REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

SETTLEMENT AGREEMENT

UNITED STATES V. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

April 7, 2013 – October 6, 2013

Respectfully Submitted By

Donald J. Fletcher
Independent Reviewer
December 6, 2013

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

This is the third Report to the Court in the Settlement Agreement (the Agreement) between the United States and the Commonwealth of Virginia (the Parties), Civil Action No. 3:12cv059. The Agreement was entered provisionally, March 6, 2012. This report of the Independent Reviewer (the Reviewer) is for the review period, covering April 7, 2013 through October 6, 2013.

There are approximately 8.19 million residents of Virginia. In October 2013, the Commonwealth's Developmental Disability System was serving 19,189 (.2%) of these Virginians, as follows:

- 10,622 (55%) were being served in the community with Intellectual and Developmental Disabilities (ID/DD) waiver funded services;
- 741 (4%) were residents of Virginia's five Training Centers; and
- 7,826 (41%) were on waitlists for waiver services.

An additional 272 children with ID/DD were living in large congregate nursing homes and Intermediate Care Facilities.

In the Agreement, the Commonwealth committed to improve the lives of people with ID/DD. It agreed to provide opportunities for them to live in integrated settings, to prevent unnecessary institutionalization, and to reform the service system. In making these commitments, the Commonwealth acknowledged the need to increase and reform its community capacity to support individuals consistent with the terms of the Agreement. The provisions of the Agreement were designed to improve lives by achieving the goals of community integration, self-determination, and quality services for individuals with ID/DD.

Since the Agreement was provisionally entered on March 6, 2012, through October 6, 2013, the end of the third review period, the Commonwealth has undertaken a broad array of initiatives to comply with the requirements of the Agreement. During these nineteen months, the Commonwealth had provided funding for new waivers, in greater numbers than required by the Agreement and for a new Individual and Family Support program. It also provided funds for other new and enhanced services, for increased oversight and monitoring, and for staff to lead and support the planning and development of new initiatives and system reforms. The Department of Behavioral Health and Developmental Services (DBHDS) had created eighteen Project Teams, each with dedicated leaders, which were planning and implementing initiatives to begin to achieve compliance with specific provisions of the Agreement. The Commonwealth transferred responsibility for the Developmental Disabilities (DD) waiver, and the staff who support its operation, from the Department of Medical Assistance Services (DMAS) to DBHDS on November 13, 2013. The purpose of the reorganization is to facilitate a more coordinated and easier to negotiate service delivery system and future system reforms following the restructuring of the Home and Community Based Services (HCBS) waivers and rates. A nationally recognized vendor has been selected and has nearly completed the first phase of a comprehensive study of the Commonwealth's HCBS waivers to address concerns, including those related to providing services in integrated settings. The Commonwealth also has made significant efforts to gather and provide requested documents to the U.S. Department of Justice and the Reviewer.

The Reviewer prioritized six areas of review for the third review period. They include: Discharge and Transition from Training Centers; Resolving Barriers; Safety in the Community; Case Management; Crisis Services; and Quality and Risk Management. Information about each of these substantive areas was gathered and evaluated through four studies. An Individual Review study of the services for forty-eight individuals who moved from Southside and Northern Virginia Training Centers was completed, as were three evaluations by expert consultants. These evaluations included a third review of the Crisis Services system's performance and initial *baseline* studies of Case Management and Quality and Risk Management.

After careful consideration of the facts and findings from these reviews, evaluations and information from other sources, the Reviewer determined that during this third review period the Commonwealth had continued in good faith to fund, to plan, and to organize efforts to implement the initiatives and reforms required by the Agreement. While significant progress has been made and some provisions of the Agreement have been achieved, there are also many areas where the outcomes through the third review period have been mixed. The Commonwealth is monitoring its implementation efforts. It is aware that additional work is needed, and is working toward fully meeting the requirements of the agreement.

The Agreement's provisions are in different stages of implementation and monitoring. As discussed in the following Report, the Reviewer determined that the Commonwealth has achieved compliance in some areas and not in others. In other respects, it is too early to determine if the current planning and developments will comply with the Agreement. The Reviewer has determined, however, that other initiatives, if implemented as currently planned, will not achieve compliance. Details of the Reviewer's findings, as well as the Reviewer's conclusions and recommendations, are provided in the Findings section of this report.

The Commonwealth has created and implemented a detailed Discharge Planning and Transition process for individuals who live at its five Training Centers. In doing so, it has complied with many provisions of the Agreement, but not all of them. Of the approximately 1050 individuals who resided at the Training Centers, at the time the Agreement was signed, more than 300 individuals and their Authorized Representatives have chosen to move to homes in the community. These choices have occurred as a result of individuals and families becoming more comfortable choosing a community option. The choices have been made after engaging in the Commonwealth's process to learn about community alternatives and service providers, about how the individual's specific essential needs would be met, and about how services would be effectively provided in more integrated settings. For those who live in a Training Center that is slated for closure, a choice of another place to live will ultimately be necessary. They will choose either to move to a community setting or to another Training Center.

The Report's sections on Discharge Planning and Transition, Resolving Barriers, and Safety in the Community provide detailed information obtained from the Individual Review study of the services provided to individuals who moved from the Training Centers during this period. Although there were individual exceptions, the themes of positive outcomes identified for the transition process included:

- The discharge planning and transition schedule was modified, as appropriate, based on the needs of the individuals and their Authorized Representatives.

- Individuals lived in homes that were attractive, in appealing neighborhoods, and close to resources.

- Individuals had improved behavioral and health outcomes.

- After decades of institutionalization, individuals had adjusted very well to their new homes.

- Authorized Representatives, who were initially reluctant to move their loved ones from a Training Center to a community residence, had visited frequently and were satisfied.

Regrettably, although the Commonwealth had facilitated the transitions of individuals from Training Centers to live in community programs, the range of options available to them, and to the thousands of individuals already living in the community, had not yet significantly changed. The Commonwealth is taking significant steps to build such capacity in the future. These steps include approving exceptional rates and bridge funding and initiating the process to restructure its HCBS waivers and rates.

The themes of "areas of concern" from the Individual Review study during the third review period are similar to findings from previous periods.

- Program options that offered "most integrated settings" were not available to many individuals.

- The individuals' support plans (ISPs) and daily routines did not actively support skill development to increase independence or participation in the community.

It is the Reviewer's professional judgment that the greatest obstacle to the Commonwealth achieving the goals of the Agreement is providing a sufficient number and variety of integrated programs that promote skill development and community participation. The greatest barrier to the Commonwealth's development of an effective Quality and Risk Management system is that its current regulations and contract relationships with service providers limit its ability to collect information about the risk of harm. The Commonwealth acknowledges that the current language of its regulations is a problem and that it will need to revise them. As it develops its quality system, the Commonwealth should closely examine its regulations and contractual relationships to determine how they can be improved to ensure that all providers consistently meet standards of expected performance.

During the next (and fourth) review period, therefore, the Reviewer has 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, and
- Mortality Review.

The next Report to the Court will be submitted on June 6, 2014. It will focus on the period covering October 7, 2013 through April 6, 2014.

In the end, it is clear that the effective implementation of the Agreement will depend on the continued contributions from individuals with ID/DD, their families, advocates, service providers, Community Service Boards, the staff of many Commonwealth and local agencies, the General Assembly, and the leadership of the Governor.

Therefore, the Reviewer is deeply appreciative of the support and efforts of all those involved in his assessment of the Commonwealth's compliance with the terms of the Settlement Agreement.

The Reviewer extends a sincere thank you to each one of the individuals with ID/DD and their families who shared their stories and perspectives. He also deeply appreciates all others who helped: service providers, local government and state agencies, the Department of Justice attorneys, volunteers, advocates, experts and consultants. The Reviewer believes strongly that involvement of all these stakeholders is critical to success. It is their on-going and vigorous advocacy, and their willingness to engage and problem solve, that will help achieve the goals of the Agreement. The active involvement of stakeholders will also help sustain success when the Agreement is no longer in effect.

II. INTRODUCTION

This is the third report of the Independent Reviewer (Reviewer) to Judge John A. Gibney, District Judge in the United States District Court for the Eastern District Court of Virginia (the Court) in the Settlement Agreement (the Agreement) between the United States (DOJ) and the Commonwealth of Virginia (the Commonwealth), Civil Action No. 3:12cv059. It covers the period from April 7, 2013, through October 6, 2013, with some information gathered through November 15, 2013.

The Reviewer's previous reports to the Court provide important background information about the Agreement. They also describe the activities of the Commonwealth to fund, plan, and implement the Agreement's provisions; as well as the Reviewer's activities and methods of gathering and verifying information to determine whether the Commonwealth is in compliance. This background information helps to understand the contents of this report. The Reviewer's Reports can be found by clicking on "Independent Reviewer's Report" at http://www.dbhds.virginia.gov/Settlement.htm#Review.

The third reporting period, like the second, included the development of new plans and the actions to implement many others. The Agreement was designed to initiate and accomplish significant change – to enhance services and to strengthen safeguards – during the first two years.

This report includes the findings, conclusions, and recommendations of the Reviewer for the areas monitored during this period. The Reviewer prioritized six major areas for the most in-depth monitoring:

- Discharge Planning and Transitions from SVTC and NVTC
- Resolving Barriers
- Safety in the Community
- Case Management
- Crisis Services
- Quality and Risk Management

Information related to each of these priority areas was gathered and evaluated through four studies. An Individual Review study of the services for forty-eight individuals who moved from Training Centers was completed and independent consultants with specialized expertise did three evaluations. The evaluation of the Crisis Services system, the third such review, studied the actions taken to follow-up on the Reviewer's previous recommendations. The evaluations of Case Management and Quality and Risk Management were both initial baseline studies of compliance.

Individual Review study: The Reviewer and expert consultants again utilized a monitoring questionnaire to gather information to review the status of services for individuals who moved from the SVTC and the NVTC to community-based homes and services. The individuals selected for review were forty-eight individuals who moved during the third and fourth quarters of Fiscal Year 2013. Two-person teams reviewed the services of a statistically significant random sample of twenty-eight individuals; one member of each team was a registered nurse with extensive experience serving individuals with ID/DD. Twenty-two of the individuals had moved from SVTC and six had moved from NVTC. 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 sample size provides a 90% confidence level and a 10% confidence interval and, therefore, offers a sufficient degree of confidence that findings can be generalized to the forty-eight individuals.

For this report, the findings from the Individual Review study are separated into categories of "positive outcomes" and "areas of concern" for the individuals in the selected sample. The Reviewer has determined that, for the cohort as a whole, the ratings above eighty-five percent compliance represent "positive outcomes" whereas below that level represents "areas of concern". The Individual Review reports have been provided to the Commonwealth so that the issues identified for each individual will be reviewed. The Commonwealth has been asked to share the reports with the individual's residential provider and CSB and to provide updates by March 31, 2014, on actions taken in relationship to the issues identified.

Many of the same questions in the Individual Review study of individuals who moved from the Training Centers were asked in a similar study of individuals who moved from Training Centers that was completed in 2012, a year earlier. Where a change of 10% or more has occurred, a comparison table in this report shows the extent of the change for specific questions.

The findings of the Individual Review study are provided in three subsections under III. Findings. They are: A. Discharge and Transitions, B. Resolving Barriers, and C. Safety in the Community.

The ***Review of Crisis Services*** was to determine the Commonwealth's follow-through on the Reviewer's recommendations, outlined in his report of June 6, 2013. The findings related to each *issue for follow-up* are listed, and the conclusions and recommendations are included in the Findings section of this report. The expert's full report lists, in detail, the primary issues reviewed. It also details the process used to determine the focus of the review, the documents reviewed, and the individuals interviewed. The full report is attached as Appendix C.

The ***Case Management Requirements*** and the ***Report on Quality and Risk Management*** evaluations were baseline assessments. Both involved studying systems that were currently operating and system reforms that were in the early stages of planning and implementation to meet the required provisions of the Agreement. As baseline studies, many important aspects of these systems were not part of these studies. Why certain aspects were or were not included in these evaluations is explained in the full reports that are attached as Appendix B and D. Each report describes the focus of the review, the methodology used, the documents reviewed, and the names of the individuals interviewed. The results of the evaluations are included in the findings, conclusions, recommendations, and suggestions for the provisions studied.

For areas prioritized for evaluation, the Reviewer and the expert consultants utilized the relevant sections of the State Health Authority Yardstick (SHAY) rating scale to evaluate and determine the adequacy of the plan and implementation efforts. The SHAY is a nationally recognized tool developed at Dartmouth University to review a state's ability to plan, develop, monitor, and evaluate evidence-based practices regarding system development and program implementation.

Reports of the Commonwealth's efforts, accomplishments, positive outcomes and areas of concern are described in the related Findings section of this report. The Reviewer's suggestions at the end of

the report are for the Commonwealth's consideration. They are steps that the Reviewer believes, if implemented, will help achieve the goals of the Agreement.

The Reviewer's determination of compliance with a provision of the Agreement is an overall judgment made at the conclusion of the review period in consideration of information gathered from all sources. Future determinations of compliance by the Commonwealth will depend on its making ongoing good faith efforts and concrete progress in the areas of concern and in addressing the recommendations.

III. FINDINGS

Below are the Reviewer's findings regarding the status of the Commonwealth's initiatives. In each section the relevant provisions of the Agreement are followed by findings, conclusions, and recommendations, if any.

A. Discharge Planning and Transition from Training Center

By July 2012…will have implemented Discharge and Transition Planning processes at all Training Centers…

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. Section: IV.A.

The Commonwealth must ensure that

...discharge plans are developed for all individuals in TC's through a documented person-centered planning and implementation process... Section: IV.B.5.

...individuals shall participate in ..discharge planning...to the maximum extent possible. Section: IV.B.3.

...final discharge plan are developed within 30 days prior to discharge…Section: IV.B.5.

...discharge planning will be done by the individual's Personal Support Team ...Section: IV.B.6.

...individuals are served in the most integrated setting appropriate to their needs…Section: IV.A.

...the PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting. Section: IV.B.11.

The final discharge plan will include…Assessment of the specific supports and services… to meet an individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available. Section: IV.B.5.c.

In the event that a PST makes a recommendation to place an individual in a congregate setting of 5 or more individuals…the PST shall identify the barriers...and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager (CIM) in accordance with Sections IV.D.2.a and f. and IV.D. Section: IV.B.15.

The Reviewer gathered information for this section from reports provided by the Commonwealth, from regular meetings and discussions with the Parties, and from an Individual Review study. The findings from the reports and discussions with the Commonwealth are presented after those from the Individual Review study.

Individual Review study: For the third review period, this study involved the discharge planning and transition of forty-eight individuals who moved from SVTC and NVTC during the third and fourth quarters of Fiscal Year 2013. Transitions from these two Training Centers were studied because they are the first two institutions that Virginia has projected to close. A random sample of twenty-eight individuals was selected from the forty-eight individuals; twenty-two had moved from SVTC and six had moved from NVTC. This sample size provided a 90% confidence level and a 10% confidence interval and, therefore, offered a sufficient degree of confidence that findings can be generalized to the forty-eight individuals.

For the most part, the Individual Review study questionnaire asked the same questions that were asked during the first and second periods. The questions were based primarily on the requirements of the Agreement and relevant DBHDS policies and procedures. In addition, for the third review period, a limited number of new questions were added to establish a baseline of the extent to which certain requirements (for example, use of rental housing, and planning for supported employment) were being met before the required date of implementation.

A two-person team of experts completed each Individual Review. One member was a registered nurse with extensive experience working with individuals with ID/DD. The reviewers studied documents related to the individuals prior to visiting these twenty-eight individuals and conducting on-site observations and interviews with their caregivers. The reviewed documents included assessments, discharge plans, post-move monitoring reports, case manager notes, and individual support plans, and, if applicable, behavior support plans.

The demographic information collected about these individuals is in Appendix A: Individual Reviews – Demographic Information. Overall, the group was older; that is, twenty-two individuals (75%) were between fifty-one and seventy years of age. Nineteen individuals (67.8%) did not speak, but could communicate with gestures and vocalizations. Nearly half of the individuals (46.4%) needed wheelchairs or total assistance for mobility.

Findings:

The reviews identified the following themes regarding the transitions and services for the individuals in the selected sample. Each of the themes represents a pattern of findings from the reviews of services for several individuals, although there were individual exceptions. The specific findings from the individual reviews are listed in tables following the description of the themes. Both the themes and the tables have been separated into "positive outcomes" and "areas of concern".

Themes: Positive Outcomes

The discharge planning and transition schedule was modified based on the needs of the individuals and their Authorized Representatives. The established pace and sequence of steps in the transition process was slowed appropriately, as needed, to ensure that discharge plans would meet the individuals' essential needs.

Individuals lived in homes that were attractive, in appealing neighborhoods, and close to resources. The home environments had been adapted for accessibility, if needed, and adaptive equipment was available.

Individuals appeared well kempt and wore clean, properly fitted clothing. These examples of desirable outcomes reflected staff attentiveness to and understanding of their role in the individuals' care.

Individuals had improved behavioral and health outcomes. There were several examples of individuals who had previous undesirable behaviors that were discovered to be symptoms of medical conditions or attempts to communicate. Medical interventions and consistent responses to behavior as communication substantially resolved these issues. An individual's poor oral hygiene was resolved by adopting a new approach to tooth brushing. Another individual, whose behaviors at the Training Center required that he eat alone, was now able to share meals with his housemates. As self-abusive behaviors diminished in frequency and intensity, and redirection was sufficient to avoid self-harm, the use of elbow restraints has been eliminated for one individual. For others in the sample, increased fluids and exercise had helped them to maintain normal bodily functions.

Individuals had adjusted very well to their new homes. This adjustment to new environments was especially impressive because most of the individuals (75%) in the sample were between the ages of fifty-one and seventy and had lived in Training Centers for multiple decades.

Authorized Representatives, who were initially reluctant to move their loved ones from a Training Center to a community residence, had visited frequently and were satisfied. Several individuals had family members visit frequently. As the family members became more familiar with the staff of the community residence and were able to note positive changes, they expressed greater acceptance of and support for the move from the Training Center to a community-based setting.

Themes: Areas of Concern

Program options that offered 'most integrated settings' were not available to many individuals. Although it was documented that the Personal Support Teams (PSTs) had described some community options to individuals and their Authorized Representatives, they did not describe supports and services that met the individual's needs and offered the most integrated settings; reportedly this was because they were not available. For example, appropriate supports and services in homes with four or fewer beds, subsidized independent housing options, supported employment, and integrated day opportunities were not described or, in most cases, currently available. For some individuals, the PST, Community Integration Manager, and Regional Support Teams had not identified the specific barriers to being able to offer such programs. Whether barriers were

identified, or not, the documentation did not indicate that steps were taken to resolve the barriers. A few individuals who had worked and earned money at the Training Center, and others who now wanted to work and earn money, were not offered supported employment options that allowed them to do so.

The individual support plans (ISPs) and daily routines did not actively support skill development to increase independence or participation in the community. ISPs did not usually include a description of the individual's current skills or what skills or community involvement were being taught or supported. Progress cannot be reliably determined without a baseline measure of existing abilities or of the skills to be developed. Without such a determination, it was not possible to analyze whether current approaches were succeeding or whether new program plans or teaching approaches should be considered. The lack of adequate attention to habilitation was also evident in the frequently observed inability of staff to describe the talents and contributions of the individuals under their responsibility. In addition, it did not appear that there was a core program expectation to help individuals to learn specific skills and to increase their abilities to participate in their neighborhoods and communities. It was noted that the individuals in the sample typically did leave their homes at least one time per week for a community trip. However, the goal for these trips appeared to be that they occur at a certain frequency, not that the individual learn skills or abilities that would enable increased participation during future community outings.

Discharge Planning – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Did the individual and, if applicable, his/her Authorized Representative participate in discharge planning?	28	100.0%	0.0%	0.0%
Was the discharge plan updated within 30 days prior to the individual's transition?	28	100.0%	0.0%	0.0%
Did person-centered planning occur?	28	100.0%	0.0%	0.0%
Were essential supports described in the discharge plan?	28	100.0%	0.0%	0.0%
Was it documented that the individual, and, if applicable, his/her Authorized Representative, were provided with information regarding community options?	28	85.7%	14.3%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	27	96.4%	0.0%	0.0%
Does the discharge plan (including the Discharge Plan Memo) list the key contacts in the community, including the licensing specialist, Human Rights Officer, Community Resource Consultant and CSB supports coordinator?	28	96.4%	3.6%	0.0%
Did the Post-Move Monitor, Licensing Specialist, and Human Rights Officer conduct post-move monitoring visits as required?	27	100.0%	0.0%	0.0%

Discharge Planning – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists?	28	92.9%	7.1%	0.0%

Discharge Planning Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Was it documented that the individual and, as applicable, his/her Authorized Representative, were provided with opportunities to speak* with individuals currently living in the community and their families?	28	14.3%	85.7%	0.0%
If a move to a residence serving five or more individuals was recommended, did the Personal Support Team (PST) and, when necessary, the Regional Support Team (RST) identify barriers to placement in a more integrated setting?	10	40.0%	60.0 %	0.0%
If barriers to move to a more integrated setting were identified above, were steps undertaken to resolve such barriers?	4	0.0%	100.0%	0.0%
Was placement, with supports, in affordable housing, including rental or housing assistance, offered?	28	0.0%	100.0%	0.0%
Were all essential supports in place before the individual moved?	28	78.6%	21.4%	0.0%

* Note: When touring homes under consideration, individuals and Authorized Representatives interacted with some individuals who were currently living in the residence. These interactions, although potentially helpful to the individuals and Authorized Representatives, were typically coincidental. There was no documentation that such interactions involved discussion about community living.

The Commonwealth has reported the availability of increased resources to assist individuals to move from SVTC and NVTC. The Commonwealth has approved an exceptional rate (awaiting approval from the Centers for Medicare and Medicaid Services) for individuals with complex needs and bridge funding to assist in transferring specific individuals with complex needs. These bridge funds will be used to ensure that community-based programs can be developed for specific residents of SVTC and NVTC who have needs that cannot be currently supported by the ID waiver.

Conclusions:

There were many positive outcomes found during the reviews of services. Some of the "areas of concern" also showed improvement in comparison with findings from the Individual Review study the previous year. As noted above, there were areas of concern that continue and will require heightened attention and focused corrective or supplemental actions.

Since the Discharge Planning and Transition process was developed, the Commonwealth has worked on providing ongoing education to staff who implements it.

For specific residents at SVTC, the Commonwealth has identified that the current ID waiver is a barrier to offering available supports and services in community-based homes. It subsequently requested and gained approval to the use of bridge funds to resolve this identified barrier. Plans are being developed to create the needed programs with the supports and services that are needed.

There are more than fifty separate provisions in the Discharge Planning and Transition (Section IV) of the Agreement. The Reviewer prioritized certain provisions for more in-depth monitoring and other provisions for monitoring of documents that are largely reports from the Commonwealth. Some provisions have not been monitored enough to reach conclusions.

Based on the results of the Individual Review study and reports by the Commonwealth, the Reviewer has determined that the Commonwealth is substantially in compliance with the following provisions of Section IV. These include Sections B.3., 4., 5.a.-b., 5.e.i, 7., 8., 9.a, 11.a., and 12.a.-c.; C.1.,2.,3.4.5.6. and 7.; D.1.,2.a.,b., and e., and 3. The Commonwealth is not in compliance with Sections A.; B.4., 5.c, 6., and 9.b.

For the remaining provisions of Section IV, the Reviewer cannot determine, or has deferred a determination of, compliance until more information is gathered and evaluated.

Most of the explanations for the bases of the Reviewer's determinations of compliance are included in the positive outcome findings listed above. The bases for the determinations of non-compliance are summarized in the two themes that describe and the tables that list areas of concern.

In regards to "most integrated settings," the Personal Support Teams (PSTs) were not describing the supports and services that met the individual's needs in community homes with four or fewer beds or day programs that provide typical days with regular integrated activities. The specific barriers to providing such options were not being identified and plans to address the barriers were not developed. Program options that offered "most integrated settings" were not available that met the needs of the individuals reviewed. Therefore, the process is not ensuring that individuals are served in the most integrated setting appropriate to their needs.

In regards to habilitation, for the sample of the individuals studied, the assessments and goals of the discharge planning and the individual support plans (ISPs) were not promoting the individuals' growth, skill development, and independence based on their strengths. In some cases, the individuals' preferences to work and earn money had not guided what was offered or provided.

Recommendations:

The Commonwealth should ensure that the discharge plans include assessments of the supports and services needed that could meet the individual's needs in homes of four or fewer beds and in integrated day activities. If such programs are not available, the specific barriers to providing such programs should be identified.

B. Resolving Barriers – Personal Support Teams (PSTs), Community Integration Managers (CIMs), and Regional Support Teams (RSTs)

To prevent the unnecessary institutionalization of individuals with ID/DD and to provide them opportunities to live in the most integrated setting appropriate to their needs consistent with their informed choice, the Commonwealth shall develop and provide the community services described in this section... Section III.

Upon referral to it (by the CRC), the Regional Support Team (RST) shall work with the Personal Support Teams (PST and the Community Integration Managers (CIM)...to resolve barriers and ensure that the placement is the most integrated appropriate to the individual's needs, consistent with the individuals informed choice. Section III.E.2.

The CRC shall refer cases to the RST for review, assistance in resolving barriers...whenever:

the PST and CRC recommend an individual residing in his or her own home, his or her family's home, or a sponsored residence be placed in a congregate setting with five or more individuals...in a nursing home or ICF...or there is a pattern of an individual repeatedly being removed from his or her current placement."

In developing discharge plans…PSTs and the CSB case manager shall coordinate with the specific type of community providers identified...to provide individuals, their families, and…Authorized Representatives with opportunities…and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities. Section IV.B.9.b.

CIMs shall be engaged in addressing barriers to discharge…Section IV.D.2

The PST and the CSB case manager shall assist the individual in choosing a provider after providing the opportunities described...Section IV.B.9.c.

The State shall ensure that information about barriers to discharge is collected from the Training Center and is...aggregated and analyzed...for development of community---based services. Section IV.B.14

...in the event of...a recommendation...to place an individual in nursing home or a congregate setting with five or more individuals...the PST shall identify the barriers to a placement in a more integrated setting...and describe in the discharge plan the steps the team will take to address the barriers...Section IV.B.15

When individuals are recommended to move to a congregate setting with five or more individuals, the Agreement calls for additional review procedures to identify and resolve barriers to serving individuals in the most integrated settings.

Findings:
The results of the Individual Review study reported that the work of the Personal Support Teams had achieved compliance in several areas.

The community residential and day services offered to the individuals in the sample were limited primarily to congregate options, i.e. group homes and day support centers.

The Individual Review study (see page 4 for description), found that twenty-five (89.3%) of the twenty-eight selected individuals moved to live in a congregate setting.

Type of Residence	**n**	**%**
Group home*	24	85.7%
Family home	1	3.6%
Sponsored home	2	7.1%
Nursing home	1	3.6%

* two (8%) of the group homes were clustered with other group home(s) on abutting property.

All twenty-four of the individuals with a day program are served in congregate day support centers.

Type of Day Program	**n**	**%**
Day Support (center-based)	24	85.7%
No current day program*	4	14.3%

* DBHDS reported that all four Authorized Representatives requested to wait to consider day support services to give the individuals time to adjust to their new residential placements.

Twenty-seven (92.9%) of the individuals participated in a community outing at least weekly. They go out primarily with their housemates as a group. Fifteen (53.6%) had the opportunity to attend religious services, whereas, thirteen (46.4%) did not. Twenty-four (85.7%) did not belong to any community clubs or organizations. None of the individuals have daily integrated activities.

Integration items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Were employment goals and supports developed and discussed?	28	0.0%	100.0%	0.0%
If no, were integrated job opportunities offered?	28	0.0%	100.0%	0.0%
Does typical day include regular integrated activities?	28	0.0%	100.0%	0.0%
Do you go out primarily with your housemates as a group?	25	92.0%	8.0%	0.0%
Have you met your neighbors?	27	29.6%	70.4%	0.0%
Do you have the opportunity to attend a church / synagogue / mosque or other religious activity of your choice?	28	53.6%	46.4%	0.0%
Do you belong to any community clubs or organizations?	28	14.3%	85.7%	0.0%
Do you participate in grocery shopping?	28	32.1%	67.9%	0.0%
Do you participate in buying your clothes?	28	32.1%	67.9%	0.0%

The Individual Review study also found many areas of concern related to the extent that the individuals who moved participated in these integrated activities in their neighborhoods or communities.

The RSTs began operating in the first months of 2013. They have met regularly, been receiving referrals, collecting data, and report having had some successes resolving barriers to serving individuals in more integrated settings. Some of the individuals selected for the Individual Review study moved from the Training Centers before the RST's first meeting. Others moved during the RST's orientation period and first few months of operations.

Conclusions:
The Individual Review studies of individuals who moved from Training Centers found that 46.9% of the individual's community-based homes were licensed to serve five or more individuals in Fiscal Year 2012; whereas 53.6% were found in such settings in Fiscal Year 2013. The proportion of individuals who moved to homes where five or more people are currently living remained steady at 33-34%. In both Fiscal Years, there were active plans to increase the number of individuals living in the homes that had licensed capacity to serve more individuals.

The additional review procedures did not had a material impact on the range of program options that were available and that met the needs of the selected twenty-eight individuals.

Program options that offered "most integrated settings" were not available to many of the individuals studied. Although it was documented that the Personal Support Teams (PSTs) had described some community options to individuals and their Authorized Representatives, it was noted that they had not consistently described available and appropriate program options for the most integrated settings that met the individuals' needs. For example, appropriate residential options with four or fewer beds, subsidized independent housing options, supported employment, and integrated day opportunities were not described or offered, and almost always were not available. The discharge plans did not include an assessment of the supports and services for these more integrated service options, and, therefore, had not identified the specific barriers to offering such programs. When barriers were identified, the documentation did not indicate that steps were taken to resolve the barriers. Some individuals and Authorized Representatives made choices without this information being made available. A few individuals who had worked and earned money at the Training Center, and others who now wanted to work and earn money, were not offered supported employment options that allowed them to do so.

Recommendations:
The Commonwealth should create residential and day program options in integrated settings that meet the needs of individuals with ID/DD who are eligible to receive such services.

The Commonwealth should ensure that its monitoring processes (i.e. case management, licensing, etc.) evaluate and, if needed, recommend strategies so that individuals are offered services consistent with the Employment First Policy and other meaningful opportunities to discover interests and participate in community life.

C. Safety in the Community

> *… individuals receiving HCBS waiver services under this Agreement shall receive case management" which means assisting "the individual to gain access to needed medical … nutritional, therapeutic, behavioral, psychiatric, nursing, personal care …and other services identified in the ISP; …*and*… monitor the ISP to make timely additional referrals, service changes, and amendments to the plans as needed. Section III.C.5.b.ii-iii.*
>
> *The Commonwealth shall provide timely and accessible supports for individuals with intellectual and developmental disabilities who are experiencing crises…*and*…services focused on crisis prevention…to avoid potential crises. Section III.C.6.a.i-ii.*
>
> *The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's … well being …Section IV.B.4*
>
> *The Commonwealth shall development and implement a system (*i.e. the Post-Move Monitoring process*)…to follow up with individuals after discharge from Training Centers to identify gaps in care and address proactively any such gaps… Section IV.C.3.*
>
> *The Commonwealth shall develop a quality and risk management system…to ensure that all services …meet the individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms…and to ensure that appropriate services are available and accessible…*and*…identify and address risks of harm…Section V.A.-B.*
>
> *The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services…* and*…shall…determine that essential supports are in place at the individual's at the individual's community placement prior to the individual's discharge…Section IV.C.5.*
>
> *…the individual's case manager shall meet with the individual face-to-face…as dictated by the individual's needs.. and in certain circumstances…at least every thirty days, and at least every two months must be in the person's place of residence. Section V.F.1.-3.*

Issues of safety in the community are addressed in several sections of the Agreement. These include, but are not limited to, provisions in Section III.C. Case Management and Crisis Services, Section IV. Discharge Planning and Transitions, and Section V. Quality and Risk Management. During the third review period the Reviewer prioritized monitoring safety in the community in several ways. These included:

- the Individual Review study;
- the *Case Management Requirements* evaluation;
- the *Report on Quality and Risk Management*; and
- the monitoring and reviews of serious injuries and deaths.

The Individual Review study gathered information about the healthcare services and outcomes for the selected individuals who moved from Training Center. It also reviewed: the frequency and content of reports from the Post-Move Monitoring process, the frequency and content of face-to-face monitoring visits and activities of these individuals' case managers, events related to individuals' high risk factors, and critical incidents.

The Individual Review study's health care outcomes for the selected individuals are presented in the tables below.

The baseline evaluation, *Case Management Requirements*, reviewed and determined the Commonwealth's compliance with the Agreement's provisions related to case management services and practices, face-to-face case management, observation and assessment, and training. The findings and recommendations from this evaluation are reported in the Case Management section (pages 20-27) of this report.

The baseline evaluation, *Report on Quality and Risk Management*, reviewed the status of the Commonwealth's plans and initiatives for selected provisions. Findings related to safety are included in the following sections of this report: Risk Triggers and Thresholds, Web-based Incident Reporting, Investigations, and Data to Assess and Improve Quality (pages 45-57).

For all individuals who moved from Training Centers, Serious Injury Reports (SIR) are monitored by the Reviewer. DBHDS requires that SIRs be submitted for many reasons. These include unscheduled visits with medical services, hospitalizations, emergency room visits, contact with law enforcement, emergency medical services, etc. SIRs that involve death or injuries that result in ongoing medical care are reviewed and reports are filed with the Court and the parties under seal. In addition to the SIR reviews during this period, the Reviewer retained an expert consultant to review the death of an individual with ID who had lived in a group home, but had not moved from a Training Center. These reports to the parties include the findings, conclusions, and recommendations, if any, that are related to the individual's events and circumstances.

