH SERVICES FOR ADULTS**

Regions continue to serve over 100 individuals per quarter as of the 2<sup>nd</sup> quarter for FY14. Joan Beasley reports they are on pace with START expectations and she believes VA will serve almost 600 individuals during FY14 which is comparable to FY13. As of March 31, 2014, the REACH Program has served 1014 individuals out of 1041 individuals who have been referred.

During the second and third quarters a total of 165 new individuals were referred to REACH. The number of referrals is uneven in that sixty-nine individuals were referred in the second quarter and ninety-six were referred in the third quarter. Referrals are no longer pre-dominantly from families and secondarily from group homes. In this reporting period, Case Managers made 30% (21) of the referrals in the second quarter and 50% (48) of the referrals in the third quarter. This is a strong indication of the system taking hold with the CSBs and the Case Managers becoming more aware of REACH services and working proactively with individuals with dual diagnoses and their families.

Only 5% of the individuals have normal or borderline intelligence, which for the time period Dr. Beasley reported on totaled twelve individuals. It remains a concern that there is no plan for outreach to families of individuals with DD. The Independent Reviewer continues to ask the DBHDS to develop an outreach plan to the DD community. The one family member I spoke with whose son has DD, was referred by the police who were called to her home. Her son has no case manager as he is on the waiting list for the DD Waiver. He has still not been provided with a case manager.

The Independent Reviewer asked DBHDS to report on the outcomes for individuals who are hospitalized as a result of the crisis and what involvement START had with them prior to and post hospitalization. DBHDS is to report if these individuals eventually return home or if an alternative placement needs to be located for them. Nineteen individuals were hospitalized in the second quarter and ten individuals during the third quarter. Out of a total number of referrals of 178 individuals with final dispositions this represents 16%. The DBHDS was able to report on the information about seventeen of the individuals. Of the seventeen, REACH was involved with all but three who did not want services. Twelve of the individuals returned home and new placements in the community were found for two of them. The availability of this data is encouraging as is the involvement of REACH with individuals who are hospitalized. DBHDS needs to ensure reporting from all five regions on this data in the future.

Training is not required of ID or DD Case Managers. REACH Program staff do train CSB Case Managers and there is a training module on the web that can be accessed by ID or DD Case Managers. The Assistant Commissioner reports that DBHDS is determining if it will require this training and may use a Train the Trainers model so that each CSB has the capacity to train new Case Managers. I highly recommend that the DBHDS adopt this approach using a standardized training module and making the training a requirement in the CSB Performance Contracts. DBHDS now oversees the DD Waiver. REACH training should be provided to all DD Case Managers and should be required.

The REACH programs for individual age 18 and older are being designed to maintain the requirements of the settlement agreement as Regions III, IV, and V transition from START to REACH. The requirements are detailed in "My Life, My Community". The services and supports offered through START will continue and the regions will emphasize more in-home support in immediate response to a crisis. As an example, Region III reports it will increase the availability of in-

home supports from seventy-two hours as START offers to fifteen to thirty days to stabilize the situation.

DBHDS has requested that Joan Beasley, PhD develop standards for the program before the contract between DBHDS and the national START Program at UNH ends on June 30, 2014. She will collaborate with VCU so that they can monitor the provision of these services starting in FY15. If these standards are in place, if they align with the requirements of the Agreement, and if the teams continue to be trained in and effectively implement evidence-based practice, the REACH program model will meet the expectations of the Settlement Agreement for adults.

**Conclusions:** The DBHDS is not in compliance with *Section III.C.6.a.i, 6.a.ii, and 6.a.iii*. As I note above many elements are in place for adults with ID and the REACH teams are meeting the expectations for serving this specific population. However, DBHDS does not have a statewide crisis system in place for children and adolescents who experience a crisis. Nor can DBHDS assure that it is reaching all of the individuals with DD who need and may benefit from the crisis system.

**Recommendations:** The DBHDS should move ahead with its plans to develop a statewide coordinated crisis response system for children and adolescents and standardize its expectations across the five regional programs. DBHDS should determine how many of adults with DD are at risk of a crisis due to a dual diagnosis or who experience significant behavioral issues (one approach would be to complete a SIS for every individual who is on the DD Waiver, or if already available analyze the results). This information should be used to develop a targeted outreach program and to project future utilization of the crisis response system to enable a determination to be made of whether the REACH program is effectively responding to the needs of this group. Training should be required of all Case Managers.

### **C. The Survey of Families Using REACH**

This review included a pilot of the START Stakeholder Perception Survey, which is used nationally by the Center for START Services. The intention was to conduct a telephone interview with a small sample of ten families to get a sense of satisfaction, and more importantly, to determine if this survey can be a useful tool for future reviews of crisis response services and if it can be used across a broader sample using either a telephone or mailed survey method. I asked the Regions to provide the names of all the individuals who used REACH services in the past three months. I randomly selected three names and sent the guardian or family contact a letter of introduction explaining the purpose of the review of Crisis Response Services in Virginia and requesting they participate in a telephone survey. I contacted a total of fifteen families in the hopes of conducting the survey with ten of them, two from each Region. I have spoken to seven of the families. While this is far too small a sample to draw any conclusions about the program it is of value to note that the range of services and supports offered by REACH are being provided and that of this small group there is general satisfaction with REACH. All of the families would recommend REACH to other families.

There are individual comments and circumstances that are of interest but cannot be generalized to the individuals receiving crisis support through REACH. One individual has been hospitalized and the family is seeking an out-of-home placement once the individual is stabilized. Another individual is awaiting hospitalization but there is not a current vacancy. In that case the family plans for the family member's return. One individual has DD and was referred by law enforcement that responded to a

call at the home. Because this individual is not yet on the DD Waiver there have not been any linkages with ongoing community supports after the helpful intervention of the REACH program. Families interviewed are generally very satisfied with REACH services. One concern was expressed about the amount of in-home support that was offered during a crisis. The family worked and need someone at the home during his or her working hours but were unable to receive that amount of in-home support. Families appreciate the availability of the crisis stabilization units for both emergency and planned respite. The only comments were about the incompatibility at times of the individuals using the REACH crisis stabilization unit and the cancellation of planned respite as a result of individuals with an emergency. The overall satisfaction and the delivery of the full range of crisis response services is a positive indication that REACH is providing successful crisis interventions.

Below is the summary of the responses to this telephone survey in **Table 2**.

**Table 2: START ADULT CONSUMER/FAMILY PERCEPTION SURVEY**

In order to provide the best possible services, START needs to know what you think about the services you received during the last six months and the people who provided it.

1. When was your most recent encounter with START?
  - Within the last week   1
  - Within the last month   2
  - Within the last three months   5
  - Within the last six months
  - Within the last year
  
2. What service/s did you receive from START? (**Check all that apply.**)
  - Consultation   7
  - Crisis intervention   5
  - Crisis plan development   5
  - Team planning   3
  - Caregiver education and training   3
  - Planned respite   4
  - Crisis respite   2
  
3. During a crisis what type of response was provided by START? (**Check all that apply.**)
  - Phone consultation   4
  - On- site consultation   5
  - On- site crisis intervention   7
  
4. What was the outcome of START intervention?
  - Was able to stay at home   6
  - Went to crisis respite   1
  - was admitted to a community hospital   1
  - Was admitted to a state hospital   0
  - You were connected to someone else who could help you?   0

**For Questions 5-17 the Scale is: Extremely, Very, Slightly, or Not At All**

5. In general, how timely was the START response to your request for assistance during a crisis?  
Extremely: 1 Very: 5 Slightly: 1
  
6. Were you satisfied with the outcome that START provided?  
Very: 6 Slightly: 1
  
7. In general, how helpful was START involvement to you?  
Extremely: 2 Very: 4 Slightly: 1



8. How knowledgeable was the START coordinator who helped you?  
Extremely: 2 Very: 5
9. How helpful was START in the development of a crisis plan?  
Extremely: 1 Very: 3 Slightly: 1 Not Applicable: 2
10. How effective was the crisis plan?  
Very: 4 Slightly: 1 Applicable: 2
11. How timely was the development of the crisis plan?  
Very: 5 Not Applicable: 2
12. How effective was START in training providers and others in the crisis plan?  
Extremely: 1 Very: 3 Not Applicable: 3
13. Were training and education events helpful?  
Very: 1 Not Applicable:
14. Was staff knowledgeable of topics presented?  
Very: 1 Not Applicable: 6
15. How helpful were the activities provided at the START respite house?  
Very: 3 Not Applicable: 4
16. How knowledgeable was staff of the START respite house?  
Very: 3 Not Applicable: 4
17. Overall, how satisfied are you with the services to you received through START?  
Extremely: 1 Very: 4 Slightly: 1
18. Would you recommend START services to others?  
Yes 7 No \_\_\_\_\_

**Recommendations:** Input from families who use REACH services is important to determine compliance with the Settlement Agreement. It is valuable to have this perspective to determine if the REACH Regional Programs continue to provide the full range of crisis supports expected, and if the program is successfully assisting families during crises and stabilizing individuals experiencing a crisis so they can stay in their home or return after short period of out-of-home crisis intervention. I recommend that future reviews include more in-depth reviews of a statistically valid sample of individuals using REACH. Each individual review should include a record review, interviews with case managers and REACH Coordinators, and satisfaction surveys with families.

## **SECTION 5: ELEMENTS OF THE CRISIS RESPONSE SYSTEM**

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

i. *Crisis Point of Entry*

A. *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.*

REACH continues to be available 24 hours each day to respond to crises. During the second quarter of FY14, fifty-nine referrals occurred during business hours, six during evening hours and four during weekend hours. The CSB ES Teams made nine referrals out of forty-one reported. Twenty referrals were not reported in terms of the source. Data is missing from Region III so information for 35 individuals cannot be included in this analysis.

Ninety-six referrals were made to START during the third quarter of FY14. Eighteen of these were after normal business hours including twelve referrals during weekday evening hours and six referrals made during weekend hours.

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

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

The Regions continue to train CSB ES staff and report on this quarterly. During this reporting period all Regions provided some training to CSB ES staff. The new reporting format initiated in Quarter 3 requires the regions to report the number of CSB ES staff trained. The total for this quarter was thirty-four. Training occurred in Regions II, II, IV and V. During the second quarter all regions provided some training to CSB ES staff.

The Independent Reviewer has requested a plan from DBHDS by June 30, 2014 that will specify that all CSB ES personnel will be trained using a standardized curriculum and this training will be tracked.

**Conclusion:** The Commonwealth is currently in compliance *with Section III.C.6.b.i.B*. To remain in compliance requires the submission of an acceptable training plan that assures all CSB ES staffs are trained to the Independent Reviewer by June 30, 2014. The plan should also include a tracking methodology. For prior reviews, DBHDS provide reports that included the total number of ES CSB staff who were trained and the number remaining to be trained. This level of detail was not available in the reports provided for this review period.

**Recommendation:** The CSB contracts should contain a provision regarding mandatory training of both CSB ES personnel and Case Managers and a reporting requirement to insure newly hired ES team members and case managers are trained in the future.

*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.*

Through December 2013 START UNH continued to provide training to all of the regional programs using evidenced based training. Regions I and II are continuing their contracts with UNH and will continue to have staff trained by the national START trainers. Connie Cochran, Deputy Commissioner expects that Regions III, IV and V will sub-contract with Regions I and II for this training or get it directly through UNH. He reports that the REACH standards will require this training so DBHDS needs to provide documentation of this for the next review. DBHDS is creating a new team to advance clinical best practice. The team will oversee crisis services and

employment. It will include a Behavioral Psychologist Level III who has a background in dual diagnosis. Dr. Beasley is working with VCU to create standards for the REACH program to be completed by June 30, 2014. These standards will include training requirements for START team members.

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

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

The teams continue to provide response, crisis intervention and crisis planning. During the second quarter sixty-nine services were requested at the time of referral including consultation, comprehensive evaluation, cross system crisis planning, emergency response services and emergency respite. While the report notes that sixty-eight individuals received follow-up as requested, the services requested are unreported for twenty of the individuals. During the third quarter ninety-six individuals requested specific services and ninety-four received the services requested during the quarter. In this reporting period the number of unreported requests dropped to four. Individuals requested consultation, cross system crisis planning, emergency response services, in-home support, planned respite and emergency respite. The REACH teams responded appropriately.

**Conclusion:** The Commonwealth is in compliance with *Section 6.b.ii.B.*

*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*

No referrals from law enforcement are reported in either the second or third quarter although one family interviewed whose son has DD was referred by a police officer.

Regions do report on training and outreach to law enforcement personnel.

- ✓ Region I trained one law enforcement team
- ✓ Region II trained Prince William County and Loudoun County law enforcement departments
- ✓ Region III developed a training schedule with regional and local law enforcement departments
- ✓ Region IV trained law enforcement personnel in Richmond and trained twenty-four officers in another department. REACH staff is compiling a listing of all police departments in the Region IV catchment area and will reach out to offer training
- ✓ Region V did not report any training with law enforcement personnel

The DBHDS has not responded to the Independent Reviewer's request to develop a plan to insure that all law enforcement departments receive training in the REACH program. To date there has been no plan submitted that provides a schedule by when a module about REACH will be formally added to all CIT training or will be offered to all law enforcement departments through another method.

**Conclusions:** The Regions are making progress by providing training but I do not find the Commonwealth in compliance with *Section 6.ii. C* until there is an implementation and schedule to train all law enforcement departments that is completed in a reasonable time period.

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

As reported in Section 4.B, the REACH Mobile crisis teams are available around the clock and respond at off hours. During the second quarter reporting period the CSB ES teams referred nine individuals to REACH, representing 13% of the referrals. This number increased during the third quarter to 16 individuals, which is 17% of the individuals who were referred to REACH.

During the second quarter 111 crisis assessments were conducted. The assessments were conducted in the individual's home for forty-six of the referrals which is 41%. Another twenty-eight individuals were assessed through telephone consultation. Twenty-five individuals had to leave their homes to be assessed at an emergency room, clinic or the START office, with the majority evaluated in the ER. Sixty-nine crisis assessments were completed during the third quarter, of which twenty-nine were done in the person's home and fifteen were done through a telephone consultation, representing 64% of the individuals assessed for a crisis. Sixteen individuals were assessed in either an emergency room, clinic or at the START office. In the second quarter 20% of individuals were assessed out of their home while during the third quarter this increased to 23%. In both quarters 13% of individuals were recorded on the other or unreported category. It will be helpful if future reports can provide an explanation of the "Other" category and if DBHDS follows up on those in the "Unreported" category for all areas of reporting.

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

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

DBHDS is not collecting or providing data on the amount of time that is devoted to a particular individual. The only report of this information is included in the second quarterly report from Region II. This region provides an average of 4.7 days of in-home respite. One family who participated in the telephone satisfaction survey reported getting fewer hours of in-home support than they felt they needed. Over a 15-day period the START staff provided in-home support on 3 occasions. This is not necessarily indicative of a pattern, but may point to the need for further review.

DBHDS was able to provide a summary of the number of individuals receiving in-home supports during the third quarter of FY14. Regions vary significantly in the number of individuals served and the number of hours of in-home support provided by REACH staff that is depicted in **Table 3**. The average number of hours of support individuals received is twelve. In four of the five regions fewer than ten hours were provided but the number of hours provided in Region I that was 43.5, skews the average. It is striking that there is such disparity between the numbers of individuals served in four of the regions compared to Region III. It is difficult to compare this information to the data provided in the REACH statewide quarterly report. There were a total of ninety-six referrals during this quarter of which fifty-two were referred for Emergency/Crisis Services. A total of 204 individuals received in-home support with the vast majority served in Region III..

**Table 3: REACH In-Home Services During the Third Quarter of FY14**

<b>Regions</b>	<b>Number of Individuals</b>	<b>Number of Hours</b>	<b>Average Number of Hours</b>
Region I	20	870	43.5
Region II	4	36	9
Region III	159	1280	8
Region IV	21	181	9
Region V	14	63	4.5

**Conclusion:** There is insufficient data to determine if the Commonwealth is compliance with the requirement of *Section III.6.C.b.ii.E*. This also places the Commonwealth out of compliance with Section IX.C. It does not appear that up to three days of in-home support and the option of three additional days is being offered in at least four of the five regions. I cannot make a determination that the Commonwealth is in compliance with this section without more data about the needs of the individuals and the period of time the in-home supports were provided.

**Recommendations:** DBHDS should include this information in all future quarterly reports and future reviews should include a sample of individual plans for crisis services and information of the services actually provided.

*F. 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*

Regions have not created new teams but have added staff to the existing teams. Determinations will need to be made in the future if this is sufficient capacity to provide the needed crisis services and to respond in the required time period.

During the 2<sup>nd</sup> quarter there were only 15 referrals for crisis intervention. The regions responded to seven of these requests in less than two hours and eight in over two hours. DBHDS is not meeting the expectation of responding within 2 hours. This becomes a more stringent requirement as of June 30, 2014 when the teams are expected to respond to requests from urban areas in less than one hour and requests in rural areas in less than two hours.

In the third quarter of FY14 the regional REACH teams responded to sixty -nine crisis events. Forty-four (64%) were responded to in less than two hours; fourteen (20%) were responded to in more than two hours. The DBHDS has no data on response time for the remaining eleven events (16%).

**Conclusion:** DBHDS remains out of compliance with *Section III.C.6.b.ii.F*.

**Recommendations:** The START teams are expected to respond more quickly to crisis requests from individuals living in urban areas starting in FY15. The Commonwealth did not create two or more teams in each region as the Settlement Agreement required. It instead added members to the existing team in each region. This may not be a sufficient response. The Court should require the Commonwealth to fund and develop additional teams if delays in response continue.

iii. *Crisis Stabilization programs*

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

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

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

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

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

All regions now have a crisis stabilization program providing both emergency and planned respite. Regions I, III, and V have six beds available. Regions II and IV have only four beds available. Region II has been limited because of a septic system issue that has been resolved so it will operate six beds starting in May 2014. Region IV has a staffing problem. DBHDS is not able to project when this will be resolved so that the unit can serve six individuals at one time. One family member reported having planned respite canceled for her son in Region IV. To date DBHDS has not provided any projections or a methodology to determine the need for crisis stabilization units.

Region IV remains in its temporary location. Staff found a home to serve as the permanent site for the crisis stabilization unit. The Advisory Council and DBHDS representatives have toured it. DBHDS reports the home will not need much renovation. The region awaits municipal approval. The region will renew the lease on the existing site through 7/15 but plan to move before the lease period ends.

**Table 4** summarizes the number of individuals who used the Crisis Stabilization Units during the second and third quarters of FY14. The regions continue to provide both emergency and planned respite in the REACH Crisis Stabilization Units. Overall more individuals (57%) use the units for planned respite. Region V opened its unit in November 2013 and has only used it for planned respite. Only Region IV serves more individuals experiencing emergencies than for planned respite. During Quarter 3 the regions began to report on the use of the crisis stabilization units as a step down from hospitalization. It was used for a total of eight individuals (noted in parentheses in **Table 4**) in Regions I, II, and III. This is a positive indication of the REACH program's efforts to work with individuals who require hospitalization to help them return to the community using effective transition services. It is also positive that DBHDS continues to offer planned respite in the REACH Crisis Stabilization Units for individuals at risk of crises.

**TABLE 4: INDIVIDUALS USING THE REACH CRISIS STABILIZATION UNITS DURING THE SECOND AND THIRD QUARTERS OF FY14**

<b>REGION</b>	<b>Q2 Emergency</b>	<b>Q2 Planned</b>	<b>Q3 Emergency</b>	<b>Q3 Planned</b>	<b>Total Emergency</b>	<b>Total Planned</b>
I	12	13	7	7 (2)	19	20
II	7	24	9	19 (2)	16	43
III	22	19	10	19 (4)	32	38
IV	6	4	21	2	27	6
V	0	10	0	5	0	15
<b>TOTALS</b>	<b>47</b>	<b>70</b>	<b>47</b>	<b>52</b>	<b>94</b>	<b>122</b>

DBHDS also reports on the individuals who are maintained in their home settings during while the crisis situation is stabilized. In the second quarter seventy-four (67%) individuals remained in their current settings with or without in-home respite and another five (4.5%) had planned out-of-home respite scheduled. During the third quarter there were 69 individuals referred for emergency/crisis services. Sixty-three (63%) of these individuals remained in their current setting with or without in-home respite and another two (3%) received planned out of home respite. This is a strong indication that the REACH teams attempt to maintain individuals in their homes and provide the supports that make this possible.

Nineteen individuals in Quarter 2 and ten individuals in Quarter 3 of FY14 required some type of psychiatric hospitalization. This may be appropriate for these individuals. However, DBHDS should maintain data about the REACH teams' involvement with these individuals while in the hospital and post-hospitalization. It is useful to now know through the third quarter report that eight of these individuals went to the REACH Crisis Stabilization Unit. Data should also be maintained on the final outcome or disposition for these individuals to determine how many eventually returned to their residence and for those who didn't where they were eventually placed.

There is no indication that any other community placements were used for crisis stabilization during Quarters 2 and 3 of FY14 for individuals who could not remain in their home setting. The Settlement Agreement requires the state to attempt to locate another community alternative before using the REACH Crisis Stabilization Unit. REACH teams are attempting to maintain individuals in their own homes with supports as the preferred approach to stabilize someone who is in crisis.

The REACH programs are not currently searching for community residential vacancies before using the Crisis Stabilization Units. In my professional opinion using vacancies in community residential programs is not a recommended practice. Dr. Beasley supports this perspective. Placing an individual who is in crisis into a home shared by other individuals who have I/DD is potentially destabilizing to those individuals for whom this is home. Additionally the practice potentially leaves the individual who is in crisis in an unfamiliar home, in the care of staff with whom he/she is unfamiliar and who is not trained to meet the needs of someone with a dual diagnosis who is experiencing a crisis. I will not recommend a determination of compliance regarding this provision until the Parties discuss it and decide if they want to maintain it as a requirement of the Agreement. I recommend that it not be a REACH practice.

The DBHDS is to determine if there is a need for additional crisis stabilization units to meet the needs of individuals in the target population. **Table 5** depicts the average length of stay for each region’s program for emergency, planned and step down respite. This information is used with the information presented in **Table 4** that indicates how many individuals used the crisis stabilization unit to determine the total number of bed days that were used during the third quarter. This is then compared to the total number of bed days that are available by taking each region’s capacity and multiplying it by the days in a quarter, which equals ninety-one. This illustrates the additional capacity that was available but unused during Quarter 3.

All regions had unused bed days ranging from sixty-four in Region IV to 506 in Region V. This seems to indicate that at this time additional crisis stabilization units are not needed. Regions have enough capacity to assist other regions if particular times one program is fully occupied.

Regions I and II both report Waiting Lists for the REACH CSU. Region I reported forty-seven individuals waiting and Region II reported seventeen individuals on the Waiting List. However the waiting lists were a result of the programs being closed for short periods of time for renovations, which does not indicate a problem with capacity. When I spoke to the REACH Directors they assured me that even though three beds are designated for emergency respite and three beds for planned respite, if a person is in crisis and a planned respite bed is available it would be offered to the individual in crisis.