Findings:
Since his previous report to the court, the Reviewer completed six reviews of serious injuries and deaths (SIR reviews). These involved individuals who had moved from the Training Centers under the agreement. Of these six SIR reviews, two involved injuries that required ongoing medical care and four involved deaths.

Between November 2011 and October 17, 2013, seven of the 313 individuals who had moved from the Training Centers had died. Six of them died during this review period. Four of these six deaths were expected and were due to cancer or other significant medical conditions. Two of these deaths were unexpected and investigations by the Office of Licensing and reviews by the Mortality Review Committee (MRC) are in process as required by the Agreement. The MRC has established a standard that reviews of unexpected deaths will be completed within ninety days of the death. The Independent Reviewer will complete a review of these deaths once the Commonwealth review process is complete.

The Reviewer's reports of the injuries and expected deaths during this period reached conclusions that were consistent with those of the internal review process. The findings and conclusions of these reports did not indicate overall trends related to the safety of the individuals who have moved from the Training Centers. Through the third review period, each of the few reviews of serious injuries to date has involved a different individual. Similarly, a different residential provider has been involved in all of the serious injury and death reviews. The number of SIR reviews, when compared with the number of individuals who have moved, is not sufficient to provide confidence that findings can be generalized to a larger group. The findings and conclusions from these reports are considered in determining compliance and in making recommendations in the appropriate section of this report.

Healthcare Items - positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Were appointments with medical practitioners for essential supports scheduled for and, did they occur within 30 days of discharge?	28	96.4%	3.6%	0.0%
If ordered by a physician, was there a current physical therapy assessment?	10	100.0%	0.0%	0.0%
If ordered by a physician, was there a current nutritional assessment?	14	100.0%	0.0%	0.0%
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	28	100.0%	0.0%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	28	89.3%	10.7%	0.0%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	28	100.0%	0.0%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	28	89.3%	10.7%	0.0%
Is lab work completed as ordered by the physician?	28	96.4%	3.6%	0.0%
Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	24	100.0%	0.0%	0.0%
If applicable per the physician's orders, Does the provider monitor fluid intake?	24	100.0%	0.0%	0.0%
Does the provider monitor food intake?	22	100.0%	0.0%	0.0%
Does the provider monitor seizures?	10	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?	27	96.3%	3.7%	0.0%
Is there documentation that caregivers/clinicians: Did a review of fluid intake?	21	95.2%	4.8%	0.0%
Made necessary changes, as appropriate?	13	92.3%	7.7%	0.0%
Did a review of food intake?	18	94.4%	5.6%	0.0%
Made necessary changes, as appropriate?	14	92.9%	7.1%	0.0%
Did a review of bowel movements?	27	96.3%	3.7%	0.0%
Made necessary changes, as appropriate?	24	100.0%	0.0%	0.0%
If applicable, is the dining plan followed?	20	100.0%	0.0%	0.0%
If applicable, is the positioning plan followed?	14	100.0%	0.0%	0.0%
Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s)?	9	88.9%	11.1%	0.0%

Healthcare Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Are there needed assessments that were not recommended?	28	21.4%	78.6%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	28	82.1%	17.9%	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%

COMPARISON – 2012 to 2013		
The dentist's recommendations were implemented within the time frame recommended?		
1st review period 2012	**3rd review period 2013**	**% change +, (-)**
66.6% (11 of 32)	82.1% (23 of 28)	+15.5%

Healthcare Items –Psychotropic Medications - areas of concern				
Item	**n**	**Y**	**N**	**CND**
If the individual receives psychotropic medication: is there documentation of the intended effects and side effects of the medication?	12	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)?	12	66.7%	33.3%	0.0%

COMPARISON – 2012 to 2013		
1st review period 2012	**3rd review period 2013**	**% change +, (-)**
If an individual receives psychotropic medication: is there documentation of the intended effects and side effects of the medication?		
66.6% (11 of 32)	82.1% (23 of 28)	+15.5%
is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?		
50.0% (7 of 14)	83.2% (8 of 12)	+33.2%
does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?		
28.6% (3 of 13)	45.5% (5 of 11)	+16.9%
do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s),		
64.3% (8 of 13)	88.9% (10 of 11)	+24.6%

The Mortality Review Committee (MRC) has established operating procedures and standards, has met monthly, and has begun reviewing serious injury data and unexpected deaths of individuals in the community. As a result of these reviews, the MRC has developed, distributed, and posted four Safety Alerts to share information with service providers. The MRC has established the standard that reviews of unexpected deaths will be completed within ninety days.

For the selected individuals moving from the Training Centers, the Individual Review study found that the Commonwealth had achieved positive outcomes for the Discharge Planning and Transition process. These positive outcomes included identifying the individuals' essential needs, developing transition plans designed to meet those needs, and identifying and making appointments within the first thirty days with all the medical specialists who will support each individual.

The Individual Review study also found a predominance of positive health care outcomes, with a few areas of concern. It also found improvements in areas of concern that had been identified in the study one year earlier.

The Individual Review study also found that the Post-Move Monitoring (PMM) visits occurred as planned and as scheduled. The PMM visits involved specialists with different areas of expertise. Their visit schedule has been modified to provide more intense monitoring during the first critical weeks after each individual moves.

Conclusion:
The community service system has undertaken several initiatives to improve quality and safety. These include:

- increased monitoring by licensing specialists and human rights advocates;
- increased case management review that includes face-to-face visits every thirty days;
- a web-based incident reporting and management system;
- the availability of Community Resource Consultants, Regional Support Teams; and
- the newly established five Regional Quality Councils and the statewide Quality Improvement Committee.

Recommendation:
The Commonwealth should ensure that for individuals taking psychotropic medications, there is documentation that the individual and/or a legal guardian have given informed consent for the use of these medication(s), that support team members know the intended effects of the medication(s), and that the potential side effects are monitored and documented.

D. Youth Residing in Nursing Homes and the Largest ICFs

> *The Commonwealth shall develop and provide the community services described in this section…to prevent the unnecessary institutionalization of individuals with ID/DD and to provide them opportunities to live in the most integrated setting appropriate to their needs consistent with their informed choice…Section III.A.*
>
> *The Commonwealth shall create… waiver slots to prevent the institutionalization of individuals with intellectual disabilities…including slots prioritized for individuals with…ID/DD…under 22 years of age from institutions other than the Training Centers (i.e. ICFs and nursing facilities).*

Findings:
The Reviewer reported in his second Report to the Court that DBHDS had established a Children in Nursing Homes work group during Fiscal Year 2013. That work group included stakeholders representing nursing homes and statewide Associations. To gain a better understanding of needs and concerns, visits were made to a nursing home with twenty children, a children's long-term stay hospital where thirteen families were met with, and an eighty-bed children's ICF. Interviews also occurred with nursing home staff. Families expressed concerns including the communities' limited capacity and gaps in the service system, especially around access to in-home nursing.

During Fiscal Year 2013, eleven children with ID, and no children with DD, not ID, moved out of these facilities. None did so as a result of the Commonwealth's workgroup's initiatives. The Commonwealth reported that it determined that the work group's initial plan should be modified to promote greater gains in this area and that a new work plan be developed to achieve compliance.

The DBHDS added new members to the workgroup from DMAS and drafted the work plan entitled: "Children in Nursing Homes and ICFs." This work plan outlines a process by which representatives of DBHDS, DMAS, independent experts and stakeholders "will develop a long term plan to reduce the number of children with ID/DD living in nursing homes, the largest ICFs/IDD and long-stay hospitals, and to reduce the risk of new admissions to these facilities for individuals with ID/DD of all ages." The goals of the plan involve assisting children and adults to move out of these facilities and implementing strategies to redirect potential admissions to community-based alternatives.

The names of 272 children with ID/DD who reside in nursing homes were identified. It has not been determined which of these individuals has been admitted since March 6, 2012, when the Agreement was entered.

Conclusions:
It was appropriate for the Commonwealth to review its progress and to revise its plan to comply with the provisions of the Agreement. The plan outlines goals and strategies to develop a full implementation plan. The plan includes identifying and implementing strategies to help individuals move to more supportive community-based living and to redirect those referred for admissions to more integrated alternatives that meet their needs. These goals are consistent with the explicit intent of the Agreement (Section I.A.) in which the Commonwealth agrees that services to individuals with ID/DD *be provided in the most integrated setting appropriate to meet their needs.*

The plan outline the Commonwealth has developed, when fully and successfully implemented, can bring the Commonwealth into compliance with the relevant provisions of the Agreement. Many of the plan's initial strategies involve evaluating and exploring options and resources and gathering baseline data.

The Reviewer has deferred a decision of the Commonwealth's compliance status pending completion of an implementation plan.

Recommendation:
Complete an implementation plan by March 31, 2014 that includes measurable mid- and long-term goals that reflect the desired outcomes for individuals with ID/DD. The plan should identify implementation milestones to achieve for each goal, the person responsible, the resources needed, and an ongoing evaluation process. The plan should identify how long term success will be measured, and the means and methods by which data will be gathered to evaluate its progress.

E. Individual and Family Support Program

> *The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization"…In FY13, a minimum of 700 individuals supported. Section III.C.2.a*
>
> *Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities (ID/DD) or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers… Section II.D.*

Findings:
The Commonwealth met the requirement to provide funds to 700 individuals and families during Fiscal Year 2013 and 1000 individuals and families during Fiscal Year 2014. The funds were distributed on a first come, first serve basis for requests for individuals on the ID and DD waitlists. Individuals and families interviewed by the Reviewer reported requesting items or services that were needed and helpful. They were especially pleased that their judgment about what was most needed was respected. It was also reported that the process was straightforward, funds were provided promptly, and the DBHDS staff involved was responsive.

During Fiscal Year 2013, the Individual and Family Support Program (IFSP) funds were distributed on a first come, first serve basis. During Fiscal Year 2014, the funds were also distributed to individuals on the waitlist on a first come, first serve basis. Of the approved IFSP awards, 20-30% go to respite for families that may be used throughout the year. No funds were withheld by DBHDS to provide support for individuals who are at risk of unnecessary institutionalization for the remainder of the year.

Case managers, families, and advocates have consistently expressed concerns that the method of distributing the IFS funds measures a family's degree of preparedness or support rather than the risk of institutionalization.

Conclusions:
For those on the waitlists for services who benefitted from the IFSP fund, it has been appreciated and helpful. The method of distributing the IFSP funds – on a first-come, first-serve basis for applications submitted on-line, however, does not appear to be consistent with providing this limited support to those most at risk of institutionalization. Distributing all the funds early in the year also seems inconsistent with the reality that the risk of institutionalization occurs throughout the year. The Agreement designates the Commonwealth to "determine who is most at risk of institutionalization." Therefore, the Commonwealth made the determination that all those on the ID and DD waitlists were those most at risk of institutionalization. It subsequently decided to distribute the IFSP on a first come, first serve basis and to distribute all the funds during the first quarter of the year. The Reviewer recommended in his previous report that the Commonwealth evaluate its initial determination that individuals on the waitlists were those most likely to be institutionalized. No evaluation has been completed.

Recommendation:
The Commonwealth should report to the Reviewer, by March 31, 2014, the number and the percent of individuals/families who receive IFS funds who are on the urgent versus the non- urgent ID waitlist and individuals with DD, not ID, who are on the emergency list.

F. Case Management

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

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

i. Assembling professionals and 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;

ii. Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP; and

iii. Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.

c. Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case 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 service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.

d. The Commonwealth shall establish a mechanism to monitor compliance with performance standards. Section III.C.5.a-d.

During the third review period, the Commonwealth was actively involved with the CSBs and private providers in changing the case management system. The Agreement requires implementation of significant changes in case management services and practices. Enhanced case management services (i.e. 30 day face-to-face visits) were required for certain individuals, as of March 6, 2013. Case managers were completing the required seven training modules. The transition raised significant challenges. These included stress for case managers and their supervisors and concerns with rigid timelines and the unintended consequences. DBHDS leadership visited each of the CSBs to share information, to gather input, and to determine needed and warranted adjustments to improve the effectiveness of the guidelines and standards.

During the third review period, the Reviewer prioritized monitoring compliance with the case management provisions of the Agreement with two studies: the Individual Review study (see description on page 4) and *Case Management Requirements* which is a base line assessment by an independent consultant with expertise in case management. The positive outcomes and areas of concern found by the Individual Review study are presented in the following tables. The results of the baseline assessment of case management are reported below the tables.

Individual Support Plan Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the individual's support plan current?	28	100.0%	0.0%	0.0%
Is there evidence of person-centered (i.e. individualized) planning?	28	100.0%	0.0%	0.0%
Are essential supports listed?	28	89.3%	10.7%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	28	100.0%	0.0%	0.0%
Medical	28	96.4%	3.6%	0.0%
Health	28	100.0%	0.0%	0.0%
Recreation	28	92.9%	7.1%	0.0%
Mental Health	14	85.7%	14.3%	0.0%
Transportation	26	96.2%	3.8%	0.0%

Individual Support Plan Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
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?	28	67.9%	32.1%	0.0%
Does the individual's support plan have specific outcomes and support activities that lead to skill development or other meaningful outcomes?	28	28.6%	71.4%	0.0%
Does the individual's support plan address barriers that may limit the achievement of the individual's desired outcomes?	27	11.1%	88.9%	0.0%

Individual Support Plan Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
If applicable, were employment goals and supports developed and discussed?	28	0.0%	100.0%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Day/Employment	27	81.5%	18.5%	0.0%
Dental	28	71.4%	28.6%	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?	6	50.0%	50.0%	0.0%
Have any identified concerns been resolved?	20	80.0%	20.0%	0.0%
Is residential staff able to describe the individual's talents/contributions, preferences and weaknesses?	28	60.7%	39.3%	0.0%
In your professional judgment, does this individual require further review?	28	35.7%	64.3%	0.0%

COMPARISON – Case Management		
1st review period 2012	**3rd review period 2013**	**% change +, (-)**
Concerns identified with the individual's supports have been resolved.		
66.7% (12 of 18)	80.0% (16 of 20)	+13.3%

Below are the positive outcomes and areas of concern found in the residential programs where case managers monitor the implementation of a significant portion of the individuals' support plans.

Residential Staff – positive outcomes Items				
Item	**n**	**Y**	**N**	**CND**
Is there evidence the staff has been trained on the desired outcome and support activities of the individual's support plan?	28	100.0%	0.0%	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)?	28	89.3%	10.7%	0.0%
Is residential staff able to describe the individual's likes and dislikes?	28	92.9%	7.1%	0.0%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	28	100.0%	0.0%	0.0%

Residential Environment Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is your home located near community resources (i.e. shopping, recreational sites, churches, etc.?)	28	89.3%	10.7%	0.0%
Is the individual's residence clean?	28	92.9%	7.1%	0.0%
Does the individual appear well kempt?	28	92.9%	7.1%	0.0%
Is the residence free of any safety issues?	27	92.6%	7.4%	0.0%

Residential Environment Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Are food and supplies adequate?	27	77.8%	22.2%	0.0%
Is there evidence of personal décor in the individual's room and other personal space?	27	44.4%	55.6%	0.0%

Case Management Requirements: The expert's evaluation of case management was a baseline assessment of compliance. The many important aspects of case management that were not part of this review are described in the full report *Case Management Requirements* (Appendix C**).** The expert's report describes the methodology used, the documents reviewed and the completed interviews. The documents reviewed include the processes that govern case management: the Operational Guidelines, the Choice Protocol, the CSB Provider Search website, and the seven module online case manager training curriculum. During the evaluation, the expert also completed the seven modules of training that are required for all case managers.

The results of the baseline assessment, the facts gathered during the Individual Review study, and the Independent Reviewer's evaluation of other information reviewed were considered in the findings and recommendations. They include direct statements and paraphrase the expert's report "Case Management Requirements".

Findings:
The Individual Review study established that all individuals whose services were reviewed were receiving case management services.

The DBHDS "Choice Protocol" is a good example of shifting toward a person-centered system. The distribution of the Choice Protocol, however, is optional and at the discretion of the case manager. The Choice Protocol does not include a formal mechanism for an individual/Authorized Representative to either choose or change among available case managers. This is an emerging best practice nationally. (The Commonwealth's DD waiver's provision for choice among private case managers is one approach to this end.)

The DBHDS website "CSB Provider Search" is a positive example of putting consumers/family members/Authorized Representatives in the 'driver's seat' by giving them an electronic marketplace where they may objectively seek out the best-matched provider. Its use, however, is only part of an established practice for Training Center placements.

Based on the review of one Licensing report from a full Licensing review and a subsequent Corrective Action Plan, DBHDS appeared to follow a well-organized approach to identifying compliance problems with CSB case management performance. Full Licensing reviews reportedly occur only once every three years; however, interim review visits can occur if conditions warrant. Other strategies are under development to comply with the Agreement's provision that requires *a mechanism to monitor compliance with performance standards*. At this time, however, there does not appear to be a formal accountability measure built into the process to supplement tri-annual licensing visits.

Conclusions:
DBHDS appears to be making substantive efforts to transform the processes which drive case management services. DBHDS and its agents are correctly articulating the aspirational intent of the case management provisions of the Agreement. DBHDS leadership got high marks from the CSB directors interviewed, based on their availability, responsiveness, and ability to effect change.

The case management and Individual Support Plan system produces positive outcomes in:

- being person-centered;
- plans that are current;
- providing the range of services identified in the ISP (with noted exceptions); and
- that the individual's essential needs for care are being met.

The staff that delivered the services that were monitored by the case managers was attentive and knowledgeable about the individual's likes and dislikes and her/his role in their care.

The case management system and the individuals' support plans, however, were frequently found not to actively promote either active habilitation or community integration. As described in Section B. of this report, the individual support plans typically did not include outcomes that related to the individual's talents and preferences or specific outcomes and support activities that lead to skill development and increased independence and self-determination.

Enhanced Case Management

F. Case Management

1. *For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.*
2. *At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.*

3. *Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals who:*

    a. *Receive services from providers having conditional or provisional licenses;*
    b. *Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS") category representing the highest level of risk to individuals;*
    c. *Have an interruption of service greater than 30 days;*
    d. *Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;*
    e. *Have transitioned from a Training Center within the previous 12 months; or*
    f. *Reside in congregate settings of 5 or more individuals.*

4. By March 6, 2013, *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. Section V.F.1-4.*

Findings:

The Case Management Operational Guidelines present the steps a case manager should follow in the event there is a problem, deficiency or discrepancy between the ISP and the ongoing provision of supports and services. The hierarchy the case manager should follow is logical and appropriate. Missing from the hierarchy, however, is an early step wherein the case manager would discuss the issue with CSB supervisors/managers. Including this step, which may now be assumed to occur, ensures the CSB is responsible for resolving implementation difficulties that the case manager is unable to resolve.

The Case Management Operational Guidelines currently require an exception report to be made to regional CRCs when thirty days visits are missed two consecutive times. Periodically aggregating these reports will help to identify trends.

As shown in the table below, the Individual Review study found significant improvement over the past year with case management review face-to-face visits now occurring at least every thirty days. The DBHDS Data Dashboard that tracks enhanced case management services (i.e. thirty day face-to-face visits) appears to have viability as an accountability tool. The Commonwealth is aware that the data entry does not allow sorting of regular versus enhanced case management. This current flaw may skew data negatively. Corrections of this flaw are planned for January 2014.

COMPARISON – Case Management		
There is evidence of case management review, e.g. meeting with the individual face-to-face at least every 30 days, with at least one such visit every two months being in the individual's place of residence.		
1st review period 2012	**3rd review period 2013**	**% change +, (-)**
46.9% (15 of 32)	88.9% (24 of 27)	+42.0%

Recommendations:
Case Management Operational Guidelines should be revised to add an early step in the process wherein the case manager would discuss the problem, deficiency or discrepancy for resolution with a supervisor or other manager at the CSB.

The current exception reports that thirty day visits are missed two consecutive times should be aggregated semi-annually at the CSB, Regional, and State levels and provided to the Reviewer as of the end of the first quarter of 2014, and semi-annually thereafter.

> 2. *At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.*
> 5. *Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observations and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3 above. Sections V.F.2. and 5.*

Findings:
The objective to measure the content of the face-to-face visits is scheduled for accomplishment in March of 2014. The Draft ECM (Enhanced Case Management) onsite report appears a good first step to address this requirement. The Draft ECM currently addresses twenty-three items to be assessed in face-to-face visits with the individual. It is "optional" to CSBs at this time.

Case Manager Training

> *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.*

Findings:
As of September 5, 2013, 4,056 case managers had completed the first six of the required case manager training modules. 3453 had completed the seventh and newest module. DMAS reported a September estimate that fifty-eight out of ninety-seven DD case managers had completed the online course.

The overall design of the seven modules Online Course for case managers is simple, attractive and easily navigated. The curriculum, which requires up to seven hours to complete, includes the range of topic areas that are central to case management. Statistics are presented as needed and appropriate philosophical emphasis on person-centered practice and self-determination is evident throughout. There is little mention, in the Online Course for case managers, of the importance of working with team members and how to assemble a team related to the responsibilities of the ID/DD case managers.

The DBHDS "Choice Protocol" addresses the choice offering process for all case managers.

The Section on "Focus on a Good Life" is very strong and provides a concrete model for case managers to follow. The Advocacy section is also well done, comprehensive and universal for all populations. The material on self-harm and harm to others is effective for caseloads with individuals who are verbal and have co-occurring behavioral health issues. It does not adequately address the needs of individuals with ID/DD who are non-verbal and where self-injury has a different topography. The motivations listed in the training modules do not apply to much of the ID/DD population. ID/DD case managers must also consider that a) self-injurious behaviors are indicating pain or discomfort, so medical causes must be ruled out and b) self-injurious behavior may be a form of communication. (Note: both a) and b) were found during the Individual Review process. In both cases attentive residential providers discovered the connections between the medical cause and communication intent.)

The teaching logic and the competency tests appear well designed and thoughtfully constructed for the learner. The concept of the team and its central role in life planning, as well as the mechanics of assembling a team, are only lightly covered. For ID/DD case managers, it is a critical skill set. The Individual Review study and other facts gathered by the Reviewer have found that this is an area of importance and, in some cases that have been reported separately to DBHDS, an area of concern.

CSB directors reported that case managers are assigned a caseload after the thirty-day requirement to complete the online course is met.

Recommendations:
If this training is not already required and provided, the Online Course should be revised to include discussion of assembling the Team and its composition as determined by the consumer/family member.

Self-harm is the analog to self-injurious behaviors in much of the ID/DD world. Content should be added to the module in future revisions to ensure case managers understand the whole spectrum of self-harm to self-injurious behaviors.

The Case Management Operational Guidelines for enhanced case management should be broadly incorporated at the next revision of the curriculum in order to ensure sustainability for the future.

The Commonwealth should set and enforce a date by which all DD case managers will have completed the online course.

G. Crisis Services

The Commonwealth shall develop a statewide crisis system for individuals with ID and DD (Section III.C.6.). The crisis system shall: provide timely and accessible support to individuals with I/D who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families; provide services focused on crisis prevention and proactive planning to avoid potential crises; and provide in-home and community –based crises services that are directed to resolving crises and preventing the removal of the individual from his current placement whenever practicable.

Crisis Point of Entry: The Commonwealth shall utilize existing CSB Emergency Services 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. When necessary the crisis hotline will dispatch at least 1 mobile crisis team member who is adequately trained to address the crisis. Section III.C.6.b.i.A.

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. Section III.C.6.b.i.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. Section III.C.6.b.ii.A.

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. Section III.C.6.b.ii.B

Mobile crisis team members adequately trained to address the crisis shall also work with law enforcement personnel to respond if an individual with ID/DD comes into contact with law enforcement Section III.C.6.b.ii.C.

Mobile Crisis teams shall be available 24 hours, 7 days per week and to respond to on-site crises. Section III.C.6.b.ii.D.

Mobile crisis teams shall provide local and timely in-home crisis support for up to 3 days, with the possibility of an additional period of up to 3 days upon review of the Regional Mobile Crisis Team Coordinator. Section III.C.6.b.ii.E.

By June 30, 2013 the Commonwealth shall have at least two mobile crisis teams in each Region to respond to on-site crises within two hours. Section III.C.6.b.ii.G.

By June 30, 2012 the Commonwealth shall develop one crisis stabilization program in each region. Section III.C.6.b.iii.F.

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. Section III.C.6.b.iii.G.

During the first, second, and third review periods, due to their singular importance, the Reviewer has prioritized monitoring the development of the Commonwealth's crisis services. Effective crisis services are a cornerstone of a community service system that is designed to prevent unnecessary institutionalization. Implementation of crisis services is a complex undertaking that impacts many aspects of the service system. Multiple reviews have been required because components of the crisis services system have been delayed and effective implementation has been uneven.

The goal of this current review of crisis services was to determine the Commonwealth's follow-through on the Reviewer's recommendations, outlined in his report of June 6, 2013. The findings, conclusions, and recommendations listed below, for each issue reviewed, are informed by, and significantly paraphrase, the expert consultant's third report, attached as Appendix C.

The independent consultant's full report lists, in detail, the primary issues reviewed. It also details the process used to determine the focus of the review, the documents reviewed, and those interviewed. As noted below, each *issue for follow-up* is listed and then followed by findings, conclusion(s) and the Reviewer's recommendation(s).

It is important to note that the Commonwealth initiated and completed a review of its crisis service system for individuals with ID/DD during this period. That review resulted in the development of a draft plan, *Crisis Response System: My Life, My Community* (the CRS Plan). This draft plan was developed to ensure that the Commonwealth meets the needs of adults and children with ID/DD while preventing unnecessary institutionalization. The Reviewer commends the Commonwealth for undertaking this evaluation. Its initiation demonstrates an understanding that implementation of complex systems must be continuously evaluated and, as appropriate; plans adjusted in order to achieve high standards and desired outcomes for individuals and their families.

1. Issue for follow-up: *the Commonwealth's ability to serve adults with DD in crisis by ensuring that individuals have case management services to assure full access to crisis services and stabilization programs, and to access community supports to prevent future crises.*

Findings:
The START program is serving adults with DD. Reportedly, of the 517 individuals referred to START for Fiscal Year 2013, eighteen (3.5%) individuals had either normal or borderline intelligence. It is not possible, however, to determine if the current utilization of crisis services by individuals with DD, not ID, reflects the number of individuals who need this service.

The Commonwealth agreed to develop a statewide crisis system for individuals with ID/DD, not only for those in the target population. The Agreement only requires that those individuals with ID/DD receiving HCBS waiver services receive case management. Case managers assist individuals to gain access to services that provide needed support to prevent and avoid future crises. The Commonwealth provides case management for all individuals that have ID and DD waivers. During Fiscal Year 2013, the Commonwealth decided to provide case management to an individual with DD who has been referred to, and used, the START program, and who is on the waitlist for the DD waiver. The Commonwealth has decided not to provide case management services to individuals who are not on the waitlist. The Commonwealth reported that it has decided instead to have this policy question studied as part of the review of HCBS waiver services that will be completed by the selected vendor during the summer of 2014.

Training has been offered to ninety-seven case managers serving the DD waiver participants and is always available on a webinar. The Commonwealth has no requirement that DD case managers take the training and no documentation of which ones and how many have been trained.

There has been limited outreach to the DD system of case managers and providers during this review period. This included outreach by the Regional START teams and representation on the Regional START Advisory Councils. CSBs do not work with people with DD and planning to include this population has been a challenge for them. Responsibility for the DD waiver and oversight of the DD case management system transferred to DBHDS as of November 12, 2013, and will allow for increased coordination. With this transfer DBHDS reports that it will determine what training will be required for DD case managers in the future.

Conclusions:
The Commonwealth has reported that it plans to train all DD case managers in the crisis system. It is the reviewer's opinion that without such training being provided, the Commonwealth is not able to provide timely and accessible crisis support to individuals with DD, not ID.

The Parties and the Reviewer cannot know the implications of the Commonwealth's decision not to provide case management services to individuals with DD, who are not on the waitlist, since there are no data kept as to how many individuals are impacted by this decision.

Recommendation:
The Commonwealth should:

- develop a method to determine which case managers have been trained about START and ensure that all DD case managers are trained by June 30, 2013;
- track the number of individuals who are referred to START who do not have a case manager and determine whether this limits access to necessary services; and
- ensure that outreach strategies are implemented, and their effectiveness evaluated, so individuals with DD and their families know about the DD Crisis Response System.

2. Issue for follow-up: *the Commonwealth's ability to provide crisis prevention and intervention services to children with either ID or DD. The review will determine the adequacy of the plan that DBHDS developed*

The DBHDS has developed a preliminary plan for Children's Crisis Supports as part of the CRS Plan. The CRS Plan outlines the mission, target population, services and requirements, a general implementation timeline and budget. It also outlines the focus of the services, the expectations and qualification of staff, staff training, and how support will be provided.

For Children's Crisis Supports, the draft calls for three staff positions to be added to each of the regional START teams during the next six months. Future staff expansion is recommended after the first six months of operation, but regions would be expected to fund additional staff with revenue from Medicaid and other insurance. The budget is based on the $1.25 M funding that was approved. There is no analysis available that projected the funding that would be needed. The Commonwealth has reported plans to collect data for future funding requests.

The CRS Plan includes a timeline for obtaining approval, establishing milestones, hiring staff, developing a communication plan, and completing home modifications. There is not an implementation plan, at this time, to initiate the Children's Crisis Supports, which are projected to be fully operational in six months.

Conclusion:
The Commonwealth is not in compliance with Sections 6.a.i-iii of the Agreement because it is not currently providing a statewide crisis system that serves youth with ID and DD. The CRS Plan has a positive mission; additional staff support will enhance the crisis teams' abilities to address the needs of individuals with ID/DD. If successfully implemented, it can bring the Commonwealth into compliance. The Plan, however, needs greater detail, including the components the Reviewer recommended in his prior report. The new DBHDS Assistant Commissioner for Developmental Services has expertise in START services.

Recommendation:
The Commonwealth should submit to the Reviewer, by March 31, 2013, its implementation plan for Children's Crisis Response Services. It should include elements that address:

- outreach to families and to organizations that provide services to children;
- education of ID and DD case managers;
- the referral process;
- the involvement of the CSBs;
- the existing supports that are available after the crisis is stabilized;
- a method for tracking children's need for out of home placement; and
- the placement outcome of children who are placed out of home.

3. Issue for follow-up: Recruitment and retention of START staff has been an issue identified in previous reviews and by the Reviewer. The Commonwealth is expected to report on the status of staffing in each of the five regional START Programs; analyze any problems in recruitment and retention; and share plans to address any ongoing staffing shortages.

Staffing information for each region indicated that the open respite crisis stabilization units are well staffed and that very few clinical positions are vacant. Of the forty START Coordinator positions, seven are vacant. This is 17.5 % of the positions statewide; however, only one region currently had three vacant positions. The CRS Plan addresses ongoing recruitment. The proposal contains recruitment strategies and a new position to complement the work of the Coordinators.

Conclusion:
There are no issues of compliance related to staffing at this time.

Recommendation:
The quarterly reports provided to the Reviewer should include any staff vacancies that occurred, the length of time vacant, and a determination whether any crisis services were not available or delivered timely due to staff vacancies.

4. Issue for follow-up: the Commonwealth's response to the training recommendations made by the Reviewer regarding: the training of CSB Emergency Services staff, including standardized information about START Services in Crisis Intervention Training (CIT); and determining the training that should be required of providers to assure coordination of follow-up for individuals who use START services.

Findings:

Training of CSB Emergency Services staff (ES): Almost half of the CSBs have the full complement of ES trained; six CSBs have between 0-10% of the ES staff trained; an additional eight are between 30-50%; and nine are between 51-90%. Region III has been able to have almost all of the ES staff in each of its CSBs trained. Region III offered CSB ES staff on-line trainings to address the training needs of ES staff working evenings and on weekends.

Region III has developed a webinar for training. There are plans to share it with other regions for their use.

DBHDS did not offer training during the first quarter of Fiscal Year 2014, had not yet developed plans for additional formal training to CSB ES staff, but has reported to the Reviewer its intention to do so.

REGION	% OF CSB ES STAFF TRAINED	CSBs WITH 100% OF ES STAFF TRAINED
I	54%	3 of 8
II	75%	3 of 5
III	98%	9 of 10
IV	62%	1of 8
V	48%	1 of 9
TOTAL	67%	17 of 40

Training of law enforcement: While some regional START programs have been involved sporadically in training with law enforcement, there has been no development of a standardized training module about the START program for CIT training statewide. The Commonwealth reported that it decided to concentrate its efforts this period on improving the operation of the START program itself.

Training of Providers: There have been numerous engagements between START and providers to offer informational sessions and training regarding START. This includes outreach and direct consultation by START Clinical Teams and training provided to residential and day providers by START Medical and Clinical Directors.

Conclusions:

The Commonwealth is not in compliance with the Agreement's provision (III.C.6.b.i.B.) requiring that CSB emergency personnel be trained on the new crisis response system. This training was required to be completed by June 30, 2012. The Reviewer recommended, in his June 2013 report, that this be accomplished within a year, since the original target date was not met. The DBHDS has another seven months to meet this recommendation. The Commonwealth has reported to the Reviewer that it plans to train all CSB ES staff.

The Commonwealth committed to develop a statewide crisis service system. The Agreement expects that the Commonwealth will have a planned approach to reaching out to and working with law enforcement personnel to improve their interactions with individuals with ID/DD. DBHDS planned to include a module about the START program in the Crisis Intervention Training (CIT) offered to law enforcement personnel. This has not occurred, however, and an alternative approach has not yet been developed. Although some regions have offered information about START in some CIT trainings, this is not compliant with the initial plans DBHDS put forward to address III.C.6.b.ii.C.

Tailoring training to providers based on the needs and circumstances of the individuals they support, who use START, is a good use of limited resources. Over time, it will be important to determine if these providers have received sufficient training and consultation to help them to successfully support individuals who experience crises and to ensure them of continuity of care.

Recommendations:
DBHDS should ensure training of all CSB Emergency Service workers by June 2014. The Department should decide if it needs to make this training a requirement of the performance contract it has with the CSBs, in order to guarantee that there is full participation.