The Regions will need to guard against the practice being extended to offer a planned respite bed to someone in crisis if the bed is already offered to an individual for a planned respite visit. Individuals and families who rely on planned respite to help support the individual staying home should not have planned respite cancelled

**TABLE 5: COMPARISON OF THE LENGTH OF STAY TO THE TOTAL CAPACITY OF THE REACH CRISIS STABILIZATION UNITS DURING QUARTER 3**

REGION	EMERGENCY LOS AVG	PLANNED LOS AVG	STEP DOWN LOS AVG	TOTAL DAYS USED	TOTAL DAY CAPACITY	DIFFERENCE
I	16.67	6.6	15	180	546	366
II	6.9	5.2	5.8	162	364	202
III	17	4	36	374	546	172
IV	13.7	6	0	300	364	64
V	0	8	0	40	546	506

**Conclusions:** The Commonwealth of Virginia is in compliance with Sections III.C.6.b.iii.A, B, D, and G determined during this review and achieved compliance with Sections III.C.6.b.iii. E. and F. in an earlier review period. I will not make a determination about Section III.C.6.b.iii.C until the Parties make a decision about the practice of using community residential resources for crisis stabilization.



## **SECTION 6: SUMMARY**

The Commonwealth of Virginia continues to make progress to implement a statewide crisis response system for individuals with I/DD. It is promising that DBHDS has developed a plan to expand to provide crisis intervention and prevention to children and adolescents. It appears that there is a smooth transition to the REACH program and encouraging that DBHDS will create standards and continued expectations for staff training.

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

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

The Commonwealth is not in compliance with the following Sections of the Settlement Agreement:

*III.C.6.a.i*  
*III.C.6a.ii*  
*III.C.6.a.iii*  
*III.C.6.b.ii.C*  
*III.C.6.b.ii.E*  
*III.C.6.b.iii.G*

Recommendations are included throughout the report. DBHDS needs to provide administrative leadership to insure that comprehensive and well-coordinated crisis response services are available to children and adolescents with ID/D; that there is formal outreach to the DD community; that there is sufficient availability of crisis stabilization emergency and planned respite; that the mobile crisis teams meet the required time to respond to crises; and that CSB ES staff, Case Managers and law enforcement personnel are trained about the REACH program.

**APPENDIX C**

**INTEGRATED DAY ACTIVITIES  
AND  
SUPPORTED EMPLOYMENT**

**By: Kathryn du Pree MRP**

**2014 REVIEW OF THE INTEGRATED DAY ACTIVITIES AND  
EMPLOYMENT SUPPORTS REQUIREMENTS OF THE US v  
COMMONWEALTH OF VIRGINIA'S SETTLEMENT  
AGREEMENT**

**REVIEW PERIOD: APRIL 7, 2013 – APRIL 6, 2014**

**SUBMITTED TO DONALD FLETCHER  
INDEPENDENT REVIEWER**

**PREPARED BY: KATHRYN DU PREE, MPS  
EXPERT REVIEWER  
APRIL 15, 2014**

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## **I. OVERVIEW OF REQUIREMENTS**

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Consultant to perform the review of the employment services requirements of the Settlement Agreement for the time period 4/6/13-4/6/14. The review will determine the Commonwealth of Virginia's compliance with the following requirements:

*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.*

*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 with a goal to pay individuals minimum wage; discussing and developing employment services and goals 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*

## **II. PURPOSE OF THE REVIEW**

This review will build off the review completed last spring for the review period through 4/6/13 and the recommendations the Independent Reviewer made in his last Report as a result of the conclusions and findings of that review. At that time the Independent Reviewer determined that the Commonwealth was in compliance with Section III.C.7.b, but not with Section III.C.7.b.i because it had not developed an implementation plan to increase integrated day activities for individuals in the target population. The Commonwealth was also not in compliance with the provisions of Section III.C.7.b.i.B.2.a and b, as it did not develop targets to meaningfully increase the number of individuals who enroll in supported employment and maintain their employment.

This review will cover all areas of compliance to make sure the Commonwealth has sustained compliance in areas achieved during the last reporting period. It will focus on those areas that were not in compliance and the Independent Reviewer's related recommendations. This focus will be on:

- The Commonwealth's ability to meet the targets it set to be achieved by 3/31/14 for the number of people in supported employment, those who remain for at least twelve months, and the average earnings for those in supported employment
- The expectation that the Commonwealth set meaningful targets to increase the number of individuals with ID/DD enrolled in supported employment by 3/31/14
- The development of an implementation plan to increase integrated day activities for members of the target population including strategies, goals, action plans, interim milestones, resources, responsibilities, and a timeline for statewide implementation by 3/31/14
- The continued involvement of the SELN in developing the plan and reviewing the status of its implementation
- The DBHDS' status to address waiver employment service definitions, rates, and provider incentives to increase the number of individuals in the target population who become and remain employed
- The expectation that individuals in the target population are offered employment as the first option by Service Coordinators and their teams during the individual planning process in which they discuss and develop employment goals

### **III. REVIEW PROCESS**

The Expert Reviewer reviewed relevant documents and interviewed key administrative staff of DBHDS, members of the SELN, and a member of the HSRI team, to provide the data and information necessary to complete this review and determine compliance with the requirements of the Settlement Agreement. Initially a kickoff meeting was held on February 14, 2014 with the Independent Reviewer, the Expert Reviewer, the Assistant Commissioner and the Employment Services Specialist to review the process and clarify any components before initiating the review.

**Document Review:** Documents reviewed include:

1. Virginia's Plan to Increase Employment Opportunities for Individuals with Intellectual and Developmental Disabilities: FY2013-2015: Goals, Strategies, and Action Items
2. The Commonwealth's Plan to develop integrated day services including volunteer activities and community recreation
3. New Targets set for the target population
4. Quarterly Reports for the time period 4/7/13-4/6/14
5. SELN Work Group meeting minutes relevant to the areas of focus for this review
6. Summary of Quarterly Employment Training Events
7. Employment Services Training Module for Case Managers

**Interviews:** The Expert Reviewer interviewed the Employment Services Specialist from DBHDS, members of the SELN, Rie Kennedy-Lizotte (NASDDS, HSRI team member); Connie Cochran, Assistant Commissioner for Developmental Services, DBHDS; Dee Keenan, Case Management Program Manager, DBHDS, and Sam Pierno, DD Program Manager, DBHDS; and Grant Revell of VCU.

**Review of Individual Service Plans (ISPs):** The Expert Reviewer reviewed a random sample of ISPs to determine if employment is being offered as the first option to individuals in the target population. This was accomplished by randomly selecting a sample of twenty-one individuals from three of the five regions for a total of 63 ISPs, from the following groups: individuals who have been on the Waiting List and are receiving funding for day services (7); individuals transitioning from the Training Centers to community services (7); and individuals already in a Group Supported Employment or Sheltered Workshop day setting (7). Individuals were randomly selected from those individuals who have been in these target groups since 2012. Unfortunately DBHDS was unable to provide all sixty-three ISPs. Four individuals selected from the Training Centers who were transitioning were excluded. Three have significant medical conditions that preclude them from participating in day programs and one person is deceased. An additional twenty-seven were not submitted from the CSBs.

The purpose of reviewing these plans is to provide a sense of the DBHDS' progress in meeting the requirement of the Settlement Agreement to offer members of the class employment as the first option for day services using the person-centered planning process. The following are the indicators to make this determination:

- Has the Case Manager and planning team discussed the availability of employment supports with the person and the guardian?
- Has the Case Manager determined the individual's interest in employment?
- Has the person been asked what type of job he or she would prefer or choose?
- Has there been a discussion of the initial steps the team needs to take to assist the person to become employed?
- Has a vocational assessment been requested and conducted if the individual, guardian or team recommends it?
- Has the Case Manager made referrals to employment service providers if the individual is interested in supported employment?
- Have employment services been developed and initiated for the individual in the time period recommended by the team?
- 

#### **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. The plan shall:*

*A. Provide regional training on the Employment First policy and strategies throughout the Commonwealth:*

Adam Sass, Employment Specialist, DBHDS continues to provide extensive training on the Employment First Initiative in Virginia. In this reporting period, April 7, 2013-April 6, 2014 Mr. Sass has presented to 500 individuals at twenty-eight meetings, conferences and regional summit. He made another presentation to twenty-seven ID Case Managers on April 8, 2014. Presentations have been made to ID and DD Case Managers; new and existing providers including a few that plan to convert to the ISE model; DARS regional managers and staff; CSB staff; employers; and advocates. It does not appear that families have been a target group to receive this training during the reporting period.

The handout materials and talking points indicate that the philosophy of employment first and its tenets are addressed. Mr. Sass reports that at recent presentations the audiences focus more on questions and issues of how to make this transition than to question why the Commonwealth is promoting employment first. Mr. Sass uses the opportunities for these presentations to create community linkages and partnerships that will further the acceptance of the employment first philosophy and encourage implementation.

The SELN sub-committee recently completed a training module on employment for case managers. I have reviewed this training and determine that it will provide case managers with the basic information they need understand employment first and begin to discuss employment with their consumers. Case Managers will not be required to take the training although it will be available on the DBHDS website.

**Conclusions:** I do not find evidence that ID Case Managers understand their responsibility to introduce employment options as part of the planning meetings to develop the ISP. The Case Management Employment Training is a first step in imparting this information. DBHDS is in compliance with provision 7.b.i.A that it provides regional training on the Employment First policy and strategies.

**Recommendations:** The Commonwealth should report to the Independent Reviewer how it provides guidelines to families that include how to access employment supports and how it will ensure that case managers understand their essential role. One approach is to incorporate the employment module into required training for ID and DD case managers.

*7.b.i.B.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 people 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.*

The DBHDS has provided information regarding the number of individuals in Individual Supported Employment (ISE), Group Supported Employment (GSE), and in Pre-Vocational Services. The department also produced data about the number of individuals remaining in ISE and pre-vocational for twelve months or more which is depicted in Table 1 and 3, with Table 3 focusing on the changes in ISE only compared to the target goal set by the DBHDS. These data are not tracked for GSE. Information about the number of new participants is provided in ISE and is depicted in Table 2 and is compared to the target goal set by DBHDS. The department cannot provide data about wages for individuals in ISE and is out of compliance with this requirement. DBHDS can only report through the second quarter of FY14 that ended 12/31/13. They are unable to provide information at this time or before this report must be completed for the third quarter (1/1/14 – 3/31/14). Therefore the analysis is somewhat preliminary since the progress is



being measured against the targets set for March 31, 2013. DBHDS should provide the data from the third quarter as soon as it is available to the Independent Reviewer so a conclusive determination of compliance can be made.

**Individuals in Supported Employment and Pre-Vocational Services**

The increase in the number of individuals in ISE has only increased by six individuals at the end of the second quarter of FY14, which is only 3% of the baseline number. The number had actually increased to 204 from 176 at the end of the first quarter of FY14 but dropped significantly from 204 to 182 by 12/31/13.

The overall number of individuals in Supported Employment has increased by fifty- nine individuals as a result of the increase in participation in GSE. The Commonwealth is interested in decreasing the participation in Pre-vocational services but that number continues to increase with 28 additional people in pre-vocational services since the baseline was set for 3/31/13. Table 1 also includes information about individuals remaining in ISE and Pre-Vocational services. The number of individuals maintaining ISE for twelve months or more dropped in the three quarters the DBHDS was able to report. However the first quarter saw the largest decline and the number is steadily increasing through the other two quarters. It was 119 individuals as of 12/31/13, which remains below the baseline number of 133.

**Table 1: Individuals in Supported Employment and Pre-Vocational Services and Those Remaining 12 or More Months**

<u>Data element</u>	<u>Individuals enrolled/remaining 12 months 3/31/13</u>	<u>Individuals enrolled/remaining 12 months 6/30/13</u>	<u>Individuals enrolled/remaining 9/30/13</u>	<u>Individuals enrolled/remaining 12/31/13</u>
ISE	176/133	180/97	204/111	182/119
GSE	634	661	660	687
SE Total	810	841	864	869
Pre-voc	819/675	805/679	828/692	847/680

**Increasing the number of individuals in ISE:** The DBHDS goal for this fiscal year is to increase the number of newly enrolled participants in ISE apart from the overall change to the total number in ISE as that number accounts for individuals who remain, leave and newly enroll. The target the DBHDS set to achieve by 3/31/14 is to newly enroll 162 individuals. Table 2 depicts the progress made. For this goal to be met an additional 58 individuals will need to be enrolled in ISE as of 3/31/14. This may prove to be ambitious since the most who were enrolled was 49 and that dropped to 23 in the last quarter the department reported.