Training that provides an orientation to the crisis services system for individuals with ID and DD should be developed and included in all regions' Crisis Intervention Training for law enforcement personnel.

5. Issue for follow-up: the Commonwealth's plan to reach out to law enforcement and criminal justice personnel to link individuals with ID and DD to crisis intervention services to prevent unnecessary arrests and incarceration.

Findings:
Region III works specifically with law enforcement, based on the specific interactions of individuals they support with the police, to coordinate roles, train, and try to engage them in some aspects of future planning for the person. Region III also worked with CSBs and providers to encourage the use of police only in response to emergency situations that cannot otherwise be handled rather than as the first response to an individual who may be non-compliant with his/her plan.

The Virginia START Annual Report for Fiscal Year 2013 indicates referral sources for all individuals referred to START. No referrals were made by law enforcement.

The CRS Plan proposes changes in the START crisis intervention service delivery approach. DBHDS reports that it did not complete the part of the plan that includes strategies and activities to reach out to law enforcement in a planned, comprehensive and consistent way. When completed, DBHDS will develop and submit its plan to do outreach with law enforcement departments and their staff.

Conclusion:
The Agreement requires mobile crisis team members to work with law enforcement personnel to respond, if an individual with ID/DD comes into contact with law enforcement. While there are vignettes from some regions about work with law enforcement, such initiatives are not consistently underway across the State. The DBHDS has not responded as yet to the Reviewer's recommendation to develop an outreach plan for the regional START/crisis services programs to work effectively with law enforcement. Therefore, the Commonwealth is not in compliance with Section III.C.6.a.ii.C of the Agreement.

Recommendation:
Each region should report on its work with law enforcement. These reports should include CIT, and any other types of trainings and consultations held. These reports should be submitted after the second quarter of 2014 and semi- annually thereafter.

6. Issue for follow-up: *The Commonwealth's response to the recommendation to provide bridge funding to residential providers to maintain a person's residential setting while they are being stabilized as a result of a crisis.*

Findings:
The Agreement requires the Commonwealth to provide crisis services that are directed at removing crises and preventing the removal of the individual from his or her current placement, whenever practicable. DBHDS reports that it does not have, and does not plan to develop, a mechanism to provide bridge funding for residential providers to assist them in maintaining the individual's placement during psychiatric hospitalization or an alternative out-of-home crisis stabilization placement.

Of the 517 referrals to START in 2013, 208 (40%) of the individuals referred lived in a group home. Of the total number of people referred and served by START, 159 people had been hospitalized at least once in the previous year. Data maintained do not show the type of residence at the time of referral. It is reasonable, however, to assume that, of the 25% of individuals referred who needed an out of home placement, many had been residents of group homes.

Conclusion:
The Commonwealth does not plan to provide bridge funding to residential providers to insure continuity of care for the individual. Doing so is not, in and of itself, a requirement of the Agreement. Preventing the loss of one's home placement, however, is a central theme of the Agreement's crisis provisions. DBHDS is not able to provide information to the Reviewer about how frequently an individual who is placed out-of-home for crisis stabilization is then not able to return to his/her original home or residence.

Recommendations:
The Commonwealth should report to the Reviewer, as of March 31, 2013, and quarterly thereafter, the number of individuals removed from their homes for an out-of-home placement during a crisis, the duration of out-of-home placements, and the number not able to return to his/her original home or residence.

***7. Issue for follow-up*:** *The Commonwealth's development of policies, procedures and protocols to guide the development and implementation of START services.*

The Reviewer made several recommendations about the need for written guidance for aspects of the START program and the Department's development of a crisis system that relies on community linkages and partnerships. These include the assignment of case managers for individuals with DD who are not on the waitlist for the DD waiver; the training expectations of CSB Emergency Service personnel; medical screenings prior to an admission to the START Respite Home; the role of the case manager in the service planning and discharge processes to assist the individual to gain access to needed services; coordinating crisis planning for individuals leaving the Training Centers; and implementing procedural changes resulting from a Corrective Action Plan (CAP) statewide.

Findings:
No policies, procedures or protocols that address these areas have been developed during this review period.

The Commonwealth reported that it decided to concentrate its efforts this period on reviewing and improving the operation of the START programs. The Commonwealth's efforts led to the draft CRS Plan. That plan proposes that some successful policies and protocols of Region III will be adopted statewide.

Conclusions:
The lack of training for CSB Emergency Services personnel does not meet the Agreement requirements of III.C.6.b.i.B.

The lack of involvement of ID and DD case managers in service planning, in assisting individuals to gain access to needed services, and in the discharge of an individual referred to START is not in compliance with III.C.6.a.i-iii and III.C.5.b.i.iii.

Since the Commonwealth's system for case management is decentralized through the CSBs and private agencies and is not under the direct authority of DBHDS, it is even more essential that the role of the case manager be specified. The case manager is critically important to effective communication between the person, family, existing providers, and the START program. It will be the case managers' responsibility to ensure that all follow-ups occur, and that the individual is linked to appropriate community resources after the crisis has been stabilized or other major events have occurred, and to assemble team members, if changes are needed to the individual's service plan. Guidance for case managers in both the ID and the DD systems should be developed and provided to them.

Recommendations:
DBHDS should develop guidance for case managers that details its expectations for their involvement in planning, coordinating, and following up on crisis intervention and prevention services.

The Commonwealth should develop policies, procedures, and protocols that govern the important aspects of crisis services operation.

8. Issue for follow-up: *The Commonwealth's ability to respond to individuals in their homes to de-escalate a crisis; the steps taken to respond to expand the mobile crisis teams' capacity to respond to on-site crises and the response time to emergency calls.*

The START Teams continue to respond directly to requests for crisis intervention for adults with ID or DD. During the first quarter of Fiscal Year 2014, 515 individuals received support. Many of the referrals were for people who need comprehensive assessment and planning, prevention strategies and community linkages.

The Agreement requires that the mobile teams respond to each crisis within two hours. During the fourth quarter of Fiscal Year 2013, the teams achieved an average response time of 1 hour and 45 minutes. Of those responses, however, 73% occurred within two hours while 27% took more than two hours for a mobile crisis worker to reach the person. Similarly, the report of the first quarter of Fiscal Year 2014 indicates that 78.6% of the responses occurred within two hours; while 21.4% took more than two hours or no response time was reported.

The draft Crisis Response System Plan (CRS), "My Life, My Community," was developed by DBHDS in response to concerns about the lack of:

- timely crisis interventions, or immediate supports, for individuals not known to CSB Emergency Services (ES) or START;
- crisis interventions for individuals under eighteen with ID/DD;
- clear collaboration with Emergency Services, and
- information about the program available to law enforcement.

The purpose of the plan is to revise the current system to provide more immediate crisis interventions for people who are experiencing a crises due to behavioral and/or psychiatric issues and to support their families. In-home and community based supports will be designed to resolve the immediate crisis and allow the person to remain at home, if at all possible. The Crisis Support Unit that is the START respite home will continue to be available as a last resort and only for emergency respite. In the CRS plan, the DBHDS will provide prevention crisis services as a secondary approach rather than continuing it as the primary focus envisioned by the current START program's vision and structure.

The expert's full report (Appendix C) provides detailed descriptions of the key components of the draft CRS Plan, including *emergency services*, *mobile crisis services*, *intensive in-home supports*, and the *crisis support units*. The DBHDS reports that it will develop additional components to the Plan once it is discussed with the START directors. The expert's report indicated that the draft plan does not yet include a detailed budget and funding sources, a communication plan to educate families, an outreach plan to school systems or community providers, a description of how coordination between CSB's Emergency Services and the START crisis programs will occur, a description of the case managers' responsibilities, or a plan to work with law enforcement. The draft timetable projects that full implementation will be achieved by August 31, 2014.

Conclusions:
The Commonwealth remains in compliance with Sections 6.b.i.A, 6.b.ii.A, 6.b.ii.B, and 6.b.ii.D. START Coordinators have been providing local and timely in-home crisis support as required under Section 6.b.ii.E.

The draft CRS Plan proposes to focus the START teams on more direct, hands-on, and immediate intervention. It will likely strengthen the teams' success in addressing crises by adding staff that can provide direct interactions for up to seven days, complementing the support offered by the START Coordinators. The draft CRS Plan proposes improvements that should make the existing system more responsive by adding resources to provide more immediate assistance to stabilize crises. A determination of the adequacy of the draft CRS Plan, however, will be determined after it is fully developed and finalized.

The Commonwealth is not in compliance with Section 6.b.ii.G that requires a response time of two hours and the availability of two mobile crisis teams in each region. The Commonwealth's decision to add staff and determine the best supervisory configuration in each region, rather than necessarily having two distinct teams, should be acceptable to meet this requirement as long as the response time requirement is met and sustained.

Recommendation:
The Commonwealth should submit, by March 31, 2014, a comprehensive implementation plan for the completed CRS and for implementing crisis services for children with ID/DD. The plan should include the outcomes and performance measures the DBHDS plans to use, and the data that will be collected to determine if measures are being met and outcomes are being achieved. These data should include measures of family satisfaction with the timeliness and quality of supports; information on how many people were able to maintain their original home setting; and information on how the changes implemented by the CRS impact out of home placements or admissions to institutions.

9. Issue for follow-up: *The availability of START crisis stabilization programs homes in each region and the utilization during the last quarter of FY13 and the first quarter of FY14.*

Findings:
The Agreement required the Commonwealth to open Crisis Stabilization homes in each region by July 2012. While none of the regions met this timeframe, Regions I (central), II (northern), and III (southwestern), opened their homes prior to or during calendar year 2013 and have provided emergency and planned respite since then. During the two most recent quarters, the utilization of all available bed days for emergency respite has remained near 50%; whereas utilization of the planned respite beds increased from 19% to 33%. Regions IV (greater Capital) and V (Tidewater) still did not have their crisis stabilization homes open during this review period. They both expected the homes to open, however, in November 2013. Both were able to refer individuals to the crisis respite programs in other regions.

The draft CRS Plan recommends that all crisis stabilization beds be used for emergency respite and that planned respite beds be eliminated. Yet in both Fiscal Year 2013 and the first quarter of Fiscal Year 2014, more individuals used the available beds for planned respite, although for fewer days. The CRS Plan did not explain how the elimination of the planned respite component would impact crisis prevention and proactive planning.

Conclusions:
The Commonwealth is not in compliance with Section III.C.6.b.iii.F that requires the establishment of one crisis stabilization program in each region by June 30, 2012. The Commonwealth should achieve compliance with this requirement by the end of this calendar year. To sustain compliance, however, Region IV must take meaningful steps and make substantial progress toward providing a permanent respite home.

Region IV invested funds and over eighteen months to purchase and begin renovations of a community-based respite home. Zoning complications, however, required the development of an alternative. Due to the needs of individuals with ID/DD who reside in the greater Capital district, the Reviewer agreed to the Commonwealth's request that Region IV open a respite home at a temporary location, while the permanent community based respite home is developed.

The Agreement (III.C.6.b.iii.G) requires the development of an additional crisis stabilization program in each region, if determined necessary to meet the needs of the individuals with ID/DD. Since the utilization rates are substantially less than 100%, and there will soon be additional capacity in Regions IV and V, it is reasonable that the Commonwealth has determined that additional settings are not needed at this time. The utilization of the respite homes, and waitlists, should continue to be monitored.

The Commonwealth's decision to end planned out-of-home respite jeopardizes the Commonwealth's compliance with Section III.C.6.b.ii.B. That provision expects that the mobile crisis teams plan and identify strategies to prevent future crises. The availability of planned out-of-home respite in a familiar setting with familiar and well trained staff is a prevention strategy that the teams have been able to offer. This service is not available through typical residential settings, especially for individuals with co-occurring or behavioral challenges. It is therapeutic in nature and is part of a comprehensive plan to address both the issues that led to the initial crisis as well as to avoid crises in the future, by providing a familiar and consistent therapeutic out-of-home support. As more states move to a family support model of service delivery that relies on the family to maintain their family member at home, therapeutic and familiar respite services in a familiar building and with knowledgeable and familiar staff is an important support to avoid potential crises and to avert the need for out-of-home placement.

It appears that the availability of START services can be more widely shared with both ID and DD consumers and their families. Outreach to individuals and their families has been primarily through CSB ID case managers. It is unclear how the availability has been made known to individuals with DD and their families. If there is more comprehensive outreach and dissemination of information about crisis services directly to individuals and their families, there may be an increase in referrals.

Recommendation:
The DBHDS should monitor implementation of the completed CRS Plan. Monitoring should include an evaluation of the impact of program modifications changes that are implemented on the prevention of future crises. It should determine if the elimination of current strategies, such as the planned respite component in the crisis stabilization settings, has reduced the ability to proactively plan and avoid potential crises. The evaluation should include "user" input from families whose members have used the program and case managers whose consumers have used planned respite.

H. Integrated Day Activities and Supported Employment

The Commonwealth shall…to the greatest extent practicable…provide individuals in the target population receiving services under this agreement with integrated day opportunities, including supported employment Section III.C.7.a.

…establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment First policy shall, at a minimum, be based on the following principles:

(1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth;

(2) the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and

(3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in ISPs. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.

i. Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreational opportunities, and other integrated day activities. The plan will be under the direct supervision of a dedicated employment service coordinator for the Commonwealth and shall:

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

1. Establish, for individuals receiving services through the HCBS waivers:

2. Annual baseline information regarding:

a. The number of individuals who are receiving supported employment;

3. Targets to meaningfully increase;

a. The number of individuals who enroll in supported employment 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.

Previously, the Independent Reviewer reported that the Commonwealth had complied with a number of the Agreement's Integrated Day Activities and Supported Employment provisions. The Commonwealth had complied with Section III.C.7b. by the development and approval of a statewide Employment First policy. This policy was included as a specific requirement in its performance contracts with the CSBs. This contract term required CSBs, as of July 1, 2013, to offer supported employment in integrated work settings as the first and priority service option for individuals with intellectual or developmental disabilities, who are receiving day program or employment services from or funded by the Commonwealth.

The Commonwealth had also developed and submitted a Strategic Plan for Employment First. However, that plan, as written, did not comply with Section III.C.7b. It lacked the requisite elements of an implementation plan and did not include a section to increase integrated day activities.

Findings:
The Commonwealth took several steps during the third review period. It met with national experts, worked with the Commonwealth's SELN (Supported Employment Leadership Network Advisory Group) and developed an updated draft plan, "*Virginia's Plan to Increase Employment Opportunities for Individuals with Intellectual Disabilities (the Employment First Plan.".* This plan was scheduled to be reviewed soon for final revisions and approval by the Commonwealth's SELN.

The draft Employment First Plan includes six goals. These goals involve formalizing an interagency workgroup, providing education, creating new sources of information, increasing awareness, and ensuring that the restructure of the HCBS waivers and rates create incentives to provide employment services.

The percentage of individuals with ID or DD who received supported employment waiver services during this review period has not changed significantly. A precise determination could not be made. DBHDS reported that eighty-one individuals were newly enrolled in individual supported employment. The number of people who have discontinued the service during that period, however, is not yet available, and, therefore, the net increase in the number of individuals currently in these programs could not be determined. The Reviewer previously reported that the Commonwealth had established a goal of newly enrolling in individual supported employment twenty-seven more individuals than in the previous year, 162 compared to 135. For two primary reasons, the Reviewer opined in his previous report that this goal was too modest. The first reason is that the overall number of individuals receiving waiver services had increased significantly, by an additional 653 individuals in a year. Second, the percent of individuals receiving supported employment in the Commonwealth was less than half the national average (8% compared with 20%). By the end of Fiscal Year15, the number of individuals with waiver services will increase to more than 10,700. To reach an overall enrollment in supported employment of 20%, DBHDS would need a multi-year plan to increase from fewer than 900 to 2,140 individuals. The Commonwealth reported that the SELN Advisory Group has discussed increasing the target by an additional 20% the second year and by 50% the third year.

The Individual Reviews studied the services of individuals who moved from the Training Centers during the third and fourth quarters of 2013. These individuals moved before DBHDS required the application of the Employment First policy. The Individual Review study found a baseline of zero percent compliance with Section III.C.7b. (i.e., the application of the Employment First Policy). Employment goals were not developed or discussed with any of these individuals or their Authorized Representatives. Two of the twenty-eight individuals had worked and earned money while residing in the Training Center. The discharge records of three other individuals indicated an interest in working and earning money. One individual had worked at the Training Center and purchased many personal items with his earnings. (These grooming supplies, movie videos and records were displayed prominently in his bedroom on the day of the site visit.) Although the discharge record indicated that work and earning money were important to him, the residential provider decided, on her own, that the individual's real interest was in socializing. Therefore, he was referred to and now attends a congregate day support facility, owned by the residential provider. He was not offered supported employment and his typical day does not involve integrated activities.

The Authorized Representative of one man who worked at the Training Center knew that he had enjoyed his job there. However, the decision was made for him to move because the family had chosen an available group home. They did not want him to lose the residential option, although they were informed that a supported employment placement was not available.

The Employment Services Coordinator provided eight trainings during the review period to a total of more than two hundred representatives of provider and case management agencies, CSBs, state offices and advocacy organizations.

Despite the initiatives described above, the Commonwealth has not developed a plan to increase integrated day activities for members of the target population.

Conclusions:
The Commonwealth is in compliance with Section III.C.7.b. by maintaining its membership in the SELN; for establishing a statewide Employment First policy and including it as a requirement in its contract with the CSBs; and for designating an employment service coordinator to monitor implementation of this policy. It is also in compliance with Section III.C.7.b.i.A. because statewide training on the Employment First policy and its related strategies was conducted during this review period.

The Commonwealth is not in compliance with Section III.C.7.b.i. It has not developed an implementation plan to increase integrated day activities for individuals in the target population. The Agreement required this plan more than a year ago. The Reviewer reported, in his second Report to the Court, that "the Commonwealth has not been engaged with any formal planning to develop an implementation plan to create a robust service delivery system that meets the Agreement's requirement for integrated day activities." The Commonwealth had reached out to various potential resources during this review period and found little guidance and information about integrated day activity program models. As a result, it did not engage in formal planning during the current review period.

The strategies of the Employment First Plan, if successfully implemented, will make it easier and more financially viable for providers to increase the number of individuals who receive supported employment in integrated work settings. At this time, however, it is not possible to determine whether the potentially improved conditions will be sufficient to counterbalance the forces that currently provide options which are primarily limited to large congregate non-work day facilities.

Finally, a determination of compliance is deferred for the Agreement's provisions (III.C.7.b.i.B.2.a. and b.) to establish targets to meaningfully increase the number of individuals who enroll in supported employment and remain employed in integrated work settings for at least twelve months. The Commonwealth has established targets. The small increases may be reasonable for the first year of implementing the Employment First policy. The Commonwealth plans to reset these targets on or before March 31, 2014. A determination of compliance will be made in the Reviewer's next report to the court based on the reviews of these targets by the Regional Quality Councils, their consultation with *those providers and the SELN* regarding the need to take additional measures to further enhance these services, and whether a meaningful increase is established.

Recommendation:

The Commonwealth should develop an implementation plan to increase integrated day activities for members of the target population. This plan should be completed by March 31, 2014, and include strategies, goals, action plans, interim milestones, resources required, responsibilities and a timeline for its statewide implementation.

.

I. Community Living Options

> *The Commonwealth shall:*
>
> *facilitate individuals receiving waiver services 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.*
>
> *provide information and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources;*
>
> *within 365 days develop a plan to increase access to independent living options*
>
> *within 365 days…establish and begin distributing, from a one-time fund of $800,000 to provide and administer rental assistance*
>
> *The plan will be developed under the direct supervision of a dedicated housing service coordinator for DBHDS and in coordination with…*other Virginia agencies. *Section III.D.*

The Commonwealth completed and submitted "Virginia's Plan to Increase Independent Living Options" (Housing Plan) on March 6, 2013, to comply with the Agreement's provision requiring that a Housing Plan be submitted within 365 days. The purpose of the Housing Plan was consistent with the provisions of the Agreement. The Reviewer's opinion was that the plan provided a foundation to increase independent living options, but that it lacked the elements typical of an action plan and important to successful implementation.

Findings:
During the third review period, the Commonwealth completed the development of a plan to implement a pilot rental assistance project, "Rental Choice VA." The Commonwealth envisioned the pilot rental assistance project "to identify and assess the most effective way to provide affordable, accessible, and high quality rentals for individuals with developmental disabilities."

The Commonwealth also completed several of the important preliminary steps to implementation. Agreements have been reached with two CSBs and performance contract modifications to implement the program have been written. A Commonwealth interagency Memorandum of Understanding was written and executed. The Commonwealth approved the design of the rental choice program. An operations manual has been written; forms and a program application have been completed. No distributions of the $800,000 rental assistance fund had occurred, however, as of November 1, 2013. Once the pilot rental assistance program begins, it is projected to serve18-20 individuals over three years.

The updated Housing Plan projects the development of additional accessible and affordable housing units. These new subsidized units will be available in the general housing market beginning in two years. These new units, if created, will not necessarily be for individuals with ID/DD receiving HCBS.

Conclusions:
The rental assistance pilot project has established the basis to begin operations during the next reporting period. The Commonwealth is not currently in compliance with the Agreement, as it did not make distributions from the $800,000 rental assistance fund, as required by March 6, 2013 (Section III.D.4.). It does plan to begin distributing these funds during December 2013.

The Agreement requires that the Commonwealth "facilitate individuals receiving HCBS waivers …to live in their own home or apartment." The Housing Plan plans for the development of new accessible and affordable units. There does not appear to be a connection between the development of these units and the individuals with ID/DD who are receiving waivers. The Reviewer has deferred a determination of compliance pending information concerning how the Commonwealth will assist individuals receiving new waivers to move into subsidized housing that is decoupled from services, as called for in the Housing Plan.

Recommendations:
The Commonwealth should report to the Reviewer the number of individuals who have been placed in apartments in the rent subsidy program and their prior living arrangements (i.e. independent apartment, family home, sponsored home, group home, facility).

The Commonwealth's report should inform the Reviewer, on a quarterly basis, the number of new waiver recipients who have been moved into living options in which housing and supports are decoupled, as called for in the Commonwealth's Housing Plan.

J. Family-to-Family and Peer Programs

> *The PSTs and the case managers shall coordinate with the specific type of community providers identified in the discharge plan…to provide individuals, their families…with opportunities to speak with…and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options.*
>
> *The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities." Section IV.9.b.*

The Commonwealth had previously created a Family Resource Consultant (FRC) who had developed a Family Mentor Network. This program was intended to facilitate family members of Training Center residents to receive coaching on and support with the process of making the transition to the community.

Findings:
During the third review period, the Training Center is providing a packet to each individual/Authorized Representative and CSB at each annual meeting and at the initial pre-move meeting. This packet gives links to websites that provide information regarding all residential community options. Additionally, at these meetings, an offer is given to refer the individual/Authorized Representative to the Family Resource Consultant as well as an offer to link the family with 1) a family mentor, 2) a peer mentor, 3) a family who has a loved one, with similar needs, being supported in the community. The offer and response are documented in the DP/DR.

The Commonwealth, in collaboration with a statewide advocacy organization, has received a grant to fund the establishment of a peer-to-peer program. A peer-mentor training curriculum is under development with community partners. The goal is to train fifteen mentors and to match them with two individuals each who will be moving from Training Centers. The project will be completed by December 2014.

The Individual Review study found that only four (14.3%) of twenty-eight families had conversations and meetings with individuals currently living in the community and their families. The individual reviews occurred when the Family-to-Family program was in its first months of operation.

Conclusion:
During the third review period, the Commonwealth had offered to link individuals and families with individuals living in the community and their families. The Individual Review study found that fewer than one in six individuals or their family members had such conversations.

The Commonwealth is making a good faith effort to develop programs that provide peer-to-peer and family-to-family programs.

A peer-to-peer program is not yet in place to facilitate conversations and meetings with individuals living in the community. The families of the individuals studied who moved from the Training Centers had been offered opportunities to have conversations with families whose loved ones lived in the community. For the individuals whose services were studied, however, few such conversations occurred. More efforts are needed to facilitate these conversations and meetings.

K. Quality and Risk Management System

> *To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harm, stable community living, and increased integration, independence, and self-determination in all life domains…and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system…" (Section V)*

The Independent Reviewer retained an independent consultant with expertise in quality systems to complete a baseline evaluation of the Commonwealth's compliance regarding the Quality and Risk Management provisions of the Agreement. Because many compliance efforts were in the planning and development phases, and after consultation with the Parties, the focus of the review was determined to be:

- areas in which some development had occurred; and
- areas which represent the essential building blocks for the infrastructure of a well functioning Quality and Risk Management system.

These areas include:

- risk triggers and thresholds;
- a web-based incident reporting system and reporting protocol(s);
- investigation of allegations of critical incidents;
- data to assess and improve quality;
- providers' quality improvement programs; and
- Quality Service Reviews.

This review included a number of draft documents that still were in the process of being modified. Also, the review did not include providers, individuals and their families. Their input will be sought during future reviews.

The full Report, *Quality and Risk Management* (Appendix D), includes descriptions of the methodology utilized for the review, the individuals interviewed, the documents reviewed, and how aspects of the Quality and Risk Management System will function. It also includes a list of the aspects of Quality and Risk Management that will require separate review and/or review by expert(s) with clinical knowledge.

The Commonwealth had made progress with regard to a number of the Agreement requirements for a Quality and Risk Management system. Clearly, there was a strong commitment to and excitement about the numerous initiatives underway to strengthen the Commonwealth's quality improvement processes for individuals covered by the Agreement. The expert agreed with the reports of those interviewed that more work was needed.

Risk Triggers and Thresholds

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

The goal of the expert's evaluation was to review risk triggers and thresholds that had been developed and to provide initial feedback. Objectives of the review were to determine what actions the Commonwealth had taken, or planned to take, to require providers to implement the risk management system and how it planned to make sure providers were implementing the system.

Adequately addressing events that cause harm or indicate the risks of harm is the purpose of defining and using uniform risk triggers and thresholds. A "risk trigger" is one, that when reached, would require the provider to address the risks for each individual involved. A "threshold" is one that, when reached, would require the provider to address the risks for the individuals and to determine whether more systemic actions are needed. For "risk triggers," the provider would document them, but not report externally the actions taken. For "thresholds," information about actions taken would be provided to the Regional Quality Councils (RQC) and to the DBHDS Quality Improvement Committee (QIC). For thresholds, the RCQs and the QIC would then take action as appropriate. They would either work with the provider to address issues specific to that provider or take more systemic actions. Such actions could involve issuing Safety Alerts, new protocols or service guidelines, or modifying departmental instructions.

Findings:
At the time of the review, the draft version (8/8/13) of risk triggers and thresholds had evolved, an indication that a significant amount of work had occurred.

The draft document included some valuable risk triggers and thresholds. An overarching concern, however, resulted in the lists not being complete. Two categories of triggers and thresholds were included: "required" and "recommended." Collection and reporting of those "recommended" triggers were to occur only at the discretion of providers and would not be monitored by the Office of Licensing. The "recommended" list includes significant indicators of potential for harm. For example, "Any individual with two (2) or more episodes of aspiration pneumonia within a quarter that require medical attention…" or "Two (2) or more choking events… by one or more individuals in a program or service area, within a quarter, where emergency measures such as the Heimlich maneuver were undertaken, but treatment by a medical professional was not provided." The Project Team had separated the "recommended" list of risk indicators from the "required" list. The

Commonwealth reported that this separation allows the system to begin with what is or can be reported under the existing regulations and contract requirements.

The draft risk triggers were not necessarily sensitive enough for individuals with high risk in these areas. For example, one incidence of aspiration pneumonia is significant. It should result in immediate review to prevent the next hospitalization and/or death.

The draft risk triggers and thresholds included some items as a result of mortality or literature reviews (i.e. aspiration pneumonia and constipation/bowel obstruction). However, other important indicators of risk of harm for individuals with ID/DD were not included, such as peer-to-peer aggression, serious injuries other than fractures/dislocations, systemic infections [e.g., sepsis, Methicillin-resistant Staphylococcus aureus (MRSA), etc.], pica behavior, and psychiatric hospitalizations.

The definition of many risk triggers and thresholds was dependent both on harm actually occurring and medical attention being required. Certain precursors that reflect dangerous conditions or circumstances were not included, if the result had only been minor or with no injuries. Examples of precursors that were not included are unauthorized departures that expose an individual without safety awareness to danger (i.e. traffic) or, in an individual with dysphasia, choking, while eating, that requires physical intervention to resolve (i.e. finger sweep or Heimlich Maneuver). The goal of a risk trigger and threshold system must be to identify events that increase the risk of actual harm, so that steps are taken to attempt to prevent that harm. The Agreement requires the system to address "risk of harm" as well as actual harm.

Conclusion:
The Commonwealth has made progress in developing risk triggers and thresholds, but significant challenges remain to develop and implement a complete list. Without an adequate list of triggers and thresholds, the potential for harm to individuals with ID/DD will likely not be identified early enough to prevent actual harm. The Commonwealth has reported that it is committed to making the recommended list of indicators mandatory, but that doing so requires significant regulatory change. It is the Reviewer's understanding that such regulatory change has historically taken multiple years to accomplish. Full implementation of the draft triggers and thresholds, as now written, will not comply with the requirement of the Agreement to address "harms and risks of harm."

Recommendations:
The required list of triggers and thresholds must include all significant harms and risks of harm. The Commonwealth should provide a plan and timeline, by March 31, 2014, to require the reporting of all harms and risks of harm.

The Commonwealth should continue to identify and/or develop relevant sources of data to allow expansion of the list of relevant risk triggers and thresholds; it should identify mechanisms to collect additional data to allow future expansion of the list and report these to the Reviewer by March 31, 2014.

Web-based Incident Reporting System and Reporting Protocol

> *The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol. The protocol shall require that any staff of a Training Center, CSB, or community provider aware of any suspected or alleged incident of abuse or neglect as defined by Virginia Code § 37.2-100 in effect on the effective date of this Agreement, serious injury as defined by 12 VAC 35-115-30 in effect on the effective date of this Agreement, or deaths directly report such information to the DBHDS Assistant Commissioner for Quality Improvement or his or her designee.* Section V.C.2

The goal of the independent consultant's review was to determine the status of the web-based incident reporting system, whether incident definitions were sufficient, what processes were in place to ensure provider staff reported directly, and whether necessary data were being entered into the system.

The full report (Appendix D) describes the status of the rollout of the web-based incident reporting system, known as CHRIS (Computerized Human Rights Information System); how the system functions; and how the data may be used.

The CHRIS system was rolled out over several months. On June 1, 2013, all Training Centers, CSBs, and licensed ID community providers were required to submit reports of allegations of abuse, neglect, and exploitation, serious injuries, deaths, and complaints of human rights violations. At the time of the review, the CHRIS system had the ability to begin to generate some reports.

The Commonwealth's on-line training regarding the CHRIS system and its related manual were user-friendly, and users were offered technical assistance. A guidance document was developed and posted to address questions that emerged. For example, these included a list of medication errors to be reported, the types of injuries considered "serious," and an explanation as to why the names of staff involved in allegations, serious injuries and deaths legally could be included in CHRIS.

The Commonwealth used multiple methods to determine whether full reporting had occurred. These included ongoing training regarding the requirements for reporting, a comparison of electronic reporting results to the prior "faxed" reporting system; a review by Licensing Specialists and Human Rights Advocates to ensure that all known incidents had been reported; and a requirement that all providers who are aware of an incident must report it (some duplication was preferred to unreported incidents). Determining whether full reporting is occurring is an ongoing challenge of any incident management system.

The Commonwealth reported that Training Centers, CSBs, and community providers are required by DBHDS Licensing and Human Rights Regulations to identify incidents or allegations that should have been reported, but were not, and to report them promptly if/when they are identified.

It was reported that mechanisms are not in place to ensure that reports were made for the individuals receiving DD waiver services from community providers other than those licensed by DBHDS.

The Commonwealth's project team recognizes that many reports filed regarding allegations and incidents are not complete and do not yet consistently meet quality standards.

Staff who enter data into the CHRIS system are not necessarily those with the most direct knowledge of the incident. The Agreement specifically requires that "staff…directly report" suspected or alleged incidents.

Conclusions:
The methods used to determine whether full reporting is occurring, when fully implemented and monitored over time, comprise a reasonable system of checks and balances.

The limitation on what providers are required to report significantly impacts the types of events about which the Commonwealth is made aware and, thus, stymies a more proactive approach to incident management. The Agreement only requires the web-based system to include reports of abuse, neglect, exploitation, and serious injuries, as defined in the Commonwealth's regulations. Some of the other categories of incidents that it would be reasonable to expect providers to report include: contact with law enforcement or emergency personnel; unexpected hospitalizations; peer-to-peer aggression, regardless of the level of injury; unplanned evacuations; infections reportable to the Department of Public Health; missing persons; and theft of individuals' funds or property.

There is a gap in the reporting system and reporting protocol for suspected or alleged incidents of abuse or neglect for individuals receiving DD Waiver funded services that are not licensed by DBHDS.

Recommendations:
All allegations of abuse, neglect, and exploitation, serious injuries, and deaths should be reported, including for individuals in DD Waiver funded services.

The Commonwealth should work with Training Centers, CSBs, and provider agencies to develop mechanisms to ensure that information entered into CHRIS reflects the information that the staff who became aware of allegations of abuse or neglect, serious injuries, or deaths "directly reported."

Investigation of Allegations and Critical Incidents

> *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.*
>
> *The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root analysis, and developing and monitoring corrective actions.*
>
> *Sections V.C.3-4.*

The goal of the expert's review related to investigations of allegations and critical incidents was to provide 1) an initial assessment of the draft uniform investigations training and root cause analysis training and 2) to determine expectations as to how compliance with this provision would modify current processes for investigations at the State and the provider levels.

Findings:

Progress had been made in developing standardized training that will be offered to community providers. Drafts have been completed of trainings entitled "DBHDS Investigation Process," and "Root Cause Analysis: A Brief Overview of the Analysis Process."

The draft trainings covered a number of important components of investigations, including relevant details of the investigation process. They were well organized and provided electronic links to additional resources for trainees. The Draft Root Cause Analysis training presented the process in an easy-to-understand and thorough manner.

Although the DBHDS Investigation Process training module was not yet completely developed, it was unclear whether it would sufficiently address the need for trainees to practice some of the more complex skills necessary in conducting investigations, such as conducting unbiased interviews, dealing with difficult witnesses, etc. The training was not currently competency-based, but the members of the Project Team indicated their intent to develop a competency-based component.

The trainings were in draft format. The expert report includes several observations and suggestions for improving the draft training.

Regulations require that community providers have "trained investigators," although no standards for training or the investigation process existed in the community system. It was reported that the training offered and the quality of investigations conducted by the community providers varied from provider to provider. The draft plan was to "offer as an option" the standardized trainings on the investigation process and root cause analysis. The Commonwealth reported that its current regulations do not specifically require that provider investigators or investigations comply with quality standards, that the best it could do was to offer the trainings. The Agreement only requires that these trainings be offered.

There is not a process in place to ensure that community provider who are considering hiring a staff know if that individual has been confirmed to have committed abuse, neglect, and exploitation while working for another community provider. There is a system in the Commonwealth that involves a central registry for people who have abused or neglected a child, but no equivalent system available for vulnerable adults. In fact, staff reported that when Adult Protective Services or DBHDS substantiated abuse, neglect, and exploitation, this information could not be shared with other providers.

Conclusions:
Given that conducting thorough investigations requires a specific set of skills, it will be important to build a competency-based component into this basic training for "trained investigators" to demonstrate their competency.

The Agreement requires the Commonwealth to require all community providers to develop and implement a quality improvement program that is sufficient to identify and address significant service issues and is consistent with the requirement of 12 VAC 35-105-620. Currently, the Commonwealth does not have standards for how it determines if the community providers' trained investigator, investigation processes, and investigation reports are sufficient.

The lack of a system to inform community providers as to job applicants who have been confirmed to have committed abuse, neglect, and/or exploitation exposes individuals with ID/DD to risks of harm and is not consistent with ensuring that all services under the Agreement include avoidance of harm.

Recommendations:
The Commonwealth should develop standards as to how its oversight and monitoring systems will determine what constitutes a trained investigator, a sufficient investigations process, and an acceptable investigation report.

A system should be developed and implemented to ensure that community providers know whether applicants to work with individuals with ID/DD have been confirmed to have committed abuse, neglect, and/or exploitation.

Data to Assess and Improve Quality

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

preventative care), timeliness and adequacy of interventions (particularly in response to changes in status));

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

5. *The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.*
   a. *The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.*
   b. *Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.*
6. *At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvements. Section V.D.*

The goal of the expert's review was to report on:

- the data that will be collected for the eight domains (Section V.D.3, a. through h.) and to determine the current status to provide a baseline from which to conduct future reviews;
- the connection between these efforts and the Commonwealth's CMS-approved waiver Quality Improvement Plan (Section V.D.1);
- the status of the Regional Quality Review Councils (Section V.D.5); and
- the status of the Commonwealth's ability to publicly report on the availability of services, including the number of people served in each type of service (Section V.D.6).

It is important to note that the independent consultant's review was based on draft documents. The Project Team members agreed that more work was needed. The expert's full report provides descriptions of the challenges and comments for the Commonwealth's consideration as it moves to finalize the list of data to assess and improve quality. It also lists examples of what data are included and what important indicators are not included.

The draft "DBHDS DOJ Settlement Agreement Domains" (7/31/13) listed each of the eight domains, one or more measures of each, and the corresponding sources of data. The list was a good start, but without a definition section it was, therefore, difficult to determine what the Commonwealth intended to measure and whether the items on the list adequately captured what should be measured. Further definition of the measures and expansion of the measures are needed.

The "Data Dashboard" also summarized measures being collected across the DBHDS system. The data definition page provided a helpful presentation of the data. It showed the measure, the definition, the entity responsible for reporting the data, the data source, and the frequency of review. Breakdowns of the data were then provided for each CSB to show their specific scores in comparison with the target.

Project Team members reported that there are significant challenges to developing a data-based system to measure quality across the Commonwealth and that more work is needed to expand current efforts.

Some of the indicators in the draft relied on individuals' ISPs as the basis for measuring whether or not individuals were receiving required supports. DBHDS staff reported, and the Individual Review study found, that the quality of ISPs varies greatly. The Individual Review study found that most ISPs do not include baselines of existing skills or measurable goals to achieve.

Limited data were available for individuals enrolled in the DMAS DD Waiver; however, some efforts were underway to educate the DD Case Managers about the requirements of the Agreement and the Commonwealth's efforts to collect needed data.

The five Regional Quality Councils had each met for the first time during this review period. All Councils include providers and CSBs; some include individuals and family members and members with quality improvement experience.

The Mortality Review Committee had analyzed data from neglect allegations and from serious injury reports. As a result, Safety Alerts had been issued to address choking, aspiration, and constipation; psychotropic medication; and when to access medical care. This was an example of good use of data that had resulted in efforts to improve supports provided to individuals.

The Quality Improvement (QI) Committee minutes reflect the discussion of the data, and, in some instances, some actions to address trends were beginning to be identified and implemented.

The Commonwealth is developing data to assess and improve quality independent of the CMS approved Quality Improvement Plan. An overall Quality Improvement Plan is reported to be under development.

The Commonwealth has not reported publicly on an annual basis, as required by the Agreement, on the availability and quality of supports and services, and, therefore, has not made recommendations for improvements. Several steps have been taken, however, to determine the needs of individuals, the types of services available through service providers, and gaps in available services.

Conclusion
The current list of data did not represent a sufficient list of data to assess and improve quality or to reliably comply with the provisions of Section V.D.2.a. The data selected for the eight domains was limited to what was already collected from providers, by Licensing, and by case managers. Other sources of reliable and valid data were not available. For individuals served through the DD waiver, few formal data sources are in place.

When ISPs do not adequately describe individuals' skills, then a measurement based on whether the ISP outcomes were being met would not produce valid data.

Recommendations:
The Commonwealth should continue to identify and/or develop relevant sources of data, and expand the measures to assess and improve quality.

The Commonwealth should report publicly, by March 31, 2014, on the availability and quality of services and supports in the community and any gaps in services; it should make recommendations for improvements.

Quality Improvement Programs

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

The goal of the expert's review was to obtain the status of efforts to identify measures that CSBs and community providers are to report, including any review of data by the Commonwealth's Quality Improvement Committee or the Regional Quality Councils. The goal also was to determine the efforts implemented to notify providers of their responsibilities; to determine what actions had been taken by providers to implement these requirements; and to assess the Commonwealth's plans to determine providers' compliance with the requirements.

Findings:
The Commonwealth had made some progress, but still was in the process of finalizing the data it plans to collect from the domains listed in Section V.D.3. Some of the data that providers will be responsible to collect had been identified, but the Commonwealth was still in the process of finalizing drafts of the data it intended to collect. Project Team members reported, and the consultant agreed, that additional data would be necessary to address the requirements of the Agreement. The independent consultant's report (Appendix D, pages 21-30) provides a full discussion of the current draft status of the development of the measures, the challenges the Project Team reported to develop a data-based system to improve quality, the Project Teams efforts to expand data collection, and comments for consideration as the Commonwealth moves forward.

Case managers will be one source of the data for the domains. They are also in the midst of adjusting practices to meet the standards of the DBHDS Operational Guidelines. DBHDS leadership staff have met with each of the forty CSBs and provided an overview of some changes occurring as a result of the implementation of the Agreement, including the role of case managers. From each CSB, information was collected about the specific changes they were making and challenges they were facing. As a result, some changes to the case management requirement were made.

Conclusions:
These meetings between DBHDS leadership and each CSB illustrate a proactive effort to share information, identify challenges, and constructively work to overcome concerns.

The Commonwealth was at the beginning stages of developing and implementing a communication plan to convey to providers their roles and responsibilities for maintaining necessary quality improvement processes and to share data with the Commonwealth. Some of the mechanisms for reviewing provider data were just being developed, such as the Regional Quality Councils.

Quality Service Reviews

1. *The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. QSRs shall collect information through:*
    a. *Face-to Face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and*
    b. *Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.*

2. *QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on the individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals).*

Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.

3. *The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.*
4. *The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.*

(Section V.I with focus on V.I.1.a)

The goal of the expert's review was to review the Commonwealth's plans for conducting Quality Service Reviews and to report on the status of planning efforts for the overall system. This included reviewing the adequacy of the Commonwealth's process for selecting a statistically significant sample and the Virginia-specific questions for individuals, families, and providers.

Findings:
The Commonwealth has decided to use the National Core Indicators (NCI) Survey Process to conduct the Quality Service Reviews required by the Agreement.

A vendor had been selected to implement the survey process. The Commonwealth executed a contract to conduct NCI surveys of over 1000 individuals in Fiscal Year 2014 to gain insight and knowledge about the Commonwealth's progress in improving its services for individuals with ID/DD. A sampling methodology had been developed and used to select the sample of individuals for the Individual Survey. A Guardian/Family survey also was being conducted; it is to be mailed to all guardians/families in the Spring of 2014. Two provider surveys that would be completed in the Spring of 2014 were in draft format. It was anticipated that data from these surveys will be used to address some of the domains for the "data to assess and improve quality" that will be reported to Regional Quality Councils and the DBHDS Quality Improvement Committee.

Training of interviewers was planned to begin in October 2013 with face-to-face interviews scheduled between November 2013 and May 2014. Training was also being provided to groups needed to assist in gathering background information, which will be important to allow for more extensive analysis of the data.

The NCI process collected information from face to face interviews with individuals. The process, however, did not include face-to-face interviews with either relevant professional staff or other people involved in the individual's life, as required by the Agreement. The NCI process assessed individuals' and their families' satisfaction with their supports and services. It did not include, however, a broader review to assess the adequacy of the person-centered planning process and the provision of supports and services outlined in the plans. Determinations regarding "most integrated setting" take into consideration the individual's and guardian's wishes, but also require input through professional assessments. Often individuals and their guardians/families are not aware of all of the options available and, therefore, review of the individuals' assessments and ISPs would be necessary to determine whether or not they were provided with information with which to make an informed choice.

The NCI Adult Consumer Survey for 2013-2014 was identified as a satisfaction survey only to be completed by the individual. It collected important and helpful information. It did not include, however, collecting information as required by this Agreement, e.g., assessment of treatment records and key indicator performance data, compliance with the service requirements of this Agreement, and a comprehensive record review to assess the quality of supports and services provided.

The sample selected for 2013-2014 totaled 1599 individuals and an additional 204 individuals who had been discharged for six months or more from the Training Centers under the Agreement.

Conclusion:
Although the NCI process will help the Commonwealth to collect valuable and helpful data, its implementation will not meet the requirements of the Agreement in relation to the Quality Service Reviews. As described above, the NCI process does not the Quality Service Review elements required by the Agreement. For example, it does not include face-to-face interviews with either relevant professional staff or other people involved in the individual's life. The NCI process also does not include a review, beyond the individuals' and families' satisfaction, to assess the adequacy of the person-centered planning process, and the provision of supports and services outlined in the plans.

Recommendation: The Commonwealth should review and develop an implementation plan, by March 31, 2014, to comply with the Agreement's requirements for the Quality Service Reviews.

IV. CONCLUSION:

It is the Reviewer's considered opinion that the Commonwealth has continued to make a good faith, coordinated, and concerted effort to meet the requirements of the Agreement during this third review period. As described in the Findings section of this report, overall, the Commonwealth's effort has had mixed results.

There has been substantial progress in some areas. These include creating waivers in greater numbers that required buy the Agreement, by implementing a successful IFSP program, by facilitating the transfer of more than 300 individuals from Training Centers to the Community, by implementing crisis services in Regions. In other areas, little progress has yet occurred.

The areas where the Commonwealth faces it greatest challenges are in creating program options that provide integrated settings and regular integrated daily activities. The Reviewer's expert consultants found that the Individual Support Plans (ISPs) and daily routines did not actively support skill development to increase independence or participation in the community. The lack of progress on the provisions that relate to creating opportunities to participate in one's community – integrated day activities and supported employment, more integrated living arrangements, and onsite prevention-oriented crisis intervention services – are cornerstones of an effective community based service system. The Commonwealth's ability to make progress on these programs will be the cornerstones for system reforms that fulfill the goals of the Agreement to improve the lives of individuals with intellectual and developmental disabilities (ID/DD by achieving goals of community integration and self-determination.

V. SUGGESTIONS

The Commonwealth should consider the suggestions below as well as those discussed in further detail in the full report:

Case Management

- The DBHDS (Drumwright/Keenan) CSB-visit status matrix review might be repeated with CSBs hitting less than 90% on the two Data Dashboard measures in order to ensure that discrepancies are indeed in the CCS3 extract data.

Observation & Assessment:

- The Project 9 Team should address, in the rollout of the Enhanced Case Management onsite report, the conversion steps to measures ("key indicators") that may be reported in the aggregate. It should be clarified that it is required at 30 days visits and pilot tested for efficiency in administration.

Case Manager training:

- If such a training does not already exist, then revise the appropriate module in the online case management training curriculum to address choice presentations by case managers, perhaps as an attachment for ID/DD case managers. The "Choice Protocol" provides substantive content for a curriculum modification.

- When describing the development of the ISP or monitoring it for effectiveness and satisfaction, providing a link to the actual document used for this purpose might provide a visual aid for the learner to be able to better connect with what goes in the document. If there are multiple documents based on populations, links might be added for each population.

- The curriculum learning objectives should be written in behavioral terms. Many are written using "understand," "understanding" or "know," none of which can be seen or measured. Consider replacing objectives containing these non-behavioral terms with behavioral terms such as identify, list, recognize, etc.

- In discussing the use of alternative modes of communication, consider the use of a "Behavior to English Dictionary" for individuals experiencing severe behavioral challenges. Use of the "Dictionary" captures what the people who know the person best think specific behaviors mean under specific conditions.

- Person First Language might be covered more thoroughly. The curriculum needs explanations of why Person First Language is important. Possible sources include these links:
  http://www.youtube.com/watch?v=Ob_rWNNGaJs
  http://www.youtube.com/watch?v=QQ0pKPxoyHs

Quality and Risk Management

Risk Triggers:

- Some terms in the draft list of risk triggers should be defined. For example, given the various types of restraint, it would help to clarify whether or not the term "restraint" encompasses all types of restraint.
- It was not clear why hospital-acquired aspiration pneumonia would not be considered a risk trigger. Any aspiration event presents a risk of harm to the individual. Hospital-acquired aspiration pneumonia requires attention to ensure proper staffing was made to the individual while at the hospital and to ensure that the individual's risk and plans to reduce risk were appropriately communicated to the hospital.
- The indicators that referred to changes in percentages in rates of, for example, overall medication errors or fractures should be reviewed. If a provider's base rates were already too high, these indicators would not capture the fact that a risk of harm already existed and might result in further risk of harm.
- Some indicators were based on measures included in Individual Support Plans (ISPs). When ISPs are not adequate, then data from these indicators would be unreliable and difficult to interpret and use.

Root Cause Analysis Training:

- This training should include more information related to developing corrective actions. It will help to provide some parameters related to such plans, including measurable action steps, identification of timeframes for completion, and persons responsible, as well as identification of the outcomes or specific changes against which success of the action plan will be measured.

DBHDS Investigations Process Training:

- Given the specific skills required to conduct thorough investigations and write reports that include strong bases for the findings, the final training should include specific competency-based components. These should include, but not be limited to, competencies with regard to the development of an investigation plan, securing evidence, conducting interviews, interviewing individuals with intellectual disabilities, reconciliation of evidence, and investigation report writing.

Domains:

- It will be important moving forward to provide definitions of what will be measured and the methodology to collect the data, and to ensure data are collected the same way each time.
- For each of the indicators identified for the Agreement Domains, definitions and methodologies should be developed; in addition to identifying the data source, as appropriate, baselines or benchmarks should be identified. In addition, targets or goals should be set.
- At a minimum and as appropriate to the particular indicator, the methodology section should include the following:

    1) how the data will be collected;
    2) how often and when;
    3) what the schedule is for assessing data reliability and validity, and who will be responsible for this;

4) what subpopulation or percentage of the population will be included in the sample);
5) the standards that will be applied to judge conformance with the measure;
6) who will be responsible for collecting and/or reporting the data;
7) clear formulas for calculating the indicator/measure, and
8) who will be responsible for analyzing the data.

- Further guidance should be provided to better define the types of serious illnesses the Commonwealth considers to fall under the category of serious injury.

- The scope of what is measured for quality improvement efforts should be designed to include a proactive as well as a reactive approach. Currently, all "Safety and Freedom from Harm" and "Avoiding Crises" indicators appear to be negative outcomes or reactive. Consideration should be given to including proactive measures as further development of indicators occurs (e.g., the percentages of individuals for whom behavior supports are effective at reducing the number of target behaviors, increasing the use of replacement behaviors, or the length of time without target behaviors.)

Respectfully Submitted By:

Donald J. Fletcher
Independent Reviewer
November15, 2013

APPENDICES

APPENDIX A

INDIVIDUAL REVIEWS – DEMOGRAPHIC INFORMATION
April 7, 2013 – October 6, 2013

INDIVIDUAL REVIEWS
Sample Demographic Information
October 2013

Sex	n	%
Male	16	57.1%
Female	12	42.9%

Region	n	%
I	1	3.6%
II	5	17.9%
III	1	3.6%
IV	11	39.3%
V	10	35.7%

Age Ranges	n	%
21 to 30	1	3.6%
31 to 40	1	3.6%
41 to 50	5	17.9%
51 to 60	17	60.7%
61 to 70	4	14.3%

Levels of Mobility	n	%
Ambulatory without support	10	35.7%
Ambulatory with support	5	17.9%
Uses wheelchair	10	35.7%
Confined to bed	1	3.6%
Total assistance	2	7.1%

Authorized Representative	n	%
Guardian	10	35.7%
Authorized Representative	18	64.3%

AR Relationship	n	%
Parent	14	50.0%
Sibling	7	25.0%
Other relative	2	7.1%
Other (e.g. friend)	1	3.6%
Public guardian	4	14.3%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	3	10.7%
Limited spoken language, needs some staff support	6	21.4%
Gestures	14	50.0%
Vocalizations	2	7.1%
Facial Expressions	3	10.7%

APPENDIX B

Case Management Requirements

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

Case Management Requirements

By

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

October 13, 2013

Introduction

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement requested a review of the case management system requirements of the Agreement. The purpose of this evaluation is to determine a baseline assessment of compliance with those requirements. Most basic case management system components had been in place prior to the Agreement, the enhanced case management provisions of the agreement went into effect March of 2013, and all components are planned for implementation by March of 2014.

Many important aspects of case management are not part of this review. Consumer/family satisfaction with the case management they receive, effectiveness of case management processes during transitions/crises, case manager satisfaction with their initial and ongoing training, and other impacts are planned for evaluation in later cycles.

The author completed the DBHDS required training for all case managers through the Department's online Knowledge Center during September 2013. This curriculum includes the topic areas Basics of Case Management, Services, Planning, Assessment, Building and Maintaining Relationships, Disabilities Defined, and Accountability. The interviews that were conducted and the materials reviewed that are referenced below were also completed during September.

This report is organized in a way that parallels the five major requirements around case management in the Settlement Agreement: Case Management Practice, Case Management Service, Face-to-face Case Management, Observation & Assessment, and Training. 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. Again, this baseline assessment evaluates primarily the processes proposed by DBHDS to achieve compliance; assessment of outcomes and impacts is planned for later cycles.

Kathy Drumwright and Dee Keenan have been most helpful in supplying materials, facilitating access, and making connections to interviewees. Lee Price clarified a number of questions. The members of the Project 10 Training Curriculum Team and the four CSB directors who were interviewed were most gracious and open in our discussions of the case management system.

Based on the documentation reviewed and interviews completed at baseline, DBHDS and its agents express their commitment to case managers coordinating services and supports in a way that ultimately creates a "Focus on a Good Life". They are correctly articulating the aspirational intent of the case management components of the Agreement.

1) Case Management Practice

Settlement Requirement*: III.C.5.a-d.*

5. Case Management

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

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

i. Assembling professionals and 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;

ii. Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP; and

iii. Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.

Review Methodology:

- Evaluated curriculum for ID/DD case manager training to assess completeness of training;
- Interviewed Dee Keenan and other members of Project Team 10 - Case Manager Training (Shank, Rheinheimer, Norton, Hollowell, Pinero) to determine the status of implementation and changes that are being considered;
- Interviewed four CSB directors from among five representing the five planning regions, as identified by Keenan; interview covered ID/DD case manager training, in order to verify congruence between field and Central Office perceptions of training.

Findings: See #5 below.

2) Case Management Service

Settlement Requirement:

c. Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.

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

Review Methodology:

- Reviewed DBHDS Data Dashboard as updated to assess system progress;
- Reviewed CCS3 (Community Consumer Submission 3, v.7.1) extract instructions to ensure dashboard is appropriately measuring case management services and practices;
- Interviewed Dee Keenan/Kathy Drumwright re CSB action plans regarding increasing compliance for CSBs reporting less than 90% compliance to verify expectations are being implemented;
- Interviewed four CSB directors from among five representing the five planning regions.
- Reviewed DBHDS Choice Protocol: Offering and Resolving Issues Regarding Choice in Virginia's Intellectual Disability and Day Support Home and Community Based Waivers (1/28/11).
- Reviewed sample CSB Licensing review (#190-16-001, 6/28/13);
- Reviewed DBHDS website 'CSB Provider Search'.

Findings

The Data Dashboard appears to have viability as an accountability tool for the tracking of enhanced case management services (30 day visits) and alternating in-home case management visits. However, everyone interviewed acknowledged a critical shortcoming in that data entry does not allow sorting of regular vs. enhanced case management. Consequently, the dashboard does not accurately reflect CSB performance; some percentages displayed in the dashboard for case management may be inaccurate because some CSBs, who actually have 90-100% compliance with the 30 day visit requirement, may have their data skewed negatively because percentages may include those who receive 90 day visits, thereby lowering the percentage compliance. Edits are planned for the CCS3 extract that are expected to correct this problem by January.

The DBHDS "Choice Protocol" is a good example of shifting the system to a person-centered system. However, distribution of the 'Choice Protocol' is optional and at the discretion of the case manager.

There is apparently no formalized mechanism for a consumer/family member to choose or change among available CSB case managers, who are providers of service. The "Choice Protocol" does not address choosing or changing a case manager, which is an emerging best practice nationally. (The Virginia DD waiver's provision for choice among private case managers is one approach to this end.)

The DBHDS website 'CSB Provider Search' is another positive example of putting consumers/family members in the 'driver's seat' by giving them an electronic marketplace where they may objectively seek out the best matched provider. However, its use is required only for Training Center placements.

Based on a review of one Licensing report and Corrective Action Plan, DBHDS appears to have a well-organized approach to identifying compliance problems with CSB case management performance. This CSB was cited for deficiencies in case management performance in the areas of: Monitoring individual health, Understanding provider ability to meet individual needs, Assessing individual needs for the ISP, Assisting individuals to locate/obtain needed services, Assuring coordination of services, Monitoring service delivery, Advocating for individuals changing needs, Human rights, Updating ISP, and missing documentation.

Recommendations to achieve full compliance:

Unless the "Choice Protocol" is determined to be legally enforceable through the CSB contract, publish it as Departmental policy.

Towards the theme of choice, DBHDS should revise the "Choice Protocol" to establish a formal mechanism so that consumers/family members can select or can change a CSB case manager.

The "Choice Protocol" needs an enhanced distribution requirement, as well as a more 'accessible' format, to ensure that consumers, family members and others function as informed users of the system.

Refine the website 'CSB Provider search' to allow consumers/family members to select directly the best suited provider; market to consumers/family members as a supplemental, optional tool to case manager discussions.

3) Face-to-face Case Management

Settlement Requirement:

V.F.1-6.

F. Case Management

1. For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.

2. [See below]

3. Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals who:

a. Receive services from providers having conditional or provisional licenses;

b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS") category representing the highest level of risk to individuals;

c. Have an interruption of service greater than 30 days;

d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;

e. Have transitioned from a Training Center within the previous 12 months; or

f. Reside in congregate settings of 5 or more individuals.

4. Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case case manager contacts with the individual.

Review Methodology:

- Evaluated the CCS3 extract to assure it appropriately measures visitation;
- Reviewed ID/DD case manager visitation data dashboard to assess progress;
- Reviewed Case Management Operational Guidelines (11/30/12) and accompanying Frequently Asked Questions (10/30/12);
- Interviewed Dee Keenan/Kathy Drumwright re CSB action plans regarding increasing compliance for CSBs reporting less than 90% compliance to verify expectations are being implemented.

Findings

The Case Management Operational Guideline presents the steps a case manager should follow in the event there is a problem, deficiency or discrepancy between the ISP and the ongoing provision of supports and services. The hierarchy the case manager should follow is logical and appropriate. However, missing from the hierarchy is an early step in the process wherein the case manager would discuss the problem, deficiency or discrepancy with CSB supervisors/managers or others in the DBHDS chain of command to achieve resolution. Although this may be assumed to occur, by its inclusion it ensures the CSB/DBHDS is responsible for resolving implementation difficulties.

The Data Dashboard does not reliably reflect CSB performance for the Settlement Agreement requirement of "*a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual*"; percentages for 30 day visits and alternating home visits as displayed in the dashboard for case management may be deflated. Edits are planned for the CCS3 extract that are expected to correct this problem in January.

Recommendations to achieve full compliance:
The Case Management Operational Guideline should be revised to add an early step in the process wherein the case manager would discuss the problem, deficiency or discrepancy for resolution with a supervisor or other manager at the CSB, as well as seek solutions up the DBHDS chain of command.

The Case Management Operational Guidelines require an exception report to be made to regional CRCs when 30 days visits are missed two consecutive times. These exception reports should be aggregated periodically at the CSB level and by DBHDS to identify trends.

DBHDS should request that CSB's hitting less than 90% on both Data Dashboard measures provide manual reports on 30 day visits until the CCS3 extract corrections can be made.

Suggestions for Departmental consideration:
The Drumwright/Keenan CSB-visit status matrix review might be repeated with CSBs hitting less than 90% on the two Data Dashboard measures, in order to ensure that discrepancies are indeed in the CCS3 extract data.

4) Observation & Assessment

Settlement Requirement:

2. At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.

5. Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observations and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3 above.

Review Methodology:

- Interviewed Dee Keenan/Kathy Drumwright regarding planning for Observation & Assessment database to verify expectations are being implemented;
- Reviewed Project Team 9 meeting minutes (3/27/13 to 7/25-13);
- Reviewed Draft ECM (Enhanced Case Management onsite report).

Findings
The objective to measure the content of the face-to-face visits (Phase II) is scheduled for accomplishment in March of 2014. The Draft ECM (Enhanced Case Management onsite report) appears a good first step addressing this requirement. The Draft ECM currently addresses 23 items to be assessed in face-to-face visits with the consumer. It is "optional" to CSBs at this time.

DBHDS leadership gets high marks from the CSB directors who were interviewed. This evaluation is based on responsiveness, ability to effect change, and availability.

Suggestions for Departmental consideration:
The Project 9 Team needs to address in the rollout of the ECM the conversion steps to measures ("key indicators") that may be reported in the aggregate, clarify that it is required at 30 days visits, and pilot test for efficiency in administration.

5) Training

Settlement Requirement:
6. The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.

Methodology:
- Evaluated online curriculum for ID/DD case manager training to assess completeness of training;
- Evaluated competency tests and pass/fail statistics for ID/DD case manager training to assure expectations are being implemented;
- Interviewed Dee Keenan and other members of Project Team 10 - Case Manager Training (Shank, Rheinheimer, Norton, Hollowell, Pinero) to determine the status of implementation and changes that are being considered;
- Interviewed four CSB directors from among five representing the five planning regions, as identified by Keenan; interviews covered ID/DD case manager training to verify congruence between field and Central Office perceptions of training.

Findings
The overall design of the seven modules Online Course for case managers is simple, attractive and easily navigated. The curriculum includes the topic areas Basics of Case Management, Services, Planning, Assessment, Building and Maintaining Relationships, Disabilities Defined, and Accountability and requires up to 7 hours to complete. Statistics are presented when needed and in both a verbal and visual format. Philosophical emphasis on Person-Centered Practice and Self-Determination is evident throughout the Modules. However, a training component that addresses assisting consumers/family members in making unbiased choices among providers is absent. The most common explanation for this was that 'it is covered in other ID/DD trainings' not linked to this curriculum.

The case manager online training modules do not adequately address conflict free choice presentation by case managers to consumers/family members. However, those interviewed at the CSB level are unanimous in reporting aggressive training locally and from the state on this

item. The DBHDS "Choice Protocol" addresses the choice offering process for all case managers.

The Section on "Focus on a Good Life" is very strong and provides a concrete model for case managers to follow. The Advocacy section is also well done, comprehensive and universal for all populations. The material on self-harm and harm to others is effective for caseloads with individuals who are verbal and have co-occurring behavioral health issues. It does not adequately address the needs of the ID/DD caseload which may be predominantly non-verbal and where self-injury has a total different topography. The motivations listed in the training modules do not apply to much of the ID/DD population. ID/DD case managers must also consider that a) self-injurious behaviors are indicating pain or discomfort, so medical causes must be ruled out and b) self-injurious behavior may be a form of communication.

The teaching logic and the competency tests appear well designed and thoughtfully constructed for the learner. The concept of the team and its central role in life planning, as well as the mechanics of assembling a team, are only lightly covered. For ID/DD case managers it is a critical skill set.

CSB directors who were interviewed were adamant that no case manager is assigned a case load until the 30 day requirement to take the online course is completed. DMAS reported a September estimate of 58 (out of 97) DD case managers had completed the online course.

Recommendations to achieve full compliance:
Revise the appropriate module in the online case management training curriculum to address choice presentations by case managers, perhaps as an attachment for ID/DD case managers. The "Choice Protocol" provides substantive content for a curriculum modification.

Knowing who has completed the case manager training is a monitoring activity of CSB performance. There should be central tracking by DBHDS of individuals who have completed the online training (a certificate is issued upon completion and data was provided that showed the number of individuals who had started the online course).

There is little mention of Team members and how to assemble the team related to the ID/DD case managers. Future revisions should consider additional discussion of assembling the Team and its composition as determined by the consumer/family member.

Self-harm is the analog to self-injurious behaviors in much of the ID/DD world. Content should be added to the module in future revisions to ensure case managers understand the whole spectrum of self-harm to self-injurious behaviors.

The Case Management Operational Guidelines for enhanced case management should be broadly incorporated at the next revision of the curriculum, in order to ensure sustainability for the future.

DMAS should set and enforce a date by which all DD case managers will have completed the online course.

Suggestions for Departmental consideration:
When describing the development of the ISP or monitoring it for effectiveness and satisfaction, providing a link to the actual document used for this purpose might provide a visual aid for the learner to be able to better connect with what goes in the document. If there are multiple documents based on populations, links might be added for each population.

The curriculum learning objectives should be written in behavioral terms. Many are written using "understand", "understanding" or "know", none of which can be seen or measured. Consider replacing objectives containing these non-behavioral terms with behavioral terms such as identify, list, recognize, etc.

In discussing the use of alternative modes of communication, consider the use of a "Behavior to English Dictionary" for individuals experiencing severe behavioral challenges. Use of the "Dictionary" captures what the people who know the person best think specific behaviors mean under specific conditions.

Person First Language might be covered more thoroughly. The curriculum needs explanations of why Person First Language is important. Possible sources include these links:
http://www.youtube.com/watch?v=Ob_rWNNGaJs and
http://www.youtube.com/watch?v=QQ0pKPxoyHs

Conclusions
In summary, DBHDS appears to be making substantive efforts to transform the processes which drive case management services. The processes governing case management include the Operational Guidelines, the 'Choice Protocol', the CSB Provider Search website, and the seven module online case manager training curriculum. Good processes usually lead to good outcomes, which should be assessed in subsequent rounds.

DBHDS ability to hold CSBs accountable for their performance (i.e. results) in the case management area should receive additional evaluation. The CCS3 Extract informs the Data Dashboard, which has potential as one measurement tool. In future review cycles the Independent Reviewer should directly probe these performance results by evaluating outcomes for specific individuals and their families.

Next Steps
In subsequent assessment cycles the strategies suggested below should be considered, above and beyond the strategies for baseline assessment of status. Future assessment strategies may need to be modified over time as goals are achieved and gaps in performance become clear.

1) **Case Management Practice**: Interview consumers, family members, and other stakeholders regarding effectiveness of case management.
2) **Case Management Service:** Evaluate Regional Quality Council Process when finalized; select recent changes in residence/work or day program for a telephone interview with a consumer, guardian and/or family member about choices offered at transition (billing or client data reflecting changes in residential or work providers); randomly select at least one ID/DD case manager per CSB to interview re conflict free choice presentations; review a sample of DMAS Form 460, Choice of Providers; review complaints filed per the "Choice Protocol" that a choice has not been adequately offered; assess the rate at which CSB providers are selected from among available

choices; review additional Licensing reviews of case management performance, including completion of CSB Corrective Action Plans.

3) **Face-to-face Case Management:** Randomly select at least one ID/DD case manager from each CSB to interview and to provide their visit calendar from the preceding quarter; review CRC reports that have been received on the number of missed 30 day visits.

4) **Observation & Assessment**: Review minutes of Project 9 Team meetings; interview Project 9 Team members; evaluate observation and assessment data collection tool when available; review guidelines, instructions, and/or procedures issued to implement this tool; sample negative outcome reports from ID/DD case managers and telephone interview appropriate consumer/case manager/guardian/family member regarding outcomes.