**Table 2: Progress Towards Meeting The Employment First Target of Increasing the Number of ISE Participants**

3/31/13 Baseline	6/30/13	9/30/13	12/31/13	<b>3/31/14 Target</b>	Difference
135	32	81 (49)	104(23)	<b>162</b>	58

**Increasing the length of time individuals remain employed through ISE:** The DBHDS reports on the number of individuals who remain employed for 12 or more months in each quarter. Table 3 includes these totals and the percentage of the total number of individuals in ISE that remain employed for 12 or more months. The goal is to reach 85% of the total number of individuals in ISE who remain employed for 12 or more months. The DBHDS reported on three quarters as depicted in Table 3. The greatest number and percentage of individuals maintaining employment was 119 individuals (65% of the total) in the second quarter of FY14, showing an improvement over the previous quarters but below the baseline set in March 2013. The data will need to be reviewed for the third quarter, period ending 3/31/14, to determine if this target is met.

**Table 3: Progress Towards Meeting The Employment First Target of Increasing The Length of Time in ISE**

3-31-13 Baseline	6-30-13	9-30-13	12-31-13	3-31-14 Target
133 (76%)	97 (53%)	111 (54%)	119 (65%)	<b>85%</b>

The data presented in the three tables presents a somewhat curious picture of employment for individuals with I/DD in Virginia. There is information about the total number in ISE, the number who have twelve or more months of continuous employment, and the number who have newly enrolled during the quarter. For the quarter ending 6/30/13, thirty two (32) newly enrolled, ninety seven (97) stayed and there was a total of 180 in ISE indicating that fifty-one (51) stayed in ISE for less than twelve months. By the end of the next quarter, 9/30/13, 111 individuals remained employed for more than twelve months, forty-nine (49) were newly enrolled during the quarter and a total of 204 individuals were in ISE, indicating that forty-four (44) individuals stayed employed for less than twelve months. In the last quarter reviewed that ended 12/21/13, there was a total of 182 individuals enrolled of whom twenty-three (23) were newly enrolled and 119 maintained employment for twelve months or more, indicating that only forty (40) individuals maintained employment for three to twelve months. This is a lower number than the cumulative number of eighty-one (81) individuals who were newly enrolled during the first two quarters.

The DBHDS should review this data to determine whether there is a reporting problem, or if there are a high number of people who have started to work but are not maintaining employment. This is reflected to some degree in Table 3 that depicts the number and percentage of individuals who retain employment for longer than 12 months. The DBHDS goal is to have 85% of individuals achieve this. Only a little more than 50% are currently employed after 12 months. This figure does not fully tell the story about those who newly enroll and what their experience is within the first 12 months of employment, but it indicates that a number of them are losing employment during that first year, some within 3-6 months. The way in which these data are collected does not track individuals so DBHDS does not know if individuals start ISE and lose a job but find another one or lose a job and are not re-employed during the reporting period.

**Conclusions:** The DBHDS is in compliance with 7.b.i.B.a, b, d, and e, as these provisions only require DBHDS to set baseline information and report on each category. DBHDS is not in compliance with 7.b.i.c. as it is unable to provide information about the amount of earnings individuals in ISE receive.

The data that are available does not conclude that DBHDS has met its targets for the number of newly enrolled individuals in ISE or the percentage that remains employed for 12 or more months. However a final determination cannot be made until the data through 3/31/14 is available for review and analysis.

DBHDS is making progress towards enrolling more individuals in ISE.

**Recommendations:** The SELN should be involved in reviewing these data on a regular basis and assisting the DBHDS to analyze the continued growth in GSE and Pre-Vocational Services to determine if there are strategies that can be put in place prior to the completion of the waiver redesign that will start to turn the curve in Virginia away from other vocational options and towards greater individualized employment for the target population. This is an important undertaking if the DBHDS is going to be able to meet the more assertive targets it has set for the next five years to increase the number of people in ISE by five percent of the total of everyone in adult day services through the HCBS waivers in each of the next five fiscal years.

The DBHDS should report separately in future reporting periods about the ID and DD waivers and the numbers of individuals in ISE so that the impact of the Settlement Agreement on both populations can be followed and tracked.

The DBHDS should also include in its reporting the number of individuals who are in the target population who receive individual supported employment through DARS. DARS does serve this population and many individuals apply directly to DARS to receive employment support and assistance. This was validated at least in small part by my review of the ISPs to determine if individuals in the target population are offered employment as the first option for day support. Individuals who are considered ready for ISE are referred to DARS. The target population is defined as *“individuals receiving services through the HCBS waivers.”* However it appears that CSBs do refer these individuals to DARS as a first option for employment support especially individuals who are initially interested in individualized employment support and demonstrate ability to work fairly independently, but who need career planning and job coaching. The Commonwealth is not tracking the number of people who are in the target population and become employed with assistance and funding from DARS. This seems to be a missed opportunity to have a more comprehensive understanding of employment trends, opportunities and barriers for the population as a whole.

As discussed this provision relates to the creation of baseline information and ongoing reporting. Future reviews of employment services will determine if DBHDS achieves its targets for increasing the number of individuals in ISE and the number that maintain employment for at least twelve months. The Parties should 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.

## **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.*

At the time of the last review 176 individuals had participated in ISE in the past year and 133 individuals had remained in ISE for at least 12 months. DBHDS worked with the SELN to develop targets for increasing the number of individuals who would receive ISE by 3/31/14. The target set at that time was for 162 new enrollees and an expectation that 138 would remain employed for at least 12 months. Data has been provided through the 2<sup>nd</sup> quarter of 2014. As of 12/31/13, 182 individuals were enrolled in ISE of which 104 were newly enrolled and 119 maintained employment for 12 months or more.

This is an increase of only 6 individuals over the baseline of 176. The DBHDS reports that there are 9648 adults who are enrolled in one of the waivers serving individuals with ID or DD. This level of enrollment in ISE represents only 1.88% of the adult waiver population. Thus is a slight reduction in the percentage of waiver participants in ISE compared to previous years.

This year's target was set for the number of individuals who would be newly enrolled not the total number enrolled in ISE. This goal is 162 and was not met by 12/31/14 the last reporting period data were available for this review.

The Independent Reviewer directed the DBHDS to set more meaningful employment targets. DBHDS has developed targets for FY15-FY19. The state SELN was consulted in setting the new targets and an independent expert assisted the department and SELN to construct the methodology used. Table 4 below summarizes the targets the DBHDS has established for the next 5 years.

These targets are significantly more ambitious than the target set for FY14. Setting the targets begins with the assumption that the Commonwealth will be providing ISE for 204 individuals by the beginning of FY15 (July 1, 2014), which represents 2.79% of the total number of individuals receiving day services in one of the HCBS waivers. The total number of individuals is now set at 7,292 rather than the previous waiver total of 9,648 to reflect only the number of waiver participants who are of adult age. The plan is then to increase the number of individuals in ISE by 5% each year. This results in a cumulative percentage of 22.79% of waiver participants receiving day supports participating in ISE by the end of FY19. This would translate to 2,026 individuals with either ID or DD being individually employed through one of the HCBS waivers.

The Commonwealth has set targets to meaningfully increase the number of individuals who enroll in supported employment each year. However, it may not meet the less ambitious target it set for itself for 3/31/14 that was based on increasing the number of participants newly enrolled in ISE. The new targets depicted in Table 4 are for the total number of individuals in ISE for each of the next five fiscal years. DBHDS projects starting FY15 with 204 individuals enrolled in ISE. This was the number enrolled as of 9/30/13 although it decreased to 182 by 12/31/13. It is very possible that DBHDS will reach this number of ISE participants again by June 30, 2014. However, the target the department has set for the end of FY15 is 568 individuals which more than doubles the expectation of serving 204 by the start of FY15 and is triple the number of individuals who were enrolled as of 12/31/13. As indicated earlier the DBHDS has to take timely and well-planned

action to address the various barriers that exist to achieving these targets if the goal of more individuals being employed in integrated work settings is to be realized. The work underway to redesign the waivers is a critical step. The DBHDS and SELN should continue to define what else needs to be put in place and what can be accomplished before the redesign is completed and implemented so that progress towards achieving and sustaining compliance is made.

The DBHDS Employment Specialist reports that the department plans to continue to use the target of eight-five (85) percent for the number of individuals who remain employed in integrated work settings at least twelve months after the start of supported employment. This was not included in the target setting proposal I received to review. If the DBHDS formally commits to this target then they are in compliance with *Section 1.B.2.b* to set a meaningful target for the number of individuals who remain employed for one year or longer. However, the current level of 65% of individuals who remain employed for 12 or more months indicates that DBHDS will need to analyze and address why the target is not currently met.

**Table 4: EMPLOYMENT TARGETS FOR FY15 – FY19**

FY	SE Total Start of FY	Total int. day/ Employment Services	% in SE at Start of FY	% in SE by End of FY	SE Total End of FY	Increase in Base %
15	204	7292	2.79%	7.79%	568	5%
16	568	7292	7.79%	12.79%	932	5%
17	932	7292	12.79%	17.79%	1297	5%
18	1297	7292	17.79%	22.79%	1661	5%
19	1661	7292	22.79%	27.79%	2026	5%

The SELN and DBHDS used national data that indicates that presently about 20% of the ID/DD population enrolled in HCBS waivers are engaged in individual employment.

**Conclusions and Recommendations:** The Commonwealth is substantially in compliance with *Section 7.i.B.2.a* as it has set targets to meaningfully increase the number of individuals who enroll in supported employment each year. This is significantly more aggressive than the target set for 2014 and reflects the Commonwealth’s commitment to its Employment First policy. It includes targets for both the ID and DD waivers and if achieved will provide many more individuals with meaningful employment and hopefully greater economic independence.

It does not project for any growth in the overall number of waiver participants although growth is expected as the Settlement Agreement is implemented. It will be important for the DBHDS and SELN to track progress towards the implementation of this plan to increase employment for individuals with ID and DD and to revise the targets to continue to achieve the same percentage goals as the number of waiver participants increases overall. I recommend that DBHDS tracks the progress towards meeting the targets that separately identifies individuals with ID and DD who participate in ISE to enable the Commonwealth and the Independent Reviewer to determine if DBHDS is successfully both groups that are part of the target population.

The Commonwealth needs to report on its goal of increasing the number of individuals newly enrolled in ISE to 162 by March 31, 2014 to the Independent Reviewer as soon as this information is available.

In order for the Commonwealth to reach the targets set for FY15-FY19 the DBHDS will need to concentrate its efforts on completing its waiver redesign plan to address employment service definitions and revise its rate structure, focus on building provider capacity, considering offering individuals the opportunity to self-direct their employment supports, and ensure case managers are trained in the Employment First policy and using the principles of person-centered planning to help individuals and their families identify and pursue their employment goals and aspirations.

The Expert Reviewer suggests 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 in the target population who become waiver participants during the implementation of the Settlement Agreement. Through discussions between the DBHDS and the SELN as to how to target these specific groups realistic and successful marketing and training approaches can be developed to reach out to families, Service Coordinators, CSBs, Schools, Training Center staff, and ESOs to assist the DBHDS achieve its overall targets in each of the next five fiscal years.

The DBHDS needs to formally set its targets for the number of individuals who will maintain employment for at least twelve months as required in Section 7.i.B.2.b of the Settlement Agreement.