5) **Training:** telephone interview at least 10 ID/DD randomly selected case managers who have been trained within preceding 3 months; interview randomly selected stakeholders regarding perceptions of ID/DD case manager competencies and performance; review NCI utilization with regards to identification of case management problems.

APPENDIX C

Crisis Services Requirements

REPORT TO THE INDEPENDENT REVIEWER FOR THE US v VIRGINIA SETTLEMENT AGREEMENT FOR THE OCTOBER 2013 REVIEW OF CRISIS SERVICES AND THE SETTLEMENT AGREEMENT REQUIREMENTS

INTRODUCTION

Donald Fletcher is contracting with Kathryn du Pree as the Expert Consultant to review the status of implementation of crisis services in Virginia to comply with the requirements of the Settlement Agreement in regard to the Commonwealth's responsibility to develop a statewide crisis system for individuals with intellectual and developmental disabilities; 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 at preventing the removal of the individual from his or her current setting whenever practicable. This is the third review of crisis services and prevention and will focus on the follow through on the recommendations made by the Independent Reviewer in his report of June 6, 2013. This review will cover the time period from 4/7/13-10/6/13.

AREAS OF REVIEW

The primary issues to be reviewed include:

- The Commonwealth's ability to serve adults with developmental disabilities in terms of crisis prevention and intervention services ensuring this target population has case management services to facilitate full access to crisis services and stabilization programs, and access to community supports to prevent future crises. To assure compliance with the requirement to serve adults with developmental disabilities the Independent Reviewer has made two related recommendations. One is that all DD case managers receive basic training regarding START services and the START referral process. The second is that DBHDS and DMAS determine whether individuals with DD who use START Services are provided with case management whether or not they are on the waiting list.
- The Commonwealth's ability to provide crisis prevention and intervention services to children with either intellectual or developmental disabilities. The Commonwealth committed to submit a plan to the Independent Reviewer due October 20, 2013 that includes information about the program model; projected costs and funding sources; family education; marketing to school systems; case management; state agency coordination; and the availability of ongoing supports and services for children who have experienced a crisis and are stabilized, including access to waiver services.
- Recruitment and retention of START staff. The Commonwealth is expected to report on the status of staffing in each of the 5 regional START Programs, analyze any problems in recruitment and retention, and share the plans to address any ongoing staffing shortages.
- The Commonwealth's response to the training recommendations made by the Independent Reviewer in his report of June 6, 2013. These include recommendations to:
    - Train all CSB emergency response staff within 1 year about the START Program and conducting clinical assessments of individuals with ID/DD experiencing a crisis.

    - Include standardized information about the START program in each region's CIT training.
    - Determine the training that should be required of providers of day and residential services to assure the coordination of follow-up for someone referred to and served by START.
- The Commonwealth's plan to outreach to law enforcement and criminal justice to both link individuals with ID or DD to crisis intervention services prior to incarceration and to arrange for consultations as necessary for individuals with ID or DD who have a mental health diagnosis and are incarcerated.
- The Commonwealth's response to providing bridge funding to residential providers to maintain a person's residential setting while they are being stabilized as the result of a crisis.
- The Commonwealth's response to the recommendation to develop policies and procedures for protocols to guide the development and implementation of START services including: collaboration with teams transitioning individuals from the Training Centers or who are in State Hospitals who are eligible for START; assignment of case managers to individuals in crisis who are referred to START but not yet on a DD or ID waiver; the training expectations for ES personnel; and the provision of medical screening prior to admission to the START crisis stabilization unit.
- The Commonwealth's response to recommendations, specific to the START Program, made in the Expert Consultant's Review of an individual's Death (7/13). While this was a review limited to one person, issues were raised that are similar to those raised in previous reports by the Independent Reviewer and the Expert Consultant regarding communication, coordination and training. These included a recommendation to address the communication between the case manager and the START program and the expected involvement of the case manager in the crisis planning process; and statewide implementation of the corrective actions taken in response to this death by the specific regional START program.
- The Commonwealth's ability to respond to individuals in their homes to de-escalate a crisis; the steps taken to expand the mobile crisis teams' capacity to respond to on-site crises; and the response times to emergency calls during the period of this review. The review will determine the Commonwealth's compliance with this requirement.
- The availability of START crisis stabilization programs/homes in each region and the utilization during the last quarter of FY13 and the first quarter of FY14.

REVIEW PROTOCOL

Initial Procedural Review Meeting: Donald Fletcher and Kathryn du Pree held a meeting with the designated program administrators and the Settlement Agreement Coordinator on October 10, 2013 to discuss the areas under review. At that time the required documents were discussed and plans refined and confirmed for interviewing key personnel.

Document Review: The Expert Consultant reviewed the DBHDS report prepared for the Independent Reviewer, due 10/20/13, The Virginia START annual report through July 31, 2013 and the Virginia START Report for the first quarter in FY14 both prepared by Dr. Joan Beasley. I also reviewed regional START program reports, data reports developed by the START State Director for the year ending July 31, 2013 and for the first quarter of FY14, and the DBHDS' Developmental Disabilities Crisis Response System entitled: My Life, My Community.

Interviews: I interviewed Joan Beasley, Ph.D., two members of START Regional Advisory Councils, and the following DBHDS staff: Heidi Dix, Bob Villa, Kathryn Drumwright, Andrea Coleman, Denise Hall, Lucy McCandish, and Pam Nichols. The interviews focused on follow up questions from the reports authored by Dr. Beasley and DBHDS and to review the proposed changes to the crisis services system including the plan to serve children with ID and DD.

ORGANIZATION OF THE REPORT

The following is a summary of the Expert Consultants' review of the issues to be addressed as outlined above. Each of the recommendations made previously by the Independent Reviewer and established as the focus for this review period will be detailed by a summary of findings, conclusions and issues for further consideration. The review of the follow up and response by DBHDS for each of the Independent Reviewer's recommendations will be framed in terms of their compliance with the relevant requirements of the Settlement Agreement as they pertain to Crisis Services.

The requirements that guide this review are:
1. The Commonwealth shall develop a statewide crisis system for individuals with ID and DD. The crisis system shall: provide timely and accessible support to individuals with I/D who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families; provide services focused on crisis prevention and proactive planning to avoid potential crises; and provide in-home and community –based crises services that are directed to resolving crises and preventing the removal of the individual from his current placement whenever practicable. (6.a.i, ii, iii.)

2. Crisis Point of Entry: The Commonwealth shall utilize existing CSB Services 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. When necessary the crisis hotline will dispatch at least 1 mobile crisis team member who is adequately trained to address the crisis. (6.b.i.A.)

3. 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. (6.b.i.B)

4. 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. (6.b.ii.A.)

5. 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. (6.b.ii.B)

6. Mobile crisis team members adequately trained to address the crisis shall also work with law enforcement personnel to respond if an individual with ID/DD comes into contact with law enforcement (6.b.ii.C.)

7. Mobile Crisis teams shall be available 24 hours, 7 days per week and to respond to on-site crises. (6.b.ii.D.)

8. Mobile crisis teams shall provide local and timely in-home crisis support of an additional period of up to 3 days, with the possibility of an additional period of up to 3 days upon review of the Regional Mobile Crisis Team Coordinator. (6.b.ii.E.)

9. By June 30, 2013 the Commonwealth shall have at least two mobile crisis teams in each Region to respond to on-site crises within two hours. (6.b.ii.G.)

10. By June 30, 2012 the Commonwealth shall develop one crisis stabilization program in each region. (6.b.iii.F.)

11. 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. (6.b.iii.G.)

REVIEW OF ISSUES FOR FOLLOW UP

The Commonwealth's ability to serve adults with developmental disabilities in terms of crisis intervention services ensuring this population has case management services to assure full access to crisis services and stabilization programs, and to access community supports to prevent future crises.

FINDINGS

The START program is serving adults with developmental disabilities. Of the 517 individuals referred to START for the time period ending 7/30/13 (as reported by Joan Beasley) 18 individuals had either normal or borderline intelligence which is 3.5% of the population served during the 7/12-7/13 operational period. She notes this is a slight decrease from the previous reporting period. Note that neither Dr. Beasley's nor the DBHDS annual report breaks out the last quarter of that fiscal year. Dr. Beasley reports that START is appropriately serving individuals with DD and is able to respond to the sub-population of those individuals who have autism.

During FY13 the Commonwealth made the decision to provide case management to anyone with DD who has referred to and used the START program that is on the waiting list for the DD waiver. The Independent Reviewer asked that case management be provided to anyone with DD regardless of his or her waiting list status. The Commonwealth does not plan to provide case management to this population at this time. They are including this policy question in the review of case management services that is being conducted by Human Services Research Institute (HSRI). That study will not be completed until August 2014 with implementation of the recommendations anticipated for July 2015.

Bob Villa reports that few if any individuals have received START services that do not have a case manager. There are 2 concerns if individuals who experience crises and access START do not have a case manager. One is that they are unable to access the START crisis stabilization units that offer emergency and planned respite. The other concern is that these individuals do not have someone to help them arrange for community supports that will help maintain their stability once they are discharged from START and can help prevent future crises.

Training has been offered to case managers serving the DD waiver participants. DBHDS has also recorded the training on a webinar that can be accessed by DD case managers at any time. Region II reported in its Quarterly ES Staff Training Report for the first quarter of FY14 that all of the DD case managers at 2 providers were trained (the Arc of NOVA and PWC). However statewide there is no requirement that DD case managers take the training and no documentation of which ones and how many have been trained. No other regions reported on the status of training of DD case managers.

I interviewed Bradford Hulcher, Executive Director of the Autism Society who is a member of the START Advisory Council in Region IV. She reports that Region IV is unsure how to reach out to the DD system of case managers and providers. DBHDS does not have a list of DD case managers to know who and how many need to be trained in the START referral process and approach to crisis prevention and intervention. To her knowledge the START Program has not been well publicized to individuals with DD and their families or to DD case managers, at least in Region IV. The START staff has shared with the Advisory Council that they are unsure as to how to reach out to the DD system and those who access it. A DD case manager was recently included as a member of the Advisory Council which will provide the group with greater insight as to how best to reach out to the case managers and providers within the DD service delivery system. Also Sam Niesman who has coordinated the DD waiver for DMAS will be transferring to DBHDS in the near future, as operation of the DD waiver becomes the responsibility of DBHDS in November 2013. He will become a member of the Region IV Advisory Council according to Ms. Hulcher.

Ms. Hulcher expressed other concerns about this initiative's lack of outreach to and inclusion of the DD population that it is required to provide crisis services. CSB ES staff is not trained to support individuals who may require crisis stabilization and need to be assessed for hospitalization. She reports that families have complained that when they seek assessment for their family member with Asperger's Syndrome who are experiencing a crisis due to their mental health diagnosis and needs that they are told by the CSB ES team that they cannot assess or support someone with Asperger's Syndrome. Region IV is planning an innovative project with the John Randolph Hospital to provide specialized inpatient services for individuals with ID. However, there is no plan at this time for the hospital to include individuals with DD who may have a co-occurring mental health need. She also reports that there are many individuals with DD who may have a co-occurring condition who are not on the DD waiver or on the waiting list.

I also interviewed Larry Barnett, Emergency Services Manager at Chesterfield CSB who is a member of the START Regional Advisory Council in Region IV. He discussed that the implementation started out with a focus on adults with ID. The later discussions of serving adults with DD and then children with ID and DD seemed to be an added expectation to the Advisory Council. CSBs do not work with people with DD and he reflects that planning for the additional populations seems daunting to the Advisory Councils. This supports earlier reviews during which I found that the department's efforts were primarily directed to the adult ID target group.

CONCLUSIONS

The Commonwealth has not been responsive to the recommendations of the Independent Reviewer regarding assuring that all case managers serving people with DD have been trained about START. While training has been given and is available to DD case managers there is no requirement that they participate nor is there any tracking to account and report on how many have been trained. There is no organized approach to identifying these case managers and having a plan to assure they are all aware of the START program, what it offers and the referral process.

The Commonwealth has specifically responded that they do not plan to provide case management support to people with DD who are not on a DD waiver or on its waiting list. This has been deferred pending the outcome of the HSRI study. It is impossible to know the implications of this decision since there are no data kept to inform the Parties how many individuals referred are impacted by this decision.

These decisions potentially place the Commonwealth out of compliance with Section 6.a.i., ii. and iii. It is not possible to ascertain if all individuals with DD who need START are aware of the service or have access to it if the case managers are not all aware of the START program due to a lack of training. Additionally people with DD who do not have a case manager will not be able to access the START crisis stabilization unit and will not have any one to assist them to access ongoing community support services.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

I recommend that the Commonwealth develop a tracking system to determine which DD case managers have been trained. The DD waiver is being transferred from DMAS to DBHDS in November 2013. That presents DBHDS the opportunity to decide if it wants to set an expectation that all DD case managers be trained about START services and the referral process. DD case managers are currently not reimbursed for training which is certainly a deterrent to taking advantage of the training that is available. This may be an issue that DBHDS wants to include in the HSRI study to determine how reimbursement for training can be addressed. If DBHDS determines that they will not mandate training for DD case managers, it should prepare written material explaining all START services and the referral process and send it to all case managers to assure every case manager is aware of this support service and understands how to access it for his or her consumers.

I also recommend that DBHDS track the number of individuals who are referred to START who do not have a case manager and what the region has done to address this. This information should be shared with the Independent Reviewer on a quarterly basis. If the data indicates there are individuals who experience a crisis that do not have a case manager and this is limiting access to necessary services, the Independent Reviewer may want to ask DBHDS to develop an interim solution until the recommendations of HSRI are completed.

The DBHDS should also work with the DD advocacy and provider communities to determine and implement effective outreach strategies to make sure that individuals with DD and their families know about the DD Crisis Response System. The issue of screening and assessment for inpatient psychiatric services for PWDD needs to be addressed as well.

The Commonwealth's ability to provide crisis prevention and intervention services to children with either intellectual or developmental disabilities. The review will determine the adequacy of the plan that DBHDS developed.

FINDINGS

The DBHDS has developed a preliminary plan for Children's Crisis Supports as part of the Crisis Response System: My Life, My Community. The plan outlines the mission, target population, services and requirements, a general timeline for implementation and budget. The mission 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. Children's crisis supports will serve children and adolescents under the age of 18. The focus of these services will be on crisis resolution, comprehensive case management and assisting families to navigate the service delivery systems that support children and youth and can be accessed after the crisis is resolved. Staff will be expected to demonstrate crisis interventions that will resolve the crisis and prevent future crises, train the family or other caregivers in these techniques and observe the caregiver using the identified interventions. Services will be provided in-home and in community settings that support the child whenever possible. Staff will also make referrals to appropriate community prevention services after the crisis is resolved. Support will be provided through phone support, in-home coaching, direct services to de-escalate the crisis, in-home respite and short and long term support planning.

The DBHDS does not plan to offer an out of home respite unit. Since children are best cared for in their family home the goal is to maintain them in their family home if at all possible. If a short term out of home placement is needed a relative, therapeutic foster home, or the existing mental health children's crisis unit will be used. Only if the person presents the risk of harm to him or herself or others will s/he be referred to a psychiatric hospital.

Staffing will be added to the regional START Teams. This will include Children's Crisis System Navigators and Community Crisis Professionals. The Navigator's job is to provide comprehensive case management and service coordination for children and youth who experience a crisis. The department's plan is to add 3 positions over a 6-month period to each region's START team. These will include 1 Licensed Regional Children's Team Lead/Navigator to be hired in the first 3 months, and 1 Child Coordinator/Navigator and 1 Child Community Crisis Professional to be hired within 6 months. All staff will be QMHP C/QIDP qualified and a Masters Level is preferred for these positions. All are full time. The DBHDS staff that authored the plan recommends that the staffing expand after the first 6 months of operation to provide comparable resources to those available to adults with ID or DD through START. This would support each team growing to 8-10 Navigators (coordinators) and 4-5 Community Crisis Professionals (also referred to as Community Crisis Stabilization Clinicians). The inclusion of the Community Crisis Professionals is based on the model used in Region III, which will be discussed in the next section of this report. There is a detailed job description for the Navigator that includes the experience the DBHDS expects, the responsibilities of the role and the Knowledge, Skills and Abilities (KSA).

Training for the staff is proposed and the DBHDS expects to hire staff with experience working with children who have co-occurring conditions. START plans to cross train during the first 6 months so all staff have some familiarity with the needs of children and adolescents.

The budget is based on the original allocation of $1.25M that was approved for providing crisis response services to children and adolescents. DBHDS staff was unable to tell me how this amount of funding was projected and admit that there isn't reliable utilization data about children accessing crisis services. Any expansion over time to include additional Navigators and Community Crisis Professionals depends upon the regions' ability to secure Medicaid or other insurance to fund the crisis services which are provided by START and covered by those healthcare insurance plans. The budget includes staff salaries and benefits, and a total amount of $75,000 per team for administrative and overhead costs that includes training. Each team will have $340,000 in the first year for start up costs and then will operate children's crisis response services with $270,000 as the annual allocation. These are estimated costs at this point.

The DBHDS expects to have children's crisis response services fully operational within 6 months. There is no specific implementation plan for initiating these children's services. The department did include a timeline to make the changes it is proposing for its DD Crisis Response Services (DDCRS) that includes expanding crisis services to serve children. The timetable includes obtaining approval from the DBHDS, reviewing the plan with the START Directors, establishing milestones, hiring children's staff, developing a communication strategy and completing home modifications.

CONCLUSIONS

The Commonwealth is not in compliance with Sections 6.a.i-iii of the Settlement Agreement because it is not currently providing a statewide crisis system that serves children and adolescents with ID and DD. The plan it has developed once implemented can bring Virginia in compliance with this requirement. DBHDS has done a good job of conceptualizing the role of Navigator and Community Crisis Professional. The addition of these positions to the regional START teams should greatly enhance the teams' abilities to address the crisis needs of this target population. The DBHDS is creating a mission that will embrace and support families' desires to keep their children at home and help to develop the community support system that is needed to stabilize these living situations.

The plan needs greater detail about outreach to families, schools and children's service providers; education of ID and DD case managers; the referral process; the involvement of the CSBs; and what existing community supports are available for children and adolescents that will support them after the crisis is stabilized.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

I recommend that the DBHDS submit a more detailed plan to the Independent Reviewer that includes the outreach, education, referral process and availability of existing community support services for children. I can review this plan using the SHAY evaluation tool.

The DBHDS is proposing to meet the needs of children and adolescents who need to leave home to be stabilized through the use of other relatives, foster homes and the existing children's mental health crisis unit. The need for temporary out of home placement should be tracked to provide information about frequency, placement type used, length of stay, and capacity. The DBHDS should include data about the final outcome for children who do leave home due to the nature of their crisis so the department and Independent Reviewer know if any children do not return home permanently.

Recruitment and retention of START staff has been an issue identified in previous reviews and by the Independent Reviewer. The Commonwealth is expected to report on the status of staffing in each of the 5 regional START Programs, analyze any problems in recruitment and retention, and share the plans to address any ongoing staffing shortages.

FINDINGS

Staffing information for each region was made available on October 18, 2013. The following positions are vacant and recruitment efforts are underway:

Region I: START Coordinators -3 of 8 positions
Nurse- 1 PT position
Respite Director- resignation effective 12/2/13
Region II: START Coordinators- 1 of 8 positions
Region III: START Coordinators- 1 of 8 positions
AFS Team Leader- 1 of 2 positions
Medical Director1 1 PT position
Respite Staff- 2 of 8 positions

Region IV: START Coordinators- 2 of 8 positions
START Team Leader position
Respite Nurse position
Region V: START Director
Co-Coordinator position
Respite positions- Respite Manager, Respite Supervisor, LPN, Respite Counselors and CSA's (the Respite Crisis Stabilization Unit is not opened yet in Region IV)

The regions that have the respite crisis stabilization units open are well staffed for this component of the program and very few clinical positions are vacant. Of the 40 START Coordinator positions, 7 are vacant which is 17.5 % of the positions statewide. However, 1 region has all of them filled and 2 others have only 1 vacancy. Only Region I has 3 of these positions vacant. The DBHDS Crisis Response System proposal: My Life, My Community, addresses ongoing recruitment. The proposal contains recruitment strategies that begin with developing staff Knowledge Skill and Ability (KSA) requirements that promote the hiring of individuals that should be successful working in a crisis program. A new position, Community Crisis Clinician is being proposed based on a working model tested in Region III. These staff will be utilized to provide direct crisis intervention in homes or other community settings used by the individual and will compliment and in some ways extend the work of the START Coordinators. (This role will be discussed further under a subsequent response to the Independent Reviewer's recommendations). Job descriptions have been developed for all of the clinical positions that are part of the START Team and include licensing requirements. The job announcements are being revised to better reflect the functions that crisis workers perform to provide candidates with a more realistic understanding of the job duties.

Region III has modified its recruitment process to include steps to accurately identify candidates for crisis services. The Region utilizes job shadowing, role-playing and a written test using vignettes to which the candidate must respond with an assessment and the development of interventions to address the particular circumstance presented in the vignette. DBHDS expects that the other regions will use these same recruitment techniques.

CONCLUSIONS

Any new program sustains periods of difficulty in recruiting and retaining staff as job candidates seeking employment gain a realistic perspective of what the job entails and existing staff work as part of a team to actually develop and implement the program and determine if it is a good fit for their interests, skills and career aspirations. DBHDS has continued to actively recruit for the START program and continuously seeks new referral sources. It is planning to replicate a successful recruitment model statewide and is adding a function to the team that should ease the workload and responsibilities of the START Coordinators that will make that role more appealing.

The program data indicates that all referrals that were appropriate were accepted by the regional START programs and were provided with the START services that were warranted with the exception of emergency and planned respite in Regions IV and V due to the lack of respite facilities. In light of the regional programs' abilities to serve all of the individuals referred the recruitment and retention of staff for the START program does not seem to be negatively impacting the services

received for individuals referred who are in crisis or trying to prevent a crisis from occurring. There are no issues of compliance related to staffing at this time.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

The quarterly reports provided by DBHDS to the Independent Reviewer regarding staffing should continue to be provided. These should include any vacancies that occurred during the quarter and the length of time they were vacant. The department should also report if there is a waiting list for any of the START services during the quarter and if this is the result of staff vacancies.

The Commonwealth's response to the training recommendations made by the Independent Reviewer in his June 6, 2013 report regarding the training of CSB Emergency Services (ES) staff; including standardized information about START Services in CIT training; and determining the training that should be required of providers to assure coordination of follow-up for individuals served who use START services.

FINDINGS

The Independent Reviewer made a recommendation that all CSB ES staff be trained about START Services and the referral process within 1 year. DBHDS provided 2 reports that document the training provided to CSBs ES teams through September 30, 2013. The table below provides a summary of the percentage of CSB ES staff that has been trained about START. While almost half of the CSBs have the full compliment of ES trained, 6 CSBs have between 0-10% of the ES staff trained; an additional 8 are between 30-50% and 9 are between 51-90%. What is noteworthy is that Region III has been able to have almost all of the ES staff in each of its CSBs trained already.

REGION	% OF CSB ES STAFF TRAINED	CSBs WITH 100% OF STAFF TRAINED
I	54%	3 of 8
II	75%	3 of 5
III	98%	9 of 10
IV	62%	1of 8
V	48%	1 of 9
TOTAL	67%	17 of 40

DBHDS informed me during the interviews conducted for this review that they were not planning any additional formalized training to be offered to CSB ES staff. None was offered during the first quarter of FY14. It is difficult for CSBs to release ES staff to attend training that is offered off site due to the nature of emergency responder jobs. Each region does continue to report about training offered. During the first quarter this included including ES workers on the Regional START Advisory Councils and providing START updates via email in Region III. Larry Barnett confirmed that it is difficult releasing staff to attend trainings. The first quarter ES staff training report does include information from Region III that it has offered CSB ES staff on-line trainings from the national START program and from its own START program to address the training needs of ES staff who

work evening and on weekends and have a more difficult time participating in classroom training. There are also notations on the FY13 ES Staff Training Report that Dr. Beasley has offered training that ES staff have attended in Regions I and III.

Training with law enforcement-While there is some documentation that regional START programs have been involved sporadically in CIT training there is no evidence of the development of a standardized training module about the START program that is included in all CIT training state wide. The DBHDS ES Staff Training Report also provides brief summaries of training provided to other groups including law enforcement. Region II reported that they have no formal agreements with law enforcement entities but provided training as part of CIT in Loudon County regarding working with people with autism. Similar training is planned for Arlington County. Region IV provided CIT training including START information to D19 in the first quarter of FY14. They are collaborating with Richmond CIT to coordinate future trainings. Regions I and V do not report any training.

Provider Training-There has been numerous engagements between START and providers to offer informational sessions and training regarding START. During the first quarter of FY14, Region I reports providing training for Wall Residences and other providers in the Lynchburg and Winchester areas. Region I START also facilitated 5 webinar trainings in September at 5 locations across the region. Region III also provided training to the provider Wall Residences. Providers in that region were invited and attended training provided by Dr. Beasley at the end of FY13.

The Virginia START Annual Report FY13 includes information on outreach provided by the START Clinical Teams. The data indicates that the majority of outreach time is being spent with service providers and family members. Thirty five % of the ***outreach*** hours are devoted to residential providers and 18% is given to day service providers. The Virginia START Annual Report also includes a summary of the hours of training and direct consultation that the START teams provide. During FY2013, the START Medical and Clinical Directors gave approximately 90 hours of ***consultation*** to residential providers and almost 50 hours to day service providers. The majority of ***training*** provided was to residential and day providers totaling approximately 40 hours.

CONCLUSIONS

The Commonwealth is not in compliance with Section 6.b.i.B. of the Settlement Agreement. This section requires that CSB emergency personnel be trained on the new crisis response system. The original date set for this training to be completed was June 30, 2012. The Independent Reviewer recommended in his June 2013 report that this be accomplished within a year since the original target date was not met. The DBHDS has another 7 months to implement this recommendation and meet the requirements of the Settlement Agreement although not within the original timeframe but has no further plans to ensure all CSB ES staff is trained.

The Settlement Agreement expects that the Commonwealth will have a planned approach to reaching out to and working with law enforcement personnel to improve their interactions with individuals with ID/DD. This will be addressed in a later section of this report. However part of the initial plan of DBHDS was to include a module about the START program in the Crisis Intervention Training (CIT) offered by the DBHDS to law enforcement personnel and this was reinforced in the Independent Reviewer's most recent report. While there is evidence of some regions offering it in

some of the CIT trainings DBHDS has not developed a module to be included as a standard part of CIT. This is not compliant with the initial plans DBHDS put forward to address 6.b.ii.C.

Training of providers serving individuals is occurring through invitations to regional training, invitations to training provided through the national START program, and through individual consultation and follow up with providers who serve an individual who is referred to and accepted in START. START is a specialized support that is available to a small group of people served by the ID/DD provider community, those individuals who have a co-occurring condition of mental health. Not all providers may need training about START if they serve a population of individuals who do not have a mental health diagnosis. As the program is still in its development period it may make sense to focus the training on those providers who currently serve people with co-occurring conditions. Tailoring the training, consultation, technical assistance and follow up based on the needs and circumstances of the individuals who use START and return to the provider that serves them is a good use of limited resources. Over time it will be important to determine if these providers have been offered sufficient training and consultation to help them to successfully support individuals with co-occurring conditions and assure them continuity of care.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

DBHDS should develop a plan to train all CSB workers by June 2013.The department should decide if it needs to make this training a requirement of the performance contract it has with the CSBs to guarantee that there is full cooperation and participation.

The department should review the approach that Region III has used to already train 98% of its CSB ES staff to determine of it can be replicated in the other regions. Consideration should be given to recording training sessions and making the recordings available to ES staff online to be used at times convenient to them that will not interfere with their emergency responder duties.

DBHDS should develop a module for the CIT that provides an orientation to START and have it included in all regions' CIT as part of the module on the needs and characteristics of individuals with ID. A determination should be made if this training should be expanded to include information on people with DD.

A future review of crisis services should include a review of a sample of cases for individuals receiving supports from residential and day providers who utilized START. The review should include a review of the provider's involvement in the planning process developing the initial crisis intervention strategies; the training and technical assistance offered to the provider; the process of returning the person to the residential setting if out of home emergency respite or hospitalization occurred; and the success of the individual's transition back to the community residential and employment or day program settings. The review should include interviews with the provider, the case manager, the family and the individual if appropriate.

The Commonwealth's plan to reach out to law enforcement and criminal justice personnel to link individuals with ID and DD to crisis intervention services to prevent unnecessary arrests and incarceration.

FINDINGS

These findings are based on a review of the DBHDS CSB ES Staff Training Report. Region III works specifically with law enforcement based on interactions of the individuals with the police to coordinate roles train and try to engage them in some aspects of future planning for the person. Region III also worked with CSBs and providers to encourage the use of police only to respond to emergency situations that cannot otherwise be handled rather than as the first response to an individual who may be non-compliant with his/her plan. Region IV plans to reach out to the Henrico police department once the Crisis Stabilization Unit/Respite Home opens later this fall. They will also be invited to the respite home for onsite observation and training. The Clinical Director has been available to work directly with police based on their involvement with individuals with ID.

The Virginia START annual Report for FY21013 indicates referral sources for all individuals referred to START. No referrals were made by law enforcement.

DBHDS developed a plan, My Life My Community that suggests changes in the START crisis intervention service delivery approach. It was anticipated that this plan would include the strategies and activities that will be used to reach out to law enforcement in a planful, comprehensive and consistent way. This part of the plan was not completed.

CONCLUSIONS

The DBHDS has not responded as yet to the recommendation of the Independent Reviewer to develop an outreach plan for the regional START programs to work effectively with law enforcement and the Commonwealth is potentially not in compliance with Section 6.a.ii.C of the Settlement Agreement. This section requires mobile crisis team members to work with law enforcement personnel to respond if an individual with ID/DD comes into contact with law enforcement. While there are vignettes from some regions about work with law enforcement it does not seem to be underway consistently across the state. Potentially the lack of referrals in a year to START from law enforcement may indicate a problem with outreach and indicate a lack of knowledge among police departments about the START program.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

The DBHDS reports it will develop and submit its plan to do outreach with law enforcement departments and their staff. I should review the report to determine if it a comprehensive response to the requirements of the Settlement Agreement.
Each region should be asked to report more formally on the interactions and training they have with the law enforcement departments in their regions. This report should include CIT trainings held; individuals consultation provided, communication protocols developed; and the outcome of cases in which law enforcement was also involved. These reports should be submitted to the Independent Reviewer and Expert Consultant semi-annually and reviewed.

The Commonwealth's response to the recommendation to provide bridge funding to residential providers to maintain a person's residential setting while they are being stabilized as a result of a crisis.

FINDINGS

The DBHDS indicated during interviews that the department does not have any current mechanism to provide bridge funding to residential providers to assist them to maintain the individual's placement in that home during a prolonged absence as a result of a psychiatric hospitalization or other out of residence short term placement. DBHDS administrative staff reports that they have no plans to develop such a funding mechanism.

Data from the Virginia START Annual Report is instructive regarding the involvement of individuals who reside with providers. Of the 517 referrals in 2013, 208 (40%) of the referrals lived in a group home. An additional 3 lived in a community ICF-IID. The highest category of living arrangement at the time of referral is a group home, followed by family home. Of the total number of people referred and served by START, 159 people had been hospitalized at least once in the previous year and 176 were hospitalized at least once in the last 1-5 years.

The annual report also contains information about the outcome/primary disposition during crisis contact. For the 195 people reported on in this section, 21 were admitted to a community mental health in-patient unit, 1 to a crisis stabilization unit, and 11 to a state psychiatric hospital. Additionally 15 were admitted for emergency respite at the START respite unit.

Forty-nine of the 195 individuals had some support provided out of their home that is 25% of the group. These data do not break down the information by the type of residence at the time of referral but since the majority of referrals lived in a group home at the time of admission it is reasonable to expect that some of those who were placed out of home to be stabilized were from a group home.

CONCLUSIONS

The Commonwealth does not plan to provide bridge funding to residential providers to insure continuity of care for the individual. This is a recommendation made by Dr. Beasley, the Expert Consultant and the Independent Reviewer. It is not in and of itself a requirement of the Settlement Agreement. The data that is maintained through SIRS and made available to me does not include data about the ability of individuals to return to their original home or residence after using the START Respite Home or being hospitalized for psychiatric stabilization. When asked about how frequently this happens, Bob Villa said that in the few instances when someone did not return to their residence it was because the provider could not meet their increased needs not because of a gap in funding. DBHDS was unable to provide information to document this.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

This remains a concern of Dr. Beasley and of mine. I recommend that DBHDS begin to collect and share data about the transition of individuals who have been placed out of home as a result of a crisis in their lives. Based on a review of the information the Independent Reviewer and I can determine if

the lack of bridge funding is impacting the department's ability to prevent future crises and maintain the necessary residential services to enable individuals who have been referred for crisis services to be stabilized in the community and experience continuity of care.

The Commonwealth's development of policies, procedures and protocols to guide the development and implementation of START services.

FINDINGS

The Independent Reviewer made several recommendations about the need for written guidance for aspects of the START program and the DBHDS' development of a crisis system that relies on community linkages and partnerships. These include the assignment of case managers for individuals with DD who are not on the waiting list for the DD waiver; the training expectations of CSB ES personnel; medical screenings prior to an admission to the START Respite Home; the role of the case manager in the planning and discharge processes; coordinating crisis planning for individuals leaving the Training Centers and implementing procedural changes resulting from a Corrective Action Plan (CAP) in Region V statewide. Dr. Beasley made many of these recommendations in her reports as well as the Expert Consultant and Independent Reviewer.

No policies, procedures or protocols that address these areas have been developed. DBHDS has indicated it does not plan to continue to train all CSB ES staff. The DBHDS response regarding the role of the case manager in coordinating with START is that it is already addressed in the expectations of case managers to be involved in the overall planning for the individuals they support and to coordinate the provision of services. However, this did not occur in the case of RP, a person who was served by DBHDS and who died earlier in 2013. This death was reviewed by DBHDS Licensing and resulted in numerous CAPs including one that addressed the gaps in coordination by the case manager.