## **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 undertaking a significant redesign of its HCBS waivers. HSRI has been hired to assist Virginia with this task which will encompass redefining waiver services for integrated day activities including supported employment, restructuring the rates for waiver services and redesigning the implementation of the SIS as it is used as an initial assessment tool and an indicator of the individual's level of need for support. Various work groups are underway and focus groups are convened to assure broad input from stakeholders. The initial report and analysis is due in July 2014. The Commonwealth plans to submit its new waiver design in FY16. The Commonwealth did submit new definitions for its recent waiver renewal for the ID waiver. These definitions promotes integrated day activities, requires skill building in pre-vocational programs and sets a time limit on a person's participation in pre-vocational services, and redefines supported employment for both ISE and GSE. Services will be designed using the person-centered planning process. The leadership of both DMAS and DBHDS are actively involved in the redesign process. Stakeholders who represent CSBs, advocacy, provider and family groups are included and some of the work group representatives are also members of the SELN.

**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 has focused its work and activities on increasing employment opportunities for individuals with ID and DD. With rare exception providers in Virginia do not offer individuals who are not employed other types of integrated day activities. DBHDS was directed by the Independent Reviewer to develop a plan by March 31, 2014, that describes its implementation plan to increase integrated day opportunities.

DBHDS submitted a preliminary plan describing the “strategies and activities necessary to create a blueprint.” The plan includes Virginia’s vision for integrated day activity, three goals with related objectives, strengths and challenges, and the project approach. I will review each section. Virginia’s vision is to have an array of integrated service opportunities available for individuals with disabilities. It wants individuals to be able to choose to have services delivered to them in the least restrictive and most integrated setting. The definition the plan offers of integrated day activities assures they are meaningful, offered at times to benefit the person to have an active community-based daily routine, and include leisure activities. Integrated day activities are to complement employment for individuals who are employed and want leisure activities as well, are employed only part time *or for those who continue to choose congregate care services* (italics added). DBHDS is to be complimented for recognizing the value and need for integrated day activities both as a supplement to employment and for individuals who do not have or wish to engage in employment. The definition should align with the Agreement, “integrated day activities include community volunteer activities, community recreation opportunities, and other integrated activities.”

DBHDS has included individuals who continue to choose congregate care services in its vision of who these services are intended to benefit. The use of the term congregate care activities sends a mixed message in terms of the Commonwealth’s intention in promoting integrated day activities. Congregate day settings may continue to exist for some time as DBHDS transitions to a system that expands the offering of integrated day activities. Providers will need time to design new program models and DBHDS will need to address infrastructure support and staffing ratios to encourage and support meaningful integration into community-based services that are not offered in congregate settings. The intent and coherence of the definition would be strengthened if the definition were reworded to instead include individuals who are not currently employed and who have retired from employment, rather than those who choose congregate care settings. Since the choice of individuals has in large part been limited to congregate day service settings a person’s participation in this type of program does not necessarily reflect informed choice.

The goals and objectives focus on developing a common understanding; ensuring policies, procedures and funding promote integrated day activities, and developing a plan to transform existing structures to support the delivery of integrated day activities. It is important to undertake activities to address these goals. However the plan lacks any specificity or depth as to how this will be accomplished. The plan projects that a common understanding and philosophy about integrated day activities will be achieved by June 2015 with work not starting until July 2014. Having policies and funding in place will be initiated in October, 2014 and completed by January 2015. These

goals seem out of sequence. It seems DBHDS needs to have its service definitions completed prior to addressing policy and funding changes. The plan indicates the SELN will be responsible for the review of policies and procedures. The SELN has a similar responsibility to review existing policies across the state agencies that might impede employment for individuals with ID or DD. To date the sub-group for this policy review has not met on a regular basis to accomplish this task according to members of the SELN.

Stakeholder involvement will be key to the successful implementation of integrated day activities. The section in the plan to list key stakeholders is left blank. No specific strategies are included for outreach or training in the plan. There is only a vague short-term objective to educate all stakeholders about integrated day activities.

It is a concern that work will not be initiated until July 2014. DBHDS has had the requirement to offer individuals integrated employment since the inception of the Agreement. Because a plan had not been developed as required “within 180 days” of the Agreement, the Independent Reviewer subsequently required an implementation plan by March 31, 2014. What has been submitted is a very preliminary plan. It does not include the planning elements or implementation specifics as to how objectives will be accomplished. There are also no measures of progress included.

The last goal is for system transformation. “Structures, both state level and provider level, will support delivery of day activities in the least restrictive and most integrated settings.” The DBHDS wants to ensure funding sources that promote and support integrated settings, ensure provider capacity, develop a guidebook for transformation, and develop a system of outcome tracking. All of these are important components of the development process. These are stated as short-term objectives with the outcome being “a logical replicable and measurable model of integrated day activities.” This is to be completed by December 2015. It appears it will be almost two additional years before DBHDS expects to have a model of integrated day services. The plan does not address when individuals in the target population can expect to be offered integrated day activities or how many individuals will be targeted to receive these integrated services. The plan also does not specifically address:

- ✓ How need for these services will be assessed
- ✓ Whether the service delivery model will include a self-directed option
- ✓ What the anticipated impact is on providers of congregate day services or how this will be determined and what the DBHDS policy will be about this service delivery model
- ✓ How teams will be instructed to use the person-centered planning process to introduce this service option and plan appropriate goals and objectives for the individual
- ✓ Outreach to families, individuals and schools
- ✓ Training for CSBs and Case Managers
- ✓ Assessing existing provider capacity and determining how to expand this if necessary
- ✓ Qualifying providers

**Conclusion and Recommendations:** The Commonwealth is not in compliance with 7.a.i. The DBHDS needs to develop an implementation plan with more specific objectives, measurable interim milestones, and an indication of the resources it will commit to complete the implementation plan within the timeframes established. This should be submitted to the Independent Reviewer by July 31, 2014. That plan should be evaluated using the SHAY evaluation tool to provide feedback and recommendations to the Independent Reviewer by August 31, 2014.



## **VI. Review of the SELN and the Inclusion of Employment in the Person-Centered ISP Planning Process**

*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.*

The Commonwealth did develop and promulgate the Employment First policy during the previous reporting period. Additionally, the Governor issued an Executive Order 55 on November 12, 2012 to bring to bear the efforts of both government and the business community to facilitate and advance opportunities for individual with disabilities to be gainfully employed. Various state agencies led this effort organizing a series of events beginning with a kick-off summit held on June 27, 2013. The summit was followed by six regional workshops involving state and business leaders and the Services Solution Teams of the local Workforce Investment Boards. Recommendations have been made to continue this initiative and DBHDS, DARS and the other involved agencies are awaiting approval from the Governor. This is an important initiative to continue the education, partnership building and support of the business community in Virginia to increase the employment opportunities for individuals in this target population.

Virginia has maintained its membership in the SELN and issued a policy on Employment First. DBHDS continues to employ the Employment Services Coordinator. This review will explore the work of the SELN and focus on whether employment is being offered as the first option to individuals in the target population.

**ISPS That Include Employment:** Part of this review is to determine if 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. I have reviewed a random sample of 31 ISPs of individuals who have transitioned from the Training Centers, individuals receiving waiver services for the first time, and individuals already enrolled in pre-vocational services or Group Supported Employment (GSE). A review of a larger number of ISPs was planned, however, DBHDS was not able to provide them, reportedly because of the unresponsiveness of some CSBs. This added to the time required to complete this review and, if repeated, could undermine the effectiveness of future reviews.

## **SUMMARY OF THE ISP REVIEW OF TEAM DISCUSSIONS OF EMPLOYMENT**

Of the 31 ISPs reviewed, 27 (87%) involved no discussion of employment and no mention of a vocational assessment.

The ISPs reviewed do not indicate that the person or guardian was asked to discuss:

- the individual's preferences and interest in employment,
- employment opportunities available to consider and explore, or
- employment services and goals.

The ISPs did not indicate discussion or support of individuals in group supported employment to pursue individualized supported or competitive employment.

The ISPs did not include goals and implementation strategies to increase the individual's employability.

To date there has been no report of specific direction given by DBHDS to the CSBs to help Case Managers and their Supervisors understand how they are expected to fulfill this responsibility, what to discuss and include in the ISPs, and how they will be held accountable.

DBHDS has met with several CSBs to offer targeted training about Employment First, but has not provided this to all CSBs.

CSBs use different formats for the Person-Centered Individual Service Plans. Generally these formats do not focus on employment. The planning templates do not emphasize or include a section that would prompt a discussion of a person's true work dreams, preferences, and work interests, or how to align the annual objectives with these interests and preferences.

Many of the ISPs have a section in which the consumer or guardian indicates whether the plan meets the person's expectations and dreams. Every ISP reviewed that included this section had all boxes checked including that "the plan meets the person's work dreams".

During the last reporting period DBHDS reported that there is a provision in the FY13 and FY14 Community Services Performance Contract that requires the CSBs to comply with *Section III.C.7.b* of the Settlement Agreement. DBHDS informed this reviewer that a reformatted planning form would be implemented so that employment would be the first topic discussed with each individual and ISP team. The case manager was also going to submit a report that confirms that employment options were discussed. Workgroup 8 was charged to verify that case managers were in compliance with this requirement.. No evidence has been provided that these practices have been implemented.

### ***Conclusions:***

The Commonwealth is not in compliance with *III.C.7.a*. It is not providing individuals in the target population integrated day opportunities to the greatest extent possible. The review of ISPs indicates a pattern of minimal, and frequently no discussion of employment by teams. This remained true for individuals who expressed liking to work and for whom increasing earnings is an aspiration.

From the sample of ISPs I reviewed there is no indication that CSBs are in compliance with the Performance Contract regarding employment planning for members of the target population. The process of checking boxes to indicate that essential steps have occurred appears to be a pro forma process and not reflective of a meaningful discussion of the individual's goals and aspirations at least in the area of employment.

The sample of 31 ISPs validates the need for more formal communication and direction to the CSBs from DBHDS.

### ***Recommendations:***

It would be helpful if specific direction were formally communicated to the CSBs that could be reviewed with Case Managers and used as a guide for Supervisors to continue to mentor Case Managers related to supported employment.

It would be helpful if the DBHDS issued guidance on its expectations for the person-centered planning process including a basic outline of how to address employment as the first option for individuals to consider.

The DBHDS must also determine how to impart this information to all DD Case Managers. DBHDS should provide reports about its supported employment initiatives to the Independent Reviewer “*to document that the requirements of the Agreement are being properly implemented* “. (Section IX.C.)

**The Engagement of the SELN:** The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, set the targets for the number of individuals in the target population who will be employed, and provide ongoing assistance to implement the plan and the Employment First Policy. This past year input was sought from SELN members to revise the definitions of employment services and to define integrated day opportunities which are also required as part of the Settlement Agreement. The VA SELN Advisory Group was established in 2008. It includes self-advocates, family members, advocacy organization members, CSB staff, state agency administrators, educators, and employment providers.

I interviewed nine members as part of the review of Employment Services in 2013. The interviews included representatives of CSBs, educators, families, advocates, state agencies and providers. In light of concerns interviewees expressed about the operation of the SELN and the group's ability to have meaningful input into the employment planning process I chose to interview as many of the same members as were available. Additionally I interviewed a self-advocate, an additional representative of a state agency and a representative of an advocacy organization. I asked all of the members interviewed about the operation of the SELN and the opportunity for input into the

DBHDS planning process; target setting; training for case managers; the development of the plan for integrated day services; and outreach to the DD community.

**1. *The operations of the SELN and the opportunity afforded to its members to have input into the planning process.*** The vast majority of the SELN members interviewed spoke of improvements in the organization of the SELN committee meetings. During the last 5-6 months of calendar year 2013 the meetings ran very smoothly which was attributed to the co-leadership of Adam Sass and Heidi Dix. Ms. Dix was in a position to speak for the administration of DBHDS and was able to support the direction being set by Mr. Sass. Since Ms. Dix's departure from DBHDS, Connie Cochran, Assistant Commissioner, DBHDS has been involved and members hope that he is able to make a similar commitment to the group so that progress on topics and decisions can be made.

Members report having greater opportunity for input and are pleased that the group is making progress. All members reported that the SELN actively participated in creating the employment targets. Various sub-committees have been formed providing a structure that can assist the SELN to continue to move forward with its work. One sub-committee was charged with developing employment modules that will be added to the training offered to the case managers. The training presentation was recently completed and shared with DBHDS. This training is discussed in another section of this report.

Although there was acknowledgement that progress had been made during the last year to improve the SELN's effectiveness some of the members interviewed believe the group can be further strengthened by formalizing the membership and advisory group structure. Some of those interviewed recommended that a charter and by-laws be developed and that members be more formally appointed. This would enable the group to be constituted with consistent membership and meet on a regular, predictable basis. There is no set annual schedule and there have been cancellations and re-scheduling. There have been improvements in getting agendas and documents shared prior to a meeting but this is not yet consistent. At the last meeting the plan to develop integrated day services was shared only the night before the meeting. Members also reported not getting written copies of the final proposal setting employment targets.

Members also report that there is still repeated discussion of certain topics without resolution. They credit this to being the result of inconsistent membership and attendance. Suggestions were made to rotate the location of the meetings and use webinars to help members participate remotely. As the DBHDS continues to address the efficiency and effectiveness of the Advisory Group the coordination of the membership's diverse perspective, knowledge and expertise will contribute to the development and implementation of strategies that will have broad stakeholder support to advance employment services in Virginia.

Goal 6 of Virginia's Plan to Increase Employment Opportunities for Individuals with Intellectual and Developmental Disabilities FY2013-2015 addresses this issue. It states that the SELN will have formalized structure with clearly defined roles and responsibilities for members. The recommended actions include agreeing on representation, developing by-laws, appointing members and orienting new members. Members do not report that there is a formal appointment process or by-laws developed yet. The DBHDS projected it would develop by-laws and formalize appointments by 1/31/14, and 3/31/14 respectively. It has recently been delayed.

**2. Development of the Employment targets for FY15-FY19:** All SELN Advisory Group members interviewed reported that the members had the chance for meaningful input into the creation of the targets and ample time to discuss the implications of setting the targets at the level established. While some members wanted to see more aggressive targets those who were interviewed believed that these increases represent a reasonable but challenging goal for Virginia. Some members expressed concern that the targets assume no growth in the waivers overall and support adjusting the targets each year to reflect the real number of waiver slots that are funded. All of the members are aware that VA DBHDS and its stakeholders need to address many aspects of the existing employment service delivery system and identified barriers for the Commonwealth to achieve these targets. Some of the advocacy groups that are represented on the SELN proposed language for the Legislative budget that would have provided legislative intent for the increases to the number of individuals who were in supported employment but it was not adopted in the Commonwealth's budget for FY15. Some of the members hope to see DBHDS concentrate on young people who are transitioning to adult services as a group to target for employment opportunities. The SELN members want DBHDS to take ownership of these targets and promote these goals with all stakeholder groups.

**3. Case Management Training:** The SELN formed a sub-group to assist the DBHDS to develop a curriculum to train case managers about the Employment First Initiative and how to present employment as an option to individuals regardless of their service needs. This was to be completed by 1/31/2014. It was recently finalized and submitted to the Case Management Coordinator of DBHDS. SELN members reported the sub-committee had significant input into the design of this module. SELN members report that training is needed if Case Managers are to understand and fulfill their responsibilities to meaningfully offer employment as an option to individuals in the target population. Some members believe this training has to be required of both ID and DD Case Managers. The DBHDS plans to review the module and make it available on its website, but not require it of Case Managers. I discuss case management training and review this curriculum in an earlier section of the report.

**4. Outreach to the DD Community:** SELN members interviewed were not aware of any specific outreach efforts to individuals with developmental disabilities or their families. This is not a topic that has been discussed or addressed by the SELN. Members report some frustration that there is not an organized outreach effort to individuals with intellectual disabilities and their families. They appreciate, however, the efforts made by the DBHDS to present employment information at various regional forums across the state. They do recommend that there be dialogue with the CSBs to more formally provide information to individuals and their families about employment services and that DBHDS share information more consistently with school systems. Now that the DBHDS has responsibility for the DD waiver it may be timely for a specific outreach plan to be developed for participants and their families. Individuals on waiting lists for the waivers could be informed of vocational support that is available through DARS. The DBHDS recently developed a DD Newsletter. This form of communication was viewed favorably by some members of the SELN and could be used for ongoing communication about the employment initiative. It will be available on the DBHDS website, but DBHDS does not have the funding to mail it directly to families. The SELN might benefit from including more representatives of the DD Community to assist the department with outreach strategies to reach this target population.

**5. Development of the Plan for Integrated Day Activities:** There have been initial discussions with the SELN regarding the DBHDS' responsibility to develop integrated day activities. The SELN has had some input into the definition of these services and discussed the need to offer integrated day activities to both individuals who are employed part time and also for individuals who are either not interested in employment or currently employed. Members are pleased that the waiver application submitted in March expanded the definition of day supports. However, the SELN has not created a sub-group to address this responsibility. The preliminary plan for integrated day activities that was submitted for this review was first shared at the recent SELN meeting (3/31/14). Members received a copy the day before the meeting. Some members want more time to review the plan and provide feedback.

**6. System Redesign:** Some members shared their concern and perspectives about the redesign of the waiver system. All agree that this essential infrastructure change is critical to successfully employing more individuals with ID and DD. The members feel strongly that all current barriers to employment need to be examined and addressed through system redesign. This includes expanding service definitions, establishing appropriate rates for supported employment, addressing the true costs providers incur offering supported employment, funding all supports related to employment, determining adequate wages for employment staff, addressing the qualification process for providers, and determining how ESO providers will be monitored. An essential support service related to employing individuals is transportation. Currently the waiver does not reimburse for transporting an individual to work unless the job coach is present. As the need for the job coach to be onsite fades it is essential that the individual can still benefit from transportation support. The SELN had understood that this was to be addressed in the recent waiver renewal, but recently was informed that this was not possible. Connie Cochran reports it will be addressed in the waiver redesign. The ESOs currently receive funding for some employment related supports through DARS that are not yet reimbursable through the HCBS waivers. DARS also qualifies and monitors these providers. DBHDS will need to analyze how best to approach these issues to create an environment that encourages ESO providers to expand employment supports to individuals in the HCBS waivers.

**Conclusion and Recommendation:** The DBHDS is in compliance with maintaining the SELN and maintaining an Employment Services Coordinator, but is not in overall compliance with *III.C.7.b*. It does not comply with the requirements to share employment as the first day service option using a person-centered process. The DBHDS cannot report on paying minimum wages in employment settings, which is another requirement of *III.C.7.b* and is not holding the CSBs responsible for their compliance with this provision of the Settlement Agreement. The DBHDS should continue to work collaboratively with the SELN and develop by-laws and guidance for appointing the SELN members.

## VII. Summary

The Commonwealth of Virginia has made strides toward implementing the employment services requirements of the Agreement since the review in the spring of 2013. The SELN is more organized and has more input into planning to improve and increase employment for individuals with ID and DD. The Employment Services Coordinator remains committed and passionate about enhancing employment services and continues to provide strong technical assistance to the SELN and is engaged in effective training and work with stakeholders. The new administration is committed to employment for individuals with ID and DD, the continued engagement with the SELN, and the waiver redesign. Providing administrative leadership and support for DBHDS's work in the area of employment will be critical to the success of the initiative. It is encouraging that DBHDS has set meaningful targets to increase the number of individuals who are employed and has outlined a plan to increase opportunities for integrated day activities.

The Commonwealth is not in compliance with *III.C.7.a*. It is not providing individuals in the target population integrated day opportunities to the greatest extent possible. The review of ISPs indicates a pattern of minimal or no discussion of employment by teams. The implementation plan to increase integrated day activities has not yet been developed or implemented.

The Commonwealth is not in compliance with Section C.7.b.i. It has developed a very preliminary plan, rather than the required implementation plan, for integrated day activities. It is currently not offering integrated day activities other than supported employment to the target population. I recommend a more detailed plan be written by June 30, 2014 and submitted to the Independent Reviewer. DBHDS needs to indicate when these options will be available to individuals and how data will be tracked and reported.

The Commonwealth is in compliance with Section C.7.b. It has maintained its SELN membership, has established the required state policy on Employment First, has included a term in its performance contract with CSBs, and has an employment services coordinator. It is a significant concern that the review of ISP indicated that case managers are not implementing that term of the contract. It is recommended that DBHDS determine how it will monitor, document, and report to the Independent Reviewer that the Employment First policy is being properly implemented (Section IX.C.)

The Commonwealth is in compliance with Section C.7.b.i.A and with Sections C.7.b.i.B.1.a, b, d, and e. It is not in compliance with Section C.7.b.i.B.1.c, as it cannot produce information regarding the wages of individuals in supported employment.

The Commonwealth is in compliance with Section C.7.b.B.2.a. It has now set meaningful targets for ISE and for the number (85% of the supported employment target) maintaining employment for twelve months for FY15- FY19.

There are numerous recommendations offered throughout this report for serious consideration by the Commonwealth. Most important is creating a meaningful and accurate data reporting system, training both ID and DD case managers in employment first and their responsibilities to the individuals they serve, holding the CSBs accountable for implementation of the employment initiative, and effectively reaching out to individuals with developmental disabilities and their families.

**APPENDIX D**

**COMMUNITY LIVING OPTIONS**

**By: Patrick Rafter**



# MEMORANDUM

**To:** Donald Fletcher, Independent Reviewer /Virginia  
**From:** Patrick Rafter, CEO, Creative Housing Inc.  
**Re:** Review of Consent Decree Housing Activities

At your request I reviewed “Virginia’s *Plan to Increase Independent Living Options*”, associated progress reports, and staff meeting minutes. I then had the opportunity to discuss the plan directly with team members involved in the plan development and implementation. I appreciate the willingness of all parties to be generous with their time and candid in their discussions.

## **General Observations:**

**Separation of Housing & Supports:**The Virginia Plan designates the separation of housing and supports as its “cornerstone”. I encourage the Virginia team stay in touch with this cornerstone as they move forward developing increased housing capacity as a parallel activity to projected waiver development. Having worked in a system where almost all new development over the last 20 years mandates a separation of housing and supports, I can attest that; while a bit traumatic at first, few, if any of us would want to revert to the system in which the residential support provider controlled housing. This separation allows for providers to focus on the care, support and growth of people with disabilities as their core competency. Most importantly, positioning people with disabilities as lessees with independent landlords; empowers these individuals and their families to select (and deselect) their preferred support provider agency. What emerges over time is a true customer-centered free market system for people with disabilities.

**Waiver Reform:**Team members generally concede that the existing Medicaid waiver does not adequately encourage the movement of individuals from congregant care situations to more independent consumer controlled living environments. DBHDS staff outlined the issues in the Virginia plan and is working to amend the existing waiver. Until amended, the waiver will serve as a burden to, and even a barrier to, helping individuals move from congregant care group homes to more independent living.

DBHDS staff also noted that the current waiver restrictions on sharing supports may result in the unintended consequence of keeping individuals in congregate care settings. Through discussions with colleagues working in other states I believe the time is ripe in the evolution of waivers to engage CMS in discussions focused on allowing consumers the option of choosing to pool their support dollars. It is important that CMS not see this proposal as a restriction on free choice of provider. Rather, it is an additional option for consumers to choose to live nearby or with each other, to collectively select the same provider, or to enable some individuals to live independently who might otherwise not have the support package to do so.