CONCLUSIONS

The lack of a policy regarding the training expectations for CSB ES personnel does not meet the Settlement Agreement requirements of 6.b.i.B.

The lack of a policy regarding the involvement of case managers in the planning, coordinating and discharge of an individual referred to START potentially is not in compliance with 6.a.i-iii. This section requires the development of a crisis system that provides timely and accessible support that includes proactive planning to avoid potential crises. This provision is for individuals with either ID or DD. Since there is a decentralized system of case management through the CSBs and case managers are not under the direct authority of DBHDS, it is even more essential that the role of the case manager be specified. The case manager is critically important to effective communication between the person, family, existing providers, and the START program. It will be the case managers responsibility to insure that all follow up occurs and that the individual is linked to appropriate community resources after the crisis has been stabilized. Guidance for case managers in both the ID and the DD systems should be developed and provided to them.

Recommendations were also made about the other topics listed in the findings section. These areas do not directly impact compliance with the Settlement Agreement although have the potential to improve and standardize the implementation of the crisis response system.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

DBHDS should develop a policy detailing the expectations that all CSB ES staff be trained in the START program and referral process. The policy should include expectations that ES staff hired in the future also be trained.
DBHDS should develop guidance for case managers detailing the department's expectations for their involvement in planning, coordinating and following up on crisis intervention and prevention services.

START should be expected to have policies, procedures, and protocols that are used consistently in all regions that govern the important aspects of its operation. It is encouraging that the DDCRS plan indicates the policies and protocols of Region III are to be adopted statewide.

The Commonwealth's ability to respond to individuals in their homes to de-escalate a crisis; the steps taken to respond to expand the mobile crisis teams' capacity to respond to on-site crises and the response time to emergency calls.

FINDINGS

The START Teams continue to respond directly to requests for crisis intervention for adults with ID or DD. According to the Virginia START Annual Report for FY13 and the First Quarter Report for FY14, 735 individuals have been entered into the SIRS database. In FY13 572 individuals were entered and an additional 104 were entered in FY14 through September 30, 2013. Five hundred fifteen (515) of these individuals were receiving support during the first quarter of FY14. Dr. Beasley estimates that START will support 700-1,000 people on an annual basis. The following table summarizes the services provided:

Quarter	Emergency/Crisis Services	In- Home Respite	Emergency Respite	Planned Respite	Grand Total
FY13 Q4	88	56	26	38	208
FY14 Q1	68	30	33	46	177

START also provides training, consultation, comprehensive assessment, treatment planning, and service linkages.

The majority of people referred live at home with their families and the next largest group of referrals is for individuals who live in group homes. Many of the referrals are for people who need comprehensive assessment and planning, prevention strategies and community linkages.

This review is focusing on the START Teams' response time and the DBHDS plans to revise the program to be more responsive to crises by providing more direct intervention at the time of the crisis.

The Settlement Agreement requires that the START teams respond to a crisis within 2 hours. By June 30,2014 the teams are supposed to respond to crises in urban areas within 1 hour and maintain the 2 hour response time for all other parts of the regions. During the last quarter of FY13 the teams achieved an average response time of 1 hour and 45 minutes. However, 73% of the calls were responded to in 2 hours or less but 27% took more than 2 hours for a mobile crisis worker to reach the person. The DBHDS report for the first quarter of FY14 indicates that there were 28 requests for the mobile crisis team to respond and that 22 of these referrals were responded to in 2 hours or less with the average response time reported as 1 hour. Only 2 referrals were responded to in more than 2 hours but there was no response time noted for 4 of the referrals that accounts for 14% of the total.

The DBHDS developed the DD Crisis Response System Plan: My Life, My Community. The plan was developed in response to concerns of stakeholders and department staff that there is a lack of immediate crisis interventions, or immediate supports for individuals not known to Emergency Services or START; a lack of crisis interventions for individuals under 18 with ID/DD; a lack of clear collaboration with ES and a lack of information about the program available to law enforcement. The purpose of the plan is to revise the current system to provide more immediate crisis interventions to people who are experiencing a crisis due to behavioral and/or psychiatric issues and support their families. In-home and community based supports will be designed to resolve the immediate crisis and allow the person to remain at home if at all possible. The Crisis Support Unit (CSU) that is the START respite home will continue to be available as a last resort and only for emergency respite. In the new plan the DBHDS views providing prevention crisis services as a secondary approach rather than continuing as the primary focus as it is envisioned by the current START program vision and structure.

I was able to interview Larry Barnett who is the ES Manager of the Chesterfield CSB and a member of the START Advisory Council in Region IV. He is very supportive of the START program providing this type of immediate direct crisis intervention. He believes there is effective coordination with the CSBs and a strong effort to connect with community partners. There is good collaboration and a strong training approach with training offered to all of the START partners.

The key components of the DDCRS are: emergency services through a single point of entry (SPOE); mobile crisis services including intensive community crisis supports, the CSU, intensive transition supports and crisis prevention planning; and quality assurance and standards compliance.

Emergency Services- The CSB (ES) are portrayed as the SPOE into publicly funded mental health, intellectual disability, and substance abuse services which provides comprehensive services within a continuum of care that includes crisis interventions and supports. In this plan they will be the SPOE for individuals experiencing s crisis, but only those who are not already known to the CSB ES or to START.

Mobile Crisis Services- mobile crisis team members will be sent to the place where the person resides or is at the time of the crisis and will decide on the need for in-home or other intensive supports including use of the CSU. They are to assure that the immediate crisis is addressed, supports are immediately provided, and non-crisis referrals are made.

Intensive In-Home Supports- Staff will implement behavioral intervention strategies, provide individual support, model strategies and interventions for the family or other caregivers, accompany the individuals to appointments, and train caregivers. Staff will be available for direct support for up to 24 hours per day for 7 days. The provision of this more direct, immediate, and hands on intervention is the most significant change to the START program. Region III has already successfully implemented this model by using Community Crisis Clinicians in addition to the START Coordinators. The DBHDS expects that all of the other regions will add these staff as well. Region III also added a Nurse Practitioner to assess whether any medical issues are contributing to the crisis.

New funding is not proposed for these staff. The expectation is that each region can afford the positions by using the funds that are generated by billing Medicaid and other insurers for covered services. Regions will use the State Pan Option Medicaid stabilization and intervention services and will bill as appropriate. Region III uses these positions successfully and has created 2 sub-teams to be more responsive to the needs of its consumers who are accepted into START. This was the original expectation of the Settlement Agreement. Other regions are using a combination of approaches to improve responsiveness including adding more staff and/or supervisors but not necessarily creating a distinct second team.

Crisis Support Unit- The CSU will be available for adults who need to be stabilized. Each home shall serve 6 individuals. The units are staffed with medical and clinical professionals. It is anticipated that the CSU will be for emergency crisis rather than a combination of emergency and planned respite.

The plan includes standards of compliance supporting providing supports where the person lives; involving existing providers; using the least restrictive intervention; using behavioral assessments and plans; providing necessary transportation; and providing immediate collaborative discharge planning. The DBHDS recommends that the Region III policies and procedures be used statewide. There is a listing of Quality Assurance data that will be collected and an understanding that performance measures and outcomes need to be developed.

There is no detailed budget or funding sources, communication plan to educate families, outreach plan to school systems or community providers, or a plan to interact with law enforcement. The DBHDS indicates these components will be developed after the existing plan is shared with START Directors and the communications plan will be completed by 3/5/14. The timeline notes the development of benchmarks and milestones by 12/31/13 but have not proposed them in this version of the plan. There is no timeline set for preparing the budget and funding sources although the DBHDS reports the plan can be implemented within existing resources. START is budgeted at $12.25M through FY15 to include children's services. In FY16 the budget is proposed to increase to $16.25M. The timetable proposes that full implementation will be achieved by 8/31/14.

CONCLUSIONS

The Commonwealth remains in compliance with Sections 6.b.i.A, 6.b.ii.A, 6.b.ii.B, and 6.b.ii.D.START Coordinators have been providing local and timely in-home crisis support as required under Section 6.b.ii.E. The plan which focuses the START teams on more direct, hands on, immediate intervention will strengthen the teams' success in addressing crises by adding staff that can provide direct interactions for up to 7 days complementing the support offered by the START Coordinators. The Commonwealth is not in compliance with Section 6.b.ii.G that requires a response time of 2 hours and the availability of 2 mobile crisis teams in each region. The Commonwealth's decision to add staff and determine the best supervisory configuration in each region rather than necessarily having 2 distinct teams should be acceptable to meet this requirement as long as the response time requirements can be met and sustained.

The DD Crisis Response System plan proposes improvements that should make the existing system more responsive by adding resources that can provide more immediate assistance to stabilize a crisis. This is a necessary component to insure the system meets its goal of stabilizing the situation and maintaining as many people as possible in their home settings.

However, the continued need to focus on prevention and systems planning cannot be minimized. If the system focuses solely on the direct and immediate response to the crisis it may not put strategies in place to prevent crises in the future. These strategies include prevention planning, providing ongoing support and training of caregivers, and helping the person and his or her family access needed ongoing community resources to avert future crises. This is accomplished through the development of comprehensive assessment, person-centered planning and the creation of community linkages. It is anticipated these aspects of START will continue but the implementation of the plan should be reviewed and data analyzed that documents how frequently these preventative strategies are provided.

As I discuss in another section I remain concerned about the loss of planned out of home respite. More people currently use the respite homes for planned versus emergency respite. Many families rely on this to provide them with a needed break to help them sustain their ability to continue to be the primary caregiver.

It remains unclear as to how the DBHDS is going to assure effective coordination between CSBs and the START program. The intake and referral process for individuals already known to the system is not changing. The CSB ES will only be the SPOE for new referrals. This makes sense for individuals already known to START but may not be as useful for individuals known to the CSB but not previously known to START. It also does not specifically address the issue of every CSB ES being responsive to requests from START for assistance. Dr. Beasley reports that this coordination is inconsistent across the CSBs. The case manager is listed as being a member of the HUB to coordinate the crisis response but there is no specificity about the case managers responsibilities.

At this juncture I cannot determine the adequacy of the plan although it is a very promising approach and adds a needed crisis intervention. In order to complete a thorough review I will need DBHDS to provide information on the budget and resources, marketing and outreach and education for both ID and DD potential referrals and their caregivers and providers. It will also be helpful to articulate the ES role when START requests its assistance and to articulate the expectations of case managers. The

plan also needs to address the access of emergency service response for individuals with DD who may need psychiatric hospitalization.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

The DBHDS should submit a comprehensive plan and it should be reviewed using the SHAY assessment tool. The plan should include the outcomes and performance measures the department recommends being used going forward and the data that will be collected to determine if measures are being met and outcomes are being achieved. These should include measures of family satisfaction with the timeliness and quality of supports and information on how many people were able to maintain their original home setting and how many had to move permanently.

If planned respite is no longer part of the prevention strategy the DBHDS should provide evidence over the first year of implementation that more out of home placements or psychiatric hospitalizations did not occur as a result.

The availability of START crisis stabilization programs/respite homes in each region and the utilization during the last quarter of FY13 and the first quarter of FY14.

FINDINGS

The Commonwealth was expected to open a START Respite Home in each region by July 2012. While none of the regions met this timeframe Regions I, II, and III opened their homes during calendar year 2013. Region III was the first to open in December 2012 so has the most experience offering both emergency and planned respite. The Virginia START Annual Report states that the 3 operational regions admitted 28 individuals for emergency respite and 31 people for planned respite. Emergency Respite for these 28 people resulted in 36 admissions with no one having more than 2 admissions during FY13. The average length of stay was 18.8 days. The recidivism rate was 28.6%. Thirty- one people used planned respite for a total of 57 admissions. Sixteen individuals had more than 1 planned stay. The average length of stay was 4.6 days. This report differs slightly from the reports provided by DBHDS that indicate a total of 30 people were admitted for respite through June 30, 2013, and 37 for planned respite. DBHDS notes the data inconsistencies and is addressing them.

The 3 regions that have homes opened them in December 2012 (Region III) January 2013 (Region I), and February 2013 (Region II). This means that for the reporting period (December 2012- June 2013), there were 1350 bed days available for emergency respite and 1350 bed days available for planned respite. A total of 677 bed days were used for emergency respite and 262 bed days for planned respite. This represents a 50% utilization rate for emergency respite and a 19% utilization rate for planned respite. The FY14 First Quarter Progress Report for VASTART Services prepared by Joan Beasley, Ph.D., summarizes the service utilization for emergency respite and planned respite which is 28 individuals with 33 episodes and 37 individuals with 46 episodes of use respectively. During the first quarter there were 810 days available for emergency respite and the same number for planned respite approximately. Region II was able to offer only 4 beds for part of the quarter. The utilization rate for the first quarter was 46% for emergency respite and 33% for planned respite.

Emergency respite stayed about the same (46% versus 50% for FY13), but the utilization of the planned respite beds rose from 19% to 33%. As was true in FY13 more individuals took advantage of planned respite than did emergency respite.

Region IV and V still do not have their respite homes open. They both plan to open them in November 2014. Both were able to send a few people to respite in one of the other regions during the reporting period. Region II is currently operating only 4 of its 6 beds due a zoning issue regarding the adequacy of the well and septic system.

The Crisis Response Systems plan recommends that in the future all of the respite beds be used for emergency respite and that planned respite no longer be offered. Yet in both FY13 and the first quarter of FY14, there were more individuals who used the respite home for planned respite, although for fewer days. The administrative staff of DBHDS did not offer a rationale for the decision to no longer offer planned respite.

CONCLUSION

The Commonwealth is not in compliance with Sections 6.b.iii.F that require the establishment of 1 crisis stabilization program in each region by June 30, 2012 in each region. The Commonwealth should achieve compliance with this requirement by the end of the calendar year. There are some concerns expressed with the type of facility and location that Region IV will be using as it is reported to not be home like nor located in an integrated community setting.

Section 6.b.iii.G requires that the Commonwealth develop an additional crisis stabilization program in each region as determined necessary to meet the needs of the target population. Since the utilization rates for both emergency and planned respite are far under 100%, and there will be additional capacity as soon as Regions IV and V open their respite homes, the Commonwealth has determined that a second setting is not needed in each region to respond to the needs of this population at this time. This is a reasonable decision at this time but the utilization of the respite homes should continue to be monitored, as should the outcome of the DBHDS decision to no longer offer planned respite but devote all of the beds to emergency respite.

The decision by the Commonwealth to end planned out of home respite jeopardizes the Commonwealth's compliance with Section 6.b.ii.B that expects that the mobile crisis teams plan and identify strategies for preventing future crises. The availability of planned out of home respite is one of the strategies that the teams have been able to offer. As more states move to a family support model of service delivery that relies on the family to maintain their family member at home, respite services become an important support to avert the need for out of home placement. The availability of out of home respite is even more critical to assist families to cope and provide a nurturing home setting if the family member has a co-occurring mental health need.

It appears that the availability of START services can be more widely shared with both ID and DD consumers and their families. From the feedback of one member of the Region IV Advisory Council, the information is given directly to CSB case managers and they determine who on their caseloads may need this service and share its availability with them. It is unclear how the availability is made

known to individuals with DD and their families. If there is more comprehensive outreach and dissemination of information about START services directly to individuals and their families there may be an increase in referrals.

RECOMMENDATIONS AND ISSUES FOR CONSIDERATION

The DBHDS should explain its rationale for planning to end planned respite in the START respite homes. Families who have used planned respite should be surveyed to determine the impact this crisis support had on their family member stability and on their ability to continue to have their family member live with them. Case managers whose consumers have used planned respite should be surveyed as well to elicit their input in terms of the value of planned out of home respite. The Independent Reviewer should then decide if he wants to recommend to the Court that planned respite continue.
The Independent Reviewer or Expert Consultant should visit the facility that will be the START Respite Home in Region IV to determine if it meets the Court's expectations for a community based respite setting.

I should review utilization in the next review of crisis services and should review how information is shared directly with families of individuals with ID and DD regarding the availability of START services including the START respite homes. This review should include interviews with a sample of START Regional Advisory Council members from each region.

SUMMARY

The DBHDS is not in compliance with the following sections of the Settlement Agreement: 6.a.i-iii; 6.b.i.B; 6.a.ii.C; 6.b.ii.F; and 6.b.ii.G. Virginia is not compliant with the requirements to effectively serve adults with DD; support children with ID or DD who experience a crisis; train emergency service staff; work effectively with law enforcement; offer a crisis stabilization unit/respite home in each region; or respond to all requests for crisis intervention within 2 hours.

This report includes a number of recommendations to address improving outreach and START access for individuals with DD; enhance the plans to serve children and to provide more immediate emergency response to all individuals with ID and DD; train all CSB ES staff; develop an outreach plan with law enforcement; develop consistent expectations for case managers; develop statewide policies and procedures for the START program; report on the impact of discontinuing planned out of home respite; and complete a case study of the coordination and follow up for individuals served by residential providers.

It was very enlightening to interview 2 members of the Regional START Advisory Councils. The individuals interviewed are both members of the Region IV Advisory Council. Representatives of the other Advisory Councils should be interviewed during a future review.

I recommend that the next review concentrate on determining the quality of START services that are provided and the satisfaction of families and individuals who have utilized the services. This should include case reviews for individuals with ID and with DD. This should include a review of in-home supports, emergency and planned respite and START's ability to link individuals with community

supports and resources to help maintain stabilized situations and keep people in their homes. Another aspect of the review should focus on the coordination and involvement of the case manager and with residential providers. There should also be a review of the outreach strategies with the DD community including individuals and families, case managers and providers.

APPENDIX D

Report on Quality and Risk Management

INTRODUCTION

In June 2013, Donald Fletcher, the Independent Reviewer in the *United States of America v. Commonwealth of Virginia* case, asked this Consultant to submit a proposal to review specific components of the Settlement Agreement related to the quality and risk management systems. On June 24, 2013, and June 27, 2013, the Independent Reviewer and the Consultant held initial calls with the Commonwealth and the United States Department of Justice (DOJ), respectively, to hear their input. Taking into consideration the initial conversations with the Commonwealth and DOJ, the Consultant's proposal recommended that at this juncture, the most helpful approach would be to provide a baseline review of a number of the components of the system. It recommended that the focus of this review be on:

1) Areas in which some development had occurred; and
2) Areas that represented the essential building blocks for the infrastructure of a functioning Quality Management system.
3) The proposal also identified Settlement Agreement requirements for quality and risk management systems that would appear to require separate review, and/or review by a consultant(s) with clinical knowledge.

The specific areas that it proposed this Consultant would review included:

1) Risk triggers and thresholds;
2) The web-based incident reporting system and reporting protocol;
3) Investigation of allegations and critical incidents;
4) Data to assess and improve quality;
5) Providers; and
6) Quality service reviews.

The proposal also set out the basic methodology for the review, as well as the State Health Authority Yardstick (SHAY) tool components that would be reviewed. The Independent Reviewer shared the proposal with the Commonwealth and DOJ. Given the parties expressed no objections, the review moved forward using the parameters set forth in the proposal. On August 30, 2013, the Independent Reviewer and Consultant held a call with the Commonwealth to further discuss the methodology with the goal of ensuring the correct documents for review and interviews were identified. The logistics for coordinating the review also were discussed.

The Consultant sincerely appreciates the assistance that Kathy Drumright, Assistant Commissioner of Quality Management and Development, provided in arranging interviews and coordinating the production of documents. In addition to Ms. Drumright, a number of other Commonwealth staff, as well as a provider representative, and staff from the Virginia Commonwealth University (VCU) Partnership for People with Disabilities took time out of very busy schedules to participate in interviews with the Consultant, as well as supply documentation. The Consultant expresses her thanks to all of those involved for their time, as well as their candid assessments of the progress made as well as the challenges that lay ahead.

The following report summarizes the findings of the review, and offers recommendations. At the request of the Independent Reviewer, it also discusses the applicable SHAY tool components.

METHODOLOGY

This review was conducted through a combination of telephone interviews and document reviews. As noted above, based on initial conversations with the Commonwealth and DOJ, the Consultant identified a number of documents and interviews necessary to learn about the status of the Commonwealth's activities. In a call on August 30, 2013, the Commonwealth identified additional documents and persons to be included in interviews.

A series of seven interviews were scheduled, and occurred between September 16 and 27, 2013. Based on input from the Commonwealth, the people selected for interviews included staff from the Department of Behavioral Health and Developmental Services (DBHDS), as well as the Department of Medical Assistance Services (DMAS), the VCU Partnership for People with Disabilities, and a representative from the provider community. At this juncture, full implementation of many of these initiatives had not yet occurred. As a result, providers, and individuals and their families were not included in the review. However, as appropriate, during future reviews, their input will be sought.

The Commonwealth submitted the requested documents prior to these interviews. As a result of review of the initial documents as well as information gained during the calls, the Consultant requested some additional documents.

The names and titles of those who participated in the interviews are provided in Appendix B. A listing of documents reviewed also is provided in Appendix B.

BASELINE FINDINGS AND RECOMMENDATIONS

For each of the areas of review, the language from the Settlement Agreement is provided in italics. This is followed by a summary of the status of the Commonwealth's efforts. Recommendations also are offered for consideration.

It is important to note that given that many of the Commonwealth's initiatives in relation to the quality and risk management system were at the beginning stages of development and implementation, this review included a number of draft documents that still were in the process of being modified. Based on interviews, the Consultant requested and reviewed some updated drafts. However, the comments in this report are based on these evolving documents. As appropriate, reference has been made to the status of the documents reviewed.

a. Risk Triggers and Thresholds (Section V.C.1)

The Commonwealth shall require that all Training Centers, CSBs [Community Services Boards], and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that

enable them to adequately address harms and risk of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.

The goal of the Consultant's review was to review risk triggers and thresholds that had been developed, and provide initial feedback. In addition, objectives of the review were to determine what actions the Commonwealth had taken or planned to take to require providers to implement the risk management system, and determine how the Commonwealth planned to make sure providers were implementing the system.

Draft Risk Triggers and Thresholds

At the time of the Consultant's review, the risk triggers and thresholds were still in draft format. Several drafts were provided showing changes over time. Clearly, based on the minutes from Project Team #11's meetings and the various drafts, a significant amount of work had been devoted to developing the draft risk triggers and thresholds.

Based on discussions with members of Project Team #11, providers would be responsible for tracking and responding to risk triggers. The expectation was that providers would review the event, determine what changes or actions were needed to prevent recurrence to the extent possible, and implement necessary actions. These events generally impacted an individual. For the risk thresholds, the provider was expected to conduct a review and take action, as appropriate, but the Commonwealth also would review these events or series of events, along with the provider's action plan to determine if necessary action was taken.

The draft document included some valuable triggers and thresholds. However, an overarching concern related to the constraints that appeared to prevent a complete list from being developed. This same issue is further discussed with regard to the section of this report that addresses data to assess and improve quality. However, the following concerns were noted with regard to the draft risk triggers and thresholds:

- The most recent draft provided, dated 8/8/13, included two categories of triggers and thresholds, including "required," and "recommended" or "internal." Providers would be required to report data on those that were identified as "required," and the data source for each had been identified, as well as the reporting frequency. For "recommended" or "internal" thresholds, the providers would be encouraged to collect data on them, but they would not be required to report them externally, and the Office of Licensing would not review them during its reviews. Based on review of documentation and discussion with members of Project Team #11, the decision was made to divide the triggers and thresholds into these categories due to the limitations on what providers currently were required to report based on regulation and/or contract requirements. Some examples of "recommended" risk thresholds were: "Any staff member who makes three or more medication errors within a quarter," "Any individual with two (2) or more episodes of aspiration pneumonia within a quarter that requires medical attention..." or "Two (2) or more choking events... by one or more individuals in a program or service area, within a quarter, where emergency measures such as the Heimlich maneuver were undertaken but treatment by a medical professional was not

provided." Given that these were significant indicators of potential for harm, it is important that ultimately, the risk system include them as "required" data points.

- In addition, the triggers were not necessarily sensitive enough for those individuals with high risk in these areas. For example, one incidence of aspiration pneumonia is significant, and should result in immediate review to prevent the next hospitalization and/or death.
- Given the Settlement Agreement provides a fairly inclusive definition of harm (i.e., "Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes), it was not entirely clear why the draft risk triggers and thresholds included some items and not others, and/or why some were removed as the process progressed. Again, based on discussions with members of Project Team #11, this in large part appeared to be due to the data that were currently available. In addition, some prioritization had occurred, based on common issues for individuals with intellectual disabilities (ID) and developmental disabilities (DD), and other available data. For example, reportedly, issues that had been identified through mortality reviews and relevant literature were included, such as aspiration pneumonia and constipation/bowel obstruction. However, other indicators of risk that are fairly typical for individuals with intellectual and/or developmental disabilities that were not addressed included, but were not limited to: peer-to-peer aggression, serious injuries other than fractures/dislocations, infections [e.g., sepsis, Methicillin-resistant Staphylococcus aureus (MRSA), etc.], pica behavior, psychiatric hospitalizations, etc.
- Many of the risk triggers and thresholds were dependent on harm actually occurring. Some examples included triggers related to self-injurious behaviors or decubitus ulcers. For both, medical attention was part of the trigger definition. As opposed to waiting for harm to occur, precursors should be identified as triggers to try to prevent harm before it occurred. For example, if an individual's behavior data are showing increasing self-injurious behavior and minor injuries are occurring, this should trigger action to prevent such a significant injury that medical attention is needed. This dependence on significant harm again appears due to the definition included in regulation of serious incidents that providers needed to report to the Commonwealth. Specifically, "serious incident" was defined in the 12 Virginia Administrative Code (VAC) 35-115-30 as: "any incident or injury resulting in bodily damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner while the individual is supervised by or involved in services, such as attempted suicides, medication overdoses, or reactions from medications administered or prescribed by the service [sic]." As a result, other data would not currently be required to be collected. These include behaviors that reflect dangerous conditions or circumstances but which result in minor or no injuries, such as: unauthorized departures that expose an individual without safety awareness to danger (i.e. traffic), individuals choking while eating that requires intervention to resolve (i.e. finger sweep or Heimlich Maneuver), etc. The goal of a risk trigger and threshold system, however, should be to identify events that increase the risk of actual harm, so that steps are taken to attempt to prevent it. In fact, the Settlement Agreement requires the system to address "risk of harm" as well as actual harm.
- Of note, the system being developed would only apply to licensed intellectual disability programs/facilities. Based on information members of Project Team #11 provided, entities that would fall outside of the scope of DBHDS' authority to require use of the triggers and thresholds included, for example, nursing homes and private homes. As indicated elsewhere in this report, most individuals served through the Developmental Disabilities (DD) Waiver

lived in private homes, and Case Managers were not required to report allegations or incidents.

As noted above, many of the risk triggers and thresholds that had been developed were important ones that should assist the Commonwealth and providers to provide increased attention to areas of potential risk. As discussed briefly above, the expectation was that providers would address each of the triggers for individuals involved. When a threshold was reached, the provider would be expected to conduct a review to determine if action needed to be taken more systemically. Information about actions taken would be provided to Regional Quality Councils. Information also would be provided to the DBHDS Quality Improvement Committee (QIC), and the RCQs and DBHDS QIC would take action as appropriate, to either work with the provider to address issues specific to the provider, or take more systemic action, such as, issuing safety alerts, new protocols or service guidelines, or to modifying department instructions.

The following list provides some additional comments regarding the draft triggers for consideration:

- Some terms would benefit from definitions. For example, given the various types of restraint, it would help to clarify whether or not the term "restraint" encompasses all types of restraint.
- It was not clear why hospital-acquired aspiration pneumonia would not be considered a risk trigger. Any aspiration event presents a risk to the individual, and hospital-acquired aspiration pneumonia requires attention to ensure proper staffing was made to the individual while at the hospital, and the individual's risk and plans to reduce risk were appropriately communicated to the hospital.
- As discussed during the phone call with members of Project Team #11, the indicators that made reference to changes in percentages in rates of, for example, overall medication errors or fractures should be reviewed. If a provider's rates already were too high, these indicators would not capture the fact that a risk of harm already existed, and might result in further risk of harm.
- Some indicators were based on measures included in Individual Support Plans (ISPs). As discussed in further detail on the section related to data to assess and improve quality, if ISPs are not adequate, then data from these indicators could be difficult to interpret and use.

<u>Providers' Implementation of the System</u>

Based on interviews with members of Project Team #11 and review of documentation, the Commonwealth plans to provide training to providers on the risk triggers and thresholds process in a number of different ways. For example, online training will be developed and be available through the Learning Management System (LMS). This system allows the Commonwealth to track who had completed training, and allows competency-checks or tests to be included as part of the training. In addition, live training will be available in a number of forums, such as upcoming provider association meetings, and in five regional sessions. Even before training was finalized, plans were to present the overall concept at conferences.

According to staff, they planned to place an emphasis on education and showing providers how the system could assist them in doing their jobs and improving outcomes for individuals. However, if

enforcement is necessary, the Office of Licensing reportedly has the authority to require licensed providers to comply with the requirements for reporting, as and to take action to address risk triggers or thresholds.

In summary, the Commonwealth had made progress in developing risk triggers and thresholds, but significant challenges remain to develop and implement a complete list of risk triggers and thresholds. A narrow list of triggers and thresholds will continue to expose individuals to risk of harm. Without adequate triggers and thresholds, the potential for harm will likely not be caught early enough to prevent actual harm. The Commonwealth should continue to identify and/or develop relevant sources of data to allow expansion of the list of relevant risk triggers and thresholds. In addition, the current "recommended" or internal triggers should be required, and the Commonwealth should identify mechanisms to collect additional data to allow future expansion of the list.

b. Web-based Incident Reporting System and Reporting Protocol (Section V.C.2)

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

The goal of the Consultant's review was to obtain a status of the web-based incident reporting system that was rolled out on 6/1/13. In addition, an objective of the review was to determine whether incident definitions were sufficient, what processes were in place to ensure provider staff reported directly, and what processes were in place to ensure necessary data were being entered into the system.

Status of Web-Based Incident Reporting System

Based on an interview with members of Project Team #12 as well as review of documentation, the web-based incident reporting system, known as the Computerized Human Rights Information System (CHRIS), was rolled out over a series of months, and on 6/1/13, all Training Centers, CSBs, and licensed Intellectual Disability community providers were required to submit reports of allegations of abuse, neglect, and exploitation, serious injuries, deaths, and complaints of human rights violations through CHRIS. The following process was used to roll out the system:

- In January 2013, the Training Centers, CSBs, as well as some large community providers participated in training on the web-based system. The State Facilities had been using the CHRIS system internally, but needed training on the web-based component. Additional training was provided to the CSBs and selected community providers. The training took the form of live training, webinars, and online training. Based on minutes from Project Team #12, in late March 2013, these groups began using the web-based system. Based on feedback from the initial rollout, changes were made to the system.

- In April and May 2013, extensive training was completed for the remaining community providers. All providers were notified that beginning on 6/1/13, they were to use CHRIS.

Based on a review of the online training and related manual, they were user-friendly, and walked the trainee through the various steps necessary to enter initial information about an allegation or incident into the system, as well as follow-up information. In addition to training, the Commonwealth also had provided technical assistance. Technical assistance could be accessed through the telephone. In addition, the Commonwealth developed Frequently Asked Question guidance, and posted it on the CHRIS website.

Based on discussion with members of Project Team #12, some challenges had presented themselves, but generally, they had been addressed. Reportedly, one of the biggest challenges was related to the necessary security for a web-based system, and specifically, ensuring that all end-users had obtained their log-on identifications and passwords. Each provider agency was required to identify a local administrator, and the administrator needed to define roles for each user. The system then set up log-on information for the users. This process took some time, and reminders had to be sent to ensure the local administrators had entered all end-users in the system. Another challenge was related to the internet browsers various agencies were using, and their interface with the system. As a result, until this recently was fixed, some providers had needed to continue faxing reports to the Commonwealth's Licensing and/or Human Rights staff.

Naturally, some reports continued to be sent through the fax, even when providers had the ability to send them through the web-based system. To address this issue, each time this occurred, the Commonwealth sent a fax back as well as an email explaining the new system for making reports.

Questions arose about what providers needed to report, and what information needed to be included in the reports. To address these issues, the Commonwealth developed and posted guidance documents on the website. These included:

- A list was provided of medication errors providers needed to report as alleged neglect and a serious injury (i.e., any medication error resulting in an injury/illness requiring medical attention by a licensed physician, doctor of osteopathic medicine, physician's assistant, or nurse practitioner), as well as medication errors that providers needed to report as alleged neglect (i.e., any medication error involving the wrong dose, wrong individual, or wrong medication; and any medication error where multiple doses were missed, or discontinued medications continued to be administered).
- Guidance was offered related to the types of injuries considered "serious injuries." The criterion for reporting was any injury resulting in bodily damage, harm, or loss that required medical attention from a licensed physician, doctor of osteopathic medicine, physician's assistant, or nurse practitioner. The list of examples, however, was somewhat confusing, because some of the items listed were serious illnesses as opposed to serious injuries (e.g., aspiration pneumonia, constipation/bowel obstruction, decubitus ulcer, and seizure/convulsion). There is no question that providers should be required to report these to the Commonwealth. However, it was not clear whether other serious illnesses also should be reported to the Commonwealth, and if so, which ones (i.e., any other illness that results in unexpected medical intervention, particularly emergency room visits or hospitalizations).

- Providers also had questions about whether names of staff involved in allegations, serious injuries, and deaths legally could be included in CHRIS. The Commonwealth issued guidance, dated 1/5/13, explaining the statutory and regulatory basis allowing the Commonwealth to require providers to include staff's names. According to the guidance: "The Department is asking that the names of employees found to have abused or neglected an individual be included in the CHRIS data base. The Department is also asking for the names of employees involved in any reported death or serious injury. The specific personnel action taken is not a required field at this time, so a provider may choose not to complete that information when reporting in CHRIS." As the guidance indicated: "The DBHDS does not have any authority to take action against a provider's individual employees. It asks for this information, however, so that it can monitor any potential trends and make sure any problems are remedied. If, for instance, the DBHDS noticed that a particular employee of a provider was involved in multiple incidents, we may ask the provider to give us an explanation of what is being done to address this." From an incident management perspective, it was positive that the Commonwealth was asking for provision of this important information for exactly the reasons stated.

Processes to Ensure Entry of Necessary Data

According to members of Project Team #12, as of 9/1/13, faxes were no longer being accepted as a reporting mechanism. Therefore, it was anticipated that full reporting would occur through CHRIS. The Team estimated that by January 2014, the data regarding frequency and types of incidents would be fairly usable/valid. A few different methodologies were being used to estimate if full reporting was in fact occurring, including:

- Within the last three months, Office of Licensing staff compared numbers of reports for similar time periods prior to CHRIS becoming operational (i.e., previous numbers of faxes) to current reporting. This required a hand-count to be completed of previous reports. According to the Associate Director of Licensing, these counts were similar.
- For certain categories of incidents, the system automatically generated a notification to the assigned Licensing Specialist. Licensing Specialists were assigned regionally, and then by provider. Some larger providers that operated programs in different regions were assigned more than one Licensing Specialist. Currently, the Associate Director of Licensing and a staff member from Human Rights were reviewing each entry into the system daily to ensure that allegations and incidents were being directed to the appropriate Commonwealth staff. According to the Associate Director of Licensing, as part of regulatory reviews, if Licensing Specialists identified any incidents that were not reported through CHRIS, they noted the oversight, and reminded the provider of the need to make a report. At this point in the evolution of the web-based system, the Licensing Specialists did not cite the provider, but as the system evolved, the members of the group indicated a citation would be a possible outcome of a failure to report. At this juncture, it was too early to determine if this enforcement mechanism was used and/or effective.
- Similarly, for certain categories of incidents, the system generated a notification to Human Rights Advocates. They also were assigned regionally. The Human Rights Advocates also were looking to determine if any incidents or allegations of which they were aware were missing from the system.

- Ongoing training on the requirements for reporting through the web-based system also was reportedly occurring. The focus was on encouraging providers to report, and educating providers about the benefits of reporting from a quality improvement (QI) perspective.
- The Commonwealth required all providers with knowledge of an allegation or incident to report it through CHRIS. Sometimes this resulted in multiple reports being submitted for the same allegation or incident. For example, when different day/vocational and residential providers supported an individual, then often, the day/vocational provider, the residential provider, and the Support Coordinator/Case Manager all reported the same incident. Efforts were underway to ensure that duplicate counts of the incidents did not occur, but for now, duplicate reporting was viewed as a better result than underreporting.
- Providers also were required to report certain allegations and incidents to local Human Rights Committees. Going forward, this also was expected to be used as a check to ensure that the list of reports matched with what was submitted through CHRIS.

Undoubtedly, an ongoing challenge in any incident management system is determining whether or not full reporting is occurring. However, if the mechanisms described above are fully implemented, then a reasonable system of checks and balances would seem to be in place for individuals in Training Centers, and those supported by CSBs and private providers. Due to the fact that the system was in the initial phases of implementation, this review did not include the effectiveness of these checks and balances. An additional recommendation is that, Training Centers, CSBs, and community providers also should be expected to implement mechanisms through their quality improvement programs to identify incidents or allegations that should have been reported, but were not, and to report them promptly if/when they are identified.

Based on an interview with the DMAS Program Manager for the DD Waiver, mechanisms were not yet in place to ensure that reports were made for the approximately 890 individuals supported through the DD Waiver. These individuals had case managers. There were approximately 90 case managers working for 37 different agencies. The individuals on the DD Waiver lived in their own homes, with family, or with friends. They did not live in licensed facilities or homes, and so did not have to conform to the regulations. This seems to be a serious gap and an area of noncompliance. The Program Manager explained that sometimes case managers would inform DMAS when they called Child Protective Services or Adult Protective Services to report an allegation of abuse, neglect, and exploitation, but they were not required to do so. The Program Manager indicated that some discussion about alternatives had occurred with the Project Teams, such as the use of an email form that case managers could complete that would be connected to an Access database. However, this issue had not yet been resolved.

Based on discussion with members of Project Team #12, they recognized that one of the next challenges is to address some of the quality issues related to the entry of information about allegations and incidents. In other words, although it appeared Training Centers, CSBs, and private providers were reporting allegations and incidents, the information about each allegation or incident and the related follow-up was not necessarily complete and thorough.

Processes to Ensure Provider Staff Reported Directly

An area that will need to be addressed moving forward related to the Settlement Agreement requirement that staff that become aware of allegations of abuse or neglect, serious injuries, or deaths "directly report" them. Based on information gained through interview, each Training Center, CSB, and community provider agency was responsible to identify the staff that would enter information into CHRIS, and not all staff was provided access to the system. As a result, many providers had had to modify their business practices in terms of collecting and reporting information. It was not currently known if all of them had developed processes that would result in staff with the most direct knowledge of the incident submitting an internal report that was then entered into CHRIS. As one example, some larger community providers had internal databases and corresponding processes for staff to enter incident and allegation information. However, there currently was no mechanism for the CHRIS system to interface with these systems. As a result, for these providers, information entered into the provider system had to be extracted and re-entered into CHRIS. As members of Project Team #12 candidly reported, at this time, the staff entering information into CHRIS was not necessarily the staff with the most direct knowledge of the incident or allegation.

Use of CHRIS Data

In terms of reports, each provider agency currently was able to run certain canned reports for the data they had entered (i.e., for their provider agency). At DBHDS, certain staff had access to statewide data. The DBHDS Data Analyst was able to extract data from the CHRIS system, and create charts and graphs showing different aspects of the data. The Commonwealth shared some of these reports with the Consultant. For example, for abuse allegations for the second quarter, data was displayed according to the numbers of reports for each type of abuse (e.g., physical, verbal, sexual), neglect, and exploitation for the CSB Regions, and the numbers and percentages of reports resulting in substantiated findings of abuse, neglect, and exploitation. Further breakdown was available by each CSB. Other charts and graphs showed this same data for the State Facilities, as well as private providers. The data also could be run according to the Waiver through which the individuals were funded. However, as noted above, there currently was no reporting for the DD waiver.

Although the system was at the beginning stages of developing and running the reports, the ability to begin generating these reports was an important step forward. Based on discussion with members of Project Team #12, previously the DBHDS staff entered the information contained in the faxes providers sent into databases that each region maintained. However, there was not one statewide system. As CHRIS is implemented fully, it should provide important data that various groups can use as part of the overall quality improvement efforts.

Project Team #12's goals were that by January 2014, it would know which reports the various committees/groups needed, and it would be able to develop and begin generating such reports. For example, Regional Quality Councils and the DBHDS Quality Council would require different reports to complete their work. Once it was determined which reports were needed, reports could be built to meet their different needs.

Of note, as mentioned briefly above, CHRIS included a process for Licensing Specialists and Human Rights Advocates to review allegations, incidents, and complaints, as well as the follow-up actions

providers had taken in response. This process was not a subject of this review, but whether and how well it was working should be reviewed during future reviews of CHRIS.

In summary, the Commonwealth had made significant progress in operationalizing a web-based incident reporting system. However, a number of issues should be addressed as the Commonwealth continues its efforts to address the requirements of the Settlement Agreement. The following recommendations are offered:

- Further guidance should be provided to better define the types of serious illnesses the Commonwealth considers to fall under the category of serious injury.
- Through their quality improvement systems, Training Centers, CSBs, and community providers should be expected to implement mechanisms to identify incidents or allegations that should have been reported, but were not, and to report them promptly if/when they are identified.
- The Commonwealth should work with Training Centers, CSBs, and provider agencies to develop mechanisms to ensure that information entered into CHRIS reflects the information that the staff that became aware of allegations of abuse or neglect, serious injuries, or deaths "directly reported."
- Efforts are needed to ensure all allegations of abuse, neglect, and exploitation, serious injuries, and deaths are reported, including for individuals in the DD Waiver system.

On a final note, the Settlement Agreement only requires the web-based system to include reports of abuse, neglect, and exploitation, serious injuries, and deaths as defined in the Commonwealth's regulations. However, as noted elsewhere in this report, the limitations in regulations on what providers are required to report significantly impacted the types of events about which the Commonwealth was made aware, and stymied a more proactive approach to incident management. Some of the other categories of incidents that it would be reasonable to expect providers to report include, but are not limited to: contact with law enforcement or emergency personnel, unexpected hospitalizations, peer-to-peer aggression regardless of level of injury, community incidents that have had or have the potential to negatively impact the individual or provider, unplanned evacuations, infections reportable to the Department of Public Health, missing persons, and theft of individuals' funds or property.

c. Investigation of Allegations and Critical Incidents (Section V.C.3)

The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken. 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.

The goal of the Consultant's review related to investigations of allegations and critical incidents was to provide initial assessment of the draft uniform investigations training and root cause analysis training, and determine expectations of how this would modify current processes for investigations at state-level and provider-level. Project Team #11 had been assigned to work on these Settlement Agreement requirements.

Based on a meeting with members of Project Team #11 and review of draft documents, progress had been made in developing standardized training that will be offered to community providers. Specifically, the Commonwealth provided drafts of training entitled: "DBHDS Investigation Process," and "Root Cause Analysis: A Brief Overview of the Analysis Process." During the meeting, staff explained that the Training Centers implemented a two-day investigation curriculum, and staff that successfully completed the training was certified as investigators. The Commonwealth's Human Rights Advocates also attended this training. The DBHDS Abuse Neglect Investigations Manager, who oversees investigations at the Training Centers, was a member of Project Team #11. Her experience and the training available to the Training Centers were used as resources in developing the training module for the community system.

Currently, regulations require community providers to have "trained investigators," but no standards for training or the investigation process existed in the community system. Based on information provided during the interview, the training offered and the quality of investigations community providers conducted varied from provider to provider, as did community providers' resources for training. Commonwealth staff indicated that regulations did not require providers to use a specific training or meet specific quality standards, but the Commonwealth was developing the online training module on the investigation process and root cause analysis as an option for providers with the goal of assisting to standardize the process used for investigations.

With regard to the quality of the training, the draft PowerPoint presentation entitled "DBHDS Investigation Process" covered a number of important components of investigations and was well organized. For each of the following topics, for example, it included a number of details relevant to the investigations process: 1) recognizing events that require investigation; 2) collecting basic information about the incident/allegation; 3) taking immediate action to protect the individual(s) involved, taking necessary personnel action, preserving evidence, and making necessary notifications; 4) developing an investigation plan; 5) conducting the investigation; 6) summarizing and reporting findings; and 7) identifying and implementing corrective actions.

The draft training slides also referenced other resources that trainees eventually will be able to access through hyper-links. Based on interview with Project Team #11 members, these resources were in the process of being collected and/or developed, and the Team was working on embedding the links into the training. The additional resources included: 1) a methodology to "connect" the information gained through the investigation (i.e., it was assumed that this meant a process for analyzing/reconciling various evidence); and 2) an Interview Guide.

While recognizing that the training slides were in draft format, the following observations and suggestions are made:

- The draft provided a good outline of the investigation process. As noted above, it was well organized and provided relevant information. The following areas, however, required further information or explanation:
    - Expectations for coordinating investigations with other investigatory agencies (e.g., when a crime is suspected, coordinating investigation activities with law enforcement to preserve the integrity of their investigation);
    - Additional considerations that should be made when developing an investigation plan (e.g., timeliness of interviews, particularly with eye witnesses and individuals with intellectual disabilities; need to review relevant documents as background information, etc.);
    - Additional types of witnesses [e.g., subject-matter experts, or witnesses that can provide background information about the individual(s) involved];
    - Additional information about techniques for preserving evidence (e.g., separating witnesses; more information about what to photograph, such as scenes, injuries, etc.; securing documentation quickly to prevent changes and methods for authenticating documents; creating diagrams; techniques for documenting witness testimony, such as having the witness write a statement, the investigator documenting the interview and having the witness sign a statement, etc.; requirements for securing physical evidence, such as bagging and labeling it; maintaining evidence in a locked area; etc.);
    - Interview techniques (e.g., not leading the witness, use of a chronology of events format, considerations when interviewing individuals with intellectual/developmental disabilities, etc.);
    - Methodologies for reconstructing the scene and related documentation (e.g., acting out portions of the scenario, taking measurements, taking pictures, creating diagrams, etc.);
    - Definition of the preponderance of the evidence standard included in regulations;
    - Additional information about weighing or reconciling evidence (e.g., considerations in weighing conflicting testimonial evidence), and providing the necessary basis for the findings in the written report;
    - Definitions for the various findings listed (e.g., unsubstantiated, substantiated, and inconclusive);
    - Potential processes for making recommendations for corrective action (e.g., responsibility of the investigator, the investigator's supervisor, or a trained group, such as an incident review committee or human rights committee); and
    - Discussion of potential personnel actions before, during, and after an investigation (e.g., expectation that alleged perpetrators will be removed from all direct contact pending the results of the investigation).
- The members of Project Team #11 indicated that the intent was to have guidelines, as well as a manual to compliment the online training course. In finalizing these, the couple resources mentioned above were important ones. Other portions of the investigation process for which resources or further delineation in the training itself should be provided include, but are not limited to: standards/techniques for preserving various types of evidence (i.e., physical, documentary, and testimonial); a template for an investigation plan; a template for a confidentiality statement for use with witnesses; and a template for an investigation report.
- Typically, training on investigation techniques involves a classroom component. As the DBHDS Abuse Neglect Investigations Manager indicated, the Training Centers investigation training consisted of two-days of classroom training, including interactive pieces, such as role-

plays. Although the training module being developed was not yet complete, it was unclear whether or not it would sufficiently address the need for trainees to practice some of the more complex skills necessary in conducting investigations, such as conducting unbiased interviews, dealing with difficult witnesses, etc.

- The training was not competency-based, but the members of Project Team #11 indicated their intent to develop a competency-based component. For example, the members of the team indicated that a pop-up test could be included at different points during the training, or a video could be embedded into the training to which trainees would need to respond to questions. Given that conducting thorough investigations requires a specific set of skills, it will be important for "trained investigators" to demonstrate their competency, and building a competency-based component into this basic training would be a good place to start.

With regard to the Draft Root Cause Analysis training, it presented the process in an easy-to-understand and thorough manner. The draft training included, for example, a description of the role of a root cause analysis, guidelines for when one should be completed, the composition and roles of a root cause analysis team, a description of what the review should include, the process for analysis and development of causal statements, and identification of actions to prevent recurrence. The area of the training that would benefit from additional information was the final part related to developing corrective actions. Frequently, developing a corrective action plan is a difficult concept for staff to understand. It will help to provide some parameters related to such plans, including measurable action steps, identification of timeframes for completion, and persons responsible, as well as identification of the outcomes or specific changes against which success of the action plan will be measured. Members of Project Team #11 indicated that work was being done to simplify the slides included in the draft. Similar to the Investigations Process training, additional resources were being developed to supplement the online training.

In terms of the use of the Investigations Process and Root Cause Analysis training, as noted above, the members of Project Team #11 with whom the Consultant met explained that this training will be offered to providers, but will not be mandatory training. They referenced the regulations cited in the Settlement Agreement that require providers to conduct investigations of abuse and neglect allegations, and explained that there were no specific training requirements for investigators. Based on discussions with the group, it was expected that eventually, community providers will be required to have investigators trained using the DBHDS Investigations Process training, or some equivalent. At the time of the review, however, this training was not finalized, and "equivalent training" had not been defined.

Based on the Consultant's review of the regulations, Chapter 115 was entitled "Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services," and had fairly broad reach for many provider types (e.g., Waiver-funded providers, all licensed providers, CSBs, and Training Centers). Within these regulations, 12 VAC 35-115-50(D)(3) sets forth the requirements for providers to have policies and procedures for their staff and others (e.g., volunteers and consultants) to report abuse, neglect, and exploitation immediately to the director or designee, and for providers to investigate such allegations using "a person trained to do investigations and who is not involved in the issues under investigation." This section of the regulations provided other specific requirements related to, for example, actions to be taken immediately to protect the individual, the timeliness of investigations,

notification of the individual and/or guardian of the results, appeal processes, cooperation with other investigations, and actions to remediate problems investigations uncover. The regulations, however, defined neither the specific training that investigators were to complete, nor the content or quality of the investigations beyond indicating that the preponderance of the evidence standard should be used, unless otherwise provided for by law.

The Settlement Agreement also references Chapter 105, "Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services." It defined "providers" and the licensing process. The specific sections of these regulations the Settlement Agreement references in relation to investigations are 12 VAC 35-105-160 and 12 VAC 35-105-170. They require providers to cooperate with DBHDS Licensing reviews, including investigations of complaints. In addition, amongst the requirements contained in 12 VAC 35-105-160 is the requirement for providers to collect certain information and report allegations of abuse and neglect, deaths, serious injuries, and seclusion or restraint that did not conform with human rights regulations or resulted in injury. Section 12 VAC 35-105-170 spells out the process related to corrective action plans required as a result of any licensing citations. Based on review of these regulations, they did not specify any requirements for providers to train investigators or conduct internal formal investigations.

Although not the specific focus of this initial review, the following were areas that were briefly reviewed, but require further inquiry:

- With regard to ensuring the quality of investigations, the roles of Licensing Specialists and Human Rights Advocates in reviewing provider investigations was discussed briefly. Within the CHRIS system, Licensing Specialists and Human Rights Advocates each have roles to review provider follow-up for certain types of incidents, including investigation reports and remedial measures taken. Based on interviews with members of Project Team #11 as well as Project Team #12, in order to close out an incident, Commonwealth staff needs to review the information the community provider had entered into the system. For abuse, neglect, and exploitation allegations, providers were required to complete investigations, and, at a minimum, Human Rights Advocates reviewed the providers' investigations. As part of licensing reviews, the quality of investigations also reportedly could be reviewed. Their review of investigations was not included as part of this review, so the nature of such reviews cannot be addressed, but should be as part of future reviews. Team members reported that no specific guidelines were being used to evaluate providers' investigations. If further action was needed, different options were available, depending on the issue. For example, requests could be made of the community provider for further information or action; the Human Rights Advocates, Licensing Specialists, or both could conduct further review; or referrals could be made to other State agencies (e.g., health services licensing boards, Adult Protective Services, etc.). Staff explained that, depending on the seriousness of the alleged incident, Licensing Specialists and/or Human Rights Advocates might initiate investigations either before the community provider agency completed and submitted their investigation or after reviewing the provider's investigation report. Because the Licensing Specialists were able to issue citations and Human Rights Advocates did not have this authority, they sometimes jointly conducted investigations. Any citations were directly related to the regulations, and the provider agencies were cited. In other words, the investigations or reviews revolved around whether or not a regulation had been violated, as opposed to whether or not abuse, neglect, or

exploitation was confirmed against a particular staff member(s). During this Consultant's review, a sample of community provider investigations and the Commonwealth's review of them was not selected and reviewed. As a result, the thoroughness and effectiveness of this process could not be determined.

- The Settlement Agreement requires investigation of "reports of suspected or alleged abuse, neglect, critical incidents, or deaths." Although the Human Rights regulations required providers to investigate allegations of abuse, neglect, and exploitation, they did not require them to investigate "critical incidents" or deaths. It was not yet clear how the Commonwealth would ensure the conduct of these additional investigations.
- In addition, in order for "remediation steps" to be taken to address confirmations of abuse, neglect, and exploitation, mechanisms need to be in place to ensure that provider agencies take appropriate action with confirmed perpetrators up to and including termination from employment. Although not reviewed in detail during this review, it appeared that the CHRIS system provided a mechanism for community providers to enter disciplinary action, but this was currently optional for providers. However, a system also is needed to ensure that other community providers do not hire staff confirmed to have perpetrated abuse, neglect, and exploitation. Based on interviews with members of Project Team #11 as well as Project Team #12, it did not appear that the necessary system was in place. For example, some other states use registries to track such confirmations, and provider agencies are required to check the names of potential and current staff against the registry, but the Commonwealth only had such a system through its Department of Social Services Child Protective Services. This system had a central registry for people determined to have abused or neglected a child, but no equivalent was available for vulnerable adults. In fact, staff reported that when Adult Protective Services or DBHDS substantiated abuse, neglect, and exploitation, this information could not be shared with other providers. This was confirmed in the guidance, dated 1/5/13, related to the inclusion of staff's names in CHRIS. As a result, there did not appear to be a process to prevent staff confirmed to have committed abuse, neglect, or exploitation with vulnerable adults from moving from one provider to another.

In summary, it was positive that the Commonwealth was developing training to address the investigation process. However, a number of issues should be addressed. The following recommendations are offered:

- As the DBHDS Investigations Process training and related guidelines and manual are finalized, consideration should be given to addressing the areas identified above in which it is recommended additional information be provided.
- Further training should be included in one or both training modules, or a separate training developed related to the development of corrective action plans, and assessment of their effectiveness.
- For both the Investigations Process training and the Root Cause Analysis training, consideration should be given to offering classroom training, as well as online training, and/or including the equivalent of experiential-based learning, such as role-plays and discussion in the online training.
- The current draft of the Investigations Process training module did not have a competency-based component, but DBHDS staff indicated their intent to build some competency-based components into the final training. Given the specific skills required to conduct thorough

investigations and write reports that include strong bases for the findings, the final training should include specific competency-based components. These should include, but not be limited to competencies with regard to the development of an investigation plan, securing evidence, conducting interviews, interviewing individuals with intellectual disabilities, reconciliation of evidence, and investigation report writing.

- It will be important to define what constitutes a "trained investigator." If training other than the Commonwealth-developed training will be acceptable, the requirements for such training should be defined.
- The Commonwealth should develop standards for adequate investigations and investigation reports for use by Licensing Specialists and Human Rights Advocates.
- If not already in place, the Commonwealth should require the investigation of critical incidents and deaths.
- If not already in place, a system should be developed and implemented to ensure that community providers do not hire staff confirmed to have perpetrated abuse, neglect, and exploitation.

d. Data to Assess and Improve Quality (Section V.D)

1. The Commonwealth's HCBS [Home and Community-Based Services] waivers shall operate in accordance with the Commonwealth's CMS [Centers for Medicare and Medicaid Services]-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers; identification, response and prevention of occurrences of abuse, neglect and exploitation; administrative oversight of all waiver functions including contracting; and financial accountability. Review of data shall occur at the local and state levels by the CBSs and DBHDS/DMAS, respectively.

3. The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area:

i. Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);
j. Physical, mental, and behavioral health and well being (e.g., access to medial care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status));
k. Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);
l. Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);

m. Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);
n. Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);
o. Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and
p. Provider capacity (e.g., caseloads, training, staff turnover, provider competency).

5. The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.

c. The councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.
d. Each council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.

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

The goal of the Consultant's review was to obtain updates on the following:

- The Commonwealth indicated that it was in the planning phase to identify the data that will be collected for the eight domains (i.e., as listed in Section V.D.3, a through h), including identifying which entities will collect which data. Therefore, the review revolved around identifying a fuller description of the current status to provide a baseline from which to conduct future reviews.
- The connection between these efforts and the Commonwealth's CMS-approved waiver quality improvement plan also was to be explored (i.e., Section V.D.1).
- In addition, a status report was to be obtained on the Regional Quality Review Councils (i.e., Section V.D.5).
- A status was to be obtained on the Commonwealth's ability to publicly report on the availability of services (including the number of people served in each type of service) (i.e., Section V.D.6).

Identification of Data for Eight Domains

The Commonwealth provided a draft document entitled "DBHDS DOJ Settlement Agreement Domains," dated 7/31/13. This document listed each of the eight domains, and for each of the eight domains one or more "measure" with corresponding sources of data. Based on review of the meeting minutes for Project Team #8 as well as discussions with members of the Team, the data included on the list was a combination of data that other Project Teams had identified (e.g., CHRIS data, and Quality Service Review data), as well as other data that Project Team #8 had identified as necessary. As discussed in further detail below, this list represented a good start, but further definition of the measures, as well as expansion of the measures was needed.

The Commonwealth also submitted a data dashboard that summarized a number of measures being collected across the DBHDS system (i.e., some of these related to mental health and substance abuse services). Two indicators related to the provision of Developmental Case Management Services. The data definition page showed: the measure, the definition, the entity responsible for reporting the data, the frequency of review, and the data source. Specifically, the definitions for the measures related to Developmental Case Management Services included: 1) the percent of individuals enrolled in Medicaid receiving developmental case management services (denominator) who received at least one face-to-face contact per month (numerator); and 2) the percent of individuals enrolled in Medicaid receiving developmental case management services who received at least one face-to-face contact per month (denominator), and who received one of those contacts every other month in their residence (numerator). The dashboard showed the denominator, numerator, percentage, previous score, percent increase or decrease, and the target. The graphs included with the dashboard were color-coded to allow quick identification of the indicators that had met or exceeded the target (green), were approaching the target (yellow), or were significantly below the target (red). Breakdowns of the data were then provided for each CSB to show their specific scores in comparison with the target. This was a helpful presentation of the data. Based on the interview with members of Project Team #8, this dashboard will likely expand to include additional case management/support coordination indicators.

During discussions with members of Project Team #8, they shared a number of the challenges to developing a data-based system to measure quality across the Commonwealth. They indicated that their priorities thus far were to ensure that specific deadlines within the Settlement Agreement were met, as well as to start building the system with data that was available. The members of Project Team #8 indicated that more work was needed to expand these efforts, but this will require careful planning, and likely an expansion of resources.

Recognizing that the drafts submitted were works in progress and that the Commonwealth appeared to agree that more work was needed, the following summarizes the discussion with members of Project Team #8, and the Consultant's review of documents. It also offers comments for consideration as the Commonwealth moves forward to finalize the list of data to assess and improve quality:

- Although the list of data included in the document entitled: "DOJ Settlement Agreement Domains," dated 7/31/13, included some important information, it did not yet represent a full listing of data to assess and improve quality. During discussions with members of Project Team #8 and members of other Project Teams, when asked about how data was selected for

review, reference was made to identification of data that providers already were required to collect through regulation or contractual requirements, data that already was being collected through current processes (e.g., licensing and support coordination), and data specifically referenced in the Settlement Agreement (e.g., data given as examples with regard to the eight domains). One of the challenges that members of Project Team #8 identified was expanding the sources of available data. The three major receptacles of data that existed were: 1) Support Coordination data at the 40 CSBs, including the electronic health records (EHRs); 2) CHRIS data; and 3) Licensing data. However, outside of these sources, the Project Teams found it difficult to identify sources of data, particularly ones that were reliable and valid. For example, private providers varied in their ability to collect usable data. An example of a specific area in which the Project Team #8 recognized data was difficult to collect related to employment. For employment, it appeared no specific requirements to collect data existed, and current processes (e.g., Support Coordination) only collected certain basic pieces of information. However, the Quality Improvement Committee recently had a national expert on employment come to speak and share methods that other states were using to collect such data. As housing options expanded, this was another area the group identified data sources will need to be identified and measures developed. Based on the Consultant's discussion with the DMAS Program Manager for the Developmental Disabilities Waiver, few formal data collection processes were in place for individuals receiving supports through the DD Waiver.

The following provide examples of areas in which expansion of the measures were needed: 1) for the "Safety and Freedom from Harm" section, five measures were included, including: neglect and abuse reports, injuries, deaths, use of seclusion or restraints, and licensing violations. However, examples of protection from harm indicators that were not included are: unexpected hospitalizations, elopements/missing persons, law enforcement contacts/arrests, etc.; and 2) the only indicators in the section on "Provider Capacity" addressed CSB case manager caseloads and staff turnover, but capacity indicators such as training or competencies to provide services were not included. Part of what should be considered in expanding the scope of what is measured is for quality improvement efforts to be designed from a proactive rather than a reactive approach. For example, in looking at "Safety and Freedom from Harm" and "Avoiding Crises" all of the indicators appeared to be negative outcomes or reactive. As further development of indicators occurs, consideration should be given to including proactive measures. Example might include the percentages of individuals for whom behavior supports are effective at reducing the number of target behaviors or increasing the use of replacement behaviors.

As noted above, members of Project Team #8 viewed the development of indicators as an ongoing process. For example, in addition to the DOJ Settlement Agreement Domain document, the Commonwealth submitted a document outlining licensing data collection and reporting ideas. This document identified additional measures that potentially could be pulled from the data generated through licensing reviews. The Commonwealth should continue to identify and/or develop relevant sources of data, and expand the measures to assess and improve quality.

- It will be important to measure the quality of services and supports as opposed to just their presence or absence. As noted above, due to the lack of definitions, it was not always clear what would be measured, for example, in indicators such as "Access to Medical Care," and "Use of Crisis Services."

- In addition, some of the indicators in the draft relied on individuals' ISPs as the basis for measuring whether or not individuals were receiving required supports, such as: "Extent to which health outcomes in ISP have been met – 3 point scale at quarterly case management ISP review." However, based on discussions with members of Project Team #8, the quality of ISPs varied greatly. If the ISP documents did not adequately describe individuals' needs or skills, then a measurement based on whether the ISP outcomes were being met would not produce valid data. No process/output indicators were included in the draft to address the quality of the ISPs.
- Unlike the Dashboard the Commonwealth provided, the Commonwealth's "DOJ Settlement Agreement Domains" document did not include a definitions section. The definition section on the Dashboard for the case management indicators identified specifically what would be measured and the formula that would be used (i.e., numerator and denominator). Due to the lack of definitions on the Domains document, it was often difficult to determine what the Commonwealth intended to measure and whether or not the items on the list adequately captured what should be measured. Examples of this included: 1) under "Physical, mental and behavioral health and well being," two of the indicators read: "Access to Medical Care (Medication)" and "Access to Medical Care (Doctors Visits)," but without further definition, it was not clear specifically what would be measured; and 2) one of the indicators under the "Avoid Crises" section read: "Use of Crises Services" and the source of the data was START data, but without further definition, it was not clear specifically what this would measure or what breakdown of data would be used/provided. It will be important moving forward to provide definitions of what will be measured.
- The draft contained a source of data (i.e., where the data were maintained). For many of the indicators, however, it will be important to detail the methodology to collect the data, and to ensure data are collected the same way each time. For example, as noted above, a number of indicators relied on Case Managers/Support Coordinators to conduct reviews to determine if outcomes included in the ISP had been met. As an example, based on review of the Community Consumer Submission 3 (CCS 3) Extract Specification document, case managers were to assess the measure that read: "Extent to which health outcomes in ISP have been met – 3 point scale at quarterly case management ISP review" by using the following methodology: identify "the extent to which desired physical, mental, or behavioral health outcomes in the individual's ISP have been met as determined by the individual, authorized representative if the individual cannot determine this, and case manager during the quarterly case management ISP review; collected and reported quarterly only for individuals receiving developmental services under the DOJ Settlement Agreement." A six-point scale was then provided, including the following options: Measure met – most goals were met; Measure partially met – some goals were met; Measure not met – no goals were met; Not applicable – use for all other individuals receiving services; Unknown – asked but not answered; and Not collected – not asked. Although this set forth a methodology, the methodology raised many questions about the reliability and validity of the data that would be collected. For example, use of terms such as "some" and "most" could result in unreliable scoring between various reviewers. Similarly, asking a question of an individual or his/her representative about the provision of a service is an important perspective, but is somewhat subjective. In addition, no specific methodology was outlined for the case manager's review (e.g., review of specific records), or the standards that they would use to judge conformance with the indicator. The 8/21/13 minutes of the

Quality Improvement Committee indicated, however, that: "The Project 9 team will be developing guidance for case managers to help them collect this data consistently."

- As noted above, limited data were available for individuals enrolled in the DMAS DD Waiver. However, some efforts were underway to educate the DD Case Managers about the requirements of the Settlement Agreement and the Commonwealth's efforts to collect needed data. On 9/10/13, an IFDDS Waiver Case Managers' Meeting was held. Amongst other topics, members of the various Project Teams presented information on: Settlement Agreement Case Management Guidelines and Case Management Data; Independent Housing, and Case Management Expectations; Employment, and Case Management Expectations; and Quality Service Reviews.

Members of Project Team #8 indicated that the focus over the next six to 12 months would be to expand the review and analysis of the data collected. Based on review of the DBHDS Quality Improvement Committee minutes for the months of January through July 2013, some discussions were occurring regarding the data, and, in some instances, some actions to address trends were beginning to be identified and implemented. For example, data were being shared with regard to founded/substantiated abuse and neglect allegations, although in-depth analyses had not yet been presented. With regard to mortality reviews, some analysis had occurred of data generated from these reviews as well as serious injury data. As a result of the QI Committee's discussions about the findings from these analyses, Safety Alerts had been issued to address choking, aspiration, and constipation; psychotropic medication; and when to access medical care. This was an example of good use of data that had resulted in efforts to improve supports provided to individuals.

One future challenge that members of Project Team #8 shared was ensuring that as quality issues were identified, DBHDS had the resources to assist providers. In addition to two QI Specialists (i.e., at the time of the review, one of the two had been hired), other Commonwealth staff working with providers included the Licensing Specialists, and Community Resource Consultants. One activity on which members of Project Team #8 were working was to better define the roles of these various staff, particularly with regard to the provision of the education and technical assistance that likely would be necessary as data analyses began to identify areas in need of improvement. This proactive approach should be helpful as quality improvement initiatives expand, and QI staffing resources should continue to be assessed.

In summary, the Commonwealth had made progress in initiating the identification of data to assess and improve quality. However a number of challenges still need to be overcome. The following is a summary of the recommendations related to these efforts:

- The Commonwealth should continue to identify and/or develop relevant sources of data.
- For each of the indicators identified for the DOJ Settlement Agreement Domains, in addition to identifying the data source, definitions and methodologies should be developed; as appropriate, baselines or benchmarks should be identified; and targets or goals should be set.
- At a minimum and as appropriate to the particular indicator, the methodology section should include the following: 1) how the data will be collected (e.g., through a monitoring tool, through review of records, through a database, through review of the implementation of individuals' ISPs, etc.); 2) how often and when (e.g., end of month, within first five days of month for preceding month, etc.) the data will be pulled; 3) what the schedule is for assessing

data reliability and validity, and who will be responsible for this; 4) what subpopulation or percentage of the population will be included in the sample (e.g., 100% or some lesser, but valid sample); 5) the standards that will be applied to judge conformance with the measure; 6) who will be responsible for collecting and/or reporting the data; 7) clear formulas for calculating the indicator/measure, including for example how the "N" and "n" will be determined, and what mathematical or statistical procedures will be used (i.e., this might be included in the definition discussed above); and 8) who will be responsible for analyzing the data.