Potential Federal Assistance: The Virginia team is cognizant of federal programs (i.e. HUD 811, Section 8 ) that provide housing options for people with disabilities. The team has outlined efforts to secure potential funding from these federal sources. While these funding options have yet to be pursued, Plan updates should be realistic with projections of available housing resources within existing and projected federal budget cuts. With the HUD 811 program engaged in slow motion reform, and Section 8 waiting lists closed, I anticipate that traditional federal housing programs will be, at best, minor contributors to the housing development for the target group and of no material benefit for at least the next two to three years.

### **The Virginia Plan:**

The Virginia Plan provides a thorough situational analysis of the challenges facing the Virginia team as they work to increase housing capacity to meet the needs of the expanding pool of waiver recipients. In addition, the Virginia Plan outlines and demonstrates tracking a broad range of administrative activities and processes. In terms of actual deliverables (i.e. specific schedules/numbers for increased housing capacity meeting the cornerstone de-coupling principle) there are significant concerns with the Plan's actual capacity to develop community-based housing for the target population. There are only two elements of the Plan that appear to have solid funding behind them: Low Income Housing Tax Credit Development (LIHTC) and the Rent Subsidy Pilot. Both programs have problematic elements.

LIHTC: The plan to develop 150 accessible/affordable units on an annual basis has no direct linkage to the waiver slots being created. That is, they will be made available in the general housing market where the development is completed. This will begin no sooner than two years from now. The units may or may not be located in areas of the state that have the most need for housing for the target population. I questioned representatives from the state housing authority about setting aside these units directly for individuals in the target population, and they indicated it was considered not possible. If these units were set aside for the target population, or, to allow other individuals to move from congregate settings to create vacancies for the target population, it would require a careful choreography with DD service providers working with housing developers. This coordination is essential for individuals with DD to access these housing resources with the supports needed to meet their essential needs. Such coordination is not addressed in the plan.

Time limitations prevented an assessment of the availability of subsidies and external funding resources that could make housing available to individuals with incomes significantly lower than those traditionally housed in LIHTC developments.

I recommend that the proposed LIHTC development for low income accessible units be restructured with a clear focus on the target population. Absent a restructuring it should be eliminated from the housing plan, as it gives the false appearance of offering housing options for the target group.

Rent Subsidy Pilot: I was able to spend some time with the team at Fairfax – Falls Church CSB. While the first person had yet to be placed, it is evident that the team, working with DBHDS staff, has put together a thoughtful implementation plan. The pilot project team is focused on the right issues and is enthusiastic regarding implementation.

The limited resources devoted to rent subsidies and its compartmentalization as a “Pilot Project” essentially takes off the table what could be one of the most useful tools in the housing plan. An expanded rent subsidy program will not require development sophistication, can move rapidly to access the existing housing market, and can be directed to specific areas of the state where individuals in the target population choose to relocate.

Given there are a number of individuals with disabilities already living in subsidized apartments in Virginia, the data is already available to move beyond this small pilot and go to scale. I encourage the Virginia team to do this as rapidly as possible to keep abreast of waiver development. As you expand the program I encourage you to think about the following issues:

- o Single Point of Contact with Landlords: Some of your clients may have initial adjustment problems to apartment living. There should have one contact person in your system that will reach out to support staff for problem resolution when contacted by a landlord. Many issues are quickly resolved if rapidly attended to. If not addressed, they can result in lease termination by the landlord.
- o Funding Flexibility: Administrators of the program should have the ability to step and make rent payments to the landlords on behalf of a tenant who may be temporarily financially struggling. This is in fact a cost savings option compared to the overall expense of having to relocate someone who has been evicted for not paying their rent. There will also be occasions when tenants are not able to pay for damages. Stepping in and making the payments develops tremendous good will with landlords whose patience may be required in the future.
- o Avoid Evictions: Once a client has an eviction on their record it restricts their access to decent housing. If a rental placement is not working out, negotiating an exit strategy with tenant and landlord is definitely preferable to leaving it up to the landlord to proceed through an eviction process.
- o Informed Decision Making: Prospective Tenants should be exposed to and visit various types of apartment living before being asked to make an apartment choice and sign an annual lease.
- o Landlord Development: The program right now excludes individuals with poor rental history. At some point you will need to serve these people. As you develop ongoing relationships with landlords you will need to find landlords who are willing to work with you to take on “tougher customers” with evictions or criminal convictions on their records.

Plan Implementation Comment: The current Virginia Plan as written calls for the development of an additional housing dimension of consumer-controlled owned or rented properties, which is a new paradigm distinct from provider- owned and operated group facilities. At the present time the new dimension has not been implemented. The individuals from the Training Centers are primarily moving to existing or expanded group home capacity. This approach may well be the necessary first step in providing post institutional placements for some individuals with extremely complex needs, but there should also be a resulting movement out of group homes into independent living situations. As it now stands Virginia is expanding capacity of congregate living facilities, but seemingly unable to come up with the resources to truly develop independent living alternatives.

**Additional Issues for Consideration:**

Broaden Housing Options: I would encourage the Housing Plan Team to continue to broaden the range of future housing options beyond the apartment living offered in LIHTC programs. There will be a number of individuals who will be better served (or prefer to live) in single family homes in residential neighborhoods utilizing a single support provider. A robust rent subsidy program opens the door to this possibility. Nonetheless finding landlords who will produce accessibility renovations and are able to deal with behavior issues is exceptionally challenging. Some states have provided grants, financed by state bonds, to nonprofit housing corporations to meet this need.

Waiver Funded Accessibility Renovations: I was not able to review the environmental modification elements of the existing waiver program. Many states have reduced potential benefits in this area in a misguided attempt at cost containment. In my experience it can represent a front end investment which pays for itself in reducing long term staffing costs. I encourage the Team to thoughtfully examine this aspect of the Waiver. Automatic door openers, track lift systems, drive-in showers and home automation systems can open the world for individuals who need wheel chairs for mobility. In many states the lack of a comprehensive accessibility program has unnecessarily kept many non-ambulatory individuals in more expensive congregate care settings. Waivers can represent a funding stream to support both housing developers and families having physically disabled individuals in their homes instead of the more costly residential system.

I am more than happy to make myself available to Virginia team members for follow up questions and clarification. I appreciate the courtesy extended to me in my visit.

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**APPENDIX E**

**LICENSING**

**By: Ric Zaharia Ph.D.**



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

Licensing Requirements of the  
Settlement Agreement

By

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

April 28, 2014

## **Introduction**

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a review of the Licensing requirements of the Agreement. This review was based on the need to assess key indicators that would produce a baseline assessment of the effectiveness of licensing processes and the more frequent licensure visitation schedules.

Licensing services in Virginia are administered through the Office of Licensing Services (OLS) at DBHDS (Department of Behavioral Health and Developmental Services). OLS operates with 32 Licensing Specialists in the field and with a central office of five (5) staff. It is the Commonwealth's primary system for regulating the conduct of provider agencies by ensuring minimum standards compliance. DBHDS also regards the Licensing system as the primary compliance mechanism for Community Service Board (CSB) case management performance under their contracts with the Commonwealth. Therefore, the effective functioning of OLS in accordance with the requirements of the Agreement is critical to the goal of improving the lives of people with intellectual and developmental disabilities in Virginia.

This report is organized in a way that parallels the two major requirements around Licensing in the Agreement: case management performance and provider performance. In each section the Methodology used is described, the findings from this evaluation are reported, and recommendations to achieve full compliance are made; suggestions are offered where an area might be improved.

Many important aspects of Licensing are not part of this review. Effectiveness of incident investigations, successful provider implementation of corrective action plans, and the management of substandard or poor performing providers via the Licensing process were not examined in this review but are proposed for evaluation in later cycles.

Les Saltzberg has been helpful in supplying materials, facilitating access, and making connections to interviewees. Appreciation is expressed to the Licensing Specialists, provider staff and CSB staff who made themselves available for telephone interviews.

## **Case Management**

Agreement:

### ***III.C. Serving Individuals with Developmental Disabilities in the Most Integrated Setting*** ***5. Case Management***

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

### Review Methodology

- 1) Reviewed current licensing standards, regulations and all licensing tools/protocols covering CSB reviews.
- 2) Reviewed all licensure survey reports with corrective action plans (19) and all *ad hoc* investigations (20) for two quarters in FY 2014.
- 3) Reviewed the survey schedule for CY 2013 for three (3) Licensing Specialists. Two were selected by OLS, one was selected by the author.
- 4) Reviewed available reports for licensing results across CSBs.

### Findings

Licensing regulations (12VAC35-105-10 to 105 1410) align generally with the case management expectations in the Agreement. The regulations do not align specifically as to the case management expectations detailed in the Agreement (i.e. regularized face to face meetings with the individual being served, enhanced visit frequency, identifying risks to the individual, offering choice among providers, assembling professionals and non-professionals who provide supports, identifying risks). Licensing protocols (e.g. checklists) align with the Licensing regulations but also do not align with the same specific requirements of the Agreement mentioned above. Per the Department's *Guidance Document for Additional Case Management Data Elements* (12/11/13 version), the role of OLS is to verify individual data elements in the enhanced case management performance documentation reported via the automated information system, CCS3. Although there was evidence in specific CSB corrective action plans that this occurs, it is not formalized in checklists or the OLS Office Protocol, which may leave it to the discretion of individual Licensing Specialists.

The current protocol for reviewing CSB case management calls for Licensing review visits "every 6 months, with a minimum sample of 10 cases". There is evidence (through a cumbersome tracking system) of CSB case management visits every six months. The majority of case management licensing reviews examined in this sample, however, resulted in a "No Violations" determination (12 of 19 CSBs). The implication is that in a review of 120 case management records out of 190 no documentation deficiencies were identified. Given the complexity of documentation requirements of case managers in general, this outcome is extraordinary for case managers who have caseloads usually over 30 individuals. Furthermore, pulling a sample of ten (10) cases to review documentation provides a) an inadequate sample at some CSBs (e.g. for a CSB with 650 clients, a sample of ten represents less than 2%, which is too low an amount on which to make a licensing judgment) and b) a review of paper and not an examination of the impacts of good (or substandard) case management. Focus on case management documentation in a Licensing review may result in problems being overlooked, substandard performance not being discovered and opportunities for improvement being missed. OLS is considering assessing case management services while it is examining services at the provider level. Some Licensing Specialists are already doing this.



OLS does not regularly compile the results of licensing reviews into a report on trends related to compliance patterns across CSBs. However, alerts and system guidances are generated by DBHDS in a way that potentially increases awareness for individuals, family members, providers, caregivers and case managers of risks and problems that may occur while someone is receiving services (e.g., constipation, choking, psychotropic medications, emergency room criteria, etc.). Nonetheless, a rich data source for other system improvements is overlooked when the results of licensing visits are not aggregated and analyzed for trends and patterns.

### Conclusion

DBHDS is not currently in compliance with the requirement to have a mechanism to monitor CSB compliance with performance standards, because the Commonwealth's monitoring protocols and regulations do not align with Agreement requirements and the OLS review process is not adequate to determine compliance with performance standards. Section IX.C requires that there be "...sufficient records to document that the requirements of the Agreement are being properly implemented..."

### Recommendations to Achieve Full Compliance

OLS should create a supplement to the case management checklist that operationalizes the expectations of the Agreement. This supplement should be outcome focused (versus documentation focused) and specifically include probes of: regularized face to face meetings with the individual being served, enhanced visit frequency, offering choice among providers, assembling professionals and non-professionals who provide supports, and identifying risks to the individual.

The OLS review protocol should require Licensing Specialists to also assess case management services while they are examining services at the provider level. The root cause of service delivery problems is often the poor coordination of services, the absence of monitoring by an outside party, or the absence of leadership/advocacy on behalf of the individual. Therefore, adding a requirement to every person-centered citation that the work of the case manager be concurrently scrutinized, will ensure the causes of many service delivery problems are addressed and not just the symptoms.