CMS-approved Waiver Quality Improvement Plan

Based on discussions with members of Project Team #8, in developing data to assess and improve quality, the Commonwealth was not relying on its CMS-approved plan. As described above, efforts were being made to identify data independent of the CMS requirements.

The Assistant Commissioner of Quality Management and Development indicated that an overall Quality Improvement Plan was in development. It will be important in this plan to define the various components of the quality improvement system, and their relationships to one another. This will be an appropriate document in which to describe the relationship between the quality improvement efforts described in the CMS-approved Waiver(s), and those designed to address the requirements of the Settlement Agreement.

Regional Quality Councils

Based on the interview with members of Project Team #8, as of the last week of September, all five Regional Quality Councils (RQCs) had had initial meetings. Three of these had occurred in August, and two in September. Some work was still being done to ensure broad membership on the RQCs. Reportedly, there had been significant interest in becoming a member of the RQCs. Some of the RQCs had individual or family members. All of them had private provider and CSB representation, including some members with quality improvement experience.

Based on review of minutes from some of the initial meetings, the Assistant Commissioner of Quality Management and Development, and/or the Case Management Coordinator had attended the meetings. Time had been devoted to reviewing the members' responsibilities, the relationship between the RQCs and the DBHDS Quality Improvement Council, and some sample data.

Moving forward, the two QI Specialists (i.e., one had been hired and recruitment was ongoing for the second) and Data Analyst were expected to attend the RQC meetings and provide support to the groups. In addition, it was anticipated that the Assistant Commissioner of Quality Management and Development, and/or the Case Management Coordinator also will remain involved with the groups.

One question that remained to be resolved was whether or not the RQC meetings were considered public meetings. As discussed during the interview, although it is often helpful to have public input, in making this decision, consideration should be given to the need for open discussion at RCQ meetings, including, at times, the need to share confidential information related to trends involving providers or even individuals.

Commonwealth staff identified one next step as the development of communication plans for the RQCs. It will be important to ensure that information is shared appropriately with various constituents, that those involved in surveys and other data collection activities have information about how the data is being used, and that the information necessary to make needed changes to the system is clearly communicated.

Public Report on Availability of Services

Based on a discussion with the Settlement Agreement Executive Advisor and the Director of Training Center Discharges and Community Integration, a report had not yet been published on the availability of services, including the number of people served in each type of setting. However, some activities were underway to assist the Commonwealth in identifying the needs of individuals at the Training Centers, and to a lesser degree, individuals in the community in need of services. More specifically:

- With regard to individuals residing at the Training Centers, Individual Needs Profiles were developed for all individuals on the active move list. The Active Move List was based on the Training Center closing schedule and the annual targets for numbers of individuals scheduled to transition to the community from each facility. If other individuals requested a transition, they also had an Individual Needs Profile developed, and were placed on the Active Move List.

The Individual Needs Profile was a brief survey that asked questions about the individual's preference for where he/she wanted to live, the type of setting in which he/she wished to live, his/her day/vocational needs, whether or not an accessible setting was needed, the individual's staffing needs, and other major needs (e.g., related to medical/therapy and behavioral needs). Using the information from the Individual Needs Profiles, the Commonwealth populated the "List of Individuals Seeking Community Services Providers." This list was published on the Developmental Services page of the DBHDS website (i.e., http://www.dbhds.virginia.gov/ODS-default.htm).

Providers also were surveyed to determine the types of supports they could provide, the areas in which they had homes or programs, and the size of homes or programs. Providers interested in being considered to support individuals on the list could complete this survey online. They also could contact the CSB and/or Training Center directly using the information provided on the list. Information about providers that could meet the individuals' needs was given to individuals and their guardians for their consideration. Licensing reportedly verified the information on completed provider surveys.

The data on this list could be sorted to provide more information about individuals looking for certain types of supports, types of settings, in particular parts of the state, or with particular needs. Barriers or gaps in services were identified when an individual was looking, but could not find supports and services to meet his/her preferences or needs. When this occurred, the Regional Support Team was consulted to assist in problem solving. In the past quarter, approximately 50 individuals with such barriers were referred to the Regional Support Teams. Information about barriers or gaps was being shared with the regional staff and CSBs. Although not yet happening, the

intention also was to share this information with the DBHDS Quality Improvement Committee, to provide input on systemic gaps or trends that need to be addressed.

Of note, in some instances, providers had indicated that they could provide services to some of the individuals on the list, but not within the current rate structure. The Director of Training Center Discharges and Community Integration explained that for specific individuals falling into this category, DBHDS was working with particular providers to describe the services and supports needed and develop corresponding budgets. Once concrete budgets are available, the next step reportedly will be to determine if funding could be obtained to fill the gap.

- With regard to individuals currently in the community and on the list for obtaining Waiver services, less data were available. According to the Settlement Agreement Executive Advisor, for years, anecdotal information had been available, but beginning in January 2013, more specific information began being collected, particularly for individuals meeting certain criteria (e.g., individuals living with five or more individuals, individuals applying for admission to the Training Centers, etc.). Specifically, the Regional Support Teams began collecting information about gaps for these priority groups.

In summary, at the time of the review, the Commonwealth was collecting some important data for individuals at the Training Centers, and making referrals to Regional Support Teams when supports were difficult to locate. Some data were beginning to be collected for other individuals in need of services. The Commonwealth had not yet published a report. However, a report to the General Assembly is due in the coming month, and will include some of this information, particularly related to individuals transitioning from the Training Centers.

e. Providers (Section V.E)

1. The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of this Agreement.

2. Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3 above. The measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from the Regional Quality Councils, described in Section V.D.5 above. The DBHDS quality improvement committee will assess the validity of each measure at least annually and update measures accordingly.

Although it was too early to review provider QI systems (i.e., Section V.E.1), within 12 months (i.e., March 6, 2013), Section V.E.2. requires the Commonwealth to identify measures that CSBs and community providers are to report. Similar to the review of data to assess and improve quality, the goal of the Consultant's review was to obtain a status of these efforts, including any review of data by the Commonwealth QI Committee or the Regional Quality Councils. A status was to be obtained of the actions the Commonwealth had taken to notify providers of their responsibilities, its plans to determine what actions providers had taken to implement these requirements, as well as its plans to determine providers' compliance with the requirements.

In terms of providers' responsibilities related to operating quality improvement programs, the Settlement Agreement set forth the requirement for providers to monitor and evaluate service quality, and referenced the DBHDS Licensing Regulations at 12 VAC 35-105-620. Specifically, the regulations required: "The provider shall implement written policies and procedures to monitor and evaluate service quality and effectiveness on a systematic and ongoing basis. Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality assurance system. The provider shall implement improvements, when indicated."

As noted in the sections above, the Commonwealth had made some progress, but still was in the process of finalizing drafts of the data it intended to collect. Some of the data providers will be responsible to collect had been identified, but in order to address the requirements of the Settlement Agreement, additional data will likely be required from providers.

In addition, Regional Quality Councils had recently had their first meetings. Either the DBHDS Assistant Commissioner of Quality Management and Development, or the Case Management Coordinator attended each of these meetings. Part of what they discussed was the need for RCQs to develop and implement communication plans. This communication reportedly will include information about providers' responsibilities related to their quality improvement programs.

It was anticipated that providers will have different levels of sophistication regarding their quality improvement processes. For example, the CSBs and many of the larger providers had operating QI Departments, but some, particularly smaller providers, might need additional support and guidance to set up and implement the necessary processes. Once expectations were clearly set in relation to quality improvement processes, and technical assistance and guidance had been provided, the Office of Licensing will have a role in ensuring providers are compliant.

The Assistant Commissioner of Quality Management and Development, and the Case Manager Coordinator also had held meetings with each of the 40 CSBs. During these meetings, DBHSD staff provided an overview of some changes occurring as a result of the implementation of the Settlement Agreement, including the role of Support Coordinators. As referenced elsewhere in this report, Support Coordinators collected some of the data the various Project Teams had identified as necessary for the quality improvement process. These meetings also were used to collect information from each CSB about some specific changes they were making, as well as the challenges they were facing. As a result of some of the information collected, the Commonwealth was working with DOJ and the Independent Reviewer to review and potentially make changes to some of the case management requirements. These meetings illustrated the Commonwealth's commitment to

proactively work with providers, including CSBs, to share information, identify challenges, and constructively work to overcome any concerns identified.

In summary, the Commonwealth was at the beginning stages of developing and implementing a communication plan to convey to providers their roles and responsibilities for maintaining necessary quality improvement processes, and to share data with the Commonwealth. Some of the mechanisms for reviewing provider data were just being developed, such as the RQCs.

f. Quality Service Reviews (Section V.I with focus on V.I.1.a)

1. The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. QSRs shall collect information through:

- *c. Face-to Face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and*
- *d. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.*

2. QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on the individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.

3. The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.

4. The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.

The goal of the Consultant's review was to provide comments on the Virginia-specific questions for individuals, families, and providers, and to review plans and report on the status of planning efforts for the overall system. Comments also were to be provided on the adequacy of the Commonwealth's process for selecting a statistically significant sample.

Status of Planning Efforts for Overall System

Based on review of the minutes for Project Team #15 as well as interview with some of the members of the Team, the Commonwealth had made the decision that the National Core Indicators (NCI) Survey Process would be used to conduct the Quality Service Reviews the Settlement Agreement requires. Although the NCI process will help the Commonwealth to collect valuable data, it will not meet the requirements of the Settlement Agreement in relation to the Quality Service Reviews. The following summarizes the Settlement Agreement requirements that did not appear to be addressed through the NCI process:

- The Settlement Agreement requires the QSRs to collect information through: "Face-to Face interviews of the individual, relevant professional staff, and other people involved in the individual's life." Although the NCI process collected information through face-to-face interviews with individuals, the process did not include face-to-face interviews with relevant professional staff. In fact, during the face-to-face interviews with individuals, staff was only to be present if the individual requested assistance, could not answer for him or herself, or had needs that required the assistance of staff (e.g., behavioral or medical). Even when staff was present, they were only to assist the individual in answering questions. In order to address the requirements of the Settlement Agreement, interviews need to be conducted with a number of professional staff (e.g., direct support professionals, management staff, healthcare staff, etc.). With regard to other people involved in the individual's life, mailed surveys would be sent to all guardians and/or family members, but these did not involve face-to-face interviews.
- The Settlement Agreement requires the QSRs to collect information through: "Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers." The NCI process did not include a comprehensive review of treatment records, and included no review of incident/injury data, key-indicator performance data, compliance with service requirements of the Settlement Agreement, or contractual compliance. Again, although the NCI Individual Survey and Guardian/Family survey process will generate some valuable data, it was essentially a satisfaction survey of individuals and their guardians/families. In fact, the introduction included in the NCI Adult Consumer Survey for 2013-2014 – Virginia tool identified Section I of the tool as a satisfaction survey to be completed only by the individual. Based on review of the survey tools, some information was gathered from records in the "Background" section, but this was largely demographic information and/or information about the types of supports provided, and timeliness of supports (e.g., medical appointments and preventative tests, such as colonoscopies). This did not represent a comprehensive record review to assess the quality of supports and services provided. Section II of the tool focused on individuals' community integration, choice, and rights. Again, these were important questions to ask the individual. However, the assessment did not include any record review to confirm responses, comparison of responses to the expectations in the individual's ISP, or other objective assessment. Similarly, the NCI Adult Family Survey for 2013-2014 – Virginia asked for some demographic information, but the majority of the questions related to the individual and family's access to and satisfaction with services and supports.
- The Settlement Agreement also requires QSRs to: "evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building

on the individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals)." Again, although the NCI process assessed individuals' and their families' satisfaction with their supports and services, the Settlement Agreement described a broader review to assess the adequacy of the person-centered planning process, and the provision of supports and services outlined in the plans. Determinations regarding "most integrated setting" take into consideration the individual and guardian's wishes, but also require input through professional assessments. Often individuals and their guardians/families are not aware of all of the options available, and review of the individuals' assessments and ISPs would be necessary to determine whether or not they were provided with information with which to make an informed choice.

Within the context of a broader Quality Service Review structure, the NCI Survey potentially could provide the valuable information the Settlement Agreement requires related to the face-to-face interview with the individual. However, it will not meet the overall requirements for the QSRs. However, the following provides a summary of the current status of the NCI Survey in Virginia:

- The VCU Partnership for People with Disabilities had been selected as the vendor to implement the survey process.
- As described in further detail below, a sampling methodology had been developed and used to select the sample of individuals for the Individual Survey. A Guardian/Family survey also was being conducted, and it would be mailed to all guardians/families in the spring of 2014. Two provider surveys were in draft format, including one entitled: "Access to Services and Supports Survey," and the other "Staff Stability Survey." These also would be completed in the spring of 2014. It was anticipated that data from these surveys will be used to address some of the domains for the data to assess and improve quality that will be reported to Regional Quality Councils and the DBHDS QI Committee. The provider surveys likely will be completed online, and a sample size had not yet been decided upon.
- In addition to two part-time Co-Investigators, the Partnership for People with Disabilities was hiring five part-time paid Regional Coordinators. At the time of the Consultant's interview with Commonwealth and VCU staff, both Co-Investigators and most of the Regional Coordinator positions had been filled. Recruitment also was underway for interviewers, who were paid a stipend for each review they completed.
- The next step was to provide training to the interviewers. Training was going to be offered in each of the five regions, and was anticipated to include role-plays and time for questions. The goal was to begin training in October 2013, and for individual face-to-face interviews to occur between November 2013 and May 2014.
- Prior to completing the face-to-face interviews, contact information needed to be completed; and once interviews were scheduled, background information was completed. The contact information was necessary to allow the interviewer to set up an interview, as well as to be prepared for the interview (e.g., identify whether translation services were needed, identify needed staffing supports, etc.). The background information was fairly extensive. Some CSB staff had completed this information for a smaller sample in years past. However, due

to an increased sample size and individuals in more service types (e.g., individuals in nursing homes, DD Waiver participants, etc.), VCU was conducting outreach and providing training to groups that would need to assist in the completion of this information, such as DD Case Managers. Complete background information was important to allow more extensive analysis of the data.

- A look-behind process was built into the NCI survey activities. For a five percent sample of interviews, two interviewers would sit in, but only one would conduct the interview. However, both interviewers would complete the survey instrument. In addition, the second interviewer would check to ensure that the checklist for interviewers was being followed. The data both interviewers collected would be compared. Discrepancies would be reviewed, and trends in discrepancies would be analyzed to determine if more training was needed for particular questions. The process described appeared to provide an appropriate inter-rater reliability system.

In discussing some of the challenges, members of Project Team #15 indicated that:

- Finding ways to communicate the results of the surveys and the ways in which data were used to change the system would be an important next step. As they stated, this would require identifying different forums, such as self-advocacy groups, family meetings, etc., and tailoring the message to meet the needs of various audiences. The group was soliciting ideas about what other states participating in NCI had done in this regard.
- Another challenge was the need to involve different groups in this year's survey, including, for example, individuals and staff from nursing homes and the DD Waiver.

Virginia-specific Questions:

Minimal changes were made to the NCI survey tools. Some additional changes were being considered for future surveys, but these also were minimal. These changes did not substantially modify the tools, and the Consultant offers no specific comments. The following were the changes that were made to the 2013-2014 tools:

1. Codes for groups of individuals receiving services under the Settlement Agreement:
    - ID waiver
    - IFDDS (DD) waiver
    - community ICF/ID
    - nursing facility
    - current training center resident
    - training center discharge with code identifying from which training center the individual was discharged

2. CSB and region codes for residence of individuals receiving services

Additions to the Individual Survey

Has your case manager told you about options or opportunities for working in the community? (Employment First) – Section 1 (Yes/No/Not Applicable/Not Sure)

Has your case manager told you about options or opportunities for living in your own home or apartment? – Section 1 (Yes/No/Not Applicable/Not Sure)

Do you know who to talk to if you have a problem with your support coordinator/case manager? – Section I

Additions to Family Surveys

If services received by the person are self-directed, agency-directed, or both (Agency directed means services that an agency provides and is the employer of the direct support professionals doing the service. Consumer directed services means that the consumer is the employer of record and hires the direct service personnel to work for them on their behalf):

Did this person or you choose his/her doctor?

Do you know who to talk to if you or this person have a problem with his/her case manager?"

Statistically Significant Sample

Based on review of the document entitled: "National Core Indicators (NCI) Individual Survey Methodology" and interview with members of Project Team #15, the total population of individuals the Settlement Agreement covers was calculated to be 11,185. The group indicated that this number was arrived at using data that DMAS provided through its reimbursement database. To select a representative sample, VCU calculated the sample size to be 371 individuals with a confidence level of 95%, and a confidence interval of five. The NCI requirement for a minimum sample size was 400. The decision was made to double this minimum sample size for a target sample of 800 individuals. In addition, all individuals discharged from Training Centers on or after October 13, 2011 would be included in the sample.

A formula then was used to calculate the percentages of individuals in each region supported in the various program groups (i.e., Training Centers, nursing facilities, ID Waiver, DD Waiver, and community Intermediate Care Facility). These percentages were then used to select proportionate samples for each Region from each of the various program groups. These numbers were doubled. This took into consideration that some individuals would decline to participate, others would have died or left the state, or contact information would be out-of-date; so fewer surveys would be completed than individuals in the sample.

Therefore, the samples selected for 2013-2014 totaled 1599 individuals in the main sample, and 204 individuals who had been discharged for six months or more from the Training Centers since October 2011. According to VCU staff, the NCI-required 400 individuals would have resulted in a 3% sample size, and although they believed this would provide a representative sample size at the

Commonwealth-level, it would not necessarily be representative at the Regional-level. By doubling the base sample to 800, however, and then accounting for some non-participation by doubling the number again, they believed the samples would be large enough to provide usable information at both the Commonwealth and Regional levels.

In summary, the Commonwealth had made progress in initiating the use of the NCI Survey tools to collect some important data. However, these reviews were not consistent with all of the requirements included in the Settlement Agreement in relation to Quality Service Reviews. The following recommendation is offered:

- The Commonwealth should review the specific requirements in the Settlement Agreement for the Quality Service Reviews, and either add to the NCI process or replace it with an alternative.

CONCLUSIONS

In conclusion, the Commonwealth had made progress with regard to a number of the Settlement Agreement requirements for a quality and risk management system. Clearly, there was a strong commitment to and excitement about the numerous initiatives underway to strengthen the Commonwealth's quality improvement processes for individuals the Settlement Agreement covered. The Project Team format had been helpful in involving many different perspectives in the development of the various system change efforts, including staff from DBHDS, DMAS, private provider agencies, and CSBs. The Team Leaders also appeared to keep the momentum going for achieving goals set forth for each Project Team.

A number of challenges remained ahead. As described in this report, many of the initiatives were in the beginning phases of implementation. Strong training will be a necessity for many of the changes to be successful. In addition, an overarching theme found during this review was the need to expand the scope of data that is available from the system to allow comprehensive and meaningful quality improvement and risk management initiatives to occur.

APPENDICES

APPENDIX A – Acronyms

Acronym	Meaning
CCS	Community Consumer Submission
CHRIS	Computerized Human Rights Information System
CMS	Centers for Medicare and Medicaid Services
CSB	Community Services Board
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice
EBP	Evidence-Based Practice
EHR	Electronic Health Record
FY	Fiscal Year
HCBS	Home and Community-Based Services
ID	Intellectual Disability
IFDDS	Individual and Family Developmental Disabilities Services
ISP	Individual Support Plan
LMS	Learning Management System
NCI	National Core Indicators
QI	Quality Improvement
RQC	Regional Quality Council
SHAY	State Health Authority Yardstick
SMHA	State Mental Health Authority
VAC	Virginia Administrative Code

APPENDIX B – Interviews and Documents Reviewed

Risk Triggers and Thresholds (Section V.C.1)

Interview: On September 17, 2013, at 2:00 p.m., with Marion Greenfield, DBHDS, Director of Clinical Quality and Risk Management; Ann Bevan, President, Virginia Network of Private Providers, Inc.; and Denise Dunn, DBHDS, Abuse Neglect Investigations Manager and Chief Privacy Officer.

Documents Reviewed:

- Project Team #11 –Provider Risk Management Team Meeting Agendas, for meetings on 12/20/13, 1/3/13, 1/17/13, 1/31/13, 2/14/13, 2/28/13, 3/14/13, 3/28/13, and 4/11/13;
- Project Team #11 –Provider Risk Management Team Meeting Minutes, for meetings on 12/6/12, 12/20/12, 1/3/13, 1/17/13, 1/31/13, 2/14/13, 2/28/13, 3/14/13, 3/28/13, 4/11/13, 5/9/13, 6/6/13, and 7/11/13; and
- Draft Triggers and Thresholds dated 1/9/13, 1/17/13, 2/14/13, 2/28/13, 3/14/13, 4/1/13, 5/8/13, 7/11/13, and 8/8/13.

Web-based Incident Reporting System and Reporting Protocol (Section V.C.2)

Interview: On September 18, 2013, at 9:00 a.m., with Margaret Walsh, DBHDS, Director of Office of Human Rights; Karen Moten, DBHDS, Data Analyst; and Keven Schock, DBHDS, Associate Director of Licensing.

Documents Reviewed:

- Project Team #12 – Critical Incidents (CHRIS Implementation) Meeting Minutes, for meetings on 12/10/12, 12/19/12, 1/7/13, 1/14/13, 1/22/13, 2/4/13, 2/13/13, 2/12/13, 3/4/13, 3/11/13, 3/18/13, 4/1/13, and 5/6/13;
- CBS Detailed Alleged Occurrences from CHRIS for Second Quarter Fiscal Year (FY) 2013;
- Facility Detailed Alleged Occurrences from CHRIS First Quarter FY 2013;
- Facility Detailed Alleged Occurrences from CHRIS Second Quarter FY 2013;
- Provider Detailed Alleged Occurrences from CHRIS Second Quarter FY 2013;
- Individual Reported Abuse from CHRIS Second Quarter 2013 - CSB by location;
- Individual Reported Abuse from CHRIS Second Quarter 2013 – Facility by location;
- Individual Reported Abuse from CHRIS Second Quarter 2013 – Provider by location;
- Information on DBHDS Website regarding CHRIS, including User's Guide, Frequently Asked Questions, guidance regarding medication errors and serious injuries, and training modules;
- Status of Abuse Cases Summary Quarterly – Actual Numbers FY 2013;
- Status of Abuse Cases Summary Quarterly – Per 1000 Cases First Quarter 2013; and
- Status of Abuse Cases Summary Quarterly – Per 1000 Cases Second Quarter 2013.

Investigation of allegations and critical incidents (Section V.C.3)

Interview: On September 17, 2013, at 3:00 p.m., with Marion Greenfield, DBHDS, Director of Clinical Quality and Risk Management; Ann Bevan, President, Virginia Network of Private Providers, Inc.; Denise Dunn, DBHDS, Abuse Neglect Investigations Manager and Chief Privacy Officer; and Keven Schock, DBHDS, Associate Director of Licensing.

Documents Reviewed:

- Draft DBHDS Investigation Process PowerPoint, dated 6/21/13; and
- Draft Root Cause Analysis: A Brief Overview of the Analysis Process.

Data to Assess and Improve Quality (Section V.D)

Interviews:

- On September 24, 2013, at 11:00 a.m., with Kathy Drumwright, DBHDS, Assistant Commissioner, Quality Management and Development; Paul Gilding, DBHDS, Director of Community Contracting; Dee Keenan, DBHDS, Case Management Coordinator; and Lester Saltzberg, DBHDS, Director of Licensing;
- On September 27, 2013, at 9:00 a.m., with Jae Benz, DBHDS, Director of Training Center Discharges and Community Integration; and Heidi Dix, DBHDS, Settlement Agreement Executive Advisor; and
- On September 27, 2013, at 2:00 p.m., Sam Pinera, DMAS, Program Manager for Developmental Disabilities Waiver, and Liaison with DBHDS.

Documents Reviewed:

- DBHDS, Quality Improvement Committee Meeting Minutes, dated 1/31/13, 3/5/13, 4/16/13, 5/21/13, 6/18/13, 7/25/13, and 8/21/13;
- Project Team #8 – Quality Improvement and Data Analysis Meeting Agendas, for meetings on 2/14/13, 3/26/13, 6/20/13, and 8/21/13;
- Project Team #8 – Quality Improvement and Data Analysis Meeting Minutes, for meetings on 12/5/12, 1/11/13, 2/14/13, 3/26/13, 4/26/13, 6/20/13, and 8/21/13;
- Community Consumer Submission 3 Extract Specifications: Version 7.1 Revision 1, selected pages, dated 9/12/13;
- DBHDS Data Dashboard with data for May 2013 and July 2013, including charts for data related to completion of face-to-face and in-home developmental case management services;
- DBHDS Draft DOJ Settlement Agreement Domains, dated 7/31/13;
- Draft Licensing Data Collection and Reporting, undated;
- Agenda for Individual and Family Developmental Disabilities Services (IFDDS) Waiver Case Managers Meeting, for meeting on 9/10/13;
- Falls with Injuries graph for Training Centers, for 1st Quarter 2012 to 1st Quarter 2013;
- Death per Patient Day graphs for Training Centers, from 1/1/11 to 3/31/13;
- Events with Injuries graphs for DBHDS Hospitals, from 1/1/12 to 3/31/13;
- Falls with Injuries graphs for Training Centers, DBHDS Hospitals, and Specialty Facilities, from 1/1/12 to 3/31/13; and
- Reported Deaths graph for Training Centers, from 1/1/11 to 3/31/13.

Providers (Section V.E)

Interview: On September 25, 2013, at 9:00 a.m., with Kathy Drumwright, DBHDS, Assistant Commissioner, Quality Management and Development; and Dee Keenan, DBHDS, Case Management Coordinator.

Documents Reviewed:

- DBHDS, Quality Improvement Committee Meeting Minutes, for meetings on 1/31/13, 3/5/13, 4/16/13, 5/21/13, 6/18/13, and 7/25/13;
- Project Team #8 – Quality Improvement and Data Analysis Meeting Agendas, for meetings on 2/14/13, 3/26/13, 6/20/13, and 8/21/13;
- Project Team #8 – Quality Improvement and Data Analysis Meeting Minutes, for meetings on 12/5/12, 1/11/13, 2/14/13, 3/26/13, 4/26/13, and 6/20/13;
- Spreadsheet for DBHDS meetings with CSBs in April and May 2013;
- Agenda and meeting minutes for Region II Regional Quality Council, for meeting on 8/29/13;
- Agenda and meeting minutes for Region IV Regional Quality Council, for meeting on 8/22/13; and
- Agenda and meeting minutes for Region V Regional Quality Council, for meeting on 8/16/13.

Quality Service Reviews (Section V.I with focus on V.I.1.a)

Interview: On September 16, 2013, at 11:00 a.m., with Charline Davidson, DBHDS, Director of Planning and Development; Tera Yoder, Associate Director, VCU, Partnership for People with Disabilities; Parthenia Dinora, Director of Research and Evaluation, VCU, Partnership for People with Disabilities.

Documents Reviewed:

- 2013 Contract between DBHDS and Virginia Commonwealth University Partnership for People with Disabilities for the Quality Service Reviews;
- Project Team #15 – Quality Service Reviews Meeting Minutes, for meetings on 12/3/12, 1/7/13, 1/14/13, 2/12/13, 3/5/13, 3/26/13, 4/18/13, 5/29/13, 6/18/13, and 8/6/13;
- Project Team #15 – Quality Service Reviews Meeting Agendas, for meetings on 3/5/13, and 3/26/13;
- Project Team #15 – Quality Service Reviews Membership, dated April 2013;
- National Core Indicators, Adult Consumer Survey, 2013-2014;
- National Core Indicators, Adult Family Survey, 2013-2014;
- National Core Indicators, Children/Family Survey, 2012-2013;
- National Core Indicators, Family/Guardian Survey, 2012-2013;
- National Core Indicators, Individual Survey Sample Methodology;
- National Core Indicators Process for Fiscal Year 2014 Surveys;
- Virginia Process for National Core Indicators, dated August 2013;
- Quality Service Reviews, DD Case Manager Training, dated 9/10/13;
- Draft Quality Service Review Developmental Services Provider Survey: Access to Services and Supports, dated 8/22/13;

- Draft Quality Service Review Developmental Services Provider Survey: Staff Stability Survey – Residential and Day Services Direct Support Staff and Case Managers/Support Coordinators, dated 8/22/13;
- Virginia-Specific Questions to the 2013-2014 National Core Indicators Individual and Family Surveys; and
- Virginia-Specific NCI Survey Questions May 2013 - Annotated with Human Services Research Institute (HSRI) Recommendations on 9/16/13.

APPENDIX C – SHAY Rating Tool

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

1. EBP Plan

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

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

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

Score

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

Evidence Used to Justify Rating:

Pieces of a plan were in place, and as discussed in detail in the body of the report, clearly planning had occurred for the initial phases of the implementation of all of the components of the quality improvement and risk management components included in this review. This was evident through the work of the Project Teams, and their ongoing methodical work to achieve specific milestones that had been established. However, many of the future implementation efforts remained in the development and planning stages, and based on discussions with staff, for some of these specific plans were being implemented, and for others, more planning was needed.

The DBHDS Assistant Commissioner of Quality Management and Development indicated that her office was in the process of developing an overall plan for the quality improvement efforts, but it remained in development and was not yet ready for review. This was positive, and once fully developed should be helpful in continuing to guide the course of the Commonwealth's efforts.

As identified in detail in the body of this report, initiatives that still were being developed included, for example, the strategies to communicate changes and requirements related to quality improvement initiatives to the full provider community, full incorporation of DMAS providers into the process, and a full set of training resources for providers. As indicated in the body of this report, some of the challenges included the limitations of the current data that were available due to the current regulations, and the potential need for additional resources at a number of different levels if this was to be expanded. A comprehensive quality improvement plan should include action steps to address these issues.

Roles of various agencies and offices had been partially defined. For example, the Office of Licensing was involved in many of the Project Teams, and its role in relationship to encouraging, and when necessary, enforcing certain requirements was being discussed and defined. However, although, DMAS was involved in some of the groups, their role and responsibilities seemed less defined.

Evaluation for implementation of the outcomes of the quality improvement efforts appears to be an area that will require additional planning.

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

4. Training: Ongoing consultation and technical support

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

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

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

5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine workflow, policies and procedures at the agency (minimum of three months, e.g., monthly x 12 months).

Score

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

Evidence Used to Justify Rating:

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

9. SMHA Leadership: Central Office EBP Leader

There is an identified EBP leader (or coordinating team) that is characterized by the following:

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

Score:

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

Evidence Used to Justify Rating:

At the time of the review, the DBHDS Assistant Commissioner of Quality Management and Development had been in her position for a year. She had worked in the intellectual/developmental system in the community for years and had joined DBHDS in September 2012.

The DBHDS Assistant Commissioner of Quality Management and Development had oversight of the eight Project Teams related to quality improvement efforts. Her full-time responsibilities related to these implementation efforts. She appeared to be well respected by team members. She had made efforts to reach out specifically to Community Services Boards to identify barriers to their successful completion of some of the new tasks that the Settlement Agreement required. When issues were identified with some of the case management responsibilities, she appropriately raised these through internal channels, and the parties were discussing them. The Assistant Commissioner was carefully selecting QI Specialists, which was important to ensure success in the long-term. In their absence, she had worked to set up the Regional Quality Councils and provide them with initial training/technical assistance, along with the Case Management Coordinator.

11. Policies and Regulations: SMHA

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

Score:

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

Evidence Used to Justify Rating:

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

- During discussions with members of Project Team #8 as well members of other Project Teams, when asked about how data was selected for review, reference was made to identification of data that providers already were required to collect through regulation or contractual requirements, data that already were being collected through current processes (e.g., licensing and support coordination), as well as data specifically referenced in the Settlement Agreement (e.g., data given as examples with regard to the eight domains). One of the challenges that members of Project Team #8 identified was expanding the sources of available data.
- The Settlement Agreement requires investigation of "reports of suspected or alleged abuse, neglect, critical incidents, or deaths." Although the Human Rights regulations required providers to investigate allegations of abuse, neglect, and exploitation, they did not require

them to investigate "critical incidents" or deaths. It was not yet clear how the Commonwealth will ensure the conduct of these additional investigations.

- Although regulations required providers to have "trained investigators" and conduct investigations, the regulations defined neither the specific training that investigators were to complete, nor the content or quality of the investigations beyond indicating that the preponderance of the evidence standard would be used, unless otherwise provided for by law.
- Based on review of documentation and discussion with members of Project Team #11, the decision was made to divide the triggers and thresholds into required and recommended (i.e. voluntary) categories due to the limitations on what providers currently were required to report based strictly on existing regulation and/or contract requirements. Many of the draft risk triggers and thresholds were dependent on harm actually occurring. Some examples included triggers related to self-injurious behaviors or decubitus ulcers for which medical attention was part of the trigger definition, and no precursors had been identified to try to prevent harm before it occurred. This again appeared to be due to the limited definition included in regulation of serious incidents that providers needed to report to the Commonwealth.

12. Policies and Regulations: SMHA EBP Program Standards

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

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

Score: **Not Rated**

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

Evidence Used to Justify Rating:

Based on the narrow focus of the current review, this could not be rated (e.g., contracts were not requested as part of the document request, nor were licensing reports to show what enforcement was occurring). In addition, given the early stage of implementation efforts, it is unlikely that clear evidence would yet be available of adherence to and/or enforcement of standards.