OLS sampling will be improved if the current ten (10) case sample review expectation of Licensing Specialists is modified to a 10% sample with a 10 case minimum for future CSB reviews.

### Suggestions for Departmental Consideration

OLS might consider compiling an annual trend report on licensing results for case management. Detecting and reporting patterns and frequencies in the results of licensing reviews across CSBs ensures system improvements are discovered and identified.

The goal of updating automation systems within OLS should continue, so that information retrieval and the “connecting of dots” across systems, services, and geography are done efficiently.

## **Provider Licensing**

Agreement:

### **V. Quality and Risk Management System**

#### **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.*

### Review Methodology

- 1) Reviewed current licensing standards, regulations and all licensing tools/protocols.
- 2) Reviewed minutes of the Licensing Stakeholders Workgroup.
- 3) Interviewed the Director of the Office of Licensing three (3) times.
- 4) Reviewed a sample of licensure survey reports with corrective action plans (44) and all *ad hoc* investigations (20) for two quarters in FY 2014.
- 5) Reviewed survey schedules for CY 2013 for three (3) Licensing Specialists. Two were selected by OLS, one was selected by the author.
- 6) Reviewed available reports for licensing results across providers.
- 7) Interviewed and reviewed the qualifications and experience of the six (6) last hired OLS Licensing Specialists.
- 8) Interviewed nine (9) provider representatives who were selected by the author (three in-home, three day support, three residential), who have experienced a recent licensing review.
- 9) Reviewed seven (7) complaint investigations from individuals/family members/guardians/anonymous sources who have made formal complaints to DBHDS.

## Findings

Licensing regulations (12VAC35-105-10 to 105 1410) align generally with the expectations in the Agreement. Licensing protocols (checklists) align with the Licensing regulations in most areas except for the Services and Supports area of the regulations, which are the heart of the Agreement (Section V.D.3). This gap leaves assessment up to individual Licensing Specialist discretion and may contribute to reliability problems in interpretation.

Provider feedback suggests confusion at the agency level as to how a variety of items are interpreted by Licensing Specialists. Although it has been utilized during the past 6 months, the recently formalized “dispute resolution process” does not necessarily reassure providers. For example, the regulation for “Monitoring and evaluating service” at 12VAC35-105-620 covers a body of work for providers that is potentially substantial, but it is described in only sixty three words and there appear to be no supplemental materials for providers or Licensing Specialists to reference in order to interpret this significant requirement. The Licensing Stakeholders Workgroup has begun work on a) clarifying current regulations, in order to address provider concerns and to potentially increase reliability among Licensing Specialists, and b) identifying needed changes in the regulations.

The sampling methodology for unannounced provider visits described in the latest Office Protocol requires that Licensing Specialists review “a representative sample (more than two) of client records...interviews staff and clients”. This low sample number and the apparent absence of a checklist for interviewing reduce confidence in the thoroughness of Licensing reviews. For example, at a provider serving 100 clients this is a sample of about 3%, which is an inadequate number on which to make a licensing judgment. The absence of a checklist for interviewing staff and clients ensures there will be variability in interpretation between Specialists.

The sample of Licensing Specialists who were interviewed for this study appeared mission- driven, well trained and appropriately qualified. There is a generally positive high regard for Licensing Specialists among providers with exceptions usually centered on contested citations where the concern is the “fair” application of a regulation. OLS has made extensive efforts to enable informal collaboration among Licensing Specialists as to the appropriate interpretation of a regulation. In addition, the Department has made available sufficient resources to support the Specialists with in depth clinical, healthcare and medical consultation.

Over the past five years the number of providers licensed by OLS has increased from 552 (FY08) to 844 (FY13), a 53% increase. During the same period licensed service locations (perhaps a more accurate indicator of workload for Licensing Specialists) has increased from 3,357 to 7,063, a 110% increase.

The Licensing reviews that were examined for this study include clear statements of provider problems and appropriate corrective action plans. Four ID providers have been moved to

provisional licenses during FY14. Again the website is unreliable: of three current ID providers with provisional licenses, only one is listed under the link “Providers with Provisional Licenses”. Providers, for the most part, agreed in retrospect with the validity of problems identified at their agencies. The reviews examined for this study also suggest that the enhanced Licensing visit frequency requirements of the Agreement are being achieved. In addition, there is evidence that some Licensing Specialists are assessing the adequacy of services and citing inadequate services or plans. The posting of the corrective action plans to the DBHDS website demonstrates a commendable effort to inform the consumer public, but the site does not reliably display all inspections (e.g. Licensee #325, 7-11-13).

The review of a sample of ad hoc investigations conducted by Licensing Specialists suggests appropriate attention to detail and fact-gathering. Investigations that reveal regulatory compliance problems evolve into corrective action plan requirements of the provider. This review of these seven (7) complaint investigations suggest investigators are thorough and appear to go to root causes. Three (3) of the seven investigations identified problems with and resulted in corrective action plans for “adequacy of services”. Investigations that result in corrective action plans are posted to the DBHDS website. Again, this posting demonstrates a commendable effort to inform the consumer public, but the site does not reliably display all investigations (e.g. Licensee #016, 7-16-13). Finally, near unanimous feedback from providers was that Licensing Specialists are professional and respectful when conducting follow-up investigations on the deaths of individuals.

The “Submit a Complaint about a Licensed Provider” link for the DBHDS website was not functioning at the time of this review. It is located on the OLS tab and is not on the DBHDS Home page; it is two clicks into the OLS page from the Home page.

OLS does not regularly compile the results of licensing reviews and report trends and patterns across providers. DBHDS is consequently relying on the memories and subjective impressions of OLS staff to know what Licensing reviews reveal about the strengths and weaknesses in the provider system. A rich data source for other system improvements is overlooked when the results of over 1500 formal licensing visits a year are not aggregated and analyzed for trends and patterns.

The work of OLS is generally respected by the provider community. In response to the query, “The Office of Licensing’s involvement in my program helps me provide high quality services,” the nine (9) providers gave it an average 4.2 rating out of 5. In the words of one provider, “their visits keep you on your toes.”

DBHDS has available in statute sufficient authority to enforce its regulations, but it appears reticent in recent years to have utilized those authorities. OLS has the necessary regulatory tools to force improvements among substandard providers and to eliminate substandard providers who have demonstrated a refusal to improve their services. These tools include mandatory training, fines up to \$500 per violation, provisional licensing, revocation, summary suspension in emergencies, probation, reduced licensed capacity, admission freeze, and funds withholding (Va. Code. §37.2-418 & 419). The use of provisional status with four (4) ID providers over the past year appears to be a modest enforcement effort in a system with 844 providers. OLS reports that it is planning to increase the use of fines in the next year. However, the lack of use of the other half dozen tools suggests continued attention and emphasis on enforcement is necessary. Finally, due process and regulatory protections appear sufficient and appropriate to ensure that actions OLS might take are based on substantive issues and only after multiple attempts to clarify, assist and support a provider.

## Conclusions

DBHDS appears to be in compliance with Section V.G.1. and 2. The schedules of Licensing Specialists, provider reports, and corrective action plans examined for this study indicate that the enhanced Licensing visit frequency requirements of the Agreement are being achieved.

DBHDS is not currently in compliance with the requirements of Section V.G.3. DBHDS does not have evidence at the policy level that OLS is producing reliable licensing data that would allow it to identify systemic patterns of compliance problems with the Agreement, including its “data and assessments” across the eight (8) domains at Section V.D.3. Weaknesses in the sampling methodology, the absence of a Licensing tool/checklist for the Services and Supports section of the regulations, and the absence of a structured approach to the outcome focus of staff and client interviews indicates policy level activity that needs to be completed before an “in compliance” determination can be reached.

## Recommendations to Achieve Full Compliance

OLS should fulfill the requirement of systemic analysis of the “adequacy of individualized supports and services” by compiling regularly, at least annually, a trend report on licensing results for ID provider services. Detecting and reporting patterns and frequencies in the results of licensing reviews across agencies and services not only ensure system improvements are discovered, but it will also allow for a continuing source for the identification of needed guidance instructions, alerts, trainings, etc.

OLS will improve the thoroughness of provider reviews if it modifies its sampling methodology to a 10% sample with a minimum of three, and it develops an outcomes focused checklist and a robust sampling methodology for interviews with staff and clients.

Implementation of a tool that all Licensing Specialists use to review providers in the Services and Supports area will improve the reliability and consistency of OLS assessments and consequently the data available to evaluate trends and patterns.

The Licensing Stakeholders Workgroup should continue its work on updating regulations, in order to formalize the requirements of the Agreement in the regulations.

The Licensing Stakeholders Workgroup should continue its work on clarifying current regulations, in order to ensure the provision of reliable results and to reassure all parties that DBHDS is committed to clear and transparent practice standards.

## Suggestions for Departmental Consideration

OLS might consider convening an advisory committee of providers and Licensing Specialists to do a monthly or quarterly review of disputed citations or questions about regulatory interpretation. An approach such as this would amplify provider input and create an anonymous source to identify the need for regulatory clarification. This could result in less time being spent on dispute resolution and informal discussions, and would address the sentiment of a few providers that Licensing Specialists can be “intimidating” and may be feared for “retaliation” for disputing citations.

OLS might consider a formal, annual inter-rater reliability check for each Licensing Specialist as part of their personnel performance evaluation. This may inspire increased confidence among providers who are skeptical about the “fair” application of the regulations.

DBHDS might consider adopting a formula for Licensing Specialists that will assure that OLS capacity is expanded with increased workload in the future. For example, one (1) Licensing Specialist per thirty-two (32) licensed provider agencies or one (1) Licensing Specialist per 220 licensed service locations.

Given the increased complexity of scheduling, OLS might consider adopting a template for the individual organization of the visit workload of Licensing Specialists; for example, an Excel spreadsheet could be adapted to allow for the retrieval of past visit dates, as well as the planning of unannounced visits. This scheduling format could then be examined in real time (e.g. files on shared drives) by central office managers to ensure retrospectively and prospectively that the required frequencies of visits are being followed.

DBHDS should assess the legal counsel resources available to OLS in the pursuit of increased enforcement activity. The ability of Licensing staff to proceed with enforcement activities is heavily based on the ready availability of legal counsel, who ultimately determines the vigor with which enforcement activities will be pursued.

DBHDS might consider refreshing the “Submit a Complaint about a Licensed Provider” link on the website and moving it to the Home page, in order to improve consumer access.

OLS should consider investing administrative support resources to ensure website accuracy. The unreliability of the data on the Licensing pages makes them virtually useless for consumers or family members to research a provider they may be selecting for services.

## **Next Steps**

In subsequent reviews of Licensing the following should be considered for assessment:

1) Section ***V.C.3,6 Quality and Risk Management System\**** identifies Licensing as the Commonwealth’s primary investigative body for abuse, neglect and other human rights violations; a sample of investigations should again be assessed to ensure a focus on root causes, as opposed to those causes that are most obvious and generally offered first. This might be accomplished by retracing the investigatory process by interviews with Licensing Specialists and involved provider parties.

2) CSB licensing results around case management requirements should be assessed longitudinally for multiple years, in order to verify that agency shortcomings are resolved and not

repeated from review to review. The case management record for a sample of individuals representing the ‘enhanced frequency’ category of clients from ‘No Violation’ licensing reviews could be examined by a 3<sup>rd</sup> party to ensure issues are not being overlooked.

3) Licensing surveys should be assessed longitudinally for multiple years of the same provider, in order to verify that service delivery problems do not recur.

4) OLS disciplinary and corrective actions with problematic providers and CSBs since August 2012 should be studied, in order to verify providers and CSBs with service delivery problems are corrected or experience consequences for substandard practice.

*\* 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.*